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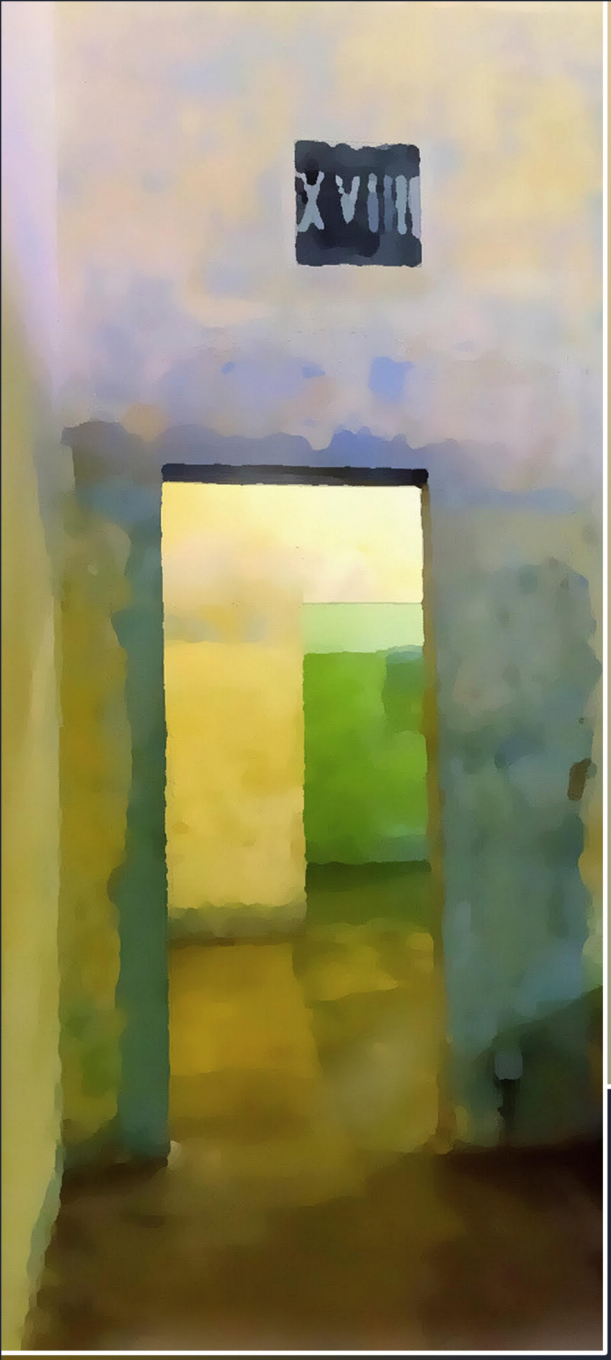

Special Issue

BIOETHICS AND THE HOLOCAUST

Guest Editors

Stacy Gallin & Ira Bedzow

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The Holocaust & (Bio-)Ethics Education: Setting the Context

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Abstract

Holocaust education is important for learning how healthcare has been leveraged to influence social change in the past and how it can be used to advocate for ethical social change in the future. By understanding how medical professionals became the social and political leaders of Nazi Germany, today's health professionals can learn how to avoid unethical politicization. By understanding how early twentieth century discourse on medico-social issues used terms and language that are similar, if not the same, as today's debates, proponents of different sides of these debates can understand the troubling subtexts and potential consequences of their – and the opposing side's – positions.

Key-words: *Holocaust education; health professionals; social discourse; bioethics*

Holocaust education has traditionally been seen as a topic of importance in modern Jewish history and, at times, modern European history, yet, regarding the latter, the Holocaust has been used as an example for the consequences of totalitarian politics. As the articles in this issue of *Conatus - Journal of Philosophy* convey, however, examination of the Holocaust simply as a Jewish historical event or as a component of political history misses the importance of Holocaust education as a means to learn how to confront ethical and medicalized social issues that are present in contemporary society. By examining and understanding how medical professionals became the social and political leaders of Nazi Germany and how they became instrumental in implementing the Final Solution, one can learn how the role of healthcare can be leveraged to influence social change. One may also learn how medical professionals themselves can mitigate the

dangers of falling into a politicized role that exacerbates social and political injustice. Similarly, by understanding how early twentieth century discourse on medico-social issues, such as eugenics, euthanasia, and the pathologizing of human diversity, used terms and language that are similar, if not the same, as today's debates on genetic enhancement, death with dignity, and the identity of people with particular (mental and physical) disorders or disabilities, proponents of different sides of the debate can understand the troubling subtexts and potential consequences of their – and the opposing side's – positions. Due to the importance of Holocaust education as a means to learn from history, and not simply to learn history, this issue hopes to show the practical relevance of the Holocaust and Holocaust education for learning tools and gaining social experience to confront the challenges of various medical and political issues contemporary society faces.

As editors for this issue, we would like to use this opportunity to provide some background into our own respective realizations that Holocaust education must necessarily cross boundaries and serve as a practical historical example from which to learn professional competencies and strategies for effective ethical social discourse.

I. Ira Bedzow's Story

I had been made aware of the importance of Holocaust education at a relatively young age, but it was not until I began teaching at a medical school that I realized how ubiquitous and imperative the need for Holocaust education really is. The necessity for Holocaust education is not simply for the sake of understanding the development of codes for ethical conduct in research or even the individual psychologies of those who suffer from trauma. Holocaust education is essential as a way to understand how connotations of medicalized language can push social and political agendas and the implications of those agendas if one does not have the tools to thwart them.

My grandparents and a few of their siblings survived the Holocaust. My grandmother outlived the death campaign in Sobibor, and my grandfather, great-grandmother, and great-aunt and -uncle fought in the Bielski brigade as partisans against the Nazis in the Naliboki forest. As a child, they did not speak of their experiences, yet as I grew to be a teenager, I heard more and more about how they lived when they were of a similar age. Their stories taught me about heroism, survival, and personal resilience and shaped my views on the choices that individuals can and do make. The social assumptions and political positions they held after the Holocaust also shaped what I perceived were ramifications of politicizing civil society and its subsumption by the state.

The major socio-political assumption that my grandparents and their siblings held, that still undergirds many contemporary debates in civil and political society, is an inherent distrust of acculturation. Their perceived inability to be fully accepted and to fully accept the countries which they called home led to a dissonant sense of identity and a deep skepticism in delegating to the state the authority to shape and reinforce social norms.

My grandparents and their siblings lived, and some continue to live, in New York, Atlanta, Miami, and Montreal. As immigrants they all quickly tried to adopt the American and Canadian ethos, to become as American and Canadian as their neighbors. Yet, at the same time that they were striving to live the American and Canadian dream, they continued to recognize that they were something other than American and Canadian. They also sensed that they were being recognized as different than American and Canadian by those around them. Partly, the recognition was driven by their desire to maintain their Jewish heritage and pass their religious and cultural traditions to their children. However, recognition was also due to nationalist or nativist sentiments that periodically grew in political strength, yet was ever present as an underlying social subtext, both in different parts of America and in Quebec. The assumption that, as minorities, they would never be truly accepted by the countries in which they lived, led each of them to be outwardly patriotic yet also proudly Zionist. Though they were grateful to the countries that gave them a new life, I believe that a component of their outward patriotism reflected their need to demonstrate that the country that accepted them, i.e. the people that were already there, did not make a mistake in letting them come. It was as if their patriotism reflected the need to assuage the doubt left by a contingent acceptance.

This sense of contingency was also a major component of their Zionism. Though very proud of the establishment of a Jewish state for religious and cultural reasons, they also possessed the sentiment that they could never be truly safe – physically and socially – unless there was a state to which they could flee if necessary, and they could not fully trust any state except for one that was governed by their brethren. This is not to say that they did not have friends and social relations with people of many different backgrounds. This is also not to say that they did not truly identify with the countries in which they lived. Rather, what this demonstrates is that they continued to see their relationship with their new homes through the lens of their experiences growing up in Eastern Europe, both before the onset of World War II and during the Holocaust. More importantly, it suggests that their experiences before, during, and after the Holocaust were different in degree but not in kind, such that they could make the connection.

I recognize that these perceptions are based on anecdotal evidence and that there cannot be an empirical study to determine whether the Holocaust

caused my grandparents and their siblings to hold these views or whether I am imposing a twenty-first century schema onto their twentieth century outlook. Yet, despite my reservations about the lack of scientific scrutiny to my observations and interpretations, I tell them for two reasons. The first is that these perceptions set the context for much of the research regarding the importance of Holocaust education today. As such, they are like clinical observations, where my recollection of the behavior of my grandparents and great-aunts and -uncles serve to form a hypothesis for further research and study. Indeed, many of the articles in this issue do just that, i.e. provide empirical and qualitative support to embed my suppositions into a larger theory. The second is that these observations align with what I have seen in medical school discussions, in terms of the underlying social and political premises that influence medical ethics and health policy debates. The main difference between the two is that my grandparents speak of their social assumptions in their own language, while the positions communicated in medical schools and other universities are communicated using medical (ethics) terminology and the language of public health.

There is one additional point to consider regarding my grandparents' and their siblings' experience. When minority groups, whether they are ethnic minorities or otherwise, are seen as "others" by majority groups, the volume of social discourse can impact the views of those very minority groups, who both learn to accept their own "otherness" as well as accept that "otherness" is an acceptable norm. This reinforcement of a divisive ethos creates further challenges to critically reflecting on established social norms and in delegating to the state, rather than to civil society, the power to prioritize social values.

Today, the underlying premise that differences create distinctions still undergirds many social and political debates, yet we are not as keen or as explicit as my grandparents in seeing the similarities between contemporary issues and those of their youth. One of the reasons for this is that, though the arguments and terminology used in today's debates are very similar to those that occurred in the early twentieth century, as a society, we do not have the same sense of history as those who have lived through both eras. Our education and our intellectual discourse do not take a long view of history, and when it does look past the present moment, it looks forwards and not backwards. History, like philosophy, has become an academic discipline whose relevance has been relegated to scholars and specialists rather than being seen as social capital, whose wealth of information can serve as lessons for the present and future. As such, medical and social issues that we face today are seen as innovative or *sui generis*, without comparison to what transpired in previous generations.

However, questions regarding the effects of immigration, how to define and ameliorate disabilities, how to distinguish between therapy and enhance-

ment, and how best to set the goals of public health are all questions that were debated in the twentieth century. Moreover, the medicalization of these debates is similar as well, both in terms of creating and using medical terminology to define and discuss the terms of the debate and in terms of health professionals taking the forefront in public discussions. Most importantly, however, is the fact that the underlying social conflict of how to consider people that are different than a (nationalist or nativist) ideal continues to be a major fulcrum for how one leans in the various debates.

It is for this reason that learning about the Holocaust is so valuable, both for medical school education and more generally. For medical training, the Holocaust is especially important because unlike any other genocide, the Holocaust was deliberately framed as a public health campaign. Physicians were the largest professional group to join the Nazi party and were the driving force behind the Holocaust, despite the fact that German medical schools set the standard of excellence for medical training at the time and the German medical profession had strong codes of ethics. Through learning why physicians so quickly joined the Nazi party and became so instrumental in promoting public health at the expense of their individual patients, today's medical students can learn how to avoid the same pitfalls as they become social advocates. As today's social debates continue to utilize medicalized terminology and to frame discussion in terms of public and population health, physicians become more vocal in pushing for social reform and have more power to assert their positions. Learning how to advocate in a way that speaks to public issues without losing professional integrity would be a valuable skill so as to be able to advance the discourse responsibly.

II. Stacy Gallin's Story

Ira's story represents a personal connection to the history of the Holocaust and the importance of that history for contemporary society. I, too, grew up in a Jewish household where I learned about the Holocaust both at home and in academic settings. I remember being told of the rabid anti-Semitism that overtook Europe while my grandparents were growing up and how they came to America looking for a better life. My grandparents survived, but their relatives did not. They were part of the six million who lost their lives because they were Jewish. As a young Jewish girl, I was constantly reminded of the sacrifices my ancestors made for our religion. I, in turn, developed a sense of responsibility to my ancestors to ensure that their fight for freedom, tolerance, and justice lived on through their descendants. Remember the past; protect the future.

As I grew older and learned more about the Holocaust, I realized that I still did not fully comprehend what took place during that time. The narrative

I had been taught remained the same: Hitler hated anyone who did not belong to the Aryan Race – particularly Jews – and eventually devised a plan to exterminate the entire Jewish population. It wasn't until my doctoral program in medical humanities that this narrative began to shift as I learned about the concept of medicalization – taking social issues and transforming them into physical problems that can be diagnosed and treated by health care professionals. I began to study the history of racial science and the ways in which medicalization and dehumanization can work together to create a powerful tool for persecuting vulnerable populations. This led to a personal and professional epiphany as I finally understood the true roots of the Holocaust as medically sanctioned genocide perpetrated not by one megalomaniac, but by a series of esteemed professionals from all walks of life. I began to see the politicization of medicine and the biologization of politics, the confluence of economic, social, cultural, and governmental forces, and the centralization of the media that led to the most successful propaganda campaign in history. For the first time, I saw the situation for what it really was – a well-oiled machine systematically orchestrated to label, persecute and destroy anyone who was not considered socially acceptable by those in power. Those who chose to act as physical barriers to ensure that the hierarchy remained intact and that the "weak" and "unfit" did not threaten society were the very same group entrusted for so long with caring for the most vulnerable. My perspective expanded to focus not only on the victims, but also on the individuals and the culture that perpetrated the Holocaust. The relevance of this historical moment for modern society became clear as the connection between past, present and future was illuminated.

The entire purpose of the Third Reich was to ensure a better future for the *Volk* by using advances in science and medicine to encourage societal progress. But what kind of "advanced society" is based on a system where the strong prey on the weak? Where a small group of those in power get to choose the people and characteristics that are deemed favorable and, thus, allowed to survive? Where a person's worth is based on his or her value to society and not as an individual who is worthy of intrinsic respect and dignity? Where politics, science, medicine, media, law, and a host of other professions can all come together and decide that entire groups of people should be considered "lives not worthy of living?" Perhaps most importantly, what kind of "advanced society" not only allows, but actively participates in the mass murder of millions of innocent victims based on a promise of scientific advancement that will lead to a better future?

Thinking that Nazi Germany did not have a system of morals is arguably the most dangerous mistake we can make when studying the Holocaust. Understanding the ways in which the morals and ethical values of an entire peo-

ple were undermined and perverted by outside forces is absolutely essential to making sure that we do not repeat the mistakes of our past. Once I understood that key fact, I knew what I had to do to fulfill both my responsibility to my ancestors and to my descendants. I started a nonprofit organization, the Maimonides Institute for Medicine, Ethics, and the Holocaust (http://www.mimeh.org) to bring the stories of the past into the present and emphasize the contemporary relevance of medicine and the Holocaust for all people. This is a topic that transcends traditional educational boundaries. It is interfaith, interprofessional, international, and intergenerational. It is both the history and the future of humankind. For if we truly want to protect the future, it is not enough to solely remember the past. We must act in the present. We must ensure that all people understand our responsibility to one another as members of humankind. We must strive to instill a moral ethos in each and every individual that values human dignity ahead of social progress and cannot be corrupted by outside forces; be those political, economic, social, or cultural. Creating a venue for discourse on the theoretical foundations and practical applications of bioethics and the Holocaust for modern society is an invaluable step towards fulfilling our generation's promise of "Never Again."

III. The Topics of this Issue

This special issue of the *Conatus - Journal of Philosophy* is a testament to our multi-faceted approach to education regarding bioethics and the Holocaust. We have been incredibly fortunate to have the support of Evangelos Protopapadakis, Editor-in-Chief, and Despina Vertzagia, Managing Editor, whose commitment and dedication to this topic were instrumental to the success of this issue. Our voluntary board of guest editors representing nine countries worked tirelessly to ensure the high quality of each article included in this issue. Finally, we received manuscript submissions from internationally acclaimed scholars representing different academic fields from various stages of their careers. We appreciate the hard work of each of the authors whose work is included in this issue. The enthusiasm of all those who contributed to this project is very promising for the future of the field, and we hope that this is only the beginning of many other collaborations that transcend boundaries.

The articles in this issue can be categorized into four different general topics: Holocaust studies for the sake of understanding the role of professions in society, Holocaust studies for the sake of medical education, Holocaust studies for the sake of ethics in contemporary social discourse, and Holocaust studies for the sake of ethics in research and technological advancement. While each article represents a specific view on a subset of the larger topic, the theme that unites this issue is the contemporary moral

relevance of bioethics and the Holocaust for modern society. Without an understanding of where we have been as a society, we will be lost, without a map or a compass to help us find a better future.

articles

I. The Holocaust and contemporary ethics

A. K. Fernandes & D. Ecret • *Conatus* 4, no. 2 (2019): 21-43
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The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?

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Abstract

Physicians, nurses, and healthcare professional students openly (and in many cases, eagerly) participated in the medical atrocities of the Shoah. In this paper, a physician-bioethicist and nurse-bioethicist examine the role of hierarchical power imbalances in medical education, which often occur because trainees are instructed 'to do so' by their superiors during medical education and clinical care. We will first examine the nature of medical and nursing education under National Socialism: were there cultural, educational, moral and legal pressures which entrenched professional hierarchies and thereby commanded obedience in the face of an ever-diminishing individual and collective conscience? We will then outline relevant parallel features in modern medical education, including the effects of hierarchy in shaping ethical decision making and conscience formation. We then propose several solutions for the prevention of the negative effects of hierarchical power imbalances in medical education: (1) universal Holocaust education in medical and nursing schools; (2) formative and experiential ethics instruction, which teaches students to 'speak up' when ethical issues arise; (3) acceptance of, and adherence to, a personalistic philosophical anthropology in healthcare; (4) support for rigorous conscience protection laws for minority ethical views that respect the role of integrity without compromising patient care.

Key-words: *Holocaust; medical education; hierarchy; power imbalance; conscience formation; conscientious objection; bioethics education*

I. Hierarchy in the dark days of medicine

In early 2019, Dr. William Husel, an intensive care physician, was accused of the murder of at least 25 patients in Columbus, Ohio (USA) over a period of five years. Dr. Husel trained at one of the most prominent hospitals in the world and yet, according to the criminal complaint, gave his gravely ill patients excessive doses of pain medication in order to hasten their deaths, without the consent of the patients or families.[1] No one forced Dr. Husel to do this, and in order to do it, he needed the cooperation of nurses and pharmacists, some of whom obeyed his orders without question. Years after it began, the killing ended when an employee spoke up and made an anonymous report. What was Husel's true motivation? Why did other health professionals follow his clearly dangerous orders? Why did no one else speak up? What will be the long-term impact on the medical profession, both in the city of Columbus and in the United States?

The horror of this contemporary malfeasance pales in comparison to the destruction wrought by physicians and nurses during the Holocaust, and demonstrates that – despite the clear lessons to be learned from that tragic time in history – certain members of the health professions continue to make irrevocable mistakes; hence all of us need to reexamine the reasons why.

The role of physicians in planning and implementing medical abuses of human persons during the *Shoah* has been well documented – most notably by Robert J. Lifton[2] and Robert N. Proctor[3] – shattering the myth that health care professionals were coerced citizens "forced" to utilize knowledge and skill against those considered unfit for existence. By 1945, half the physicians in Germany had joined the Nazi party and 7% had joined the *Schutzstaffel* (SS), much higher rates than other professions.[4] The Nazi physician played a critical role in organizing and implementing efficient, medicalizing killing by garnering public support using the profession's prestige and status and justifying (to themselves and an eager society) practices such as eugenic sterilization and euthanasia by labeling them with the omnipotent moniker, "science."[5] It is important to realize that the role of medicine in the organization

[1] Bennet Haeberle, "Former Mount Carmel Doctor Pleads Not Guilty to 25 Counts of Murder; Bond Set at $1 Million," *Columbus Dispatch*, https://www.10tv.com/article/former-mount-carmel-doctor-pleads-not-guilty-25-counts-murder-bond-set-1-million-2019-jul.

[2] Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 2000).

[3] Robert N. Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge, Massachusetts: Harvard University Press, 1988).

[4] Proctor, 62-66.

[5] Alessandra Colaianni, "A Long Shadow: Nazi Doctors, Moral Vulnerability and Contemporary Medical Culture," *Journal of Medical Ethics* 38, no. 7 (2012): 435-438.

and implementation of discriminatory public health practices continues to this day.

Paralleling much of modern medicine and academic scholarship, the critical role of (primarily female) nurses in the Holocaust has been understated. Scholars in the field have shown without question, however, that the active participation of nurses (whose party affiliation was as high as 30%)[6] in medical research abuse, eugenic sterilization (especially, but not exclusively, at Auschwitz),[7] and nonvoluntary euthanasia was extensive.[8] The murder of six million Jewish persons, and nine million non-Jewish persons at the hands of the Nazis simply could not have occurred without the active participation of physicians and nurses.

In teaching a course on *Medical Ethics after the Holocaust* for the last eight years, the first author is struck by the most common sentiment among final year medical students at the start: "This simply could not happen here." The egregious human rights violations, torture and medicalized murder that occurred during the Holocaust, as barbaric as they were, are inconceivable to comfortable American students in a democratic republic. Initially, the students fail to recognize that the educational and cultural climate in which they exist – a climate permeated by hierarchy – is not completely dissimilar from that of Germany in the early to mid 1900s. Our hypothesis is that the hierarchical nature of medicine, so ingrained in both clinical education and practice, yet often unnoticed, had a role in shaping the moral actions of healthcare professionals during the Holocaust.

Why stay silent in the face of such evil? According to Colaianni, fear of punishment is not an answer:

> [...] 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.[9]

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[6] Mary Deane Lagerwey, "The Third Reich, Nursing, and *AJN*," *American Journal of Nursing* 109, no. 8 (2009): 45-48.

[7] Susan Benedict, and Jane M. Georges, "Nurses and the Sterilization Experiments of Auschwitz: A Postmodernist Perspective," *Nursing Inquiry* 13, no. 4 (2006): 277-288.

[8] Linda Shields, and Thomas Foth, "Setting the Scene," in *Nurses and Midwives in Nazi Germany: The "Euthanasia Programs,"* eds. Susan Benedict, and Linda Shields, 1-12 (New York: Routledge, 2014).

[9] Colaianni, 435.

We are humble in our ambitions and do not intend to provide a complete account of the reasons for complicity in the murder of innocent persons, nor to suggest that hierarchy is the sole or even main culprit. Our view, however, is that the reexamination of the role of physicians and nurses in the Holocaust from the point of view of education is vital; the suffering and death of our brothers and sisters in the camps, at our professions' hands, is an inexhaustible, perpetually renewable source of deep ethical reflection *in every age*. In this paper, we hope to highlight the role of hierarchy in medical education and in medicine broadly, and how reflecting on its effect may help us to avoid profound ethical pitfalls that begin with merely staying silent, yet end tragically with, in Primo Levi's words, "the demolition of a man."[10]

II. What is hierarchy and why is it so important?

i. Hierarchy in healthcare

Those who practice clinical medicine often speak colloquially (and sometimes jokingly) of "hierarchy" as a reality of medical and nursing school, with little further reflection on its effects. While in some respects one could argue for a place for hierarchy in both medical education (e.g., the teacher and student do not – and should not – occupy the same roles) and clinical medicine (e.g., in a cardiac arrest and subsequent code, not every member of the team should be simultaneously giving orders), here we will focus on the potential negative effects that hierarchy can have, both on medical outcomes and moral formation.

Hierarchy in medicine, nursing and other health care structures can be conceptualized by describing unequal power gradients between doctors, nurses, professionals and patients that are common within organizational healthcare system structures; doctors and nurses in training depend upon the supervisory role or oversight of training mentors or preceptors during their educational training and clinical experiences.[11] The supervisory role of the mentor or preceptor builds relationships based upon evaluation processes that determine successful demonstration of competencies through subjective assessment evaluations, or based upon perceived adherence to professional standards of clinical practice. Poor communication, decreased supervision, poor role modeling, human error made in clinical judgments, blaming those with less experience, or the infliction of apprehension or fear for those who

[10] Primo Levi, *Survival in Auschwitz: The Nazi Assault on Humanity*, trans. Stuart Woolf (New York, New York: First Collier Books, 1993), 26.

[11] Bill Runciman, Merry Allen, and Merrilyn Walton, *Safety and Ethics in Healthcare: A Guide to Getting it Right* (Burlington, VT: Ashgate Publishing, 2007), 72.

are in positions of lower authority can contribute to factors that increase harms to those who are being cared for in health care systems.[12] [13]

However, the hierarchical power imbalances do not begin or end with the training of inexperienced nurses and doctors by their immediate supervisors or with the hierarchical imbalances that occur between prescribing physicians and professions that carry out orders in clinical practice; in fact, the entire organizational structure is dominated by hierarchy.[14] The dominance of organizational structures today requires professionals to increase patient outcomes, decrease patient length of stay, and decrease cost of care, all of which becomes a daunting task for professionals in response to the complexities of patient health conditions.[15]

In the time of National Socialism, organizational structures might have been legal and regulatory forces, including the bureaucracy charged with medical education, health care delivery (and discrimination), employment, and the execution and implementation of the racial hygiene and anti-Semitic exclusionary laws, which further stigmatized Jewish professionals and citizens.

Perhaps the heightened hierarchical imbalance today is best displayed through the vulnerability of a patient who seeks the care of trained professionals during moments of intense human vulnerability and illness. During a physiological and psychological stressed state, the patient encounter with the health care provider and health care system remains a relationship of particular or special vulnerability; despite initiatives to diminish this vulnerability for patients through patient centered care initiatives, those with the authority, resources, and knowledge to manage such illness and disease continue to function within a hierarchical authority gradient that places the care of those with the least authority, education, and support at risk for harms.[16] This relationship highlights the "downward slope" of hierarchy – if physicians occupy the higher positions, and then the nurses, the influence of the power differential becomes exaggerated as one considers the patient and family.

ii. Hierarchy's effects on patient care

The hierarchical relationship between physicians and nurses and supervisors and trainees is known to have negative effects on interprofessional commu-

[12] Ibid., 72-79

[13] Robert M. Wachter, *Understanding Patient Safety* (New York: McGraw Hill Medical, 2012), 149-157, 260-262.

[14] Ibid., 149.

[15] Ibid., 149-150.

[16] Henk ten Have, *Vulnerability: Challenging Bioethics* (New York: Routledge, 2016), 126

nication and relationships – effects that can directly affect patient care.[17] [18] Often, the silencing of nurses (voluntarily or involuntarily), can increase the risk of medical errors, as one nurse writes:

> This isn't about hurt feelings or bruised egos. Modern health care is complex, highly technical and dangerous, and the lack of flexible, dynamic protocols to facilitate communication along the medical hierarchy can be deadly. Indeed, preventable medical errors kill 100,000 patients a year, or a million people a decade [...] Because successful health care needs to be interdependent, the silencing of nurses inevitably creates more opportunities for error. In a system that is already error-prone and enormously complicated, where health care workers are responsible not just for people's well-being, but their lives, behavior that in any way increases dangers to patients is intolerable. When I became a nurse, that's not the kind of harm I signed on for.[19]

Silence has an effect on conscience, and the hierarchy of the Nazi establishment attempted to suppress conscience and ensure absolute silence amongst their nurses by requiring written nondisclosure agreements that prohibited interactions with the inmates or discussion of the daily activities within the concentration camps.[20] Maria Stramberger, a nurse of the resistance, signed the nondisclosure statement without intention of keeping silent, but rather with the conviction to help those in need, despite the risk to her own life.[21] The more a human person is reticent to speak out (whatever the reason), the less they are able to discern *when* to speak out the next time. We note, however, that medical error today (in which both physician and nurse are truly looking out for the patient's best interests) is vastly different in kind than the deliberate harm of Nazi physicians and nurses. The point we are trying to make is that there is a *moral lapse* when an error is *deliberately* not disclosed or a potential harm not stopped because of reticence; the moral lapse is much worse if the harm is intentional (as in the Nazi healthcare profession-

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[17] Erika Gergerich, Daubney Boland, and Mary Alice Scott, "Hierarchies in Interprofessional Training," *Journal of Interprofessional Care* 33, no. 5 (2019): 528-535.

[18] Carolyn DiPalma, "Power at Work: Navigating Hierarchies, Teamwork and Webs," *Journal of Medical Humanities* 25, no. 4 (2004): 291-308.

[19] Teresa Brown, "Healing the Hospital Hierarchy," *New York Times*, March 16, 2013, https://opinionator.blogs.nytimes.com/2013/03/16/healing-the-hospital-hierarchy/.

[20] Susan Benedict, "Maria Stromberger: A Nurse in the Resistance in Auschwitz," *Nursing History Review* 14, no. 1 (2006): 189-202.

[21] Ibid.

als and the story of Dr. Husel at the beginning of this paper). All of these stories relate to how the hierarchy of medicine, without proper controls, can encourage silence and moral apathy, which harms patients.

iii. Hierarchy's effect on moral conscience

It is not difficult to imagine how deference to authority might lead to the erosion of one's conscience through not "speaking up" when unprofessional or unethical behavior occurs. Numerous studies confirm this phenomenon,[22] [23] including the disturbing notion that medical trainees are introduced to the "hierarchy" through processes of humiliation and fear.[24] In one Irish study focusing on emotional responses to hierarchy, the responses of two trainees are quite telling: a female trainee commented, "There's very much the patriarchal thing of the consultant [senior physician], you never question them and you're there to do exactly what they say' (Participant 40, female);" another said, "You're dealing with people who've been there for 10 years, 20 years, 30 years [...] You can't really say anything because it's so poorly received' (Participant 10, male)."[25]

In addition, little incentive is given to alter the structure of the hierarchy, nor are such mechanisms accessible – especially to trainees. Medical professionals have not only become accustomed to unprofessional behavior toward themselves and others within the hierarchy, but the fear of retaliation and the lack of institutional incentives to change (e.g., accreditation) have further eroded students' empathy.[26]

"Empathy erosion," like the hierarchy, is a well-documented phenomenon in medical and clinical education, and the two are clearly interrelated. Melanie Neumann and colleagues systematically reviewed reasons for medical trainees' empathetic erosion and discovered that not only does hierar-

[22] Catherine V. Caldicott, and Kathy Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal: Lessons in Ethics from Third-Year Medical Students," *Academic Medicine* 80, no. 9 (2005): 866-873.

[23] William Martinez, Sigall K. Bell, Jason M. Etchegaray, and Lisa S. Lehmann, "Measuring Moral Courage for Interns and Residents: Scale Development and Initial Psychometrics," *Academic Medicine* 91, no. 10 (2016): 1431-1438.

[24] Heidi Lempp, and Clive Seale, "The Hidden Curriculum in Undergraduate Medical Education: Qualitative Study of Medical Students' Perceptions of Teaching," *British Medical Journal* 329 (2004): 770-773.

[25] Sophie Crowe, Nicholas Clarke, and Ruairi Brugha, "'You do not Cross Them:' Hierarchy and Emotion in Doctors' Narratives of Power Relations in Specialist Training," *Social Science & Medicine* 186 (2017): 70-77.

[26] Edison Vidal, et. al., "Why Medical Schools are Tolerant of Unethical Behavior," *Annals of Family Medicine* 13 no. 2 (2005): 176-180.

chical mistreatment play a significant role, but over time, empathy erosion can have a negative impact both on patient outcomes and on what one study called "moral judgment competence" – "the capacity to make decisions and judgments which are moral (i.e., based on internal principles) and to *act* in accordance with such judgments."[27] This is, essentially, the definition of conscience.[28] Simon Baron-Cohen takes the 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.[29]

III. The entrenchment of hierarchy under National Socialism

In a recent paper, Shmuel Reis and his colleagues, in reflecting on lessons learned from the Second International Scholars Workshop on Medicine during the Holocaust and Beyond (2017) affirmed the crucial role of the hierarchy in the corruption of the medical profession:

> Medicine is a hierarchical profession, with senior clinicians issuing orders to be carried out by junior ones, and where physicians often direct or command allied health personnel. While these features of medicine are applied with the noble goal of healing and administering best practices within humanistic care, the combination of elements of hierarchy, obedience, and power constitutes a risk factor for abuse of power.[30]

What factors led to the entrenchment of a malignant hierarchy in medicine under National Socialism? We wish to highlight three: educational/cultural; moral/philosophical; and legal. These three overlapping factors all profoundly influenced ethical decision making for both physicians and nurses during this time period and are instructive to revisit.

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[27] Melanie Neumann, et al. "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," *Academic Medicine* 86, no. 8 (2011): 996-1009.

[28] Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 135-149.

[29] Simon Baron-Cohen, *The Science of Evil* (New York: Basic Books, 2017): 1-17.

[30] Shmuel Reis, Hedy Wald, and Paul Weindling, "The Holocaust, Medicine and Becoming a Physician: The Crucial Role of Education," *Israel Journal of Health Policy Research* 8, no. 1 (2019): 1-5.

i. Educational/cultural factors

All persons are moral beings, and any act is a moral act if it is performed with both intellect and will. Hence moral acts by moral beings do not occur in a vacuum, and the cultural milieu in which the "actor" lives will affect the decisions she makes. Likewise, persons and their ethical acts will also affect the culture at large. In particular, because of the high esteem the medical profession held in Nazi Germany with the general populace, Nazi leadership prioritized the active participation of the medical profession. Martin Bormann, the secretary to Adolf Hitler, famously said, "The Führer holds the cleansing of the medical profession far more important than that of the bureaucracy, since in his opinion the duty of the physician is or should be one of racial leadership."[31] 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. German academies, especially psychiatrists, were leaders in theories of racial superiority, social Darwinism, and the genetic transmissibility of mental illness before Hitler came to power.[32]

In short, like a firestorm whose own heat and energy continues to sustain it in a swirling, diabolical fashion, culture and medical ideology continuously circle back to one another.

Thinking of how cultural education might influence medical education, we must again reflect on the structure of hierarchy. The "sage on stage," so common in our medical education, has the medical or nursing professor as the disseminator of true wisdom, of objectivity, and of the knowledge and power of science – the latter being perhaps the most coveted of the three. Even today, medical and nursing students in both the classroom and clinic are reluctant to question a "superior." Sometimes this may be out of fear, but often - though rarely mentioned – it is simply because the nature of education in a hierarchy is to simply *believe* one's teacher. Medical and nursing students living in the time of National Socialism would have no reason to disbelieve their professor or mentor – particularly in a larger culture of anti-Semitism, where the "strongman" will-to-power rules and the individual's duty is to subjugate

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[31] Naomi Baumslag, *Murderous Medicine: Nazi Doctors, Human Experimentation, and Typhus* (Westport CT: Greenwood Publishing, 2005), 47.

[32] Edmund D. Pellegrino, "The Nazi Doctors and Nuremberg: Some Moral Lessons Revisited," *Annals of Internal Medicine*, 127, no. 4 (1997): 307-308.

their own desires to the broad interests of the state. Florian Bruns has documented that the teaching of medical ethics in Nazi-era medical schools (a new course in a revised curriculum in 1939) was done solely by party loyalists as lecturers. They used a textbook authored by Rudolph Ramm that praised the cleansing of the medical professions from those foreign to the Aryan race, openly advocated for the killing of disabled persons, and supported eugenic sterilization laws. Ramm

> [...] believed in the authoritarian paternalistic role of the physician as a 'health leader' and blatantly defined the Nazi physician's ethical obligation as being responsible for ridding society of certain groups: Jewish persons, disabled persons, and any others who were deemed unable to contribute to society.[33]

German physicians and the Nazi leadership over time thus created a powerful biological metaphor, easily understood by the common man or woman: *Germany is a body*. To keep the body healthy, it was the duty of each citizen to preserve those things in the racial state that led to "health," and to destroy or cut out those things that could lead to the death of the Reich. Hence, Jews were a "disease" that must not merely be suppressed, but rooted out. This is a powerful, easily understood metaphor by lay people, people willing to put physicians and nurses in charge of eradication. A "biological organism" is one that is predictable, empirical, material. There is no mystery that we cannot discover or manipulate for our ends. While we cannot own the metaphysical or mysterious, we can own, control, and dominate the material body – including those of others, for the sake of the state.

The cultural and educational environment of nursing is understandably different, and, given the diminished power and autonomy of nurses (and in particular, female nurses) during this time, the ethical pressure and influence on them from those higher in the power structure would have been tremendous, and the prominence and profiles of male Nazi "physicians and scientists" would have, no doubt, been higher. Susan Benedict and Jane Georges point out that "the very nature of nursing as a female-dominated profession, with its historical commitment to the relief of suffering, has rendered its involvement in the Holocaust unthinkable, and therefore, invisible." Yet, the fact remains that nurses were active, willing participants in the horrors of Auschwitz and other death camps.[34]

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[33] Florian Bruns, and Tessa Chelouche, "Lectures on Inhumanity: Teaching Medical Ethics in German Medical Schools Under Nazism," *Annals of Internal Medicine* 166, no. 8 (2017): 591-596.

[34] Benedict and Georges, 286-287.

ii. Moral factors

Duty was another critical concept in understanding the moral culture of nursing at the time. According to Andrew McKie, nurses were able to justify doing horrific, unpleasant things because it was their duty to do so – they did not have to "like it" to do it. Furthermore, important and necessary principles of past and current nursing practice – executing orders, precision, and confidentiality all took on a new meaning when applied to participation in the killing of others.[35] It should be noted that moral actions for the sake of duty still involve an active will – nurses, whatever the justification – were committing and cooperating with moral evil, albeit in an extreme of the hierarchical environment.

Thus, while Stanley Milgram's "agentic state" theory of moral agency – the notion that a perpetrator sees himself as an *instrument* of another (person, state) and therefore ceases to feel personal responsibility – has often been associated with health professionals in the Holocaust, this association has more recently come under scrutiny. In large part, this is due to the fact that most physicians and nurses (unlike the participants in Milgram's experiments) felt no regret while committing medical atrocities, nor did they actively seek a way out.[36, 37] Instead, the agentic state should be seen as a moral choice,[38] rather than a psychological state. That is to say, especially within the hierarchy of medicine, it would be easy for a person (e.g., a medical resident or nurse) to make a moral choice at the direction (but not compulsion) of another and then choose to transfer responsibility to the person responsible for training them.

Michael von Cranach has commented on the effect the medical hierarchy had on the individual's conscience within Nazi psychiatry, a negative effect leading to the abuse and murder of some of the most vulnerable patients in medicine. He estimates that 200,000 such persons were killed with the aid of the "elite" of the psychiatric profession. Von Cranach concludes that hierarchies tend to "blur" the concepts of responsibility and conscience, allowing a person to transfer responsibility for an individual action to the authority over them. Hence, "openness, transparency, and civil dialogue" – *not* typically compatible with hierarchy – are sacrificed.[39]

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[35] Andrew McKie, "'The Demolition of A Man:' Lessons From Holocaust Literature For The Teaching Of Nursing Ethics," *Nursing Ethics* 11, no. 2 (2004): 138-149.

[36] Allan Fenigstein, "Milgram's Shock Experiments and the Nazi Perpetrators: A Contrarian Perspective on the Role of Obedience Pressures during the Holocaust," *Theory and Psychology* 25, no. 5 (2015): 581-598.

[37] Allan Fenigstein, "Were Obedience Pressures A Factor in the Holocaust?" *Analyse & Kritik* 20, no. 1 (1998): 54-73.

[38] Nestar Russell, and Robert Gregory, "Making the Undoable Doable: Milgram, the Holocaust, and Modern Government," *The American Review of Public Administration* 35 no. 4 (2005): 327-349.

[39] Michael von Cranach, "Ethics in Psychiatry: The Lessons we Learn from Nazi Psychiatry," *European Archives of Psychiatry and Clinical Neuroscience* 260, no. S2 (2010): 152-156.

iii. Legal factors

Hierarchies – medical or otherwise – are also not very compatible with change or upward mobility: there is a natural resistance to it. The Nuremberg Laws of 1935 codified racism and banned marriages and other sexual activity between Jews and non-Jews, purportedly to prevent "mixing of blood."[40] Such laws no doubt created a tremendous stigma in a culture already primed for anti-Semitism by centuries of scapegoating; but, by being embraced by physicians, researchers, and the major medical and scientific journals throughout Germany, the Nuremberg Laws tied legal regulation to "science." Now physicians or nurses in training had a consistency of messaging.

Prior to Hitler's rise to power in 1933, Jewish doctors had risen to prominence in many of the large cities in Germany and Austria, and the national health system's rules meant that physicians had to wait for vacancies before they could rise within the ranks.[41] When the Nazis came to power, they systematically banned Jews from medical teaching positions, stripped them of academic rank and title, removed the ability to have pensions or insurance, and did not allow them to practice medicine on non-Jews. Jews permitted to practice medicine as an exception (in part, to not overburden non-Jewish physicians with patients) were not allowed to call themselves "physicians," but had to be referred to as "attendants." The ban on Jews treating non-Jews was even incorporated into Ramm's medical ethics textbook in 1942.[42] Even Dr. Otto Loewi, the Jewish Nobel Prize winner in Medicine (1936) was forced to leave Germany in 1938, but only after transferring his award money to a Nazi-affiliated bank.[43] Because of their absence, Nazi-affiliated physicians and other non-Jews could now occupy ranks of the hierarchy hitherto out of reach. By 1940s, as Proctor notes, Ramm had declared that "no man of German blood is treated by a Jewish doctor."[44] Once Jews were excluded, non-Jewish physicians filled the open spaces; indeed, as a result of the Nuremberg Laws and the purging of Jews from medicine, the numbers of physicians in Germany actually *increased*.

Why is this important? The legal exclusion of Jewish health care professionals created a powerful conflict of interest for physicians and nurses; even

[40] Proctor, 131-176.

[41] Alexa R. Shipman, "The German Experiment: Health Care without Female or Jewish Doctors," *International Journal of Women's Dermatology* 3, no. 1 (2015): 108-110.

[42] Proctor, 138-155.

[43] The Nobel Prize, "Otto Loewi: Biographical," https://www.nobelprize.org/prizes/medicine/1936/loewi/biographical/.

[44] Proctor, 154.

if they did not support Nazi racial policy, the laws provided them a financial incentive to stay silent, and in doing so, to improve their economic and social position. Once ensconced in the hierarchy of medicine – then as now – it is extremely difficult to withdraw from it, to have the courage to do the right thing in a culture where the laws not only stigmatized Jewish physicians and health care workers, but their very blood as well.

IV. The dangers of modern medicine and possible answers

i. Cultural/educational dangers and possible solutions

We believe the involvement of nurses and doctors in the Holocaust can teach us perpetual lessons that deserve revisiting. It is well known that medical students face the ethical and professional dilemmas of "speaking up,"[45, 46] and that, as practicing physicians, the moral courage to do so becomes even higher stakes when patient safety is at risk.[47] David Malloy and colleagues, in a comparison study across four different countries, describe the phenomenon so present in nursing culture, of the "silenced voice:" "Despite their belief that they were aware of patients' needs and wishes, and capable of acting and/or recommending treatment, their voices were often silenced by the system, physicians, and patients and their families, albeit sometimes voluntarily."[48] These are dangerous developments for the moral health of the profession. Will the health care professionals of today have the courage to speak up, especially when the vulnerable human person is at risk? Will they be willing to challenge the existing hierarchy when they think someone is wrong *morally*, and if so, how?

In medical education, several reforms should be undertaken in practical ethics. First, we believe that "Medicine and the Holocaust" courses can be very successful and should be mandatory in every medical and nursing school in the United States. M.K. Wynia and his colleagues reported the results of a Liaison Committee for Medical Education (LCME) survey of 140 medical schools in the USA and Canada that showed only 22/140 (16%) "have any

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[45] James Dwyer, "*Primum Non Tacere*: An Ethics of Speaking Up," *Hastings Center Report* 24, no. 1 (1994): 13-18.

[46] Dimitri A. Christakis, and Christopher Feudtner, "Ethics in a Short White Coat: The Ethical Dilemmas that Medical Students Confront," *Academic Medicine* 68, no. 4 (1993): 249-254.

[47] William Martinez, et al., "Speaking Up about Traditional and Professionalism-related Patient Safety Threats: A National Survey of Interns and Residents," *British Medical Journal Quality and Safety* 26, no. 11 (2017): 869-880.

[48] David Malloy, et al., "Culture and Organizational Climate: Nurses' Insights into their Relationship with Physicians," *Nursing Ethics* 16, no. 6 (2009): 719-733.

required curricular elements on the roles of physicians in the Holocaust, and half of these (11/22) teach this material using a lecture format only."[49] In recent years, important first steps have been made, both in the US and internationally, and demonstrate the success of both online and in-person teaching modalities.[50] The first author of this paper has shared a model for teaching medical ethics and the Holocaust that is flexible, low-cost, and generates a high level of student satisfaction; he has continued to teach this course in online and in-person formats for medical students and graduate students in bioethics.[51] The Galilee Declaration, signed by scores of physicians, bioethicists, historians, and medical educators, calls for the universal adoption of Holocaust education for the health professions.[52]

Second, ethical education that focuses on vital concepts such as improving empathy through faculty development in modelling and small group interactive cases,[53] defining virtues such as moral courage,[54] and, above all, *practice* and simulation in speaking up during ethical encounters,[55, 56] will provide preventative measures to slow the pattern of moral erosion and loss of empathy we have already alluded to.

Finally, interprofessional education and collaboration that encourages teamwork, transparency, and the ability for physicians, nurses, and trainees to practice "speaking up" is critical. This important work is already being done in a number of medical contexts,[57, 58] and needs to be expanded to empower

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[49] M. K. Wynia, W. S. Silvers, and J. A. Lazarus, "How Do U.S. and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust?" *Academic Medicine* 9, no. 6 (2015): 699-700.

[50] Reis, Wald, and Weindling, 3-5.

[51] Ashley K. Fernandes, "Nazi Medicine and the Holocaust: Implications for Bioethics Education and Professionalism," in *Nazi Law: From Nuremberg to Nuremberg*, ed. John J. Michalczyk (London: Bloomsbury Press, 2017): 149-153.

[52] Western Galilee College, "The Galilee Declaration," http://english.wgalil.ac.il/category/Declaration.

[53] William T. Branch, "Supporting the Moral Development of Medical Students," *Journal of General Internal Medicine* 15, no. 7 (2000): 503-508.

[54] Olivia Numminen, Hanna Repo, and Helena Leino-Kilpi, "Moral Courage in Nursing: A Concept Analysis," *Nursing Ethics* 24, no. 8 (2016): 878-891.

[55] James Dwyer, and Kathy Faber-Langendoen, "Speaking Up: An Ethical Action Exercise," *Academic Medicine* 93, no. 4 (2018): 602-605.

[56] Ashley K. Fernandes, et. al., "Integrating Simulated Patients in TBL: A Strategy for Success in Medical Education," *Medical Science Educator* 29, no. 2 (2019): 383-387.

[57] Liane Ginsburg, and Lorna Bain, "The Evaluation of a Multifaceted Intervention to Promote 'Speaking Up' and Strengthen Interprofessional Teamwork Climate Perceptions," *Journal of Interprofessional Care* 31, no 2 (2017): 207-217.

[58] Nancy Berlinger, and Elizabeth Dietz, "Time-out: The Professional and Organizational Ethics of Speaking Up in the OR," *American Medical Association Journal of Ethics* 18, no. 9 (2016):

those "lower" on the hierarchy to utilize their conscience without fear or apathy setting in.

ii. Moral dangers and possible solutions

While in the US and Europe, the political forces of the "will-to-power" that made fascism possible seem remote, philosophical threats to the human person remain ever acute and urgent. Physicians, nurses, and those who work in the health care field will never be able to safeguard the dignity of human persons from society's threats, and – perhaps especially – from our own corruption, unless we can adopt, first and foremost, a *philosophical solution*.

The philosophical anthropology of personalism was beautifully articulated by French philosopher Jacques Maritain in *The Person and the Common Good*, where he advanced a *relational aspect* of personhood that is critical for our discussion.[59] In National Socialism, Maritain lived through the danger of having a concept of "person" which is not absolute, one in which other "goods" (race, state, profit) obscured the good of the individual human person. Nazi physicians had, in fact, a robust concept of person – but only if one contributed to the race. The elimination of the vulnerable made perfect sense, for society was merely a collection of individuals who live together out of convenience or self-interest. Personalism, by contrast, posits the ultimate unit of value is the individual person herself. Society is and ought to be built around this value. 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. Integrating this kind of rigorous, universal philosophical anthropology is an antidote to the corruption of medicine, and vital for the prevention of future genocides.

Today, we seem to be caught in a medical and educational culture of radical individualism, where we cannot "impose" *any beliefs* about right or wrong on others, and where the value of persons seems to be exclusively up to oneself (whether in error or not). We are often taught in training (within the "hidden curriculum") to prioritize "population-based medicine" over the individual patient. The medical profession proposes, permits, or participates in euthanasia and assisted suicide for persons with severe dementia,[60] depres-

925-932.

[59] Jacques Maritain, *The Person and The Common Good*, trans. John J. Fitzgerald (South Bend: University of Notre Dame Press, 1985).

[60] Tony Sheldon, "Dutch Approve Euthanasia for Patient with Alzheimer's Disease," *British Medical Journal* 330, no. 7499 (2005): 1041.

sion and schizophrenia,[61] autism,[62] addiction,[63] and even transgenderism.[64] Tours of Auschwitz have been given as a "learning experience" for supporters of euthanasia.[65] Abortion has been touted as a form of good eugenics that reduces crime[66] and disability.[67]

But, if a person is the fundamental unit of value of our society, then no "other good" can eclipse her. Practically, this must mean an expansive definition of person, and the end of physician and nurse involvement in killing of any kind – in state-sponsored torture, capital punishment, euthanasia, and eugenically motivated sterilization and artificial reproductive technologies. Then, as now, the consequences of a disordered philosophical anthropology necessarily have an impact on relationships to others, and to society.

iii. Legal Dangers and Possible Solutions

We have discussed the connection between hierarchy and the dulling of one's moral conscience. It should be obvious, then, that the protection and right use of conscience in medicine is an essential virtue, both for speaking up as individuals when wrongdoing occurs – and collectively as a profession of nurses and physicians, for the safeguarding of our shared values. Now, however, the right of conscientious protection for health care professionals who oppose the prevailing moral view on issues such as abortion, sterilization, or euthanasia is under siege. Julian Salvulescu and Udo Schuklenk, for example, recently made this startling claim which seeks to exclude physicians from practice who refuse to perform (legal) procedures they deem (medically or morally) harmful to their patient:

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[61] J. Scott, Y. H. Kim, Raymond De Vries, and John R. Peteet, "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014," *Journal of the American Medical Association Psychiatry* 73, no. 4 (2016): 362-368.

[62] Maria Cheng, "Belgium Investigates Doctors Who Euthanized Autistic Woman," *Associated Press News*, November 27, 2018, https://www.apnews.com/249a8067af6740d2af22ed66fc9e1a90.

[63] Wayne Hall, and Malcom Parker, "The Need to Exercise Caution in Accepting Addiction as a Reason for Performing Euthanasia," *Addiction* 113, no. 7 (2017): 1178-1180.

[64] G. Heylens, et. al., "Transgender Persons Applying for Euthanasia in Belgium: A Case Report and Implications for Assessment and Treatment," *Journal of Psychiatry* 19, no. 1 (2016): 347-348.

[65] K. Kuntz, "Euthanasia Doctors Seek Existential Answers at Auschwitz," *Spiegel Online*, November 21, 2014, http://www.spiegel.de/international/zeitgeist/belgian-euthanasia-doctors-seek-answers-at-auschwitz-a-1003441.html.

[66] J. J. Donohue, and S. D. Levitt, "The Impact of Legalized Abortion on Crime," *The Quarterly Journal of Economics* 116, no. 2 (2001): 379-420.

[67] D. P. Dixon, "Informed Consent or Institutionalized Eugenics? How the Medical Profession Encourages Abortion of Fetuses with Down Syndrome," *Issues in Law and Medicine* 24, no. 1 (2008): 3-59.

> 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.[68]

What the deafening silence from medical professionals in the Holocaust has taught us, however, is that conscience is everything – and, even if we do not agree with the minority view, the default position should be tolerance, if we are to empower those who would protect medicine's values from (present and) future corruption. We must therefore have rigorous conscience protection for physicians, nurses and other health care providers. While contemporary literature in bioethics favors the removal of conscience protection laws, particularly on "hot button issues" such as abortion, contraception, sterilization, and now euthanasia, some have made powerful defenses of it.[69] We side with this "minority" view – a physician or nurse's oath to her patient is only as strong as her conscience; allow (or even force) her to break it, and we have forgotten that conscience is an active, driving force that is part of who we are as persons.

Ronit Stahl and Ezekiel Emmanuel[70] have also argued for the end of conscience protection laws, citing (in part) the fact that physicians are bound by duties set by the regulatory agencies that license them. Therefore, if something is both legal and permitted by a medical licensing body, a physician (and, in our view this applies *a fortiori* to nurses) should not be permitted to refuse. They even call for the (voluntary) exclusion of conscientious objectors from the profession. While not strictly statutory in nature, it should be noted that regulatory bodies and licensing agencies still exert the force of law on health care professionals and exert tremendous social and economic pressure on practitioners. This pressure can be nefarious when ethical reform is actually needed – and indeed might silence it, if physicians or nurses are

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[68] Julian Savulescu, and Udo Schuklenk, "Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception," *Bioethics* 31, no. 3 (2017): 162-170, 164 [italics by the authors].

[69] Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 135-149.

[70] Ronit Y. Stahl, and Ezekiel J. Emmanuel, "Physicians, Not Conscripts – Conscientious Objection in Healthcare," *New England Journal of Medicine* 376, no. 14 (2017): 1380-1385.

worried that speaking out, or refusing to act, might result in not being able to practice.

Calls for exclusion and ostracization[71] of physicians with minority ethical views should alarm us, regardless of our own political or religious affiliation. The exclusion of Jewish physicians under National Socialism had a tremendous moral cost as an inherently unjust act, but it also had a medical and economic cost, since it oppressed some of the brightest, most capable physicians Germany had – simply because as persons their existence went against the prevailing medical ideology. Christopher M. Radlicz and Ashley K. Fernandes note that there is also a potential cost to the suppression of conscience today that will hurt medicine in the long run:

> Medical training is naturally hierarchical and inherently tends to encourage a culture of subordination. During training, there are incentives not to speak up, even when there is explicit evidence of wrongdoing. Since residents and attending physicians often complete evaluations in places of authority, students will readily subjugate everything from bodily needs to their conscience in order to appease their attending physicians [...] The weakness of conscience leads to a chipping away of one's moral compass, which changes the person herself. Inaction can occur when there is worry about repercussions from conscience expression. For the physicians and students who try to do right, this may lead to a deep resentment or apathy, which may prompt an exit of the medical field of those we need the most, certainly to the patients' detriment. 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.[72]

In order to stop the cycle of empathetic erosion, conscience dulling, silence, and moral apathy, persons need to be free to decide the right, and empowered to act on that right within the medical system. Had physicians and

[71] Christian Fiala, and Joyce H. Arthur, "'Dishonourable Disobedience' – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection," *Woman - Psychosomatic Gynaecology and Obstetrics* 1 (2014): 12-23.

[72] Christopher M. Radlicz, and Ashley K. Fernandes, "Physician Conscience and Patient Autonomy: Are They Competing Interests?" *Linacre Quarterly* 86, no. 1 (2019): 139-141, quote from 140-141.

nurses in the Holocaust done more of precisely this, many of the medicalized horrors might have been prevented.

V. Conclusions

Physicians and nurses during the time of the *Shoah* committed moral acts of omission and commission that were reprehensible and sacrificed the lives of millions of innocent patients. The hierarchy of medicine contributed to the silence of health care professionals, the suppression of moral courage and the individual and collective conscience. In this paper, we have tried to suggest that cultural, educational, moral, and legal factors all played a role in strengthening the power of the hierarchy and exerting negative moral influences and pressures on people sworn to protect the vulnerable patients. There are significant warning signs for the ethical character of contemporary medicine. We call for universal medical and nursing education in Holocaust studies that incorporate empathy-building exercises, which emphasize universal practices in the art of "speaking up." We also suggest a rigorous adherence to a personalist philosophical anthropology that reaffirms legal commitments to conscience protection for doctors and nurses. Such acts will demonstrate that the lessons learned from the Holocaust have not been forgotten and that initiatives to speak up against hierarchy will build resilience and ethical character within an environment that actively seeks to protect the vulnerability of the patients we serve.

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Benedict, Susan. "Maria Stromberger: A Nurse in the Resistance in Auschwitz." *Nursing History Review* 14, no. 1 (2006): 189-202.

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First Victims at Last: Disability and Memorial Culture in Holocaust Studies

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Abstract

This essay begins with a Berlin memorial to the victims of National Socialist "euthanasia" killings first unveiled in 2014. The open-air structure was the fourth such major public memorial in the German capital, having followed earlier memorials already established for Jewish victims of Nazi atrocity in 2005, German victims of homosexual persecution in 2008, and Sinti and Roma victims in 2012. Planning for the systematic persecution and extermination of at least 300,000 infants, adolescents, and adults deemed "life unworthy of life" (Lebensunwertes Leben) long preceded and extended beyond the 12-year Nazi period of massacre linked to other victim groups. Yet those constructing collective memory projects in Berlin appear to consider these particular victims as an afterthought, secondary to the other groups. Rather than address the commemorations themselves, this essay addresses the sequence in which they have appeared in order to demonstrate a pattern of first-victimized/last-recognized. I argue that the massacre of Jews, Roma, homosexuals, and others had to come into legal jurisprudence, scholarship, and public memory projects first before the murdered disabled body and its related memorialization could be legitimized as a category of violence important in and of itself. I argue further that the delay is rooted in a shared trans-Atlantic history that has failed to interrogate disability in terms of the social and cultural values that categorize and stigmatize it. Instead, the disabled body has been seen as both a physical embodiment of incapacity and a monolith that defies historicization. An examination of the broader foundation behind delayed study and representation that recognizes the intersection of racism and ableism allows us to reconfigure our analysis of violence and provides fertile ground from which to make connections to contemporary iterations still playing out in the present.

Key-words: *Holocaust; Holocaust historiography; memory studies; disability; violence; Nazism; European history; eugenics; war crimes trials*

In September of 2014, 79 feet of tinted blue glass embellished with ten stone plaques was unveiled at the edge of the Berlin zoo. The memorial site was chosen for its proximity to Tiergartenstrasse 4, the street address from which the infamous Nazi wartime euthanasia program was directed as well as for which the initial operation, *Aktion T4* had been named 75 years

earlier. The open-air structure was the fourth such major public memorial in the German capital. Earlier memorials had already been established for Jewish victims of Nazi atrocity in 2005; this was followed by a site dedicated exclusively to German victims of homosexual persecution in 2008. A few years later in 2012, a third commemoration for Roma and Sinti victims was constructed. Planning for the systematic persecution and extermination of at least 300,000 infants, adolescents, and adults deemed "life unworthy of life" *(Lebensunwertes Leben)* long preceded and extended beyond the 12-year Nazi period of massacre linked to other victim groups. Yet those constructing collective memory projects in Berlin appear to consider these victims as an *afterthought*, secondary to the other groups.[1]

This delayed memorial in Berlin parallels the historiography of Holocaust research, which has come late to and has studied too minimally so-called "first victims" as if they were a mere "prologue" to genocide, thereby missing the critical relevance of the group in both the past and the present. Whereas modern scholars have seen race, gender, sexuality, and religious affiliation as cultural constructs, the "disabled" body has hardly been examined in terms of the social and cultural values that categorized and stigmatized it. Rather, it has been seen as a physical embodiment of incapacity. Disability, simultaneously an insular and transcultural phenomena, has been understood in the modern West as a monolith, defying historicization.[2] Despite the fact that disability cannot be defined outside of particular social, cultural, and legal contexts and would be better understood as "a fluid rather than a sharply delineated category [...] and [a] category of human variation,"[3] we use the term as if a temporal and geographic continuity were self-evident.

Rather than asking why the disabled matter so much, by now we ought to consider why they have not mattered enough. So much has been said about this group from the late nineteenth up through the mid-twentieth century yet collective historical study of disability during the Nazi period and its related memorialization is relatively minimal. This essay will argue that the pattern of delay in memorial culture and scholarship is rooted in discomfort and ambivalence around a shared history far more than it is explained by legitimate factors involving privacy records, victim scale, or the absence of community. The massacre of Jews, Roma, homosexuals, and others had to come

[1] This article was developed during my stay as a Norman Raab Foundation Fellow at the Jack, Joseph, and Morton Mandel Center for Advanced Holocaust Studies at the United States Holocaust Memorial Museum. I am grateful for their support.

[2] Sharon Snyder, and David T. Mitchell, "The Eugenic Atlantic: Race, Disability, and The Making of An International Eugenic Science, 1800-1945," *Disability & Society* 18, no. 7 (2003): 843-864.

[3] Carol Poore, *Disability in Twentieth Century German Culture* (Ann Arbor: The University of Michigan Press, 2007), xvi and 45.

into legal jurisprudence, scholarship, and public memory projects before the murdered disabled body and its related memorialization could be legitimized as a category of violence important in and of itself. Those crimes too were waged against humanity as a pathological practice justified and carried out by scientists who mapped these ideas across an extraordinary geographical range long before medical practitioners, scientists, and German fascists applied them to policy. The purpose of this paper is not to assert a hierarchy of victimization or suffering. Rather, it is to examine the problems within our own cultural context that cloud our ability to recognize rhetoric surrounding particular medical practices and scientific research. The inability to recognize the victimhood of disability in Nazi Germany has prevented us from seeing how we continue to imagine and devalue certain bodies through our shared history. Our responses to the memory of disabled Germans during the Nazi period, defined variously from 1939 onward, were thus shaped and continue to be shaped in a manner that differs from other victim studies.

I. The First Victims' History

In the most immediate sense, the 2014 "Memorial and Information Point for the Victims of National Socialist Euthanasia Killings" in Berlin is a remembrance about the first victims of organized mass murder during the Nazi period. From August of 1938 to May of 1945 – notably even before WW II began and nearly a month after the German submission to the Allies – approximately 300,000 "disabled" Germans were deliberately starved, lethally injected, gassed, or otherwise euphemistically "given the good death." Although an extensive science of race and the body was central to German fascism, eugenics had been a fundamental intellectual currency of the trans-Atlantic for decades within and across political parties, academic institutions, professional corridors, countless scientific publications, and more.

In Germany the eugenics movement was represented through a single organization, the German Society for Race Hygiene (*Deutsche Gesellschaft für Rassenhygiene*) and one journal, the *Archiv für Rassen- und Gesellschafts-Biologie,* founded by Alfred Ploetz, who conceived and popularized the term "racial hygiene" in Germany. By the 1930's, Nazi policy was less a radical divergence from turn-of-the-century conversations than it was an extension of a set of shared ideas within the German state writ large, given its exceptionally coordinated and narrow academic and political context.[4] The *Gleichgeschaltung* (synchronization, Nazification) of all German agencies and institutions from 1933-1934 only intensified this unique circumstance. By

[4] Henry Friedlander, *The Origins of Nazi Genocide: From Euthanasia to the Final Solution* (Chapel Hill: The University of North Carolina Press, 1995), 9-10.

July, 1933, committees of population and racial policy experts drafted legislation for the mandatory sterilization of Germans with specific physical and psychiatric conditions presumed to be hereditary in nature such as congenital "feeble-mindedness," schizophrenia, manic depression, hereditary epilepsy, Huntington's chorea, hereditary blindness, hereditary deafness, severe hereditary physical deformity, and chronic alcoholism. Health courts drew up "intelligence" tests – a few dozen open-ended questions – to assess the educational ability and moral 'outlook' of individuals in order to grant an air of scientific objectivity to the sterilization of approximately 350,000 people. In essence, the "biological sciences [...] simply recorded traditional prejudices" and treated bodies as if living texts inhabited with objective information to be unlocked by the proper scientific intermediary.[5] A *völkisch* struggle with "degenerates" was waged in ever-broadening terms that rendered the biological distinctions alleged therein less and less meaningful. The concept of degeneracy was expanded to include "antisocials" *(Asozialen)*, which included habitual criminals, prostitutes, the indigent, so-called hysterical or sexually loose women, sex offenders as well as homosexuals and individuals whose conduct was perceived as "alien to the community" (*gemeinschaftsfremd*). "Racial aliens" were seen as possessing inborn and irreparable mental attitudes that led to immorality and legal conflict and were therefore understood to be a "threat to humanity." Over time, those who were seen as threatening came to include all non-Caucasians including Roma, Black Germans, and European Jews, the latter of whom were viewed a "special threat to the German race" as "alien penetrators" (*jüdische* Überfremdung).

On August 18, 1939, before the outbreak of WW II, Hitler authorized a program to exterminate children designated physically or mentally "weak" as he had proposed to do already ten years earlier at a Nuremberg Party rally. Selected children, and later adolescents, would be deliberately starved or given lethal injections. By 1945, an estimated 5,000 to 10,000 toddlers, babies, and adolescents were exterminated, a portion of whom were vivisected, ostensibly to explore physiological questions thought to be related to mental illness, although the argument has also been made that the real intention was to give doctors a more palatable rationale for killing children. By October, *Aktion T4* expanded the killing to "unfit" adults to be carried out at six psychiatric institutions throughout Germany and Austria. An abstract formula, 1000:10:5:1, predicted that for every 1,000 Germans, 10 would need treatment, from which 5 would need institutionalization, from which 1 would qualify for extermination; thus, a goal to exterminate 65-70,000 people was set. Assessment protocol required no review of prior medical data or physical encounter with a patient.

[5] Ibid., 2.

By January 1940, T4 experts began testing the mechanics of gas extermination followed by cremation on tens of thousands of disabled Germans at special "asylums" (killing centers) to which postal vans directed by SS impersonating medical professionals were sent. Patients were often sent to more than one facility for "treatment" thus making it harder for family to visit or even to find patients. Most of those transported were killed within 24 hours, after which point fake death certificates accompanied by random ashes were sent to family.[6] The process used on disabled Germans, gassing, stacking, autopsy, looting, and/or "processing" (cremation), was applied to broader populations in the mass extermination camps in Poland. Those camps were directed almost entirely by the same people who had run the T4 program. They were given full autonomy to create on-site conditions in those camps with regard to extermination structures, reconstruction work, and personnel changes. Viktor Brack, who had initiated the T4 "murder campaign" alongside others, "had already contemplated a final solution of the Jewish question" wherefore T4 served as a kind of "preschool for Poland." According to Erich Bauer, who was a master of gas (*Gasmeister*) at the time, "it could be said that murder was already their profession."[7]

Over time, the T4 program operated as an open secret around which there was a mix of resistance and complicity, or at least passive corroboration. On August 24, 1941, Hitler suspended the T4 program and personnel were offered "jobs in the east."[8] Ostensibly this was a response to growing criticism of the T4 program but may in fact have been announced because the initial goal to gas 70,000 Germans had been met and had even been exceeded by approximately 23,000 more "merciful" deaths by other means: lethal injection, deliberate starvation, and intentional overdose. Despite the public termination, euthanasia killings continued in decentralized fashion throughout the duration of the war.

By 1942, the killings were directed through a new operation called *Aktion 14f13* designed "to 'free' concentration camps of 'sick' inmates." Additional asylums were established as killing points, including thirty pediatric killing centers and asylums across the Reich that were advised to kill their own patients directly. Rather than slowing the extermination of selected individuals, 14f13 tripled the T4 death toll reaching more than an additional 200,000

[6] Michael Burleigh, and Wolfgang Wippermann, *The Racial State* (Cambridge: Cambridge University Press, 2005), 148-154.

[7] Sara Berger, "'Murder Was already their Profession.' Aktion T4 Staff in the 'Aktion Reinhardt' Extermination Camps," in *Mass Murder of People with Disabilities and the Holocaust*, eds. B. Bailer, and J. Wetzel, 203-210 (Berlin: Metropol Verlag, 2019).

[8] The "east" referred to death camps planned within Polish territory. See Deborah Dwork, and Robert Jan van Pelt (eds.), *Holocaust: A History* (New York: W.W. Norton & Company, 2002), 264.

Germans by the end of the war. This included fully 45% of all psychiatric patients in Germany (with a disproportionately higher ratio of women to men), nearly all polio survivors, and all institutionalized Jews among others.[9] The decentralization of the operation allowed it to function more secretly than did T4. Moreover, although the Nazi party directed the policy, it was carried out almost entirely by medical professionals and administrators without the need for party officials. In fact, the program was so deeply embedded within medical institutions and personnel that the last victims were killed several weeks after the German surrender to the Allies in Europe. Just as the extermination of children preceded the other euthanasia killings, so too was the final victim a child. Richard Jenne was killed on May 29, 1945 at Kaufbeuren-Irsee state hospital in Bavaria. The town had already been occupied by US troops for over three weeks.

II. The Medical Trials and the Politics of Forgetting

At the end of the war in Europe, prisoner doctors newly liberated from Auschwitz implored the Allies and neutral states to collect evidence and prosecute the perpetrators of "coerced human experiments and medical atrocity" to which they were witnesses. They wanted to prevent such abuses from taking place again and establish a consent-based approach to medical research guided by ethics. Other witnesses and survivors urged prosecutors to seek justice and compensation for their collective suffering. This process led to the creation of an International Scientific Commission whose charge was to document genocidal, coerced human experimentation and medical ethics violations. Their findings exposed abuses so massive that, for some, the high esteem in which the German medical sciences had been regarded in the West was replaced by a profoundly disturbing view of modern medical research.[10] Thus, the first of the 12 Nuremberg trials began on December 9, 1946, on US-occupied territory. The Medical Trial ("US versus Karl Brandt et al") focused on racial research, bacteriology, and experimental medicine in contrast to the October 1945 Hadamar Trial, which had focused on the murder of "Allies national," meaning Poles and Soviets in particular.

A conflict between the prosecution and the defense emerged around just what the role of medical research was to the "the Nazi war machine." The Allies scrutinized a series of problems regarding the connection between war-

[9] Polio survivors have had a significant influence on the development of disability studies in both Great Britain and the United States but, by contrast, not in Germany.

[10] See, for example, Werner Süskind in the *Süddeutsche Zeitung*, December 14, 1946, as cited by Paul Julian Weindling in *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent* (New York: Palgrave Macmillan, 2004), 2.

time goals and racial policies. Of particular importance was the connection between eugenics and genocide, especially with regard to the killings by gas. The Allies also concerned themselves with the validity of the science undertaken.[11] Also yet to be determined was whether the trial should aim to indict individual doctors or Nazi medical research overall. Given the disturbing evidence collected about crimes without historical parallel, the Allies were presented with a series of options. They could collect evidence about the experiments, sterilization, and killings in order to pursue a series of trials about mass murder. Alternately, they could consider the perpetrators themselves to be mentally unsound and subject them to psychiatric analysis. Or, they could turn over evidence to scientific experts who could then establish new ethical guidelines for medical research. Finally, the Allies might use the data itself for weapons research about aviation, atomic bomb radiation, chemical weapons, and more.[12]

Two days after the Medical Trial began, the United Nations declared genocide a crime under international law and proposed a Genocide Convention to legislate, prevent, and punish murder on such a scale. Both the Medical Trial and the Genocide Convention aimed to prevent doctors from engaging in acts directed toward the racial purification of states. Raphael Lemkin, having newly coined the term 'genocide' in 1943 in relation to Nazi mass murder, advised the head of the war crimes division, Mickey Marcus, to characterize the medical abuses as genocidal in nature.[13] Genocide as a term of legal indictment in international law was only later established by the 1948 Convention on the Prevention and Punishment of the Crime of Genocide.

The prosecution of war crimes generally, and medical war crimes specifically, quickly became subject to Cold War politics. Global power relations made the preservation or recovery of state authority essential, particularly in the U.S. and West Germany. Both the American Medical Association and the British Medical Association expressed fears that revelation of the full extent of the role doctors played in Nazi mass murder might destabilize public confidence in future medical research projects across the trans-Atlantic.[14] A need to normalize rather than inculpate western medical practices and science drove the process to impeach only a limited number of Nazi doctors rather than engage the larger behavior and complicity represented by the full medical establishment within the state: doctors, nurses, administrators, therapists, psychiatrists, medical researchers, and others. The overall effect was one that

[11] Weindling, *Nazi Medicine,* 2.

[12] Ibid.

[13] Ibid., 3.

[14] Ibid.

protected the German medical sciences, and more broadly, trans-Atlantic eugenic theories, medical research, and mainstream academic work.

The charges against the doctors included conspiracy to commit war crimes, crimes against humanity, and membership in a criminal organization. Of critical importance, the "euthanasia" crimes were seen as a "first step" to the genocide of the Jews. Therefore, the murder of the disabled was not seen as a distinct and prosecutable crime against humanity; instead, the killings were indictable per the December 1945 Allied Control Council Law No. 10, which allowed the Americans to try German nationals for "crimes against humanity." This distinction established by the International Military Tribunal (IMT) at Nuremberg meant that the trial would engage a larger wartime conspiracy and "euthanasia as an auxiliary to the Nazis' efforts to wage aggressive war against their European neighbors" by necessity.[15] Without such a link, the U.S. policymakers worried that the euthanasia program would be understood as a domestic program thereby setting a "dangerous precedent in international law." The October 1945 Hadamar medical trial, by contrast, only brought indictments against non-German doctors because it was held prior to the IMT's new distinction. Therefore the US military had no jurisdiction to try German nationals who killed other Germans.

Given these limitations, some scholars have argued that the trials "solidified rather than interrogated a key foundation of Nazi ideology: namely, that the extermination of disabled people in Germany and the occupied countries was unconnected to the horror of the concentration camps." In other words, had the Nazis refrained from extending a "biologically-based" notion of deviance to the genocide of racial, ethnic and sexual minorities, an abstract distinction between "'medical intervention' and murder would not have been crossed" thus eliminating the need for war crimes trials.[16] The euthanasia crimes were not deemed international offenses because they aimed to purify Germany of "life unworthy of life." Rather, the international crimes were correlated specifically to actions taken to free up resources for larger wartime goals in order to maintain the authority of both the Western alliance and medical sciences. Along these same lines, defendants sentenced to less than 15 years at the Nuremberg trials were granted amnesty by U.S. authorities in January 1951. Were there no broader Holocaust, the legal strategy engaged by the prosecution at Nuremberg for various extra-legal reasons would not have provided the grounds for an American prosecution of German euthanasia perpetrators.

More fundamentally, the paradigm established by the verdicts of the medical trials was about the corruption of the medical establishment by

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[15] Michael S. Bryant, *Confronting the "Good Death:" Nazi Euthanasia on Trial, 1945-1953* (Bolder: University Press of Colorado, 2005), 15.

[16] Snyder and Mitchell, 845.

the state, and in particular, through the socialization of medicine. The approach linked ethical violations to individual Nazis and coercive Nazi medicine rather than indicting German medical research and science for having outlined precisely the same sequence of events that transpired as early as 1920: racial hygiene, selections of degenerative invaders, mandatory sterilization, and selective murder by trained medical professionals without fear of legal consequence. In circumscribing ethical violations and unprecedented medical crimes entirely as a product of socialized medicine, the verdicts offered a rebuttal to mid-nineteenth century arguments about health as an individual right. They opted instead for an indictment that, for some, even reached back to the late nineteenth-century policies concerning sickness insurance established by Bismarck in 1883. The trials allowed researchers and medical specialists to claim innocence in the face of totalitarianism, socialized medicine, and corporate industrial interests. A rush to forget from multiple perspectives prevailed. What had started as first victims *first* rapidly became first victims never.

III. Disability Among Foxes and Hedgehogs: Holocaust Historiography

In reflections about the historiography of the Holocaust, Michael R. Marrus organized his thoughts around a metaphor about hedgehogs and foxes.[17] The metaphor presents a simple binary about the nature of understanding, where hedgehogs are single-focused and relate everything to one "system" or "organizing principle" from which to access deep meaning and "impalpable wisdom." Foxes, on the other hand, are curious about everything and produce knowledge through "methodological inquiry." They possess a range of information and make connections, at times, that appear unrelated and even contradictory. Their "scattered" and "diffused" data capture a range of experiences without the rigid aim of forcing them into one "unitary internal vision." For Marrus, early 1960s and 1970s scholarship was dominated by "hedgehogs" who wrote within grand framing systems that concerned anti-Semitism, totalitarianism, and modernity.

A watershed of foxes appeared in the 1980s and 1990s from a litany of scholars. Survivor-scholars formerly living in exile "grappled with the collapse of civilization as a problem of human existence, of suffering, good, evil, sociopolitical structures, personality disorders, and the Death-of-God" in works

[17] Marrus took the metaphor from Isiah Berlin's 1986 essay about Tolstoy. See Michael R. Marrus, "Reflections on the Historiography of the Holocaust. The Hedgehog and the Fox: An Essay on Tolstoy's View of History by Isiah Berlin," *The Journal of Modern History* 66, no. 1 (1994): 92-116.

of political philosophy, sociology, psychology, literature, and theory.[18] New work engaged the history of racism in Germany and, more specifically, Nazi racial policies; the persecution of the Roma and Rhineland 'Bastards;' the history of everyday life and ordinary people; the history of Nazi women, youth, film; and the persecution of the "hereditarily ill," "asocials," and homosexuals. Debates about the singularity of the Holocaust (*Historikerstreit*), the intentionalist-functionalist dispute about the implementation of the Final Solution, and the very limitations of representation itself drove research.

After 1989, new archives opened, seeding regional works that became the basis for the so-called "European turn" that has dominated the twenty-first century. An avalanche of original work engaged questions about the Final Solution in the East. Surprisingly late came victim studies and Jewish Studies. Substantive research about postwar trials has emerged recently alongside a range of interdisciplinary scholarship engagement, including "lawyers, criminologists, forensic scientists, archaeologists, curators, conservators, anthropologists, genealogists, [and] musicologists, among others."[19] The geographic center of research also shifted in recent years from Germany to what Timothy Snyder called "the Bloodlands" (i.e. Poland, Ukraine, Belarus, the Baltic States, and western Russian regions occupied by Germany). This "spatial turn" has brought with it transnational perspectives, paradigm shifts, language challenges, and interdisciplinary methodological models.[20]

Major scholarship placing "disabled" Germans at the center of research regarding Nazi policy, practice, and extermination did not emerge until the 1990s. Studies about Nazi doctors, racial hygiene, killing by gas, German eugenics, and medical experimentation first trickled out in works that that balanced empirical research and new perspectives about the origins of the Final Solution, the murder of the disabled, and Nazi medicine.[21] By the turn of the century, interdisciplinary works about disability and ableism in Nazi Germany, German medical careers before and after 1945, postwar trials, comparative studies of racism and eugenics, and a growing literature about deafness were explored in significant scholarship.[22] Gallaudet University held an important conference in 1998 about the deaf experience in Nazi Germany

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[18] Wendy Lower, "The History and Future of Holocaust Research," in *Tablet*, last modified April 26, 2018, https://www.tabletmag.com/jewish-arts-and-culture/culture-news/260677/history-future-holocaust-research.

[19] Ibid.

[20] Ibid.

[21] See, for example, Henry Friedlander, Ernst Klee, Michael Burleigh, Götz Aly, Robert N. Proctor, Wolfgang Wippermann, and Robert Jay Lifton.

[22] See, for example, Paul Julian Weinding, Michael S. Bryant, Patricia Heberer-Rice, Jürgen Matthäus, Edwin Black, and Horst Biesold.

and the United States Holocaust Memorial Museum installed a major exhibition in 2004 about so-called "Deadly Medicine" in what was the first such exhibition of its kind curated by the museum. Most recently, methodological studies about the "disabled" body in modern German culture and notions about sub-normality, the so-called degenerate biology, and "ableism" have emerged. More broadly, studies have examined medical practices in the West in transnational studies on war crimes, racism, and mass murder in works from scholars of history, philosophy, public health, anthropology, bioethics, and disability studies.[23]

The delay in this scholarship is owed to multiple factors. The social and political culture through which research is produced has inhibited discussion of the disabled body; unsurprisingly, some of the earliest works were published just after disability studies and disability rights movements emerged in the U.S. and Europe. The very inter-disciplinarity of the work and the transnational, historical, medical, and legal knowledge required for complex studies about a diasporic topic is not supported easily within academic institutions that produce research, more often than not, within the boundaries of nation-states, disciplinary status, and distinct categories of periodization. Indexes and finding aids are rarely designed to include basic categories of inquiry relevant to such work. Privacy laws around medical records have constrained research tremendously, making even a count of victims still an abstract calculation. For the 360,000-400,000 mentally and physically disabled Germans who were sterilized and quarter million victims killed as part of Nazi "euthanasia" policies, a complete listing of victims simply does not exist.[24] Scholarship about "first victims" has grown substantially over the past few decades. It did not arrive last. It was merely 30 years late.

IV. First Victims at Last: Forerunners, Opening Acts, and Afterthoughts

On September 2, 2014, Berlin Mayor Klaus Wowereit welcomed the "long overdue" memorial to victims of "euthanasia" from the foyer of the Berlin Philharmonic before a crowd of about 600 guests. The concert hall is surrounded by monuments about the mass crimes of the National Socialist regime. These include not only major memorials about Jewish, Roma, and German homosexual victims of Nazi persecution – all within 3,000 feet of one another – but also the Topography of Terror History Museum and a series

[23] See, for example, Carole Poole, Brigitte Bailer and Juliane Wetzel, Sharon L. Synder, David Mitchell and Sandy O'Neill.

[24] Paul Julian Weindling, "The Need to Name: The Victims of Nazi 'Euthanasia' of the Mentally and Physically Disabled and Ill 1939-1945," in *Mass Murder of People with Disabilities and the Holocaust*, eds. B. Bailer, and J. Wetzel. 49-84 (Berlin: Metropol Verlag, 2019).

of smaller-scale art installations and information points like Richard Serra's Curve sculpture, a bronze plaque to "euthanasia" victims, and the (now roaming) Monument of the Grey Buses. The Philharmonic was built in 1963 directly upon the demolished villa that had housed the T4 administrative headquarters where 60 bureaucrats and doctors planned and conceived "most of the atrocities that happened" to disabled Germans.[25]

The memorial has been described in European and American media variously with language stressing its "obligation" to educate, to remember, to honor victims, to never forget. Some have emphasized its worthiness as a place to maintain the memory of some 300,000 "disabled and ill people" murdered. For others, it is a "symbol" that informs people about the very "scope" of the killings. The events memorialized by the 2014 unveiling were described in conflicting ways as both a "forerunner of the extermination of European Jews" and a symbol of "the first systematic mass crimes of the National Socialist regime."[26] Multiple individuals have remarked that this memorial will likely be the fourth and final major commemoration concerning the victims of National Socialism in Berlin.

According to Wowereit, activists had been waging a campaign for the memorial since 2007 in which they "had to fight not only against [people] forgetting but also against powerful opponents-science organizations that denied any participation in the 'euthanasia' murders and protected scientists who became criminals."[27] Nevertheless, the history of the fight has roots that preceded 2007 by half a century. According to Dr. Andreas Jürgens, former member of parliament and disability rights activist, that fight had begun as soon as the war ended. The disabled were simply not included in the equality clause of the Federal Republic of Germany's constitution. German Basic Law, Article III made absolutely no mention of them. "We had to fight for years to get the addition made: 'No person shall be disfavored because of disability' [which makes] Tuesday's unveiling all the more important [...] on the 75th anniversary of the authorization of the euthanasia program."[28] Most perpetrators of the "euthanasia" crimes, who sterilized, persecuted, and murdered Germans were never prosecuted apart from a handful of doctors and nurses indicted at two postwar international trials in Hadamar and Nuremberg. A

[25] Gabriel Borrud, "Nazi 'Euthanasia of the Disabled' Can Never Be Forgotten," in *Deutsche Welle*, September 2, 2014, www.dw.com/en/nazi-euthanasia-of-the-disabled-can-never-be-forgotten/a-17895611.

[26] AFP/The Local, "Glass Memorial Honours Nazi Disabled Victims," accessed January 15, 2019, https://www.thelocal.de/20140902/glass-memorial-honours-nazi-disabled-victims. AFP, "Berlin to Open Memorial to Nazis' Disabled Victims," and *Times of Israel*, August 31, 2014, https://www.timesofisrael.com/berlin-to-open-memorial-to-nazis-disabled-victims/.

[27] Gabriel Borrud, "Nazi 'Euthanasia.'"

[28] Ibid.

few others were indicted across a series of German trials at which defendants were depicted as accomplices (*Gehilfe*) rather than perpetrators (*Täter*).

Nazi medical practitioners and bureaucrats were viewed in the German trials "as accomplices driven less by ideology than characterological shortcomings," which led to lenient treatment of defendants and eased the reabsorption of medical professionals into private practice after 1945.[29] Soviet trials were more critical of defendants and therefore led to more punitive sentences. Neither of the two postwar German states acknowledged the full severity of the crimes. Among others, Hugh Gregory Gallagher has noted a general failure of the German medical trials to indict individual perpetrators or the German medical establishment of crimes during the war. He noted that in Munich, at a trial in which 14 nurses were indicted for the murder of over 8,000 children and adults, all were acquitted. One nurse stated that upon her objection to carrying out the murder of a child, she was subject to a "big bawling out."[30] In West Germany, those forcibly sterilized were rarely considered "eligible for payment" under the Compensation Law. In 1957, the West German government declared that the 1933 "Law for the Prevention of Genetically Diseased Offspring" was not "a 'typical' example of National Socialist legislation." The law was only repealed officially in 2007. According to Gerrit Hohendorf, a historian at the Technische Universität Munich, "[t]he stigmatization of people with psychological illnesses and intellectual disabilities did not end after 1945, which is certainly a reason why the public acknowledgment of these crimes has remained so difficult to this day."[31] Historian Robert Parzer has noted that taboos surrounding mental illness in Germany have also obscured the history of these victims whose stories were sometimes only researched by third-generation descendants. Additionally, the taboos have led some to consider these Germans "victims of second rank."[32]

More broadly speaking, serious efforts to establish memorials at the physical sites of murder, or so-called "dark tourism," did not begin in Germany until the 1980s. The former site of the Gestapo and SS headquarters in Berlin, which became the site of the Topography of Terror museum in 2010, was used for exhibitions beginning in 1987. Excavations began two years lat-

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[29] Bryant, 15.

[30] Hugh G. Gallagher, *By Trust Betrayed: Patients, Physicians, and the License to Kill in the Third Reich* (Arlington: Vandamere Press, 1995), 204-233.

[31] Melissa Eddy, "Monument Seeks to End Silence on Killings of the Disabled by the Nazis," in *New York Times*, September 2, 2014, https://www.nytimes.com/2014/09/03/world/europe/monument-seeks-to-end-silence-on-killings-of-the-disabled-by-the-nazis.html.

[32] Franziska Rosher, "Euthanasia Program: The Forgotten Nazi Victims," in *Handelsblatt*, October 21, 2016, https://www.handelsblatt.com/today/politics/euthanasia-program-the-forgotten-nazi-victims/23541798.html?ticket=ST-348135-Lysn7NoYMV7J2415Gqj5-ap5.

er, and a foundation was established to care for the site. In 1993, an architectural competition was launched. The first rendition of the museum remained unfinished for a decade and was ultimately demolished due to inadequate funding. A second competition was launched in 2005 from which a new design and further funding led to the 2010 opening of the building. In 2007, a working group called the "T4 Round Table" was established, which then led to the "Memorial of the Grey Buses." The installation before the Philharmonic remained only from 2008 to 2009, after which it began to "roam" to other "euthanasia"-related sites throughout Germany. In 2011, "[a]fter countless letters, extensive lobbying and meetings with victims' families and other groups," the German Bundestag voted to create what eventually became the "Memorial for the Victims of National Socialist 'Euthanasia' Killings," and opened a design competition.[33] In 2013, a memorial to the victims of mandatory sterilization and "euthanasia" was installed where the Berlin-Buch clinic had once stood as the main transit camp for victims coming from Berlin. Also in 2013, the foundational stone was set for the Berlin 'Euthanasia' Killings Memorial. The following year, the memorial was unveiled before the German minister of culture and the mayor of Berlin alongside disability rights activists, community organizers, some family members of victims, media, and the public. In 2016, the German parliament made the decision to dedicate the 2017 Holocaust Memorial Day ceremony to victims of "euthanasia."

Originally a full center had been planned but budgetary limitations forced the project to be scaled back to a glass front with information boards, multimedia stations, and a bench for reflection. According to Berlin's *Der Tagesspiegel*, "unlike other groups, the 'euthanasia' victims lacked a 'strong lobby'" and many were forgotten for decades by their own families, if remembered at all.[34] The Deutscher Bundestag slated 500,000 Euros for the project, which was ultimately completed through the collaboration of multiple government departments and private institutions including the Foundation Memorial to the Murdered Jews of Europe. The tinted blue glass has been described as having to do with notions of reflection, entrapment, and crimes planned in open sight. Others have suggested that the glass symbolizes the sky "permeable only by gaze [...] [demonstrating] how quickly fellow humans although they are visible, can be systematically excluded."[35] Multiple German texts are represented in braille as well as in deliberately simplified Ger-

[33] Eddy, "Monument Seeks."

[34] AFP, "Berlin to Open."

[35] Visit Berlin, "T4-Memorial and Information Centre for the Victims of the Nazi Euthanasia Programme," accessed January 15, 2019, https://www.visitberlin.de/en/t4-memorial-and-information-centre-victims-nazi-euthanasia-programme. Also, see Erinnerungsort 2014, "Gedenk- und Informationsort für die Opfer der nationalsozialistischen 'Euthanasie'-Morde," accessed January 15, 2019, http://www.sigrid-falkenstein.de/euthanasie/t4_erinnerungsort.htm.

man and English for learning-disabled visitors. Audio commentaries for the blind and sign language videos for the deaf are available. The physical design accommodates visitors in wheelchairs while the 2005 memorial to Jewish victims is not accessible to people with certain impairments thereby underscoring problems encountered when victim identities are commemorated as if existing in isolation from one another.

The gestalt of the memorial echoes Richard Serra's nearby Curve sculpture (*Berlin Junction*). Serra's sculpture is considered a "euthanasia" memorial although it was neither conceived for that purpose nor understood and appreciated as such from a public that greeted it with controversy in 1988. Serra created *Berlin Curves* expressly for the exhibition, *Der unverbrauchte Blick* from January 1987 - April 1987. When the piece did not fit inside the atrium of the Marin-Gropius-Bau as planned it was moved outside the museum. There, framed by an unintended "historically very heterogeneous and vulnerable" backdrop of Berlin, Serra suggested moving it to stand by the Philharmonic for aesthetic reasons concerning the relationship between architecture and sculpture. He "overlooked" the specific history of the location. The sculpture then acquired an a priori T4 meaning that many found unconvincing; in response, the Berlin Senate added a memorial plaque about "forgotten victims" and perpetrators to link the sculpture to the genocide of disabled Germans in 1987. To a lesser extent, the Monument of the Grey Buses too incorporated aesthetic reference to Serra's piece when it was presented in 2008.

At the September 2014 inaugural ceremony, several family members of the victims spoke including two individuals whose relatives are featured in images on the ten stone plaques. When Sigrid Falkenstein was digitizing her family history, she looked into the image of a woman in a family photo and found that her father's sister, Anna Lehnkering, was a Nazi euthanasia victim. Falkenstein explained that her father had "fragmented memories of his sister [...] he only knew that she eventually died in some asylum."[36] Lehnkering had a learning disability and was gassed at Grafeneck in early 1940 at 24. Ms. Falkenstein continued to research her aunt, later publishing a book about her in 2012.[37] "More than 70 years after these crimes, we finally owe these people a place in the memory of our families and a place in the collective memory of our country."[38]

Hartmut Traub learned about his uncle Benjamin's history decades after the war. Diagnosed with schizophrenia, his uncle was gassed at the age of 27 in 1941. Traub described his uncle's decidedly unmerciful death through near tears at the opening ceremony of the memorial. Traub's extensive personal re-

[36] Rosher, "Euthanasia Program."

[37] Sigrid Falkenstein, *Annas Spuren: Ein Opfer der NS-'Euthanasia'* (Herbig Verlag: Stuttgart, 2012).

[38] AFP/The Local, "Glass memorial."

search about his uncle revealed that Benjamin had been admitted to a psychiatric hospital near the Dutch border in 1931. Nine years later, he was selected for transfer 190 miles away to a Nazi "intermediate facility" in the western state of Hesse. In 1942, he was taken to a nearby "clinic" in Hadamar, which was in fact a killing site. According to Traub, "Benjamin stood wedged with 63 other naked men in the narrowest of spaces. The doors closed. Carbon monoxide streamed from the 'faucet' of the showers. Benjamin felt sick. He lost consciousness. After a few minutes he and his 63 comrades in suffering suffocated on the gas." Later, his parents were told that their son had "died suddenly and unexpectedly of the flu with meningitis" and that "because he suffered from a 'serious, incurable mental illness' [...] [his] family should see his death as 'a relief.'"[39] Upon the opening of the 2014 monument, Jürgens reflected. "I personally welcome the notion of a memorial being erected in Berlin as a symbol of recognition for the victims of Nazi euthanasia [...] It must be remembered that [people] were considered 'unfit for life.' We need to start a kind of dialogue that deals with these inhuman occurrences, with the ideas that led to the political goal of creating a 'perfect race' – at the expense of human life."[40]

V. First Excluded Last Included: 'Disability as Master Trope of Human Disqualification'

The complex path that confined postwar trials and delayed both scholarship and memorialization is a product of our shared trans-Atlantic history. This history has led us to miss links and progressions that concern the manner in which bodies themselves have been understood variously as the physical representation of degenerative forces, invaders, aliens, animals, and parasites. Just how did we reach a point in the West where the physical body might be seen as such a threat that physical annihilation was viewed as both a genetic solution and a preemptive defense? And why did revelations about sterilization and mass murder, as Dagmar Hertzog has asked so thoughtfully, fail to "lead directly into any fresh concern for disability rights or make negative attitudes toward the disabled unacceptable in the postwar era [...] for four decades?"[41] Not unrelated, one might ask why so many members of the largest minority in the United States do not, cannot, or wish not to identify as such. Could we, or even would we, construct a federal museum about the history of disability?

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[39] Ibid.

[40] Gabriel Borrud, "Nazi 'Euthanasia.'"

[41] "Debating Abortion and Disability Rights: The Lasting Impact of Nazi Eugenics," in *Items*, accessed January 15, 2019, https://items.ssrc.org/sexuality-gender-studies-now/debating-abortion-and-disability-rights-the-lasting-impact-of-nazi-eugenics/.

This paper has foregrounded a leitmotif of first-victimized/last-recognized in order to examine the rationalization of violence and the devaluation of particular human beings at their core as grounded in abstract, loose, and often arbitrary physical distinctions projected onto bodies past and present. Given this, we might consider contemporary debates about "illegal aliens" and the separation of families or health care and pre-existing conditions to be legacies of this common history; these conversations continue to juxtapose ideas about race, the body, and the health of the nation that, at times, appear to desensitize us to the lives of others; most vulnerable are those for whom a trifecta of disability, immigration status, and childhood converge. Late nineteenth- and early-twentieth century motifs seem to repeat themselves. In the West, health care and human rights have always been tied to politics and propaganda, in part because of the very porousness and subjectivity of our fluid relationship with the body and our perceived ideas about disability. This paper has examined cultural and political rhetoric before, during, and after the Nazi period in order to propose the careful reexamination of the relationship between the past and the present. I argue that first victims have come last because of an adherence to subjective binaries about health and fitness through which we sort individuals in patterns that repeat across memorialization, jurisprudence, historiography, the academy, and beyond.[42]

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AFP/The Local. "Glass Memorial Honours Nazi Disabled Victims." Accessed January 15, 2019. https://www.thelocal.de/20140902/glass-memorial-honours-nazi-disabled-victims.

[42] Edward T. Linenthal's lucid 1995 work *Preserving Memory: The Struggle to Create America's Holocaust Museum* about the 15-year political debate that preceded the opening of the USHMM in 1993 contains just over 100 words about the disabled body and "first victims" across 336 pages. Billings, Montana, is covered in greater detail, for example. My point is not to criticize Linenthal's text or the critical and ethical merit of the Montana story. Rather, I am noting the absence of political debate about "first victims" reflected by the volume. An examination therefore of the history of the museum's Permanent Exhibition (PE) with a first victimized-last recognized pattern in mind would be valuable, especially given the PE's audience of 1.7 million people annually. See Linenthal, *Preserving Memory* (Columbia University Press: Columbia, 1995).

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Lebensunwertes Leben: Roots and Memory of Aktion T4

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Abstract

What the Nazis called Aktion T4 was a euthanasia program, officially started on August 18th, 1939. The registration operations for individuals with physical or mental handicaps were followed by forced sterilization and transfer to clinics organized to kill. In this article, I try to explain the mechanisms that allowed the memory of Aktion T4 to be preserved and passed from one generation to the next; memories of the "merciful death" of approximately 70,000 "lives unworthy of life," that find themselves embedded in family records and family history. In the first section, I summarize the discussion that resulted from the theories of Charles Darwin and Francis Galton. Even if those theories do not in any way allude to the consequences that we have witnessed decades after their publication, they started a debate about the value of life and the legitimacy of human intervention in the selection of hereditary character traits, as well as the concept of race and the different methods and forms of theories and eugenics that were later adopted in Europe and in the United States. In the case of Germany, translated into Rassenhygiene, those concepts flowed into the Nazi project of purification of the German people. Through interviews with families who had a relative interned in one of the program's clinics spread across the Reich territory between 1939 and 1945, I investigate the evolution and passage of memories stored within the family sphere, paying attention to the generational steps and processes of trauma. These stories are born from a complicated process of reconstructing these memories via interviews. Their recollections were full of painful silences and negations, similar to the thought process which led the victims to live in a condition that they could not understand, and separated them from the world before they were each made to face a solitary death, far from any contact with their families. The trauma that I analyze concerns actions that had been carried out by previous generations; in the majority of cases, younger generations were not aware of the destiny of their murdered relatives and therefore tried to rebuild the stories of people who they never had the opportunity to meet. I examine the problematic relationship of those being interviewed with the end-of-life issue and also the sense of guilt which is generated by the awareness of crimes that were committed. Aktion T4 was not a crime committed outside the national borders, nor a crime that extended beyond the private sphere to the "others." Instead, it existed within the most central and intimate place of Nazi culture: the family.

Key-words: *Nazi euthanasia program; transgenerational trauma; racial hygiene; Social Darwinism; eugenics*

I. Introduction

In 1935, barely two years after Hitler and the National Socialist party came to power, the Office for Racial Politics sponsored the making of a short film directed by Carl C. Hartmann entitled *Das Erbe* (*The Heritage*). In a very effective visual way, the film shows the mechanism by which the struggle for survival takes effect, selecting the strongest individuals of different species: "Even animals pursue a racial policy!," the young assistant of the scientist exclaims, while he explains the meaning of the video, showing it to his colleagues. The short film's narrative follows images of individuals faces, deformed by various diseases, to show that by allowing weak elements to survive, man has encouraged the reproduction of pathology in society. The work is particularly interesting because although it was not designed to educate and prepare people for the killing of "ballast existences," and "useless eaters,"[1] it shows how nature's selection includes, among animals, not only the discrimination and persecution of weaker individuals, but also their death. As such, the film could be considered the symbol of the moment of transition in which the eugenics theory married the totalitarian politics of National Socialism and bent to its advantage the reflections that for decades had powered the international debate about "racial hygiene."

What the Nazis termed *Aktion T4* was a euthanasia program officially started on August 18th, 1939. The registration operations for individuals with physical or mental handicaps were followed by the forced sterilization and transfer to clinics organized to kill people considered unworthy of life. In Kaufbeuren-Irsee, where one of the clinics used for the implementation of the program was located, the last killing took place on May 29th, 1945, three weeks after the end of World War II.

I worked on the research project "Lebensunwertes Leben: The Memory of *Aktion T4* in the Victims' Families" in Berlin, a city where historical memory is a legacy with an easily perceivable weight. Although almost all the buildings have been rebuilt following the bombing and the fall of the wall, there is a clear feeling of being surrounded by recent history and that around every corner of the city lies either a memory or a memorial. These different memories do not seem to be isolated, but in dialogue with each other, almost in competition. They fight, they try to make space on the scene and stand out in the eyes of today's spectators.

What do the Germans of today know about the *Aktion T4*? Why do they find it so hard to relate to this crime, compared to the others committed by Nazi Germany? Why in German public libraries is it possible to find entire

[1] Karl Binding, and Alfred Hoche, *Die Freigabe der Vernichtung lebensunwerten Lebens, ihr Maß und ihre Form* (Leipzig: Verlag von Feliz Meiner, 1922), 55.

sections dedicated to the Holocaust, but only a few shelves on the *Aktion T4* program?

My work does not claim to give definitive answers or to provide data that can define the matter conclusively, but to illustrate the mechanisms through which the memory of the actions that led to the "merciful death" of about 70,000 "lives unworthy of life" has been preserved in the private and family dimension and how and with what characteristics it has been handed down from one generation to the next.

The story of Jörg's family, which I will summarize in the second part of this paper, well represents all the other stories I have collected. It can be considered a specific example of mechanisms active in the transmission of a trauma that is a part of the difficult elaboration process of the National Socialist past, which involved the entire German society from the post-war period to today. Whether the will to put an end to one's life or the lives of those who are considered without a chance of recovery is legitimate or not, it is a problem that has aroused interest since ancient times, and the debate concerning the possibility of making euthanasia practices legal is still going on. Focussing on German society for this particular debate, that began centuries ago, and in particular on Nazi Germany, undoubtedly makes this case worthy of interest.

II. Philosophical and scientific context

In his opening speech at the Sociological Society Symposium at the London University in May 1904, Francis Galton used a fairy tale as a device to define the scope of his eugenic theory:

> If we imagined that all the animals in a zoo had capacity for thought and speech and, asking a wise creature among them to collect the opinions of all others to create a system of absolute morality, we would be faced with a vastness of too many different conceptions, given from the different points of view of each species compared to the others (predators, prey, parasites).[2]

All animals, in the opinion of Galton, however, would agree in considering it more desirable to be healthy than sick, strong rather than weak, well-structured than the opposite. As such, he concludes: "The aim of eugenics is to represent each class or sect by its best specimens; to leave them to work out their common civilization in their own way."[3] It was Charles Darwin,

[2] Francis Galton, *Essays in Eugenics* (London: The Eugenics Education Society, 1909), 35-36.

[3] Ibid.

cousin of Galton, who combined the concepts of "species," "adaptation," and "evolution," in his theory of evolution of the species and natural selection.

Darwin had observed that among individuals of the same species, there could be noticed similarities for various factors, and he had concluded that in each population there could be found some differences inherited from the successive generations, but not produced by the surrounding environment. As claimed by his theory, species evolve in the long run, thanks to the action of natural selection that restrains the indiscriminate multiplication of individuals, leaving only the specimens that have reached a better adaptation, and therefore live and reproduce better, to survive.

The new members of the species that have appeared in a generation are selected by the environment itself. Evolution proceeds randomly, according to Darwin, but is directed by the action of natural selection as influenced by environmental factors. In his writings, there is never any reference to eugenics, a term that did not yet exist when he was alive. His theory did not foresee or theorize the need for any intervention outside the action of nature's selection and there was in his theory no vision that could be defined racially, in any way. As Darwin himself wrote: "He blamed a mixture of ignorance and self-interest for the common belief that the distinct races of man were separable species. Has not the white man, who has debased his nature by making slave of his fellow Black, often wished to consider him as another animal."[4] However, it was precisely from the study of his work that Galton founded the new science of the *eu* – meaning '"good" – and *genos* – meaning "lineage:" *eugenics*.

A turning point in 1900 was the rediscovery of Mendel's studies on heredity, conforming to which the physical characteristics, evident in a generation, would be the result of the union of the parents' traits. Also in this case, it was Galton who took the next step, introducing a concept that we could define as "ancestral inheritance." Traits would be understood as hereditary, not resulting only from a mix of the parents' characteristics, but from those handed down by all previous generations.

Recall that the power of selection of a species' characteristics is for Darwin natural, therefore it is determined by a slow variation by the same nature; an evolutionary law that through numerous variations, proceeds step by step, modifying and increasing the adaptation of the species' specimens in relation to the surrounding environment. Is it possible, Galton asked himself, to intervene in this transmission of hereditary traits, or can one be only passive in Nature's hands, without the power to modify what we have received as a gift from it? If we improved our habits, would our children then have better habits,

[4] Jonathan Howard, *Darwin: A Very Short Introduction* (Oxford: Oxford University Press, 2001), 182.

inherited from us? Galton concluded, "What nature does blindly, slowly, and ruthlessly, man may do providently, quickly, and kindly."[5]

Referring to Galton, in order to take charge of directing the action of nature, and bring about a correction to the evolution of the human species, society would have to intervene. As he wrote: "If unsuitable marriages from the eugenic point of view were banned socially, or even regarded with the unreasonable disfavour which some attach to cousin-marriages, very few would be made."[6] This power of intervention is not a simple possibility, but "it is a duty to humanity" and should be exercised in the most advantageous way for the human species, creating a society in which the qualities that are most necessary can produce better and individuals more capable "to refuse representatives of criminals, and of others whom it rates as undesirable."[7] In this point of view, the individual has no value of uniqueness and his existence has the sole purpose of contributing to the progress of the species.

The biological vision of the organism as a set of different organs is thus translated into the social sphere, and goes to define a system-community that has its own life and that, with the advent of Nazism, will also take on a sacred value. The idea that mankind divides into races is certainly linked to scientific and ideological development and has been a specific cultural trait for centuries, becoming the basis of the claim of superiority by the West, "white," world. The meeting of Europe with non-European populations produced a comparison largely based on the observation and description of the physical characteristics of indigenous peoples, and the subsequent belief that these were linked to alleged corresponding psychological-behavioural characteristics.

As the world slowly approached modernity, the concept of race varied and took on different meanings according to the historical phase. Race marked the reassuring boundaries of the distances to be maintained in the phase of conquering the new worlds. Race allowed the increase of the claim of superiority at a point in time when ancient systems had been destroyed. Race put itself at the service of scientific progress, which led to the birth of the concept of nation, and embodied the process in which human beings were ordered and classified according to degrees of inferiority and superiority.

The concept of race slowly took a political-biological connotation, moving from the cultural to the physical sphere. Of great importance was the moment when the idea that humanity divides into races overlapped with the creation of the national states and the birth of the different nationalisms; the

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[5] Francis Galton, "Eugenics: Its Definition, Scope, and Aims," *The American Journal of Sociology* 10, no. 1 (1904): 50.

[6] Ibid., 42.

[7] Galton, *Essays in Eugenics*, 37.

biological component was placed side by side with what we could call *spiritual*, in line with which every people would have been a bearer of a specific "Geist des Volkes," the Spirit that crossed the centuries and inhabited every individual belonging to the national community. If the homeland is, especially for German thinkers, the way in which history implements the divine plan, the "Volksgeist" is then the instrument that makes this realization possible.

The theories that developed from the Darwinist reflection, referred to as Social Darwinism, are distant from the work of the English naturalist, and take on different forms and meanings in every historical and geographical context. Starting from the principles of natural selection and struggle for survival, albeit with distinctly different political implications, they applied the results to the human community with reflections far distant from the conceptions of the English naturalist. These doctrines were born when, in the wake of industrial development, the differences between the bourgeoisie and the proletariat became more pronounced, the importance of the natural sciences and their technical applications grew and new ideas on the action of man began to spread in the social context and in history.

In Germany, it was the doctor and naturalist Ernst Haeckel who first spread the theory of evolution and the struggle for survival, through his own studies and theories. He did so by completely distorting Darwin's thought and theorized, starting from the reading of the evolutionary law, his fundamental biogenetic law, in accordance with which the individual development of the embryos would be a recapitulation of the evolutionary development of the whole species: "ontogenesis recapitulates the phylogeny."[8] His philosophical reading of the whole world, called *Monism*, brought all forms of creation back to a single substance, both material and spiritual at the same time, and quickly took the form of a religion when he founded the *Monisten Bund*. It is interesting to note that in the opinion of Haeckel, suicide was not a reprehensible act, but rather a redemption.

The theme was of great interest in mid-nineteenth-century Germany. Stressing the spread of hereditary diseases and the ever-increasing number of poor people, the German doctor wondered about the possibility of helping those who, affected by an incurable disease, would express their desire to end their suffering and could die. At the base of the formation of eugenic thought and common to most of the different currents, it was the concept of "degeneration," which began to assume ever greater importance in the historical moment in which, after the development of the industrial society, the ruling classes became aware of the conditions of economic and hygienic misery in which the popular classes had to live.

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[8] Ernst Haeckel, *Generelle Morphologie II: Allgemeine Entwickelungsgeschichte der Organismen* (Berlin: Georg Reimer Verlag, 1866), 372.

Once again, the basis on which many theorists built their own speculation was the work of Darwin, who, although he had again no direct connection with subsequent theories, perfectly embodied the role of starting point. As J. Howard wrote:

> The question is simply, when does a variation earn its characterization as 'useful' or 'harmful,' when does an individual earn its characterization as 'fit' or 'unfit?' The right answer must be, after selection. Since the outcome of Darwin did not make this point entirely clear, it was perhaps because he saw the whole argument for natural selection that was to involve a paradox, in that it is the destruction of individuals which is to condition for adaptive or constructive change. If, however, he labelled the variations to be selected as 'useful.' Then the paradox seemed to go away. There is no paradox, of course. Whether they vary or not, because of the struggle for existence.[9]

As Galton hoped, the eugenics theory spread "into the national conscience, like a new religion,"[10] and when the first International Eugenics Congress[11] was opened in 1912, the scientific community had already accepted Galton's new religion, recognizing it as full scientific legitimacy.

From this moment on, the parallel between science and religion characterized the spread of this new faith and shaped its aesthetic vision. If man replaces God and becomes creator of himself, then science takes the form of a "religious temple." In the same way as traditional religion, even the new scientific faith founded by Galton promised perfect and eternal immortality, capable of overcoming even the theological promise of the continuation of life in the kingdom of heaven. The immortality promised by eugenics was the creation of perfect individuals. Just as eternal life, as believed by Christian theology, would have redeemed the pain and suffering of the earthly one, then the eugenics faith promised to overcome the degeneration of the present times by promising the arrival of a healthy future. "The language of eugenics was, from the outset, situated within the climate of the late nineteenth-century interaction between religion and science."[12] Born of the century of scientific dynamism and in opposition to religious dogma, the eugenic ideal assumed the appearance of

[9] Howard, 89-90.

[10] Galton, "Eugenics: Its Definition, Scope, and Aims," 50.

[11] Over 400 participants took part in the Congress, inaugurated in London.

[12] Marius Turda, *Modernism and Eugenics* (New York: Palgrave Macmillan, 2010), 15.

a biological theology and both Europe and the United States welcomed this new theory with open arms, concentrating their attention on different areas of the problem.

What in Germany was defined as "Rassen und Gesellschafts-biologie," was the union of the new nineteenth-century science, anthropology, with social philosophy, eugenics and a particular reading of Darwin's doctrines, and it had as its object of study the improvement of the race, elevated to the role of main nucleus of every social doctrine. The founder of this new social science was the physician, biologist and eugenicist Alfred Ploetz. He coined the term "Rassenhygiene" and directed attention to the two parallel fields of study of the improvement of the race and the prevention of degeneration. The new discipline in fact stood as the union of social science and hereditary biology, and conceived the whole society as a single body, whose preservation had to have priority over the individual's life. The individual was not granted to have a value per se, but only in relation to the community. Without this conception, it would have been difficult to postulate the will to delegate to the State the choice of individuals to be suppressed and those to be multiplied.

The question of eliminating the unsuitable would be the central theme of German eugenicists' thinking, and also the guiding thread in the construction of the subsequent totalitarian ideology. The connection between the collection of statistical data on cranial conformations and on the color of the hair and eyes, by the German Anthropological Society, in 1871 and those of "racial data" made by the Nazis decades later, is evident. Following a well-traced path by the theories of numerous scholars of different backgrounds, National Socialism became the first European government to make racial hygiene a topic of national politics[13] thanks to the previous decade of thought and attention given to the legalization of euthanasia.

III. The memory of the Aktion T4

In the last chapter of his *Die Belasteten*,[14] Aly Götz recounts an instance that took place in 1983, when 192 funerary urns, containing the ashes of victims of the National Socialist euthanasia program, were found in a cellar inside a cemetery near Konstanz, never claimed by the families. The urns have been buried more than forty years later by the authority of the municipality.

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[13] Georg L. Mosse, *Il razzismo in Europa. Dalle origini all'Olocausto,* trans. L. De Felice (Bari: Laterza, 2007), 91.

[14] Götz Aly, *Die Belasteten. Euthanasie 1939 –1945. Eine Gesellschaftsgeschichte* (Frankfurt am Main: S. Fischer Verlag, 2013), 276.

This story can be taken as a paradigm of how a very large number of patients have been killed in a general indifference, without the interest of any member of their families about their fate in life and even in later years. Aly Götz shows us that the bureaucratic apparatus of the clinics was not able, for one patient out of four, to establish who the close relatives were and where they resided.

However, even among the remaining three out of four families who were therefore warned, there was not necessarily an interest. Many other urns have certainly remained in the cellars of many German cemeteries for decades, and perhaps still today, they rest in the darkness of some rooms. Though for the transfer of minors it was always necessary to have written authorization from the family, for adults it was not necessary for authorities to warn family members in advance.

The doctors who presented to the parents the possibility of subjecting their children to risky therapies had often exaggerated the possibility of positive success, and therefore in many cases it cannot be said that the relatives were really able to understand what would have happened, in the same way as the families of adult patients, who only became aware of transfers from one clinic to another when the transfer had already taken place.

The entire structure of the forced euthanasia program had been built so that nothing could leak to the outside, and consequently with the aim of making the space of personal responsibility unstable, allowing (if that was possible) that the families of the patients should not ever come face to face with the truth. However, the "secret" was somehow revealed. News of the killing of patients spread among the population and in the summer of 1941 the operations were officially interrupted. It, however, continued, in a decentralized way, until the end of the war and beyond, as we have seen. Jörg's story is an example of how the memory of these events has remained in the family dimension with much pain, many difficulties and a lot of unresolved feelings.

To be able to identify the traumatic mechanisms with which memories have been handed down, it must always be kept in mind that the value that the German culture attributed to the family had, at the time, very different characteristics and nuances from those of today, and defined, a different concept of identity.

The trauma analyzed concerns actions carried out by previous generations of my interviewee, who was not aware of the history of the great uncle killed in the *Aktion T4* program. After having encountered this family secret, he tried to reconstruct for the first time the series of events that occurred to this relative he never knew.

Jörg was born in 1977, has a degree in history and works in Berlin as an archivist. Alois Zähringer, his great-uncle, was born on September 20th, 1921, in Bleichheim, Baden-Württemberg. On August 9th, 1929, he was admitted to the St. Joseph Catholic institute, in Herten, with the diagnosis of epilepsy and profound dementia. He remained there until August 20th, 1940, when he was transferred to the Emmendingen psychiatric center, an intermediate stage of the T4 program. Eighteen days after his arrival, on September 6th, 1940, Alois was taken to Grafeneck, where he was killed on arrival.

Jörg did not have a good relationship with his paternal grandparents, the relatives of Alois. During the interview, he emphasizes how the victim's sister, his grandmother, was a woman full of hate:

> The relationship to the parents of my father were always very distant. My grandmother on my father's side (the sister of the victim) was a woman with a lot of hate. She and her husband (my grandfather) were not heartful, they were bitter people, they didn't like to talk about personal things, their lives or feelings.[15]

When the woman died, Jörg's father dreamed of hearing her still alive in the coffin, and of someone jumping on it to not let her come out:

> When my grandmother died in 1993 my father felt relieved. He dreamed that his dead mother would be in the coffin and trying to escape because she was not really dead. In his dream my father jumped on the coffin until it was quiet inside and he was sure she couldn't escape.[16]

Jörg was a curious child and tried, during his childhood, to ask the grandparents about the Nazi period, even wanting to know if his grandfather had committed crimes, unlike many of his peers. The father's interest in history and current affairs has certainly facilitated the breaking of the taboo present in German society, creating the space and the possibility for a generational exchange, often unthinkable in other German families.

When I asked him to tell me on what occasion and from whom he had known of the existence of his great-uncle, he used the verb "discover." It was a discovery, even if casual, that he came across when asking his grandmother for help to reconstruct the family tree.

[15] Jörg W., Personal Interview realized by Erika Silvestri, Berlin, November 2018.

[16] Ibid.

From the woman's words, he learned that Karl Friedrich, her younger brother, died when he was still a child. Searching for documents at the registry office, however, Jörg discovered that Karl Friedrich had never existed: The boy's real name seemed to be Alois, and he did not appear to have died as a child.

> I discovered the fate of my great uncle by coincidence. When I was 12 years old I was interested in family history and I did some genealogical research. At the begin I asked my grandparents about their siblings and parents and grandparents. I wanted to draw a family tree and needed this kind of information. My grandmother told me, that she was born in 1913 in Bleichheim, that she had several siblings, Oskar, Karl Friedrich and Anna Zäzilia. I asked for the dates of birth and death. She didn't know them all. Karl Friedrich, she told me was younger than her and died as a baby (or small child). She couldn't know that I wrote letters to the Standesamt in her birth town and asked there for the birth certificate and death certificate. They answered me that there is no Karl Friedrich Zähringer, my grandmother must have been confused, his name was Alois, he was born in 1921 (so 8 years younger than my grandmother). They also told me that he didn't die as a baby, but that on his birth certificate is a note regarding his death. Unfortunately, I could not read this note. I only could read "1940" and a place like "Grafenruck," "Grafeneck," but I didn't know where it is.[17]

Incredulous, Jörg asked for explanations from his grandmother, who seemed then to remember other details: perhaps her little brother was sick, perhaps he lived in a hospital.

> I asked my grandmother and she seemed to be surprised about what I had discovered. The only thing she admitted was, that he was kind of sick and had sometimes "attacks" and that he lived in an hospital. More information I was not able to get from her. Only one year later in November 1990 I read in the local newspaper an article, that in Grafeneck a memorial site was inaugurated for the victims of the Nazis who were murdered because they were disabled or handicapped. Only then I started to understand and went on with my research.

[17] Ibid.

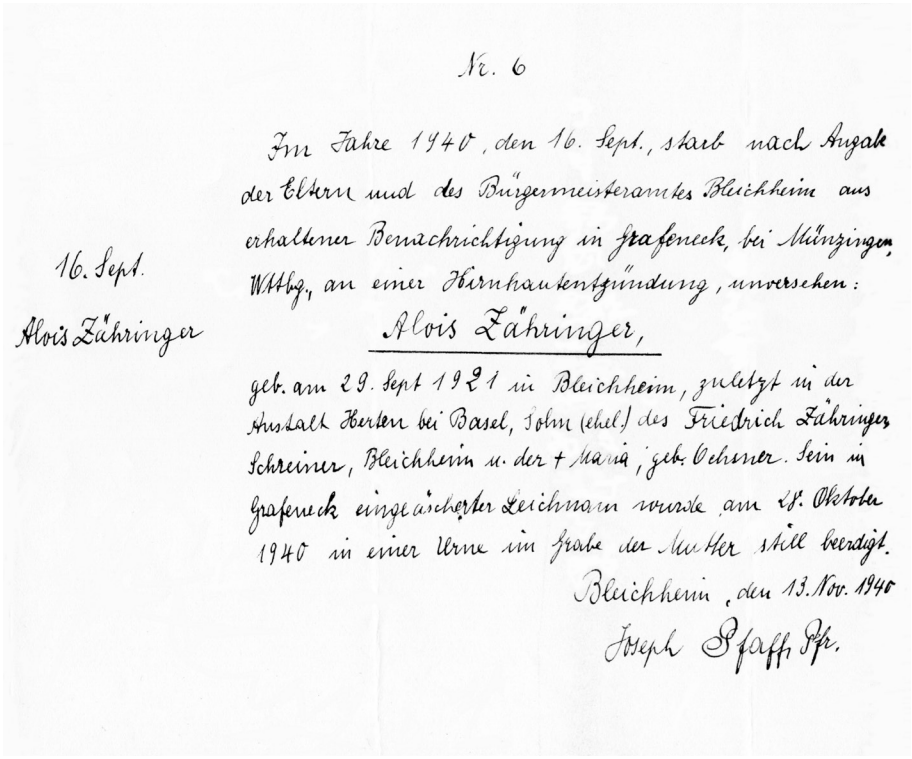
> Although my father was a teacher for history and also interested in the Nazi time he never had heard from Grafeneck before. He knew, that handicapped and disabled people were murdered but he didn't know anything concrete about it.[18]

Intrigued by the strange behavior of his grandmother and determined to shed some light, Jörg made the decision to undertake research. The initial failure discouraged him for a few years, but he did not lose all his interest, until he decided to enroll in the faculty of history in Berlin.

> When I was 12 years old, I found out the existence of Alois and only one year later, in 1990, I understood why he died in Grafeneck, after I read by coincidence a newspaper article about the memorial site in Grafeneck. I contacted the "Samariterheim" in Grafeneck and asked for further information. They told me that all the documents were destroyed by the Nazis in WW 2 and that they can't give me further information. They recommended a small monography about Grafeneck and I bought that, and I thought that's the end of my research, because as they said, the Nazis destroyed all the other material. I lost my interest. In 1996, I had finished the Gymnasium, I continued during my civilian service with my genealogical research and suddenly I found an important document: in the burial register [see Image 1] I discovered an entry, that Alois was buried in his hometown in Bleichheim, with information about his official date of death and cause of death and with the information that he lived before in Josefsanstalt Herten. So, I had a new trace. I contacted Herten, they told me from when to when he lived in Herten. And they told me that he was deported on August 20, 1940 to Emmendingen, before being deported to Grafeneck. So, I contacted the psychiatry in Emmendingen and they had also one document about him. I visited Herten and Emmendingen – and also Grafeneck, several times –, because I wanted to see these *sites* with my own eyes. I made a step and contacted the only half-sister of my grandmother who was still alive, Margarete.[19]

[18] Ibid.

[19] Ibid.



Nr. 6

Im Jahre 1940, den 16. Sept., starb nach Angabe der Eltern und des Bürgermeisteramtes Bleichheim aus erhaltener Benachrichtigung in Grafeneck, bei Münzingen, Wttbg., an einer Hirnhautentzündung, unversehen:

16. Sept.

Alois Zähringer

Alois Zähringer,

geb. am 29. Sept 1921 in Bleichheim, zuletzt in der Anstalt Herten bei Basel, Sohn (ehel.) des Friedrich Zähringer Schreiner, Bleichheim u. der † Maria, geb. Ochsner. Sein in Grafeneck eingeäscherter Leichnam wurde am 28. Oktober 1940 in einer Urne im Grabe der Mutter still beerdigt.

Bleichheim, den 13. Nov. 1940

Joseph Staffl Pfr.

Image 1

It was Margarete herself who revealed to him a decisive detail: Alois would have been born healthy and his disease could have been caused by a fall, while Jörg's grandmother was holding him in her arms.

> She told me, that Alois was healthy when he was born, that my grandmother when she took care for him as a babysitter, was not careful enough and he fell down on the floor and from that day on he was disabled. I don't know if the story is true, it can also be that this is another fairy tale in my family, to keep the family "clean" it was not a genetic disease, it was just an accident. Only now I found in Herten information about his diagnosis [see Image 2] and a description of his disease: *Angeborener Schwachsinn* (inherent idiocy) mit *Epilepsie* (epilepsy) und *Seelenstörung* (mental disorder).[20]

[20] Ibid.

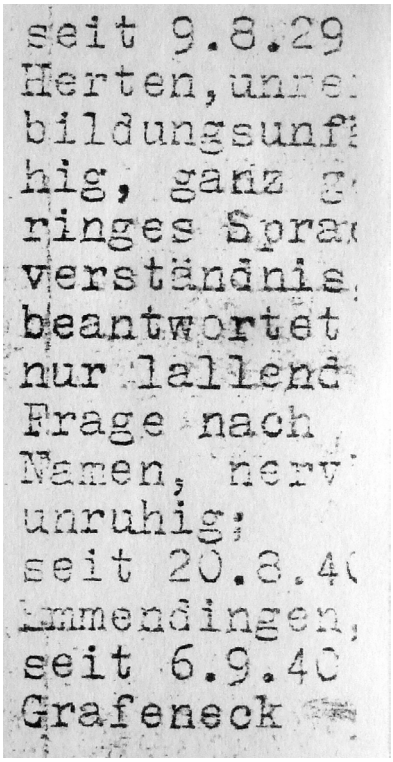


Image 2

Margarete kept a photograph in which Alois also appeared. But the child is apart, far from the rest of the family, it is almost impossible to find him [see Image 3]. Significantly, there are no other pictures of him, in the family's archive. Jörg defines the discovery of this family secret as something extraordinary:

> At the begin I was more fascinated that I found out a family secret as a 12/13 years old boy. When I moved to Berlin and studied history I put my focus immediately on the Nazi time and the Holocaust. For me it was very clear from the start that I can't deal with the crimes of the Nazis in an academic way if I ignore what had happened in my own family. More and more I also felt that it is my obligation for Alois to remember him. That's the only thing I can do for him. The Nazis murdered him, my family collaborated in that way that they made him forgotten, he didn't exist any longer. I had to go on with the research to bring him back to the memory, back to my family, back to life. I'm aware that this is only possible on a symbolical way,

because he was murdered and he remains dead. But that's the only thing I can do for him.[21]

Image 3

All my interviewees have expressed, although in different forms and at different times, a tenacious desire to break the taboo of silence concerning National Socialism, trying whenever possible to question their grandparents or older relatives about their memories of the war period. This tenacity seems to be the manifestation of a strong inter-generational tension and this is even more evident considering that in Germany, from the post-war period to the present, the inter-generational dialogue between grandparents and grandchildren was almost non-existent, to the point of becoming a tangible sign of a social break.

When I questioned German acquaintances about why it is still considered so difficult to talk about Nazism in the family circle, I was told that "it is / was not the case," "it is not a sign of good education," "one does

[21] Ibid.

not have the right to put elderly people in the position of having to justify themselves, without knowing what we would have done in their place," and "speaking of this in the family is considered a taboo." Why, then, was Jörg the first to break the family taboo, forcing the rest of his family to confront their own heavy past?

In my opinion it was precisely the connection of these stories familiar with the *Aktion T4* that allowed the last generations to break the heavy caesura present in German society. They discovered they are exceptions – and they discovered it by coming across a family secret – because having a direct link with the world of the victims, they are not tied only to that of the executioners, like the other Germans.

Although in different ways, everyone claimed to have perceived in their families something undeclared and unresolved, a sort of Freudian emotional process in place, capable of generating complex sensations, coming from a past event that they neither knew nor knew to explain, yet they clearly felt. To come across this "secret-non-secret," which the family does not want to talk about, but seems to have disseminated clues to highlight its existence, is the younger generation, that of the grandchildren or great-grandchildren of the victims. Strengthened by their temporal distance from the tragic events, they had the strength to want to understand what was being silenced. Hidden in a heavy silence, the closest relatives of the victims have instead tried, with time, to forget the fate of their loved ones.

No family unit came out unscathed from the will of the youngest to reconstruct the history of the victims. Relationships between the members of the same nucleus have been altered, for better or for worse. Those who were tied in a particular way, now feel even more bound; those who had a difficult relationship now have a greater distance. The fact that these changes have occurred is complex to explain. The factors involved are multiple and closely linked to each other, to the point of creating a dense network of pain and silence, similar and different at the same time for each family unit.

In the text *Die Unfähigkeit zu trauern. Grundlagen kollektiven Verhaltens*,[22] psychoanalysts Alexander and Margarete Mitscherlich explain how thousands of German citizens who had been enthusiastic supporters of Hitler, developed psychological defenses after the war to respond to guilt, shame and remorse. Among these defenses, the most notable was the dissociation of conscience, which allowed the crisis to be overcome without a real awareness of it.

[22] Alexander and Margarete Mitscherlich, *Die Unfähigkeit zu trauern. Grundlagen kollektiven Verhaltens* (München: Piper, 1967).

"Trauern," to grieve, is necessary, Mitscherlich tells us, for a healthy mental evolution.[23] For Germany, it was not possible. There was no time, it was not the case, and legitimate mourning could not exist in the eyes of the world for people who had committed crimes so heinous, that they redefined "crimes against humanity."

IV. Conclusions

Talking to the Germans about the euthanasia program implemented during the Third Reich is still very difficult. This is because it is linked to a very problematic relationship that many people have with the concept of "the end of life," as well as a sense of guilt that was generated by the awareness of the crime committed. But why is the argument still perceived as one of the most difficult to deal with?

The killing of the handicapped and the mentally ill, (among which many were depressed and misunderstood) is perhaps the crime that most of all, in my opinion, managed to fit into the private sphere of the citizens of the Nazi Germany, breaking up the emotional balance and family dynamics in the name of the purification of the "Aryan race."

If it is true that man is a social animal, then it is precisely feelings that bring him closer or away from other human beings, that define him.

As is in evidence from the story of Jörg's family, and other stories that I have collected during my research, there was never an external enemy that could be pointed out from a safe distance, an enemy from whom one could be disinterested, but fathers and mothers, and sons and daughters, were sacrificed by a will that was stronger than any bond of blood.

This is perhaps the scariest face of *Aktion T4,* the one that reflects our ability to hate, in the name of any faith, even a part of ourselves.

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[23] Mitscherlich, Chapter 1.

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"Weakness of the Soul:" The Special Education Tradition at the Intersection of Eugenic Discourses, Race Hygiene and Education Policies

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Abstract

According to Vera Moser, the first professorship of healing pedagogy, Heilpädagogik at the University of Zürich in 1931, established pedagogy of the disabled as an academic discipline. Through the definition of the smallest common denominator for all disabilities, which Heinrich Hanselmann called "weakness of the soul," a connecting element of "imbecility, deaf-mutism, blindness, neglect and idiocy" was established. Under Nazi rule, school pedagogy advanced to völkisch, nationalist special pedagogy, shifting from the category of "innate imbecility" to a broader concept of disability. As an outcome of these programs and policies, 300,000 people with disabilities were killed as a part of the "T4 Aktion." Within just a few decades after World War II, special pedagogy expanded its sphere of influence through professionalization and institutionalization in West and East Germany and across Europe. This paper explores how special pedagogy aligned itself with the Nazi regime's discourse and policy on eugenics and race hygiene, leading to the murder and mass sterilization of "disabled" children and adults. It probes questions regarding the extent to which the professionalization of special pedagogy has drawn from the Nazi-era terminology of the deficient and foreign to legitimate the contemporary migrant bias in German and Austrian special pedagogical care.

Key-words: *special pedagogy; special schools; eugenics; euthanasia; DisCrit in education; inclusion*

I. Introduction

In 2006, the United Nations embarked on a policy shift that would recognize the social model of disability and turn toward ensuring the dignity of human beings with disabilities by addressing barriers to their participation and inclusion in all aspects of social, personal, and professional life. These policy shifts were embodied in a document known as the United Nations Convention on the Rights of People with Disabilities (UNCRPD). Article 24.2b of the

Convention mandates that signatory countries ensure inclusive education of all students close to the communities in which they are growing up. The thrust of this international agreement made segregation into special schools illegal and pushed toward closing all of them. More importantly, this piece of legislation, which is supported by EU policies on greater inclusivity for social coherence,[1] forced the issue of abolishing barriers that limited access to quality education not only for children with disabilities, but also for other children disadvantaged by poverty or migrant status. Although Germany and Austria have signed the UNCRPD, in these countries perceivable tensions exist in the way they implement these ideas in the context of highly fragmented school systems that place students with disabilities at the bottom of the performance hierarchy.

As a new phenomenon, inclusion does not have a chance in the face of special education, which educators perceive as having a long tradition without questioning its past. Dagmar Hänsel draws attention to blind spots in the historiography of the academic discipline of special education. She argues that it tells the tale of a discipline unencumbered by its National Socialist (NS) past, despite the role educational facilities played in the mass sterilization or even murders of people with disabilities during the Nazi era. Hänsel stresses: "[I]t was often overlooked that the law of enforced sterilization of hereditary defective offspring affected not only patients of mental hospitals, but most prominently students in special schools."[2] The absence of this examination of the past led to the undisrupted expansion of special education in postwar years. Within just a few decades after World War II, special education widened its sphere of influence through professionalization and institutionalization in West and East Germany and across Europe.[3] In this article, I investigate and illuminate the continuities of special education terminology, discourses, and practices that contribute to the construction of the deficient and foreign "other," creating barriers for students along the lines of physical and mental abilities, poverty, ethnicity, and migration.

I will start by analyzing the medicalization of education abilities that resulted in the profiling of healing pedagogy (*Heilpädagogik*) as a splinter branch of education studies, which took place gradually throughout the 19th century. To make my point more explicit, I will review notions that circulated around the connection of educability, soul and human being from the 17th century on

[1] See for example "European Union Council Recommendation of May 22, 2018, On Promoting Common Values, Inclusive Education, and the European Dimension of Teaching (2018/ C 194 /01)," *Official Journal of the European Union* (June, 2018).

[2] Dagmar Hänsel, "Special Pedagogy in National Socialism," *University of Innsbruck Lecture Series: Inclusive Pedagogy*, filmed 10 November 2016 at Universität Innsbruck, video, 14:22-14:41, https://www.youtube.com/watch?v=5WCoWkNxh5U.

[3] Lisa Pfahl, *Techniken der Behinderung: Der deutsche Lernbehinderungsdiskurs, die Sonderschule und ihre Auswirkungen auf Bildungsbiographien* (Bielefeld: Transcript, 2011), 94ff.

to show that different approaches to disability existed before the natural sciences entered pedagogical discourses and foregrounded the trope of "deficient blood" as the common denominator for deviant behavior. Second, I want to shed light on the formative years of special education, which are strongly debated in academia. Some scholars contend that special education ceased to exist under Nazism, while others argue that the discipline flourished because of the ideology of race hygiene and eugenics. Finally, I will return to the present debate and the pushback that the implementation of inclusion receives in Germany and Austria. I will highlight the idea emphasized by the UNCRPD – that a social model of disability has not yet entered general education and that mainstream education continues to rely on the deficit view of students to channel the disabled, racial and poor Other into specialized tracks.

II. The Common Denominator of 'Disability'

For centuries, scholars assumed that the soul was the distinctive characteristic that allowed humans to learn, to think, and to be. Beings who could not verbally perform these acts were in turn considered to be deprived of a soul, possessed by the devil, or simply less than human. In *Cretinism and Imbecility* (2015), Johannes Gstach focuses on the pedagogical treatment of people with cognitive disabilities and mental abnormalities from 1780 to 1900. Tracing different belief systems on educating people with disabilities through the centuries, Gstach highlights the work of Czech philosopher and pedagogue Jan Amos Comenius. As the author of the first comprehensive textbook, *Magna Didactica* (1657), his philosophy was "to teach everyone everything."[4] Despite this inclusive approach, Comenius also stated that those without reason did not need to attend school.[5] Moving into the 18th century, Johann Heinrich Pestalozzi founded the Neuhof, a school for poor children to develop and cultivate their minds through farming.[6] Opening schools for the poor (*Armenschule*) represented a development in pedagogy: educators recognized that impoverished conditions had detrimental effects on a person's ability to learn, grow, and develop reason. Poorhouses and schools for the poor were signs of an increasing social responsibility, albeit one limited to religious or philanthropical initiatives. Drawing on Michel Foucault's broad ideas on the great confinement

[4] Johannes Gstach, *Kretinismus und Blödsinn. Zur fachlich-wissenschaftlichen Entdeckung und Konstruktion von Phänomenen der geistig-mentalen Auffälligkeit zwischen 1780 und 1900 und deren Bedeutung für Fragen der Erziehung und Behandlung* (Bad Heilbrunn: Klinkhardt, 2015), 89.

[5] Gstach, *Kretinismus*, 89.

[6] Fredalene Bowers, and Thom Gehring, "Johann Heinrich Pestalozzi: 18th Century Swiss Educator and Correctional Reformer," *Journal of Correctional Education* 55, no. 4 (2004): 309.

helps to understand control, separation and differentiation when government policies started to manage social immiseration. In *Discipline and Punish* (1977), Foucault uses the example of the leper and the plague to describe two closely related mechanisms that can characterize the governing of populations. The existence of the leper, he contends, led to the binary division between the sick and the healthy, while the plague enforced disciplinary projects through "differential distribution (who he is; where he must be; how he is to be recognized; how a constant surveillance is to be exercised over him in an individual way, etc.)."[7] I share Foucault's interest in studying how governmental power manifests through policies that structure and affect the lives of individuals. Through this frame, one recognizes that it was a crucial moment when children with disorders and disabilities were considered educable and became subjected to government interventions. Foucault stresses the 19th century was peculiar in that "it applied to the space of exclusion [...] the technique of power proper to disciplinary partitioning."[8] Translating this peculiarity to the context of education, the 19th century not only discovered the educability of the "abnormal" child but also formulated different ways to partition and compartmentalize deviance. Furthermore, through the medicalization of social, health, and educational policies, children and adults with disabilities were gradually placed in the hands of state institutions that concentrated, counted, and tracked them.

With Foucault's perspective in mind, the 19th century brought differentiation among special educators into three groups, focusing on the deaf-mute, the blind, and the mentally and cognitively impaired. The first special schools were established for the sensory-impaired: for the deaf-mute in 1780 and the blind in 1804. Considering the triad of education, soul, and verbalization, schools for the deaf-mute and the blind presented a revolutionary breakthrough, as education and therapy enabled children to externalize thoughts and communicate. Sieglind Ellger-Rüttgardt points out how significant the founding of public schools for the deaf and the blind was, as these "schools guaranteed the right to education for disabled students permanently."[9] Whereas students of sensory schools could gradually claim full personhood, for children with cognitive disabilities the issue of expression nevertheless still remained. From the 1840s on, mentally disabled children were included in (pseudo-)educational facilities[10] such as "idiocy wards" ("*Id-*

[7] Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books), 199.

[8] Ibid.

[9] Sieglind Ellger-Rüttgardt, "Sonderpädagogik – Ein blinder Fleck der Allgemeinen Pädagogik? Eine Replik auf den Aufsatz von Dagmar Hänsel," *Zeitschrift für Pädagogik* 50, no. 3 (2004): 419.

[10] Johannes Gstach, "Heilpädagogik in der Zeit zwischen den Weltkriegen," in *Behinderung und*

iotenanstalten"), which focused on practical treatment and care; schools for the poor that tended to consist of children from impoverished homes; and help schools (*Hilfsschulen*) that concentrated on children with weak cognitive abilities (*schwachbefähigt*). Under the influence of healing pedagogy, help schools advanced to the strongest sub-group. Gstach notes the 1864 publication of the healing pedagogue Heinrich Stötzner *Schools for the Weakly Abled* as a milestone in the establishment of help schools.[11] Stötzner argued in favor of help schools that would take up the space between the Volksschule, i.e., general education, and idiocy wards. Whereas the idiotic student was a lost cause "since already dead," the "feeble-minded" ones would drown in general education and be returned to their communities as burdens without skills or knowledge. Hence, help schools for the feeble-minded were the ideal place to turn these students into productive members of society. In his text Stötzner characterized the typical help school student as follows:

> Experience has shown enough that also mentally weak children – not the idiotic ones because those must already be called dead – can be lifted to a higher level and be educated to sensible, useful humankind [...] however, this task cannot be taken over by the general school [...] The general school has different tasks to solve than to struggle with the mentally weak and feeble-minded. [...] Especially in the lower social classes where proper nourishment, a healthy home, careful education of children is lacking, the number of the feeble-minded turns out to be truly terrifying.[12]

This quotation situates the help school clientele in particular in the lower social classes of society, thereby adding an aspect of charity and welfare care to its pedagogical agenda. Ellger-Rüttgardt highlights the fact that the Volksschule in Germany profited immensely from help schools (later called special schools), which were relieved of educational responsibility for students who did not fit a fictitious norm.[13] Lisa Pfahl, on the other hand, argues that help schools were the driving force in creating demand for their own establishment. Stötzner's elaborations above support Pfahl's hypothesis. She summarizes, by segregating the "poor, sick, help school students" from the general student population, the Volkschule would be cleansed and the help school would safeguard the socially

Gesellschaft, ed. Gottfried Biewer, and Michelle Proyer, 22-44 (Wien: University of Vienna, 2019), 25.

[11] Gstach, "Heilpädagogik," 26.

[12] Heinrich Stötzner, *Schulen für schwachbefähigte Kinder: Ein Entwurf der Begründung derselben* (Leipzig: Winter'sche Verlagshandlung, 1864), 8-9.

[13] Ellger-Rüttgardt, "Sonderpädagogik," 420.

deprived student clientele. Pfahl points out that healing pedagogy increasingly sought cooperation with medical doctors and the police to suppot, but also to report and register, its own student population.[14] Hence, the criminalization of help school students perpetuated their Othering and contributed to the stigma of a potentially dangerous student population that had to be removed from the center of society. From 1893 to 1912, help schools and their student populations increased significantly in Germany. Over roughly 20 years, 37 help schools consisting of 2,300 students mushroomed into 305 schools consisting of 34,300 students.[15] In Austria, Gstach explains, the decline of the Austro-Hungarian Empire and the subsequent reach of the nation-state through education policies allowed for the rapid expansion of help schools in "Red Vienna" and a few other regions of the country until the 1930s.[16] However, through these efforts, the invisible hand of governance, as Foucault described, received extensive access to parts of the population that were considered deviant and disabled. Coinciding with growing social care through government institutions, *Rassenhygiene* – race hygiene, a term coined by Alfred Plötz in 1895, based on Darwin's theory of the survival of the fittest – gained wide recognition. The "'Sonderweg' of German Eugenics," as coined by Paul Weidling, encapsulates the fact that the pseudo-science of eugenics was not a German invention alone. Darwin's concept of "natural selection" that he laid out in *On the Origin of Species* (1859) turned into an experiential playground for followers, such as Francis Galton or Karl Pearson who claimed that as much as physical features were inherited from generation to generation so must be character traits and certain predispositions.[17] In his 1869 work *Hereditary Genius: An Inquiry into Its Laws and Consequences*, Galton expresses out:

> I wish again to emphasise the fact that the improvement of the natural gifts of future generations of the human race is largely, though indirectly, under our control... We must distinguish clearly between our power in this fundamental respect and that which we also possess of ameliorating education and hygiene. It is earnestly to be hoped that inquiries will be increasingly directed into historical facts, with the view of estimating the possible effects of reasonable political action in the future, in gradually raising the present miserably low standard

[14] Pfahl, *Techniken*, 87.

[15] Gstach, "Heilpädagogik," 27.

[16] Ibid.

[17] Daniel Okrent, *The Guarded Gate: Bigotry, Eugenics and the Law That Kept Two Generations of Jews, Italians, and Other European Immigrants Out of America: Bigotry, Eugenics and the Law That Kept Two Generations of Jews, Italians, and Other European Immigrants Out of America* (New York: Scribner, 2019), 15.

> of the human race to one in which the Utopias in the dreamland of philanthropists may become practical possibilities.[18]

At the late 19th century, Galton presented the scientific community with the concept of "positive eugenics," i.e. the manipulation of the gene pool through education, hygiene and deliberate breeding to produce, healthy, strong bodies; it is not yet the destruction of life considered unworthy of life in the National Socialist sense of eugenics. Nonetheless, Galton explicitly ranked African peoples inferior to what he described as the accomplishments of European civilization, thereby paving the way for extending individual features to an entire group of people, perpetuating a language of white superiority. Theorizing of this kind fell on fertile ground in the context of U.S. immigration policies as Daniel Okrent details in his book *The Guarded Gate* (2019). Incoming population demographics were controlled through prioritizing entrance for "White," Nordic ethnicities, shutting out Jews, Italians, Eastern European and Asian migrants, etc. from 1924 to 1965.[19] Also government-funded forced sterilization of mostly African American women and women of lower socio-economic status who were labelled "feebleminded" took place from 1900 to 1970s, resulting in an estimate of 60,000 victims of eugenics.[20] It is, thereby a very poignant question to ask as Henry Friedlander does in *The Origins of Nazi Genocide* (1995) "why American eugenics withered and died while German race hygiene succeeded in imposing on society its radical vision of a biological-social utopia."[21] Other than in England or the United States, the German *Sonderweg*, special path, describes the wedding of science with nationalistic fantasies of a superior race that presented the Nazis with a pseudo-scientific ideology upon which enslavement of "inferior races," such as Slavs, Jews, Roma, etc. was legitimated. In this spirit, Plötz and colleagues argued for breeding of desirable human characteristics through sterilization and marriage ban for "Asocial" people, meaning those who did not have a job, who were alcoholics, prostitutes, suffered from mental illness or were cognitively disabled.[22] Looking at larger institutions of social care, in

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[18] Francis Galton, *Hereditary Genius: An Inquiry into Its Laws and Consequences* (London: Macmillan, 1869), xxvvii.

[19] Okrent, xv.

[20] Zanita E. Fenton, "Disability Does Not Discriminate: Toward a Theory of Multiple Identity through Coalition," in *DisCrit: Disability Studies and Critical Race Theory in Education*, eds. David J. Connor, Beth A. Ferri, and Subini A. Annamma, 203-212 (New York: Teachers College Press, 2016), 208.

[21] Henry Friedlander, *The Origins of Nazi Genocide: From Euthanasia to the Final Solution* (Chapel Hill and London: University of North Carolina Press, 1995), 16.

[22] Georg Lilienthal, "Rassenhygiene im Dritten Reich. Krise und Wende," *Medizinhistorisches Journal* 14, nos. 1-2 (1979): 114-115.

the 1920s, also hospitals and schools became complicit in eugenic research when they provided "records of many hundreds of twins needed for research in hereditary disease,"[23] as Paul Weidling points out.

While the sensory special schools were adamant about remaining distinct from help school teachers, student clientele, institutions, and funding, the discipline of healing pedagogy strived to combine all three branches into one special school complex outside mainstream primary education.[24] For this to happen, healing pedagogy needed to distinguish itself as an academic discipline that not only focused on the "feeble-minded" student body but on all types of disabilities. As the natural sciences advanced into the sphere of pedagogy, psychopathology and medicine turned out to be great assets in this endeavor. While putting an end to the demonization of the disabled as possessed by spirits, rational observations brought remarkable understanding of medical conditions.[25] However, the alliance of psychopathology and pedagogy turned out to be especially fruitful in the professionalization process of healing pedagogy. Pfahl explains that the medical and psychological perspective on the individual child was enforced through the IQ test brought forward by Alfred Binet and Theophile Simon in 1905.[26] Intelligence measurement as an objective tool to distinguish students' abilities joined the repertoire of healing pedagogy, through which it could claim scientific credibility as well as authority over diagnosis, classification, and treatment of the child who performed below average. Under the framework of DisCrit (disability studies and critical race theory in education), Subini Annamma, Beth Ferri and David Connor have continuously analyzed scientific racism. They show how racial segregation of African-American students has been justified through lower performance rates on apparently objective IQ testing scales.[27] Although the German government points out that intelligence tests alone are problematic in determining a child's special needs status, they are still a trusted tool in school practice. During my ethnographic field research at a German primary school in 2018, the special education specialist explained that the IQ test was "the tool of last resort" to determine a child's mental abilities if all other observations and assessments produced no distinct diagnosis. Return-

[23] Paul Weindling, "Weimar Eugenics: The Kaiser Wilhelm Institute for Anthropology, Human Heredity and Eugenics in Social Context," *Annals of Science* 42, no. 3 (1985): 310.

[24] Moser, "Gründungsmythen," 265.

[25] For example, iodine deficiency was identified as a reason children were born with cretinism. With supplementary nutrition, the child's growth and development were stabilized. See Gstach, *Kretinismus*, 225.

[26] Pfahl, 101.

[27] Subini Annamma, Beth Ferri, and David Connor, "Dis/ability Critical Race Studies (DisCrit): Theorizing at the Intersections of Race and Dis/ability," *Race Ethnicity and Education* 16, no. 1 (2013): 1-31.

ing to the foundational years of healing pedagogy, the IQ test was just one phenomenon that was distinctive at the beginning of the 20th century, when biological answers were being sought to social questions. Paul Weidling has presented remarkable scholarship that illuminates eugenic ambitions in the German-speaking territories from the Kaiserreich to the Nazi regime.[28] He points out: "Weimar administrators hoped that eugenics could solve intractable social problems with its promising combination of genetic, medical, and demographic expertise."[29]

When Heinrich Hanselmann finally closed the gaps among the three branches of special education, he also achieved full academization of the discipline as the first professor of healing pedagogy at Zurich University in 1931. Hanselmann, who was also honored by the medical society for his achievements, developed the term "weakness of the soul" (*Seelenschwäche*) as the smallest common denominator of conditions, such as "imbecility," "deaf-mutism," "blindness," etc. Vera Moser and Detlef Horster characterize "weakness of the soul" as a state consisting of "the inability to think sufficiently, the inability of sensory organs to perceive impression from the environment or insufficient will power due to social deprivation and neglect."[30] The construct of "weakness of the soul" built on the long tradition of associating disability with an inferior quality of the soul that educators had been discussing since the 17th century. At the same time, "weakness of the soul" rendered social aspects of disability and deviation invisible and attributed difference to some innate fault. Under the influence of the eugenics movement, everything that was presumably at fault with the human being was traced back to inferiority of blood, which then allowed for Nazi ideology as a "nation of pure blood" to deem any type of mental or physical a deviance from the norm. "Weakness of the soul" enforced the binary division between normal and deviant and at the same time differentiated deviance into individual "disciplinary projects," in Foucauldian terms, to which laboratories, wards, and special schools directed their attention. Furthermore, the construct not only pushed a deficient and humiliating view of the mentally and cognitively disabled student, but also imposed an inferior perspective on the sensory-impaired. Plurality of abilities was exchanged with inferiority to the standard norm, commencing an obsession with the perfect human body and mind.

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[28] Paul Weindling, "The 'Sonderweg' of German Eugenics: Nationalism and Scientific Internationalism. The British Journal for the History of Science," *Genetics, Eugenics and Evoultion: A Special Issue in Commemoration of Bernard Norton (1945-1984)* 22, no. 3 (1989): 321-333.

[29] Weindling, "Weimar," 304.

[30] Vera Moser, and Detlef Horster, "Einleitung: Ethische Argumentationen der Behindertenpädagogik – Eine Bestandsaufnahme," in *Ethik in der Behindertenpädagogik. Menschenrechte, Menschenwürde, Behinderung*, eds. Vera Moser, and Detlef Horster, 13-22 (Stuttgart: Kohlhammer, 2011), 15.

III. Special Schools: Accomplices of National Socialism

Whereas Sally Tomlinson points out that the eugenics movement affected education systems globally,[31] in the following, I will narrow the perspective on healing pedagogy/special education more strictly to the German and Austrian context. Aktion T4 and the "decentralized euthanasia killings" were carried out in both parts of German-speaking Nazi territory. With the annexation of Austria in March 1938, both countries officially fell into ideological and institutional lockstep. So did the two countries' social, educational, and health institutions. As Dagmar Hänsel explains: "In Vienna, the German Association for Children Psychiatry and Healing Pedagogy was founded. Its founding date was Sept. 5, 1940, at the University of Vienna in the Great Auditorium of the Neurological-Psychiatric University Clinic."[32] In a 1990 documentary by the Austrian Broadcasting Company (ORF), the historian Michael Hubensdorfer publicly detailed how Austrian psychiatrists and doctors took up leading positions in German medical facilities or killing sites established by the Nazis in occupied Poland, and Germans in Austrian facilities. He stated:

> The highest-ranking psychiatrist in Germany, the Berlin psychiatrist Maximilian Dekrenis, came from Graz in Austria and was crucially involved in medical science politics, as well as a doctor who was a concentration camp commander: Dr. Irmfried Eberl, who had previously studied in Innsbruck [Austria] before taking a position at a psychiatric clinic in Berlin [Germany] and then becoming the director of Treblinka [Poland].[33]

Herwig Czech's scholarship shows that from 1939 to 1941, Nazi officials operated six central killing institutions in which over 70,000 people were deemed unfit to live and were consequently murdered.[34] Hartheim was the first institution in history in which production-line, mass extermination took place, serving as a blueprint and harbinger for Aktion Reinhardt, the most atrocious period of the mass killing of Polish Jews in Nazi-occupied Poland. The laws for Prevention of Heredi-

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[31] Sally Tomlinson, *A Sociology of Special and Inclusive Education: Exploring the Manufacture of Inability* (London: Routledge, 2017), 65.

[32] Dagmar Hänsel, "Sonderschullehrkräfte im Nationalsozialismus," in *Behinderung und Gesellschaft*, eds. Gottfried Biewer, and Michelle Proyer, 120-135 (Wien: University of Vienna, 2019), 120.

[33] Johannes Neuhauser, "Hartheim: Behindert, ausgegrenzt, getötet," *Sendereihe Orientierungen, ORF 1990*, video, 18:37-19:42, https://www.youtube.com/watch?v=tFUQZNi372I.

[34] Herwig Czech, "Von der 'Aktion T4' zur 'dezentralen Euthanasie:' Die niederösterreichischen Heil- und Pflegeanstalten Gugging, Mauer-Öhling und Ybbs," in *Fanatiker, Pflichterfüller, Widerständige: Reichsgaue Niederdonau, Groß-Wien*, ed. Christine Schindler, 219-266 (Wien: Dokumentationsarchiv des Österreichischen Widerstands, 2016), 219.

tary Deficient Offspring (*Gesetz zur Verhütung erbkranken Nachwuchses*, GzVeN), issued on July 14, 1933, and the Law of Protection of German Blood and German Honor" (*Gesetz zum Schutz deutschen Blutes und der deutschen Ehre*) from Sept. 5, 1935 created the legal reality that gave way to the frenzy of eugenics. In Foucauldian terms, "where judicial institutions and medical knowledge [...] intersect, statements are formulated having the status of true discourses with considerable judicial effects."[35] Discourses that were generated on the basis of these laws led to the disenfranchisement, dehumanization and mass extermination of European Jews, Sinti and Roma, homosexuals and the disabled. As Henry Friedlander writes, "Nazi genocide did not take place in a vacuum."[36] Considering that teachers in help schools were "over-proportionally represented among authors of the race-hygienic discussion of the NS regime,"[37] pedagogy's participation in the perpetuation and practice of isolation and extermination must be scrutinized.

When Hitler became Reich Chancellor in March 1933 and the NSDAP took power, the Weimar Republic ceased to exist, and the NS state was reorganized on the basis of complete lockstep of government institutions, unions and interest groups. At the end of this process, 97 percent of all educators were organized in the National Socialist Teachers Association (National Sozialistischer Lehrerbund, or NSLB).[38] The NSLB had already been founded in Bayreuth in 1926 and integrated into the National Socialist German Workers Party (NSDAP) in 1929.[39] After 1933, the NSLB organized all teachers in subgroups corresponding to their main areas of service, such as subchapter IV "Volksschule" (primary school) or subchapter V "Sonderschule" (special school).[40] Hänsel contends that the common task of working on the 1933 Law for the Prevention of Hereditary Deficient Offspring (*Gesetz zur Verhütung erbkranken Nachwuchses*, or GzVeN) contributed to uniting the different groups of special educators (deaf-mute, blind, help school and "idiocy wards"). Derived from this task was a new professional ethos that saw special education as essential in protecting the nation. The GzVeN law de-

[35] Michel Foucault, *Abnormal: Lectures at the Collège de France 1974-1975* (London: Verso, 2003), 11.

[36] Henry Friedlander, *The Origins of Genocide: From Euthanasia to the Final Solution* (Chapel Hill: The University of North Carolina Press, 1995), 1.

[37] Dagmar Hänsel, "Quellen zur NS-Zeit in der Geschichte der Sonderpädagogik," *Zeitschrift für Pädagogik* 58, no. 2 (2012): 244.

[38] Astrid Ludwig, "Was geschah im Lehrerbund?" *Jüdische Allgemeine*, November 13, 2017, https://www.juedische-allgemeine.de/kultur/was-geschah-im-lehrerbund.

[39] Uwe Schmidt, *Lehrer im Gleichschritt: Der Nationalsozialistische Lehrerbund Hamburg* (Hamburg: Hamburg University Press, 2006), 11.

[40] Individual interest groups of special educators for the deaf-mute, the blind, the help school, and the care wards remained intact only as "sub-units" (Fachgruppe) within subgroup V "Sonderschule" (Special School) of the NSLB.

fined psychiatric diseases such as schizophrenia, epilepsy and bipolar disorders as hereditary, and it enumerated as "hereditary diseases" congenital feeble-mindedness, inherited blindness, inherited speech impediment and inherited deafness.[41] In April 1934 sub-division V of the NSLB published its first journal, "Die deutsche Sonderschule" ("The German Special School"). In the journal's first issue, the editor wrote:

> We have to make sure that the growing German power of the people [Volkskraft] is not diluted through nation-foreign, race-damaging humanity. For the care of the disabled, but still promising, student with regard to the life of the nation, we have to act in adequate form responsibly; to eradicate the completely invalid is the duty to sustain the nation. Herein lies the heavy responsibility of all special school teachers toward our father country.[42]

The author of these lines was Paul Ruckau, a teacher of deaf-mute students, who left no doubt about the newly acquired professional ethos of "sustaining the people's power of the nation" through appropriate education or "ausmerzen" – eradication. As Henry Friedlander remarks, "spreading the gospel of race hygiene, the scientists offered courses on race and eugenics to public health officers, SS physicians, teachers, nurses, and civil servants."[43] At this point, the 1942 handbook *Erbe und Schicksal* (*Heritage and Faith*) by Karl Tornow and Herbert Weinert must be taken into account to understand that eugenics was an essential part in the curriculum of special school teachers' education and sterilization of help schools students a declared goal. Tornow, a help school rector and a member of the Gau leadership of Magdeburg-Anhalt, and Weinert, a teacher of deaf-mute students and a Gau leadership member of Saxony and a Wehrmacht soldier, were both employed in the NSDAP's race politics bureau. This propaganda institution, as Werner Brill describes it, aimed for acceptance and understanding of NS racial and population politics among the general public.[44] Tornow and Weinert de-

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[41] Hänsel, "Sonderschullehrkräfte," 122-123.

[42] Original text: "Wir haben dafür zu sorgen, dass die aufwachsende deutsche Volkskraft nicht durch volksfeindliche, rasseschädigende Überhumanität gedrosselt wird. Für die Betreuung behinderter, aber für das Volksleben noch aussichtsvoller Schüler haben wir in angemessener Form verantwortungsbewusst zu wirken, das völlig Unwerte auszumerzen verlangt die Selbsterhaltungspflicht der Nation. Darin liegt die schwere Verantwortung aller Sonderschullehrer dem Vaterland gegenüber." See Marietheres Triebe, *NS-Ideologie in der NSLB-Zeitschrift "Die deutsche Sonderschule" 1934-1944: Eine dokumentarische Analyse* (Frankfurt am Main: Protagoras Academius, 2017), 53.

[43] Friedlander, *Origins*, 20.

[44] Werner Brill, "Die Verankerung der Eugenik durch die Sonerpädagogik während des Nationalsozialismus: Historische Fakten und sonderpädagogische Historiographie," in *Behinderung und Gesellschaft*, ed. Gottfried Biewer, and Michelle Proyer, 107-119 (Wien: University

clared that they had intended *Heritage and Faith* to be a book that would help its readers "find the necessary understanding for the existential race-hygienical questions of our nation and guide them toward the appropriate attitude."[45] The book would be especially welcome by "special schools and their teachers,"[46] they recommended. *Heritage and Faith* is divided into three parts: "Of heredity and genetics," "Of physically and mentally inherited diseases" and "Of the prevention of hereditary deficient offspring." In the first part, the basics of genetic laws are explained through genealogical family trees and the laws of Mendel to exemplify how human characteristics are inherited.[47] Part two deals with inherited physical disabilities, such as missing limbs or mild and severe malformations; inherited diseases of the eyes and ears; inherited speech impediments; nervous and cognitive diseases; and "family diseases" such as alcoholism, suicide or "undignified character" that showed itself in the "asocial" or the "antisocial." The final part then proposes answers to the question what the "hereditary deficient" should do if he/she wants to get married and have a family. It is followed by the subchapter on "Von der Unfruchtbarmachung" – "On creating infertility," i.e. sterilization. Each part is designed like a textbook that prepares its readers for passing a test. Questions at the end of each subchapter and solutions at the end of the book invite them to practice the "right" answer. For example, after muscular atrophy is discussed, question number 80 asks: "Why is it good that the person in picture 1 already died in his youth?"[48] The answer may be found in the back of the book: "Because he felt very unhappy and death relieved him of his heavy suffering."[49] In between chapters are calculations to exemplify the financial burden of different types of students. While the government spent on students in the help school and the Volksschule an annual amount of only 200 and 125 Reichsmark respectively, the uneducable mentally disabled cost 950 Reichsmark and the hereditary blind or deaf student 1,500.[50] The book repeatedly stresses that help school students who proved their usefulness to the nation were not a burden as long as they did not pass on their hereditary deficiencies.[51] Space here does not suffice to detail the extent to which the book negates the dignity of human beings. Pictures of abled-bodied, strong German girls or boys next to those of children with impairments evoke the patronizing, dehumanizing effect at which the book is aiming.

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of Vienna, 2019), 112.

[45] Karl Tornow, and Herbert Weinert, *Erbe und Schicksal* (Berlin: Alfred Metzner Verlag, 1942), 5.

[46] Ibid.

[47] Ibid., 19ff.

[48] Ibid., 69.

[49] Ibid., 219.

[50] Ibid., 187.

[51] Ibid., 167.

The book trains special school educators to convince their students that their own sterilization and reintegration into the German nation as "silent heroes" was the only honourable deed they could perform.[52] As Hänsel shows, Karl Tornow was a highly influential special educator. He advocated renaming healing pedagogy as special pedagogy/education (*Sonderpädagogik*) so that aspects of healing, rehabilitation and education would take a backseat in pedagogical efforts for children with disabilities and impairments. Under Tornow's influence, special education operated under the NS premise of protecting the nation from deficient and damaging elements of society. From Hanselmann to Tornow, the move to couple and combine genetic predispositions, social class and deviant behavior into one concept of "disability" (*Behinderung*) had been performed and made operational.

IV. Special Education and Inclusion: The Paradox Continues

Through the decades, special education has continued to hold a tight grip over the education of children with disabilities. In both former East and West Germany, children with special needs and disabilities were educated primarily in special facilities, the largest subset being to this day the "learning-disabled" (38.8 percent), followed by those with cognitive development issues (16 percent).[53] In a report by Klaus Klemm on inclusive education in Germany, the author notes: "for the 1950s and 1960s, without a doubt, a strong expansion of the area of special schools can be spoken of: within 20 years, educational participation in special schools of 12-year-olds rose from two to five percent."[54] This expansion cannot be explained through a normal increase in children who needed special pedagogical care, the authors state, but through an increase in special educational facilities that recruited more and more students. This dynamic should seem familiar, as the former help schools established themselves in a very similar fashion through the "pull-in" function they held with regard to "cleansing" general education of slow and "feeble-minded" students (see Stötzner quote). Another peculiar development can be detected since the implementation of inclusive education in Austria in 2008 and in Germany in 2009. The Tyrol monitoring report for Austria and Klemm's study for the German context note that inclusive education did not lower the number of students under special educational care; on the contrary. Whereas more students have been included in mainstream education, the number of students in special schools has barely decreased.[55]

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[52] Dagmar Hänsel, *Karl Tornow als Wegbereiter der sonderpädagogischen Profession: Die Grundlegung des Bestehenden in der NS Zeit* (Stuttgart: Klinkhardt, 2008), 160.

[53] Klaus Klemm, *Inklusion in Deutschland: Daten und Fakten* (Bertelsmann Stiftung, 2015), 32.

[54] Ibid., 14ff.

[55] See Tiroler Monitoringausschuss zur Umsetzung der UN-Konvention über die Rechte von

Hence, inclusion has *de facto* led to an expansion of special education in the whole education system.

Despite the horrendous experiences in care wards and residential institutions from which children and adults were deported, often directly to the killing premises, the practice of isolating people in centralized institutions away from home continued after the war. At the hands of religious orders (West Germany, Austria) or state educators (East Germany), cases of violence, violation of human dignity and the trope of "ineducability" surfaced over the decades.[56] Brigitte Wanker's autoethnographic accounts are just one example that depicts the failure of centralized institutions to protect the dignity of their residents. The UNCRPD responded to the detrimental legacy of collecting people with disabilities in mass institutions with its phrase "inclusive education close to home." Despite Austria's proximity to Italy, where students with disabilities have been fully included in the general education system since the 1970s, the special school system and care wards have prevailed even today. Norbert Myschker emphasizes: "After World War II, the German special school system continued its work where it had been interrupted in 1933. A closer analysis of the violations that were committed in the name of the discipline or the murder of children was not discussed."[57] Hänsel goes so far as to contend that the NS era was the most significant time of establishing special pedagogy as a professional discipline in Germany and Austria.[58] What can be said for certain is that only in 2009 did Benjamin Ortmeyer present one of the first substantial and critical re-evaluations of leading educational scholars in the time of National Socialism.[59] Whereas contemporary scholars of special education, such as Sieglind Ellger-Rüttgardt, Heinz-Elmar Tenorth and Andreas Möckel, argue that special educators have acknowledged the pain and crimes inflicted on people with disabilities under the veil of special pedagogy during the time of the NS, Brill, Ortmeyer and Hänsel contradict this notion. They demand an honest and comprehensive self-evaluation of the discipline and a way forward that takes the past into account. In 2009, when Ortmeyer presented his study, Germany ratified the UNCRPD. The international call for inclusive education increased pressure on special schools and special educators to justify the continuous segregation of their students from mainstream facilities. Strong ideological debates ensued.

Menschen mit Behinderngen, *Inklusive Bildung in Tirol*, 2011, 7ff; Klemm, 6.

[56] Brigitte Wanker, "Mauern Überall," in *Behindertenalltag - Wie Man behindert wird*, eds. Rudolf Forster, and Volker Schönwiese, 21-34 (Wien: Jugend und Volk, Youth and Nation, 1982).

[57] Norbert Myschker, "Geistigbehindertenpädagogik," in *Geschichte der Sonderpädagogik*, ed. Svetluse Solarova, 84-120 (Stuttgart: Kohlhammer Verlag, 1983), 114.

[58] Hänsel, "Sonderschullehrer," 122ff.

[59] Benjamin Ortmeyer, *Mythos und Pathos statt Logos und Ethos: Zu den Publikationen führender Erziehungswissenschaftler in der NS-Zeit: Eduard Spranger, Hermann Nohl, Erich Weniger und Peter Petersen* (Weinheim: Beltz Verlag, 2009).

Instead of depicting the range of arguments, I would like to add to the debate with a few statistics on the student population of special schools.

In a 2009 report, the Boston Consulting Group (BCG), an international management firm, focused on the devastating consequences for the German economy if students with migrant backgrounds continued to be "the great losers in the German education system."[60] The report highlighted that 9.6 percent of students in Germany shared a migration background. In secondary education, these students made up only 4 out of 100 of those who enrolled in the Gymnasium – the academic secondary schools. Much larger proportions of migrant students attended the *Hauptschule* (20 percent), which qualified them for basic, vocational training, or special schools, where students with migrant backgrounds made up 16 percent.[61] In the Austrian context, the government report *Migration and Integration* presented the following statistics regarding the 2016-2017 school year.[62] Whereas 3.3 percent of students whose first language was Turkish attended special schools (*Sonderschule*), only 1.7 percent attended general education (*Volksschule*). This means twice as many children with a Turkish migrant background are educated in separated facilities for children with disabilities and special needs than in mainstream schools. In addition, more children whose first language was Bosnian/Croatian/Serbian attended special schools – 4.8 percent, compared to 2.9 percent in general education. The Tyrol monitoring report also points out a clear gender bias in special schools "male children and teenagers are strongly overrepresented in special schools."[63] Klemm's study shows that in the 2013-2014 school year, across Germany, 71.3 percent of special school students did not graduate, thereby losing the opportunity for further training education, and financial independence.[64] Considering the statistics, students in special schools belong primarily to an at-risk group of students, characterized by their migrant backgrounds and low socio-economic capacities. This phenomenon has also been noticed by DisCrit scholars in the United States, who constantly call out "the disproportionate placement of students of color in

[60] Christian Veith, Martin Koehler, and Monika Reiter, "Standortfaktor Bildungsintegration: Bildungschancen von Schülern mit Migrationshintergrund entscheidend für Standort Deutschland," *The Boston Consulting Group*, June 25, 2016, https://www.bcg.com/de-de/perspectives/141130.

[61] Veith, Koehler and Reiter, 10.

[62] Statistik Austria, *Migration und Integration: Zahlen. Daten. Indikatoren 2018* (Vienna, 2018), 47, https://www.bmeia.gv.at/fileadmin/user_upload/Zentrale/Integration/Integrationsbericht_2018/Statistisches_Jahrbuch_migration__und_integration_2018.pdf.

[63] Tiroler Monitoringausschuss, 7.

[64] Klemm, 23.

special education."[65] A look back at Stötzner's description of the help school population rings familiar, to some extent. In light of the statistics above, special schools reproduce the stigma of a place for criminalized, dangerous and deficient Others. As students are referred to special schools at particular points of transition, i.e., from kindergarten to primary school or on entering secondary education, it is possible that some children in Austria and Germany will never spend a day of education at the centre of society but always in specialized institutions.

Only when the UNCRPD was ratified by Germany in 2009 and Austria in 2008 did individual states/regions in both countries move forward with the implementation of more inclusive concepts in education. Because of both countries' federal organization, some German states, such as Bremen, or Austrian regions, such as Reutte in Tyrol, have shown promising initiatives in inclusive education through learning centers that supplement mainstream schools to better cater to the needs of a diverse student population. In other states, such as North Rhine-Westphalia in Germany or parts of Tyrol in Austria, the segregation quota has not changed much, and new special schools have even opened. The argument that parents should be able to choose where to educate their children helps win election campaigns for candidates who defend the differentiated school system.[66] Even in areas where special schools have been eliminated, disability is managed through special pedagogical needs status, a label placed on students in inclusive settings based on performance in assessments. In other words, despite the major paradigm shift pushed by UNCRPD, pedagogical assumptions and toolboxes are still based on medicalized practices and terminologies, which serve the Othering of special-needs children through differentiation and segregation. Drawing on the analogy between governing a city and managing a school, the Foucauldian notion of a "pure community"[67] helps in understanding how special schools provide a place to keep the general school community "pure" – in other words, homogeneous. The German and Austrian differentiated school systems build on mainstream and special schools, thereby following the illusion of homogenized schools that can be upheld through the option of channeling unsuitable students out of the mainstream and into special facilities. Paradoxically, this logic does not

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[65] Claustina Mahon-Reynolds, and Laurence Parker, "The Overrepresentation of Students of Color with Learning Disabilities: How 'Working-Identity' Play a Role in the School-to-Prison Pipeline," in *DisCrit: Disability Studies and Critical Race Theory in Education*, eds. David J. Connor, Beth A. Ferri, and Subini A. Annamma, 145-156 (New York: Teachers College Press, 2016), 145.

[66] Ministry for School and Education of the State North Rhein-Westphalia, *Bildungsportal des Landes Nordrhein Westfalen*, https://www.schulministerium.nrw.de/docs/Schulsystem/Inklusion/index.html.

[67] Foucault, *Discipline*, 198.

change in inclusive settings, which build on nine different classifications of special pedagogical needs status. As a former teacher in a Berlin secondary school, I, together with the special educator, was confronted with the possibility of awarding my students up to nine different classifications of special education needs status (*sonderpädagogischer Förderbedarf*): learning (*Lernen*), emotional and social development (*emotionale und soziale Entwicklung*), language (Sprache), cognitive development (*kognitive Entwicklugn*), physical and motor development (*körperliche und motorische Entwicklung*), seeing (*Sehen*), hearing (*Hören*), autism (*Autismus*), and compensation of disadvantage due to: illness" (*Nachteilsausgleich bei "Krankheit"*).[68] These categories bear striking similarity to the "disability" construct that Tornow established. The fact that inclusion cannot be realized without the diagnostic tools (IQ testing) and the terminology of special pedagogy (*sonderpädagogischer Förderbedarf*) speaks to the prestige and the power of the discipline which I hope to have shown through a historical perspective regarding the origin of special pedagogy and the developments it underwent.

V. Concluding remarks

Stacy Gallin and Ira Bedzow remark that "the Holocaust is a unique event, both in the history of genocide and in the history of professional ethics."[69] The Holocaust also marked a time in which educators turned in their students to be sterilized and/or murdered for the greater good of the "healthy and powerful nation." One goal of this paper was to illuminate the extent to which special education was infiltrated by racist and eugenic discourses that led to complicity in the murder of the disabled, Jews, Sinti, Roma and homosexuals. Another was to point out how special education continues to construct the racial and disabled Other, with detrimental effects on the educational chances of the students who fall under its influence.

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[68] Compare Berliner Senat, *Leitfaden zur Feststellung sonderpädagogischen Förderbedarfs an Berliner Schulen*, https://www.berlin.de/sen/bildung/schule/.../leitfaden_foerderbedarf-2017.pdf.

[69] Stacy Gallin, and Ira Bedzow, "Holocaust as an Inflection Point in the Development of Bioethics and Research Ethics," in *Handbook of Research Ethics and Scientific Integrity*, ed. Ron Iphofen, 1-20 (Dordrecht: Springer, 2019), 2.

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The Holocaust, the Human Corpse and the Pursuit of Utter Oblivion

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Abstract

The purpose of this article is to show that the current incineration techniques of corpses are directly related to the Holocaust itself and its purposes. It is the same technique which, in the inhuman years of Nazi atrocities, was developed to be applied massively against the Jewish people and the other groups, because as a method it served and expressed both politically and ideologically the plan of a "final solution:" the final "dis-solution," the disappearance of the human body even as a residue, because the human body, even as a corpse, still retains identity and value. The findings of this study suggest a different analysis of the Nazis' choice to eliminate the corpses of the Jews, while, at the same time, exploring the original approach offered here helps to understand better the value that the human corpse retains. Many social and religious groups that currently refuse to accept this way of managing human corpses become more understandable in their choice not to accept what nature itself denies but modern technique imposes, namely perfect oblivion, extinction of the corpse. Initially, it is presented in historical and intercultural terms in which ways human societies mainly behave towards the human corpse along with the most prevalent funeral burial customs. Subsequently, the semiology of the human corpse is evaluated in terms of philosophical aesthetics and is included in the corresponding aesthetic categories. Finally, this work airs and analyzes new bioethical issues which arise considering this ever-increasing tendency towards the practice of those responsible for the Holocaust, namely the disappearance of the human corpse.

Key-words: *Holocaust; utter oblivion; human corpse; living bones; incineration; pulverizing; decomposition; annihilation; ugliness; tragedy; sublime*

I. Introduction

By using the historical term *Holocaust*, one denotes the implementation by the Nazis of the program of the so-called "final solution,"[1] which culminated in the camps of mass extinction and the conclusive murder, among others, of about six million European Jews during the Second World War.

[1] Pierre-André Taguieff, *Ο Αντισημιτισμός*, μετάφραση Γ. Σιδέρης (Αθήνα: Άγρα, 2019), 115-120.

In its realization, the Holocaust took on the character of total extermination: extinction of the synagogues, of archives, books, of all the evidence which could substantiate the existence of the targeted Jews. This means that the perpetrators did not find destruction sufficient but beyond this they also intended utter oblivion. Why did they actually decide to extinguish the Jews? Because for them it was the only possible way to achieve a definite, a final solution. In any other case, for instance if they merely changed the use of the synagogues while leaving intact the buildings, they would leave behind a certain piece of evidence for the existence of the Jews and no total extinction would be achieved. This would mean that a revival of the Jews could potentially take place sometime later. Any of us can figure out in which way the empty places of worship and the "lifeless" Jewish archives could pose a threat: they would clearly be living testimonies, evidence of a historical discontinuity, of an unnatural vacuum in the new German society which underwent a process of violent transformation at that time. They would still as well represent the future potentiality to give back to the Jewish faith and Jewish culture their prior place in the German society. The means employed towards the extinction were as regards the buildings the violent deconstruction/dissolution and as regards the spiritual evidence (archives, books etc.) to set them on fire, which literally amounts to the Holocaust on a material scale. In other words, what could not dematerialize by means of fire was definitively eliminated by deconstruction and dissolution.

An issue, the significance of which has not been so far assessed the way it should, is the fact that exactly the same combination of the two aforementioned forms of destruction of the material (synagogues) and the spiritual elements (books) of the Jewish existence, i.e. on the one hand fire and on the other deconstruction/dissolution, was chosen by the Nazis with regard to the corpses of the Jews.[2] It should certainly be noted that the annihilating cremation and pulverization of human corpses was not an invention and a creation of the Nazis. In the 18th century we have already the first mechanical cremations of dead bodies. But it was Nazism that for the first and so far the only time in history imposed the mass incineration against certain targeted groups of people on the basis of racist criteria. This means that a technique was selected which was meant to bring upon the corpses of the Jews just the same radically negating effects: absolute disparition, annihilation, oblivion.

We consider that the tactic of the mass burning[3] of the corpses of the Jews was not at all chosen by chance and that it cannot be explained solely

[2] On the history of the cremation of the dead I recommend the very accurate, concise and unsurpassed study of Jakob Grimm, *Über das Verbrennen der Leichen* (Berlin: F. Dümmler, 1850).

[3] Facing History and Ourselves, *Holocaust and Human Behavior* (Brooklyn, MA: 2017), 494, 497.

according to the argument of saving space and time – or exclusively for hygienic reasons. We take into account that from mid-March until the beginning of April 1943 three gas chambers and correspondingly three crematoria had already begun their operation in Auschwitz (in the camp that after the war was to be considered as the historical symbol of the Holocaust) thus increasing dramatically the "production" of death and the conveyance of corpses. By June of the same year one more unit with a gas chamber and crematorium had been added to Auschwitz. All these units exterminated on a daily basis 4,756 corpses which were speedily made into powder. In the summer of 1944, six complete units comprising gas chambers and crematoria were operating and the daily destruction of corpses exceeded the number of 9,000. The crematoria were not enough and so cremations began to be carried out in holes in the outdoors area of the camp.[4]

In general, we refer only to some of the practical reasons that have been stated but we insist on the other hand that there always were ideological reasons behind the Holocaust, as it has been elsewhere mentioned.[5] While on the one hand, the fact that the killing of the victims happened in the form of an offense to their religious faith expressed an insult to the dignity of the victims and at the same time resulted in them being dishonored, on the other hand it constituted an integrated expression of the ideological convictions of the Nazis. As Evangelos Protopapadakis rightly observes, Nazi Germany invented "practical methods" that were allegedly based upon some reason (e.g. the right to opt for euthanasia) but in their implementation they served the ideological orientation of the ruling party (finally, after several manipulations and pretexts, they characterized the Jews as "not justifiably" living creatures).[6] By acting in this way, the whole talk about the methods served in the last instance as an alibi for the centrally planned tactics. The origin of these tactics can be traced back to 1939 when Adolf Hitler was the first to make a public appearance after a case of child euthanasia which later enabled him to subordinate this technique to Nazi ideology and in the end to turn it massively against Jewish people but also against any dissident.[7] This

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[4] See more in the official website of Central Board of Jewish Communities in Greece: https://kis.gr/index.php?option=com_content&view=article&id=369:2009-06-05-10-49-42&catid=99:2009-06-04-07-06-01&Itemid=76, viewed in June 2019.

[5] The fundamental issues at stake are the same as they have always been: balancing protectiveness against autonomy, risks against benefits, efficiency against deontological concerns. See Glenn I. Cohen, and Holly Fernandez Lynch, "Introduction," in *Human Subjects Research Regulation: Perspectives on the Future*, eds. Glenn I. Cohen, and Holly Fernandez Lynch, 1-8 (Cambridge, MA: MIT Press, 2014).

[6] Cf. Ευάγγελος Δ. Πρωτοπαπαδάκης, *Η Ευθανασία απέναντι στη Σύγχρονη Βιοηθική* (Αθήνα: Αντ. Ν. Σάκκουλας, 2003), 32.

[7] Πρωτοπαπαδάκης, 32.

example emphasizes my view regarding the ideological background and the initial stage for the massive generalization of the Holocaust practices. At first there came the elimination of life and then the dematerialization in order to achieve the disappearance of the victims from the country's history.

The Holocaust was in fact insulting and dishonoring because the Jews according to their traditional convictions were against the incineration of the dead, which means that this time they would suffer once again a *post mortem* torture and a humiliation. This selective hatred which was unprecedented in human history and extensively put into practice expressed and served ideologically the Nazi political decision of the total extinction, the aim of which was to achieve utter oblivion and to eliminate any remnant of Jewish origin. For these reasons I dare to claim that only by burning the corpses of the Jews – apart from all their sufferings while still being alive – and not by just killing them at an earlier moment the Nazis did accomplish the plan of the Final Solution and the genocide, because this was exactly the final, the total Holocaust. The only faint shadow in the logic of this project is that Judaism is not solely tied to a racial or genetic origin, it is not restricted to the factor of inheritance, but it has also a broader character. It was Nazi racism that made them focus on the total elimination of the Jewish race. But by interpreting in a narrow sense the doctrine of the Aryan Race they forgot that even if they succeeded in totally exterminating all Jewish people on the whole Earth there would always exist the possibility that someone could be born who by adopting Judaism could become a Jew himself!

So the existing fear, generated by the very existence of a corporeal residue in form of a corpse, reveals also in this way the inherent value that a human corpse somehow retains (to the extent that it even constitutes, as in the case of the Holocaust, a "living" menace). Thus this article deals with the technique of incineration which was chosen as an effective means to make the corpses disappear but even more with the current tendency towards the prevalence of the same technique as regards the total burning of human corpses, taking into account that the latter occurs at times by tacitly concealing the real facts and at times by employing embellishing images.

II. Management of the human corpse: Two options throughout history and a third one at present

Death, that is the confirmed, total and definitive stop of the bodily organs from functioning, raises necessarily the problem of dealing with the human corpse. During the long-lasting presence of rational human beings on Earth, single individuals and societies have not only established particular burial places but have also introduced burial customs for the deceased. As far as the human corpse is concerned there are two major options of dealing with it throughout historical ages: burying or burn-

ing.[8] Since the 19th century a new way of dealing with the human residue, aimed at its annihilation, has been implemented – a practice which during the 20th century has been increasingly adopted. This is the misleadingly called *incineration*. Thus we shall distinguish between the traditional burning of the dead and the relatively recent method which is to be characterized as *mechanical cremation*.

i. Burial of the dead

Burial is the option of dealing with the human corpse which has prevailed throughout history. Through burial the corpse is left to physical decomposition which is characterized by the fact that it takes the corpse several months to decay and become a constant residue. The buried body takes a course of partial decomposition which stands in a proportional relation to the time that was necessary for the attainment of its complete shape: just as it took it a long time to remain in the body of the pregnant mother and then to be raised so it takes many months to decay. Dissolution does not come at once. There is an essential difference between growth and decomposition of the body: since it has a biological beginning in time as an entity, it does not go back to a state similar to prior "nonexistence" but it leaves a certain residue behind. This means that it takes a long time for the flesh to become fully decomposed and in the end there is the skeleton which remains.[9]

ii. Traditional cremation of the dead

Cremation of the dead is the other option of dealing with the human corpse, although it is less prevalent. This practice corresponded to the convictions of the societies that opted for it either because in some cases it served more effectively

[8] We do not mention as a separate case the practice of the Zoroastrian Parsis who in some remote places of India even nowadays leave the corpses exposed to external factors on the so-called *Dakhma* (towers or columns of silence) to be devoured by the vultures because of the limited number of followers and also because the logic of this practice does not differ from the logic of traditional cremation as the main aim in both cases consists in accelerating the decay of the flesh. We find some very brief and valuable insights about the way these customs of the Parsis came to be considered in the Torah and the Talmud as a negative example of dealing with the dead in the first part of the tetralogy of Rabbi Dr. Kohn which was published in sequels as a reply to Rabbi Dr. Wiener, see Dr. Kohn, "Die Erd- und Feuerbestattung," in *Jüdisches Literatur-Blatt* 15-16 (1886): 181-208; from the standpoint of architectural aesthetics cf. an interesting approach in Melanie Dawn Michailidis, *Landmarks of the Persian Renaissance: Monumental Funerary Architecture in Iran and Central Asia in the Tenth and Eleventh Centuries* (PhD diss., Massachusetts Institute of Technology, 2007), 127-142, 276-318.

[9] About the special significance of the preservation of the skeletal residue – even greater than that ascribed to the flesh, which for instance can be removed in the case of a transplantation – according to the supporters of the burial, a certain idea can be obtained from Aslihan Sanal, *Flesh Yours, Bones Mine: The Making of the Biomedical Subject in Turkey* (PhD diss., Massachusetts Institute of Technology, 2005).

some extraordinary and practical needs (for instance they buried the dead fighters in order to facilitate the transport of their bones)[10] or because in some places there was a regional abundance of materials suitable for burning. The traditional cremation of the corpses was essentially nothing more than an acceleration of the main stages of the burial process. This means that because of the fire the flesh was able to complete its decomposition process in a shorter period of time.[11] Its soft tissues were burnt and dehydrated and at the end of the process there remained only the ashes and the skeleton.[12] Ashes and bones were kept in urns,[13] or the ashes were dispersed, and the bones were buried separately.

iii. The current method of mechanical incineration

In mechanical incineration[14] the body is put into crematoria where unnaturally high temperatures are reached until in the end only the skeleton remains. It must be stressed and clarified that the terminology used, which actually has been derived from the traditional cremation ceremonies, does not depict the final effect of the process. It is misleading to call *incineration* a process that does not lead to the production of ashes, inasmuch as the soft tissues of the flesh and the other organs while burning at these unnaturally high temperatures get fully destroyed,[15] and they finally dematerialize.[16] We can talk of incineration in the sense that in

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[10] Cf. Σταυρούλα Οικονόμου, *Ταφές Πεσόντων. Πολυάνδρεια, Κενοτάφια και Ηρώα* (Διδακτορική Διατριβή, Πανεπιστήμιο Κρήτης, 2012), 59-60.

[11] It was exactly this sense of the slight difference between the accelerated but fundamentally successful natural decomposition and the violent mechanical cremation that made the Indians, who were by tradition and since many centuries accustomed with the process of burning, oppose culturally and not immediately accept this western innovation that seemed alien and awkward to them. For more about the way the Eastern peoples with long traditions in the cremation of the dead saw the new technological innovation and about the propaganda that was spread to make it acceptable cf. David Arnold, "Burning Issues: Cremation and Incineration in Modern India," *NTM Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin* 24, no. 4 (2016): 393-419.

[12] For details about the traditional cremation of the corpses and the way it was performed, see Jonathan Parry, *Death in Benares* (Cambridge: Cambridge University Press, 1994).

[13] The residue of Buddha for instance was allegedly buried in two ampullae: the ashes were buried separately from the bones, see B. N. Datta, "Vedic Funeral Customs and Indus Valley Culture," *Man in India* XVI (1936): 223-307, 290.

[14] For historical information and details about this modern technique, as it was initially invented, and the first positive and negative reactions to it cf. Franz von Berndorf, *Beerdigung oder Verbrennung der Leichen?* (Berlin, 1892), 27ff. and 38ff.

[15] This is exactly what the intended effect of cremation is cf. Sigrid Hünewinkel, "Spätbronzezeitliche Brandbestattungen im ägäischen Raum" (PhD diss., Albert-Ludwigs-Universität Freiburg im Breisgau, 2007), 19: "Die Verbrennung eines Verstorbenen bedeutet die vollständige Vernichtung seines Körpers."

[16] Δημήτριος Ν. Βαρυτιμιάδης, *Η Αποτέφρωση των Νεκρών* (Διπλωματική Εργασία, Αριστοτέλειο Πανεπιστήμιο Θεσσαλονίκης, 2015), 36.

the end only residue and ashes are left (with the exception of the bones), as opposed to traditional cremation.

But following this description, a question arises: what is the material that the relatives get back after the end of the process while being told that it is the ashes of the deceased? For it is well known that with the use of poetic images the relatives are urged either to disperse this material into the sea or into picturesque landscapes or to bury it into urns.

The dehydrated skeleton that remains after the mechanical cremation, being still soft due to the heat, is put into a grinding bin that works the same way that household mixers do. In this device the skull and the bones are broken; they are smashed and crushed until they become pulverized and then these crumbs of the broken bones, the powder that has emerged, is handed over to the relatives and falsely labeled as ashes. The avoidance of the factual term *pulverization* in favor of the inaccurate expressions about ashes and cracks in the bones, even in studies which focus on the subject,[17] is disappointing. I consider the term *incineration* to be misleading because it creates the association and the image of a complete combustion while the combustion is, in fact, incomplete. For the process to be completed more actions need to be undertaken, which are being hidden from the interested persons probably because they are generally seen as particularly vandalizing, disgusting and dishonoring as far as the whole process results in smashing and pulverizing the skull and the other bones of their loved one(s).

iv. Differences and similarities between the three ways of dealing with the corpse

Soft tissues and organs: In the burial they are left to decay gradually. The traditional cremation turns them into ashes. Therefore, in both cases there is a temporary residue left. Mechanical cremation causes them to dematerialize and thus leaves no residue behind.

The skeleton remains complete in all three cases. Traditional burial leaves the skeletal residue and all its genetic data intact.[18] Traditional cremation

[17] For instance such is the case in Tim Flohr Sørensen, and Mikkel Bille, "Flames of Transformation: The Role of Fire in Cremation Practices," *World Archaeology* 40, no. 2 (2008): 253-267.

[18] The discovery that genetic information are present in bones and remain unchanged over time should support the reevaluation of classical philosophical considerations regarding death and the human corpse that were originally formulated on the basis of external observations which do not correspond to the level of our present knowledge. It was for instance Epicurus who linked the atoms constituting Flesh with the constitution of the Soul and inferred that if the former is dissolved then the same happens also with the latter while on the other hand he ignores totally the value of the skeletal residue. Epicurus may be excused according to the fact that all bones look the same and void of content to the naked eye but on the other hand it is understandable that he would have composed his philosophical thought differently if he

also means that the skeleton to a great extent retains its genetic data before finally being buried. However, through the process of contemporary mechanical cremation the skeleton retains its integrity after the burning process but its genetic data suffers a radical deformation before being put into grinding bins where the skull and the other bones completely disintegrate into powder which contains no genetic information at all. This complete dissolution of the corporeal residue is very accurately compared by David Arnold to the management of the urban waste that the modern states prefer; in both cases fire is employed the same way.[19]

v. Funeral and burial customs reveal their value

Whichever way is chosen for the management of the corporeal residue, the human corpse seems to have an inherent value and by this it is also possible to explain that it never has been treated as a piece of flesh which has meanwhile become indifferent, but on the contrary it serves as a point of departure for unfolding certain customary behaviors towards it, the so-called funeral and burial customs. It is important to point out that burial customs have existed since the dawn of the humans' presence on Earth[20] and of course they have been preserved until today. This begins with certain primeval habits, such as closing the eyes of the dead so that they do not remain open,[21] washing the corpse,[22] waiting for a certain period of time until the burial can take place, placing the dead into a tomb with a symbolic orientation,[23] and progresses to the more complex ceremonies and rituals as regards the inhumation of the corpse and its residue[24] which also even include distinctive marks of the of-

had known about the genetic chain preserved eternally in the bones. Cf. Evangelos D. Protopapadakis, "'Death is Nothing to Us:' A Critical Analysis of the Epicurean Views Concerning the Dread of Death," in *Antiquity and Modern World: Interpretations of Antiquity*, edited by Ksenija Maricki Gadjanski, 316-323 (Belgrade: The Serbian Society for Ancient Studies, 2014), 319.

[19] Arnold, 393-419.

[20] A very interesting analysis of the burial ceremonies and their rituals can be found in Milton Cohen, "Death Ritual: Anthropological Perspectives," http://www.qcc.cuny.edu/SocialSciences/ppecorino/DeathandDying_TEXT/Death%20Ritual.pdf.

[21] *Genesis*, 46, 4.

[22] More about burial rituals in Eastern countries in Anusaranasasanakiarti Phra Khrû, and Charles F. Keyes, "Funerary Rites and the Buddhist Meaning of Death; An Interpretative Text from Northern Thailand," *Journal of the Siam Society* 68, no. 1 (1980): 1-28, 7ff.

[23] Μαρία Κουμαριανού, *Η Αντίληψη του Θανάτου μέσα από μια Σημειολογική και Ανθρωπολογική Προσέγγιση του Αστικού Νεκροταφειακού Χώρου* (Διδακτορική Διατριβή, Εθνικό Μετσόβιο Πολυτεχνείο, 2007), 25-28.

[24] Rijan Maharjan, "A Brief Introduction of Funeral Rites and Rituals in Theravada Buddhist Countries (Sri Lanka, Thailand, Cambodia, Myanmar)," *Academic Journal of Buddhist Studies* 1 (2018): 458-465.

fice, the social class, the sex of the deceased etc.[25] These customs have multiple recipients: they are addressed not only to the surviving relatives, in the form of a consolation or a reminiscence, but also to the soul of the deceased itself or to the new spiritual environment, and to the world which is supposed to be the next stage in the course of his/her life.[26] The particular behavior towards the human corpse is certainly inferred not only from the honors paid, but also from the cases where a negative or revengeful treatment prevailed, if for instance the corpse belonged to a person who had done damage or who had been confronted with a hostile attitude on the part of the community.[27] But apart from philosophical, theological, psychological, or socially focused considerations which can be expressed on this issue there is one thing that can be noticed throughout positive and negative behaviors, namely that the dead body has value and that this value cannot be separated from it.[28] It is even the case that the violation of the space pertaining to the dead body in all times is considered as a sacrilegious and punishable act, while the removal of objects from the dead since the ancient times constitutes the crime of grave robbery.

III. Aesthetic semiology of the human corpse

The assessment of an object in the terms of philosophical aesthetics consists usually in determining its aesthetic value and necessarily in subsuming it into the relevant aesthetic categories with the aim of its assessment.[29]

The search for information on an aesthetic approach of the cremation or the burial of the corpses returns usually a superficial aesthetic description of the crematories, of the ways the residue is buried or, more frequently, of the preceding ceremony; this happens more easily by avoiding to describe the procedure that is adopted between the cremation and the emergence of the residue.[30] In other words, we obtain information on any other issue beside the

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[25] Fredrik Fahlander, and Terje Oestigaard, *The Materiality of Death Bodies, Burials, Beliefs* (Oxford: Archaeopress 2008), 7, 10, and 11.

[26] This may refer to God, to Hades or the Underworld; cf. Γεώργιος Αντουράκης, *Ταφή, Καύση και Ανάσταση των Νεκρών: Μηνύματα από την Παράδοση και την Τέχνη* (Αθήνα, 1981), 5ff.

[27] For a brilliant piece of scientific information about the burial process, taken literally out of "anonymously" mixed bones who were buried into a hole, along with a detailed analysis and substantiated inference towards the detection of a revengeful behavior, see S. Mays, et al., "A Multidisciplinary Study of a Burnt and Mutilated Assemblage of Human Remains from a Deserted Mediaeval Village in England," *Journal of Archaeological Science: Reports* 16 (2017): 441-455.

[28] Rashmi Gupta, "Death Beliefs and Practices from an Asian Indian American Hindu Perspective," *Death Studies* 35, no. 3 (2011): 244-246.

[29] Ευάγγελος Παπανούτσος, *Αισθητική: Ο Κόσμος του Πνεύματος* (Αθήνα, 1969), 277ff.

[30] For a relevant example cf. Norbert Fischer, "Körper – Asche – Natur: Über Transformationen

main point, which are the dead body and its cremation by mechanical means. This accordingly renders impossible the proper aesthetic assessment of the procedure.

The aesthetic value of the human corpse is assessed by evaluating the elements provided by the corpse itself. A corpse is distinguished by the gradual change of its qualitative traits and causes emotional feelings or impulses of thought that either come from the external appearance of the deteriorations occurring in it or from the internal impact of these elements on the psyche of all the people having in some way to do with it or finally by the corporeal residue itself regarding the special elements of its identity.

i. Aesthetic categories

The death of the body itself with the subsequent deteriorations in its form and its composition along with the contrast to the image that was formerly shaped by its living presence, involves as far as aesthetic experience is concerned not only the dimensions of *ugliness* and *tragedy*, but also that of the *sublime*.

From the standpoint of Aesthetics, the human corpse is evaluated as ugly. The notion of the ugliness focuses mainly on its external features and on the reactions that it inspires. The color changes from rosy to ecru white, the facial features lose their contours (the face and especially the nose immediately become disfigured, with the mouth and the eyes shut[31]), the limbs become frozen and stiff, an unpleasant odor spreads out, several fermentations and changes follow due either to internal parasitic microorganisms that were hosted in the living body and after the moment of the death cause its erosion or to external factors that now cause its decay. All these constitute a gradual course comprising consecutive phases which result in the elimination of the prior form and of the physical elements and finally lead to the ultimate negation, the dissolution of the body. The spontaneous reactions of many persons, such as aversion, fear or refusal to touch the dead body manifest the element of its ugliness.[32] This sense of ugliness is even considered to be somehow contagious, for in some traditions the corpse is even seen as impure to the extent that whomever comes in contact with it becomes similarly impure

des Leichnams durch Krematoriumsbau und Feuerbestattung vom späten 19. Jahrhundert bis zur Gegenwart," *EthnoScripts* 19, no. 1 (2017): 81-98.

[31] Matthias Mißfeldt, "Vergehende Zeichen. Der tote Leib und die trauernde Erinnerung," in *Tot und toter Körper*, eds. Dominik Groß, et al., 179-186 (Kassel: Kassel University Press, 2007), 182.

[32] If in the world of Art something Ugly may imply the Beautiful, an essentially ecological approach to the unpleasant fact of mortality could add more life to our life, cf. Emily Brady, "Ugliness and Nature," *Enrahonar* 45 (2010): 27-40, 31.

for a certain period of time,[33] as regards the ritual sense of impurity.[34]

The human corpse also involves elements of the *tragic*, i.e. of an aesthetic category that arises out of no other creature than the humans themselves[35] and in this case expresses the internal affect and the mixed feelings that are caused in the spectator by the absence of life and get intensified by the view of the human corpse. The living memory of the acting person is absolutely opposed to the inert body, which lies lifeless, inactive, unable to defend its integrity and its dignity, completely and involuntarily abandoned to be managed by other people's hands or by natural forces.[36] All these traits are incompatible with the previous situation during its life, and therefore the view not only of the corpse but also of all these new and contradictory situations concerning it create inside the soul sadness, sorrow, screams and cries but also ironic comments and, in some cases, scorn. The body itself was the substrate of a set of various interactions: it had contributed to the creation of life, it had given birth, it had been a source of consolation, protection, love, inspiration or fear, its presence could even pose a threat but now it has been stripped of all these special characteristics. It resembles a hero of a tragedy who after a hard and long itinerary of personal achievements now suffers consecutive blows, debasements by disproportionately more powerful forces or collusions until at the end he/she yields and unexpectedly gets defeated by them. The view of this utter contradiction between the past that belonged to life and the present that belongs to non-being deepens the sense of the tragic in the spectator in two ways: on the one hand it activates inside him/her an association of memories and sentiments like the ones we have already described, on the other hand, it makes him/her bear in mind, even in an unconscious and associative way, the moment he/she will enter the same condition of a corpse.

In the human corpse, parallel to the dimensions of ugliness and tragedy, is also the element of the *sublime*. This is perhaps the most important aspect of its aesthetic value which unfortunately, as the relevant literature shows,

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[33] The flesh is in general considered even more impure than the bones, cf. Terje Oestigaard, "Death and Ambivalent Materiality – Human Flesh as Culture and Cosmology," in *Combining the Past and the Present: Archaeological Perspectives on Society*, eds. T. Oestigaard, et al., 23-30 (BAR International Series 1210) (Oxford: Archaeopress, 2004), 23ff.

[34] Cf. *Numbers*, 19.11ff.

[35] Παπανούτσος, 288.

[36] In the ancient Egyptian culture the technique of mummification of the corpses for the Pharaohs and the high rank officials had been developed as a way to escape from this tragic situation, along with the use of several objects that were supposed to inhibit the tragic process of putrefaction. Cf. Martin Fitzenreiter, *Tod und Tabu – Der Tote und die Leiche im kulturellen Kontext Altägyptens und Europas* (Berlin: IBAES I, 1998), http://www2.rz.hu-berlin.de/nilus/net-publications/ibaes1/Fitzenreiter/text1.pdf.

is commonly neglected or dissociated from it. One of the main features of the aesthetically sublime is that it transcends time. Whatever seems to go beyond certain limits and continues to exist without being subject to the bonds of a visible and definitive end or annihilation, whatever tends to persist and in some way to break the limit of an estimated period of time, involves a sublime symbolism, because the notion of the end, of the limit and of decay are interwoven with the circle of the natural order of things.[37] In the case of the corpse the skeletal residue remains eternally unchangeable: it obtained its existence from generative parts that do not exist anymore (from the fluid egg cell and the sperm – from elements that were produced by the same organism in thousands and millions but most of them were lost anonymously and without a trace) and it keeps existing after having completed the course of its life. There will always be something that belongs to someone and can be concretely identified only with reference to him/her. Its bearer existed undoubtedly for some time but something of him/her will always exist and thus it will always transcend the limits of his/her living existence. This is the essence of the sublime, timeless aesthetic value. This importance of the human residue has been surrounded by such a great value and has exerted such a deeply existential influence upon humans that already since the dawn of every artistic expression and of every thought that has come down to us the bones were considered as worthy of respect and involving life. An example that remains vivid throughout the ages, is the well-known and commonly accepted belief of billions of Jews, Christians, and Muslims, which is depicted in their Holy Books in a very nice symbolic manner, that human bones contain life and some day they are destined to sprout again. This belief which sums up, expresses and conforms wholly with the sublime aesthetic value of the skeletal residue with this beautiful symbolic illustration of new shoots out of "dead" branches, is also confirmed by the relatively recent scientific discovery of DNA.[38] Dead bones as well as dead flesh that have been well-preserved retain eternal and immutable traits pertaining to the identity of the dead.[39] It is even scientifically possible by means of well-developed laboratory techniques to make them "sprout" again and to extract new life from them in some regard. In order to illustrate this thought it would be enough to say that the identi-

[37] Cf. Filotheos-Fotios Maroudas, *Aesthetics of the Holy Prayer Rooms of the Abraham Religions: Synagogue – Mosque – Church* (University Lectures, Athens 2018/2019), 8-11.

[38] Beside the widely known DNA genetic code, there are also further methods who reveal many identity marks; we mention for instance the very interesting study of Richard Dirnhofer, "VIRTOPSY – Auf dem Weg zur minimal-invasiven Autopsie," in *Tot und toter Körper*, eds. Dominik Groß, Andrea Esser, Hubert Knoblauch, and Brigitte Tag, 147-150 (Kassel: Kassel University Press, 2007).

[39] Even in bones that come from traditional cremation the sex, the age and some more characteristics can be easily discerned, cf. Hünewinkel, 20-21.

fication of all the corpses that were pulverized in the crematories during the Holocaust could be in theory achievable, it would thus be possible to give them back to their surviving relatives but also to obtain "confessions" from them about the conditions of their life and their martyrdom.

ii. Aesthetic assessment of the methods of inhumation, cremation and pulverization

Inhumation and traditional cremation are both compatible with the assumptions and the principles of aesthetics: for whether they leave the body to decay naturally in the earth or they expose it to fire, also a natural process, the enduring result of the presence of the skeletal residue and of all the data that are contained in it and that actually constitute its identity, is that they all remain as they had been determined by nature. If we approach the problem more cautiously, we notice that fire shortens the time needed for the decomposition and consequently it does not give those involved in the process the necessary time to shape completely the impressions that otherwise would have been unavoidable. It deprives the temporarily emerging notions of the ugly and the tragic of their duration and so finally it denies the spectator the valuable benefits of an empathetic[40] experience which is a pivotal element of the psychic life. The contemporary mechanical incineration (or any other technique that leads to similar results, such as the environmentally more "friendly" method of defrosting and then composting of corpses) while aesthetically succeeding in the removal of the temporary ugly or tragic elements of the dead, permanently strips the corpse of its more important and constant aesthetic value:[41] the sublime character of its eternal skeletal residue, the individualized information about its identity that is, as has been proven, hidden within. It also removes from the corpse all those things that have an instructional value for humans and for science. Of course, one could argue that for the dead themselves this instruction has no sense at all, and, even if the surviving persons obtain some lessons, this does not benefit the person who had opted for the mechanical cremation. However, the clear reply to this way of thinking consists first of all in accepting that the dead themselves certainly won't sense any of these changes. Human beings are not born as ready genetic packages that just unfold the information engraved in them during their lives; they also become what they are by the acquired characteristics of

[40] The term *empathy* ("Einfühlung") was initially introduced by Friedrich Theodor Vischer and it denotes philosophically the particular appropriation of representations and experiences.

[41] Hubert Knoblauch, "Der Tod der Moderne, die neue 'Kultur des Todes' und die Sektion," in *Tot und toter Körper*, 197.

their nurture or by their own deeds thanks to their education.[42] Therefore the humans' attitude towards the final annihilation and the decisions they make about the management of their residue do have an impact upon their attitude in life and influence both their own lives and the societies they live in. One can easily imagine that the official legislation and the general social tolerance take on completely different forms if society cares for its dead members the same way it treats the rest of its waste or if the inherent value of the dead is duly recognized.

Relatives and friends do not just see and know all that goes on during the process of mechanical incineration. Guided by a limited sense of reality and moving within a hedonistic view of life without really understanding their own experience, they stick to a fictional frame and form the meaningless illusion that this procedure can avoid worm infestation of the corpse, while it is their own intervention that causes a suffering even worse than that.[43] Apart from this, for the first time in history we have "urns" void of content, without any data being provided by the dust stored in them, because after the cremation by unnaturally high temperatures and after the pulverization of the smashed bones, the existing genetic code has actually been completely extinguished. Any genetic information is annihilated and this means that in the end the use of the genetic code itself as a transmitter of information about individual identity dies with the body. In the case of mechanical cremation, we perform placebo-rituals for the relatives and funerals for a vague residue that does not correspond to the person to whom it supposedly belongs. Regarding its genetic information, the residue has the same value as carbon dust or desert sand.

IV. Bioethical issues about the annihilation of the human corpse

The considerations and dilemmas that arise after our presentation of the annihilation of the genetic material and the identity of the skeletal residue, are connected with issues that go far beyond the narrow limits of a simple personal decision about being buried or cremated after death. They reach in fact the sphere of the bioethical approach to the subject because we can now talk not only of the grey zones of life but also of the "grey zones of death."[44]

The first question is if it can be accepted within society that the financial concerns about the costs of funeral ceremonies may inevitably lead to the

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[42] Cf. Μυρτώ Δραγώνα-Μονάχου, "Ηθική και Βιοηθική," *Επιστήμη και Κοινωνία* 8-9 (2002): 1-26, 8.

[43] "Experiences of ugliness have epistemic value, they increase our 'aesthetic intelligence' through the development of an engaged appreciative awareness of ugliness and all forms of aesthetic value," see Brady, 38.

[44] Γεώργιος Κουμάντος, "Οι Γκρίζες Ζώνες της Ζωής," *Η Καθημερινή*, 2 Ιουνίου, 2002.

physical annihilation of the dead by the interventional destruction of all genetic data pertaining to his/her corporeal residue.

Then, in case the interested person is not clearly informed about the procedure of mechanical cremation and the subsequent genetic disappearance of all personal data due to crushing and pulverizing, the next question to be asked is to what extent relatives and friends have the obligation to fulfill the will of the deceased. It would certainly be possible, in keeping with the bioethical principle of autonomy, to argue in favor of the personal right of the individual to decide about the fate of his/her corporeal residue. However, if no clear information is being provided about the stages of the adopted procedure, the basic question concerning the persons who are rightfully eligible to decide about the genetic annihilation of the corporeal residue of someone (a question that already goes one step beyond the penultimate one concerning the human existence, i.e. who has the right to decide about the premature death of someone through euthanasia) becomes even more complicated than the already mentioned bioethical triptych "what people want, what doctors do and what the law permits."[45] Since individuals do not receive the opportunity to make informed decisions the first biomedical principle, namely the principle and the right to autonomy, is immediately violated.[46] Especially in the case of pulverization and the total destruction of genetic residue we have beside this a violation of the third bioethical principle of non-maleficence, or avoidance of harm/damages.[47]

The third question results from the following observation: if we assume that the objective genetic value of the dead human body is not accepted and respected, namely, if we handle the dead bodies as objects without any real value, then it is rather possible that new discussions will start about the remaining value of the living but brain dead bodies or the bodies with loss of self-consciousness (Alzheimer's disease). What I mean is, if society stops to respect the objective genetic value of the corpses of their dead ones,

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[45] Cf. Ira Bedzow, "Dying with Dignity: State vs Patient," *The Aspen Times*, A14, July 14, 2015. https://www.aspentimes.com/opinion/columns/guest-column-dying-with-dignity-state-v-patient/.

[46] The issue of *informed consent* first rose to prominence after the Holocaust in the *Nuremberg Code* from 1947. Cf. Stacy Gallin, and Ira Bedzow, "Holocaust as an Inflection Point in the Development of Bioethics and Research Ethics," in *Handbook of Research Ethics and Scientific Integrity*, ed. R. Iphofen (Dordrecht: Springer, 2019), 3, and 12-4; a more detailed presentation of the four principles of Biomedicine is contained in the classical work, where they were originally formulated Tom L. Beauchamp, and James F. Childress, *Principles of Biomedical Ethics* (New York: Cambridge University Press, 1979).

[47] See Sue Cannon, "Reflections on Fieldwork in Stressful Situations," in *Studies in Qualitative Methodology, vol. 3, Learning about Fieldwork*, ed. Robert G. Burgess (Greenwich, CT: JAI Press, 1992), as cited in Martyn Hammersley, "Ethics of Ethnography," in *Handbook of Research Ethics and Scientific Integrity*, ed. R. Iphofen, 1-13 (Dordrecht: Springer, 2019).

than, in a further state of mind, it is not very far from what led to the Nazis euthanasia program of the feebleminded, and sure then, this is a "proper object of fear."[48]

V. Conclusions

The Holocaust, which was chosen by the Nazis as the final and ideal solution in order to fully express their hatred and their will towards extinction, could not be regarded as completely implemented by those who thought up and perpetrated it without the imposition of utter oblivion, the disappearance of any element of identity and identification of its targeted victim groups. As an ideal means to be implemented in the last stage of the final solution, the perpetrators chose the posthumous, mechanically mediated and unnatural annihilation of the corporeal dimension and presence of those murdered. This historic example and its consequences must be taken into consideration by every human being because the essence of the management of the remnants of his/her presence on Earth is something that exceeds by far the duration of a funeral closing ceremony.

To the existing individual and bioethical rights one more is now added: the right to be protected from the imposed genetic oblivion and annihilation.

What has been stated in the present article makes the dictum of the great Arthur Caplan seem eerily prophetic: the "whole discipline of biomedical ethics rises from the ashes of the Holocaust."[49] Our responsibility is to ensure that the powder resulting from the Holocaust serves as the foundation for protecting the dignity of the human body, in life and in death.

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[48] Evangelos D. Protopapadakis, *From Dawn till Dusk: Bioethical Insights into the Beginning and the End of Life* (Berlin: Logos Verlag, 2019), 141.

[49] Arthur Caplan, "The Stain of Silence: Nazi Ethics and Bioethics," in *Medicine after the Holocaust: From the Master Race to the Human Genome and Beyond*, ed. Sh. Rubenfeld (London – New York: Palgrave Macmillan, 2010), 82. This statement, which in the meantime has become famous, refers back to the study of Robert F. Drinan, "The Nuremberg Principles in International Law," In *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*, eds. George J. Annas, and Michael A. Grodin (Oxford: Oxford University Press, 1992), 174-175.

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II. The Holocaust and research and technology

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The Medical Manipulation of Reproduction to Implement the Nazi Genocide of Jews*

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Abstract

Holocaust literature gives exhaustive attention to direct means of exterminating Jews, by using gas chambers, torture, starvation, disease, and intolerable conditions in ghettos and camps, and by the Einsatzgruppen. In some circles, the term "Holocaust" has become the ultimate description of horror or horrific events. The Nazi medical experiments and practices are an example of these. Nazi medical science played a central and crucial role in creating and implementing practices designed to achieve a "Master Race." Doctors interfered with the most intimate and previously sacrosanct aspects of life in these medical experiments – reproductive function and behavior – in addition to implementing eugenic sterilizations, euthanasia, and extermination programs. Manipulating reproductive life – as a less direct method of achieving the genocide of Jews – has been less acknowledged. The Nazis prevented those regarded as not meeting idealized Nazi racial standards – and particularly Jewish women – from having sex or bearing children through legal, social, psychological and biological means, as well as by murder. In contrast, they promoted reproductive life to achieve the antithesis of genocide – the mass promotion of life – among those deemed sufficiently "Aryan." Implementing measures to prevent birth is a core feature of the UN Convention on the Prevention and Punishment of Genocide. As with many other aspects of the Holocaust, science and scientists were inveigled into providing legitimacy for Nazi actions. The medical profession was no exception and was integrally involved in the manipulation of birth to implement the Holocaust.

Key-words: *Nazi; medicine; reproductive life; medical experiments; eugenics; euthanasia; sterilization; medical ethics*

The Nazis used, and abused, reproduction and sexuality to achieve their ideological goal of creating a so-called Master "Aryan" Race. On the one hand, they prohibited or prevented women and men regarded as not meeting idealized Nazi racial standards – and particularly Jewish women

* This manuscript is based on Beverley Chalmers' multiple-award winning book *Birth, Sex and Abuse: Women's Voices under Nazi Rule* (Surrey, UK: Grosvenor House Publishers, 2015).

– from having children through legal, social, psychological and biological means, as well as by murder. On the other hand, they promoted reproductive life and sexuality to achieve the antithesis of genocide – the mass promotion of life – among those deemed sufficiently Aryan.

The Jew in Nazi ideology was an "embodiment of everything considered evil, and fit only for extermination."[1] Not only were Jews regarded as biologically impure, but they were also depicted as socially, economically, and politically contaminating and, moreover, responsible for all the world's ills, including the loss of World War I. Viewed – remarkably – as simultaneously, and impossibly, Marxist, Capitalist and Democratic, they were seen as bent on world domination.[2] Such dehumanizing views of Jews were not new although the biological component of Nazi anti-Semitism, based on their racially focused ideology, was a novel addition to traditional anti-Semitic views.

The literature on the Holocaust gives exhaustive attention to direct means of exterminating Jews, including the use of gas chambers, torture, starvation, disease, and intolerable conditions in the ghettos and camps as well as through the actions of the *Einsatzgruppen*. The manipulation of reproductive lives – as a less direct method of genocide – has not yet received the same exhaustive attention. Imposing measures to prevent births is, however, included in the internationally accepted definition of genocide found in Articles II and III of the 1948 United Nations Convention on the Prevention and Punishment of Genocide.[3]

Nazi policies preventing pregnancy and birth among Jewish women were a constantly evolving combination of ideology and practice. As with other extermination processes under the Third Reich, the manipulation of Jewish reproductive life was neither static in its conceptualization nor consistent in its application.

I. The Eugenics Program

Doctors played a central role in manipulating reproductive and sexual lives to achieve Nazi goals. The Nazis implemented eugenics and euthanasia programs, medical experimentation and extermination to achieve their goal of eradicating those perceived as *lebensunwertes Leben* (lives unworthy of life). The Nazis manipulated reproductive life to promote the births of racially pure Aryan babies through prohibiting abortion and restricting contraception for

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[1] Dana Lori Chalmers, "The Influence of Theatre and Paratheatre on the Holocaust" (Master Thesis, Concordia University, 2008), 16.

[2] Ibid., 17.

[3] Adam Jones, *Genocide: A Comprehensive Introduction* (Routledge/Tayor & Francis Publishers, 2006), 13.

those considered to be of sufficient Aryan purity. They also approved interruption of pregnancy if the future child was likely to inherit 'defects' such as mixed Jewish and non-Jewish parentage, and forced sterilization of so-called 'undesirable life.' Negative eugenics was focused on the threat posed by mental illness in particular as well as other undesirable medical and social ills: it was not directed specifically at Jews but at all Germans, although Jews were frequently identified as having such unwanted characteristics.

Within months of the Nazi party coming to power, the *Law for the Prevention of Genetically Diseased Offspring* was promulgated and took effect on January 1, 1934.[4] The removal of earlier restrictions preventing the compulsory sterilization of those with hereditary mental or physical defects, or other social or racial "undesirables," opened the door for enthusiastic cooperation by doctors and psychiatrists to work in collaboration with police and local government authorities through the so-called Hereditary Health Courts. Not only Nazis, but also professionals in a range of fields could take advantage of this, justifying their actions through recourse to the wishes, intentions or aims of the *Führer*, the interests or needs of the national community and racial health.[5] The law targeted both mental and physical illness.[6] Compulsory sterilization was implemented for congenital feeblemindedness, schizophrenia, manic-depressive psychosis, hereditary epilepsy, Huntington's chorea, hereditary deafness, blindness or severe deformity, or severe alcoholism.[7] Definitions of these categories were narrow at first but later became loosely defined and broadly interpreted. People who were unaffected by any of the illnesses that were specified by the Law and who were perfectly capable of passing the intelligence tests which were required for selection were nevertheless compulsorily sterilized.[8] Many victims simply deviated from "normal" behavior, as judged by their apparent social "superiors." For example, people who failed to be monogamous, thrifty, clean, efficient, tidy, responsible, and striving upwards were designated "socially feebleminded" on the basis of intelligence tests, spurious diagnoses or, more usually, gossip or hearsay.[9] A considerable number of the victims were from the poorer sections of society or were those discharged from asylums.[10] Regardless of their actual state of

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[4] Richard J. Evans, *The Third Reich in Power* (USA: Penguin Books, 2006), 507-509.

[5] Ian Kershaw, *Hitler: Profiles in Power*, ed. Keith Robbins (London: Longman, 1991), 103.

[6] Mark Mazower, *Dark Continent: Europe's Twentieth Century* (New York: Vintage Books, 1998), 97.

[7] Michael Burleigh and Wolfgang Wipperman, *The Racial State: Germany 1933-1945* (Cambridge: Cambridge University Press, 1991), 507-509.

[8] Ibid., 168.

[9] Ibid., 49.

[10] Gisela Bock, "Racism and Sexism in Nazi Society: Motherhood, Compulsory Sterilization,

health the latter were alleged to have recessive genes. Roughly two-thirds of those sterilized were the inmates of mental hospitals. The scope of sterilization, organized and administered by the medical profession, widened as time passed to include convicts, prostitutes and even children in orphanages who were considered uncooperative. Eventually, even social problems like poverty were attributed to genetics.[11] Between 1934 and 1936 about 250 special sterilization clinics were established and race hygiene experts along with judges decided on the desirability of sterilizations. Doctors had to undergo training in recognizing hereditary degeneracy, for example though the shape of the patient's earlobes, the patient's gait, or the configuration of the half moon at the base of the patients fingernails.[12] Doctors were required to record all cases of serious alcoholism and what were termed incurable hereditary or congenital diseases such as imbecilism, and highly contagious diseases like venereal diseases, except in women over forty-five who were regarded as less of a threat to the potential racial pool, and could be fined for failing to do so.[13] These people were termed "useless eaters" and a burden to the German war machine. [14] The Nazis implemented a ruthless sterilization program that ultimately victimized approximately 350,000 Germans[15] divided equally between men and women, including an unknown number of Jews. Also included were Roma and Sinti, classed as "disorderly wanderers," and approximately 500 "Rhineland bastards" – children of liaisons between German women and black French soldiers.

II. The Euthanasia Program

In 1939 the Nazis moved from sterilization to mass murder. Virtually the entire medical profession had been involved in the sterilization program. For an unknown number, moving to euthanasia was but a short step.[16] The lawyer Karl Binding and the forensic psychiatrist Alfred Hoche coined the phrase "life unworthy of life" in their writings, and argued that what they called "ballast

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and the State," in *Different Voices: Women and the Holocaust*, ed. John K. Roth, and Carol Rittner, 161-186 (New York: Paragon House, 1993), 161-180; 70-75.

[11] John Cornwell, *Hitler's Scientists: Science, War and the Devil's Pact* (New York: Viking, 2003), 348.

[12] Evans, *The Third Reich in Power*, 145.

[13] Richard J. Evans, *The Coming of the Third Reich* (USA: Penguin Books, 2005), 145.

[14] Vivien Spitz, *Doctors from Hell: The Horrific Accounts of Nazi Experiments on Humans* (Boulder: Sentient Publications, 2005), 46.

[15] Evans, *The Coming of the Third Reich*, 508.

[16] James M. Glass, *Life Unworthy of Life: Racial Phobia and Mass Murder in Hitler's Germany* (New York: Basic Books, 1997), 34.

existences" – people who were nothing but a burden on society – should be killed. They proposed that as the incurably ill and mentally handicapped were costing millions of marks and taking up thousands of needed hospital beds, doctors should be allowed to put them to death. Those targeted for euthanasia included children born with congenital anomalies including Down's syndrome/mongolism and vaguely defined conditions such as "idiocy," especially when associated with blindness or deafness; mental retardation; hydrocephaly; microcephaly; spina bifida; muscular dystrophy; limb malformations of all kinds; and paralysis including spastic conditions such as cerebral palsy.[17] All Jewish patients were to be killed regardless of illness.[18] Doctors and midwives were paid 2 Reichsmarks for every case they reported.[19] In December 1939, questionnaires were sent to every German mental institution to be completed for each inmate.[20] Inmates with stays of five years or longer were at particular risk.[21] At first concerned with physical issues, the reports were considerably expanded in June 1940 to include: details about a person's birth and family history, especially concerning such things as hereditary illness and excessive use of alcohol, nicotine or drugs, evaluation of the illness including expectations for improvement and life expectancy, prior institutional observations and treatment, details of physical and mental development, and descriptions of convulsions and related events.[22] After this time, the questionnaires also inquired about the ability of the inmate to work.[23] Eventually all physicians, not only psychiatrists, were allowed to complete the questionnaire.[24] The methods of killing involved injections of morphine and cyanide, or carbon monoxide gassing in sealed chambers, chemical agents including luminal and veronal in addition to morphine and scopolamine, and occasionally the injection of phenol directly into the heart,[25] all of which were the responsibility of the medical profession.

Eventually 30 killing centres were established including some of Germany's most prestigious hospitals – Hadamar, Hartheim, Sonnenstein and

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[17] Richard J. Evans, *The Third Reich at War* (New York: The Penguin Press, 2009), 80.

[18] Frank Chalk and Kurt Jonassohn, *The History and Sociology of Genocide* (New Haven: Yale University Press, 1990), 534.

[19] Evans, *The Third Reich at War*, 84-85.

[20] Chalk and Jonassohn, 534.

[21] Ibid.

[22] Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, Inc, 1986), 270-278.

[23] Chalk and Jonassohn, 534.

[24] Ibid.

[25] Lifton, 100.

Grafeneck – which were set up as medical schools conducting classes, not in curing, but in killing.'[26] The main killing centers were in isolated areas and had high walls although onlookers could see and smell the crematory smoke and could view the buses transporting patients to them. Between 70,000 and 93,000 inmates of asylums were gassed by medical professionals before the euthanasia program (the T4 program) was shut down after opposition from Church leaders. On or about August 24, 1941, Hitler gave a verbal order to end or at least to "stall" operation T4.[27] Only the visible aspects of the program were discontinued – the large scale gassing of victims which resulted in obvious smoke from burning bodies in the crematoria – while the killing by other means continued.[28] The special gas chambers were dismantled and shipped to the east where they were re-assembled in such places as Belzec, Maidanek and Treblinka. The program continued on a lesser scale for the remainder of the war,[29] with killing now by drugs, lethal injection or by starvation.[30] Many of these doctors spoke with pride about their work after the war, maintaining that they had been contributing to human progress.[31]

III. Other manipulations of reproductive life

In addition to the eugenics and euthanasia programs, the Nazis manipulated birth and factors contributing to birth to implement the Shoah of the Jews and the genocide of all those deemed *lebensunwertes Leben*. These actions included preventing social and sexual contact between those regarded as "desirable" and those deemed "undesirable," to avoid contamination. More severely, the Nazis prevented those they regarded as "undesirable," from reproducing through segregation of the sexes in camps, forbidding births in ghettos and camps on pain of death, and enforcing abortion amongst those who did conceive. Among Jews, reproduction was, in addition to the actions described above, prevented by murdering pregnant women on arrival at concentration or extermination camps or later, if pregnancy manifested after admission to the camps. Mothers and their newborns were murdered if a birth occurred. The Nazis gassed Jewish children on arrival at the camps to prevent them from growing into adults who could then reproduce. Nazis also inflicted significant sexual degradation and humiliation such as forced nudity and

[26] Glass, 9.

[27] Lifton, 95-97.

[28] Ibid.

[29] Glass, 62.

[30] Lifton, 95-97.

[31] Evans, *The Third Reich at War*, 82.

shaving of all bodily hair, contributing to a dehumanization of these psychologically significant components of reproductive self-concept.

To promote the achievement of a "pure Aryan" race among those deemed to meet racial purity criteria; on the other hand, the Nazis rewarded motherhood socially with distinctive medals and respectful salutes being awarded to mothers with many children, and financially, with grants (e.g. marriage loans) for those likely to produce "pure Aryan" offspring. More drastically, among Aryans, the Nazis supported childbirth outside of marriage and divorce on the grounds of being past childbearing age; condoned infidelity within marriage; officially promoted interpersonal relationships and sexual practices ('joyful heterosexuality')[32] that were deemed to be acceptable (e.g. among those deemed racially 'pure' enough); forbade birth control and abortion; and even kidnapped "desirable" children in occupied lands to promote the Aryan racial pool.

IV. Doctors Roles in the Camps

Doctors fulfilled numerous roles during the Holocaust that contributed significantly to achieving Nazi goals.[33] For instance, their role in the eugenic sterilization and euthanasia programs was extensive. In the camps they selected prisoners from the incoming transports and supervised the extermination process in the gas chambers by overseeing the application of Zyklon B and ensuring that the extermination process had been carried out once the doors were opened. Doctors also ensured the removal of all gold teeth and valuables that might have been hidden in bodily orifices from the gassed victims, as well as the melting of the teeth and their safekeeping until delivery to the SS. They selected prisoners who could no longer work or those with infectious diseases for extermination and decided which bedridden inmates they would kill with lethal injections or which would be sent to gas chambers. Doctors certified that the prisoners to whom they administered lethal injections had died and had to be present at executions to verify that the executed were dead. They were required to examine prisoners sentenced to receive corporal punishment for reasons that might prevent this punishment, and had to be present when this was carried out. They were also expected to perform abortions on foreign women at least up until the fifth month of pregnancy. In addition, many doctors and medical institutes were directly involved in ghastly medical experimentation and some, like Professors Clauberg, Schumann, and Mengele, worked on medical experiments involving reproductive function.

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[32] Dagmar Herzog, "Hubris and Hypocrisy, Incitement and Disavowal: Sexuality and German Fascism.," *Journal of the History of Sexuality* 11, no. 1/2 (2002): 9.

[33] Rudolf Höss, *Death Dealer: The Memoirs of the SS Kommandant of Auschwitz*, trans. Andrew Pollinger ed. Steven Paskuly (New York: Da Capo Press, 1996), 223-224.

V. Sterilization Experiments

The period between the arrival of prisoners in the camps and their ultimate murder provided the Nazis with an opportunity to conduct medical experiments on them – mostly hidden from public view. These experiments gave the Nazis the opportunity to implement both of their ideological goals – the refinement of the "Master Race" and the elimination of the sub-human Jews and others categorized as undesirable.

A great deal of scientific attention was dedicated towards determining ways of mass sterilization. Sterilization experiments were conducted from March 1941 to January 1945 in Auschwitz, Ravensbrück and other camps.[34] Women subjected to such experiments were called "rabbits" or "guinea pigs."[35] Carl Clauberg requested permission from Himmler to conduct sterilization experiments in Auschwitz on May 30, 1942. Himmler agreed, through his assistant Rudolf Brandt, on July 10, 1942, indicating that he would be "interested to learn [...] how long it would take to sterilize a thousand Jewesses."[36] He also advocated a practical follow-up experiment "locking up a Jewess and a Jew together for a certain period and then seeing what results are achieved," [37] and whether the sterilization procedures had been effective in preventing conception. Three methods were tried: sterilization by medication, x-rays and chemicals.

VI. Sterilization by Medication Experiments

The first approach involved using drugs that were designed to induce infertility developed from a South American plant *caladium seguinum* (American arum) and tested on animals by the firm Madaus and Co., Dresden-Radebeul. Dr. Karl Tauboeck at the University of Vienna was ordered by Himmler in 1942, to produce sizeable quantities of a drug obtained from the Brazilian plant of the same family*, dieffenbachia seguina* (Dumb cane), which he was informed was to be used for the mass sterilization of the mentally-ill Polish and Ukrainian populations.[38] The drug was believed to reduce sexual excitation

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[34] Hester Baer and Elizabeth Baer, "Introduction," in *The Blessed Abyss: Inmate #6582 in Ravensbrück Concentration Camp for Women*, eds. Hester Baer, and Elizabeth Baer, 13-51 (Detroit: Wayne State University Press, 2000), 1-30.

[35] Wanda Poltawska, *And I Am Afraid of My Dreams*, trans. Mairy Craig (London: Hodder and Stroughton, 1964), 80.

[36] Lifton, 270-278.

[37] Ibid.

[38] British Intelligence Objectives Sub-Committee, "Interrogation Report No 518. Ref No Aiu/

and to induce impotency in males at least: for females, the effect appeared to be temporary. Dr. Tauboeck reported destroying all the available plants by allowing them to freeze as he thought the research unethical. In addition, Dr. Adolf Pokorny testified after the war that he had worked on a second series of experiments using these plants, and had also used delaying tactics to prevent such research from being successful: he was acquitted at the Nuremberg trials.[39] Mitscherlich and Mielke report that a sworn statement of Rudolf Brandt, Himmler's personal adjutant, explains that experiments with *caladium seguinum* were actually performed on concentration camp inmates, but all efforts to discover the details proved fruitless at the time of the 1947 Nuremberg trials.[40]

In contrast to these experiments designed to reduce fertility, Dr. Tauboeck was also ordered by Himmler to produce a drug that would excite the sexual desires of women to facilitate the actions of spies in cases where women might have desired information.[41] This manipulation is yet another manifestation of the Nazi's willingness to use or misuse women, as sexual and reproductive beings, to facilitate their cause.

VII. Sterilization by X-Rays Experiments

A second method tried to provide a method of mass sterilization explored the use of x-rays in both men and women. Dr. Horst Schumann's experiments were directed towards castrating Jewish men by means of x-rays to the genital organs. Schumann was the director of Grafeneck euthanasia centre and later Sonnenstein. Following this, he became active in project 14f13 as a member of the medical commissions visiting camps.[42] Victims of his experiments reported having their sperm collected, being forced to masturbate, having their prostate glands brutally massaged by means of wooden or iron instruments inserted into the rectum to induce ejaculation, and having operations to remove one or both testicles, or even a portion of a testicle. They were questioned about the result of the "treatment," their desires, nocturnal emissions, and loss of memory. Brutality and minimal anaesthesia made their

Pir/137. Target No: C24/744, Bwce/N/Int/"T"/1 162 " (London: Imperial War Museum, 12 June 1947).

[39] US Government, "Trial of the Major War Criminals before the International Military Tribunal. Official Text in the English Language. Published at Nuremberg, Vol. XXIX," (1947).

[40] Alexander Mitscherlich and Fred Mielke, *Doctors of Infamy: The Story of the Nazi Medical Crimes*, trans. Heinz Norden (New York: Henry Schuman Inc, 1949), 131-135.

[41] British Intelligence Objectives Sub-Committee, "Interrogation Report No 518. Ref No Aiu/Pir/137. Target No: C24/744, Bwce/N/Int/"T"/1 162."

[42] Lifton, 278.

experiences disastrous. Haemorrhage and septicaemia often followed as well as absence of muscle tone from wounds so that the men died rapidly.[43] Robert Jay Lifton also reports castration experiments on a group of healthy Polish men to whom unusually high doses of x-rays were given causing their genitals to rot away. After long suffering, the men were sent to the gas chambers.[44]

Prof. Schumann's experiments on women involved the use of x-rays of the pelvic organs to induce sterility. He forcibly sterilized women by positioning them between two x-ray machines aimed at their sexual organs. Ovariectomies were later performed – often by a Polish prisoner Dr. Wladyslav Dering. Most women died after suffering greatly.[45] Schumann and his co-workers performed 90 sterilizations in one day on at least one occasion.[46] Operations were done without sterile procedures for hands or instruments and executed extremely rapidly – in about 10 minutes – followed by hasty and rough suturing. In women, symptoms induced by x-rays included the cessation of menstruation, changes in body hair, and changes in metabolism. As it was not possible to prevent irradiation of other body parts, irradiation sickness also ensued together with burning of the skin.[47] Danuta Czech testified that 15 of the girls experimented on by Dr. Schumann on November 2, 1942 were between 17 and 18 years of age: only a few survived. Because of the experiments, the girls completely changed in appearance and resembled old women.[48]

Victor Brack reported to Himmler, on the basis of Schumann's experiments, that men or women could step up to a window where they could be asked questions or have to complete a form thus detaining them for the desired time needed to expose them to the x-rays. The official behind the window could operate the x-ray tubes. He reported that "a two-tube installation could thus sterilize 150-200 persons a day, twenty installations some 3,000 to 4,000 persons a day."[49] Schumann himself, however, reported on April 29, 1944, that castration of men by this method was not feasible and probably

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[43] Ibid., 282.

[44] Ibid., 283.

[45] Hartmut M Hanauske-Abel, "Not a Slippery Slope or Sudden Subversion: German Medicine and National Socialism in 1933," *BMJ: British Medical Journal* 313, no. 7070 (1996): 137, note 11.

[46] Gerald L. Posner and John Ware, *Mengele: The Complete Story* (New York: Cooper Square Press, 2000), 31-32.

[47] Mitscherlich and Mielke, 136.

[48] Danuta Czech, *The Auschwitz Chronicle 1939-1945*, trans. Barbara Harshav, Martha Humphreys, and Stephen Shearier (New York: Henry Holt, 1990), 172.

[49] Elie Cohen, *Human Behaviour in the Concentration Camp* (London: Free Association Books, 1988), 97.

too expensive. He suggested that castration by surgical means was cheaper and took no more than 6-7 minutes but that this method was not fast or inconspicuous.[50]

VIII. Experiments on Sterilization with Chemicals

Prof. Clauberg, an SS Brigadier-General and MD from Köningshütte, working under the supervision of the chief SS physician Dr. Eduard Wirth, was particularly involved in a third approach to sterilization: the injection of chemical irritants into the uterus. [51] On April 1, 1943 Commandant Höss, put Block 10 at Auschwitz at his disposal for these experiments. By May 5, 1943, there were 243 women prisoners – Jews and Roma or Sinti – housed in Block 10 who were to be used for this research. Both Jews, Roma and Sinti were subjected to these experiments.[52] In addition to wards, Block 10 had an elaborate x-ray machine and four experimental rooms, one of which served as a dark room for developing x-rays.[53] Clauberg's program began on December 18, 1942 with about 350-400 Greek and Dutch women. He injected iodiprin, F12a, which was diluted Novocain, and citobarium or barium sulphate into the uterus and subjected the women to x-rays. This resulted in peritonitis, inflammation of the ovaries, and high fever, causing closure of the fallopian tubes and permanent sterility. Sometimes the belly of the woman was opened to observe the lesions. The ovaries were then removed, usually in two separate operations, and sent to Berlin for analysis. Clauberg reassured women that he would not return them to Birkenau but would send them to his private research clinic in Königsshütte a few kilometers from Auschwitz. After the successful experiment Clauberg planned that every one of the female prisoners at the end of a year undergo sexual intercourse with a male partner chosen especially for this purpose in order to carry out a practical test of Clauberg's sterilization method. This test was never performed "because of the course of the war" and most of the women were later sent to the gas chambers.[54] On June 7, 1943, Clauberg reported to Himmler – under whose direct orders he was working – that he could sterilize, without an operation, as many as a thousand women a day. He suggested that a single injection into the cervix was sufficient and it could be administered during the "usual gynaecological examination familiar

[50] Höss, 350.

[51] Leni Yahil, *The Holocaust: The Fate of European Jewry*, trans. Ina Friedman and Haya Galai (Oxford: Oxford University Press, 1990), 369.

[52] Guenter Lewy, *The Nazi Persecution of the Gypsies* (Oxford: Oxford University Press, 2000), 161-162.

[53] Lifton, 270-278.

[54] Ibid.

to every physician." X-ray photographs made during certain preliminary tests performed at Ravensbrück showed that Clauberg's injections "penetrated to the end of the ovarian duct; in several cases even to the abdominal cavity."[55]

IX. Other Experiments on Reproductive Organs

A further series of experiments were conducted on menstruation and the menstrual cycle in women, largely using the bodies of women to be executed by the Gestapo. German scientist Hermann Stieve of the University of Berlin was notified of the date of execution of women of reproductive age. During her period, the prisoner was also informed: "You will be shot in two days."[56] Stieve then studied the effects of the impending trauma on the woman's menstrual cycle. Upon her death, her pelvic organs were removed for histological examination. Stieve continued to lecture on his research in Berlin after the war and was sought after by Russian scientists.[57]

A series of additional experiments involved the reproductive organs and behaviours of prisoners. Lengyel reports that experiments on artificial insemination were tried although the experiments yielded no results.[58] In alternative experiments, a Dr. Treite performed surgical tying of the oviducts.[59] Further experiments in Buchenwald and Neuengamme attempted to counteract homosexuality by gland implants and synthetic hormones. These experiments were suggested and executed by the Danish SS Major Dr. Carl Vaernet.[60] In Buchenwald, 15 inmates were treated of whom two died. No positive findings emerged.[61] Dr. Franz Blaha testified at Dachau during the war trials that the infamous freezing water experiments conducted by Dr. Sigmund Rascher utilized either a heating apparatus to re-warm frozen prisoners or – at Himmler's suggestion – the person was placed in a bed between two women.[62] In eight

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[55] Cohen, 97.

[56] Olga Lengyel, "Scientific Experiments," in *Women and the Holocaust: Different Voices*, eds. Carol Rittner, and John K. Roth, 119-129 (New York: Paragon House, 1993), 121.

[57] William E. Seidelman, "Medicine and Murder in the Third Reich," *Dimensions: A Journal of Holocaust Studies* 13, no. 1 (1999): 1-9.

[58] Olga Lengyel, *Five Chimneys: A Woman Survivor's True Story of Auschwitz*, First Academy Chicago edition, 1995 ed. (Chicago: Ziff-Davis Publishing Company, 1947), 190.

[59] Hanauske-Abel, 138.

[60] United States Holocaust Memorial Museum, "Homosexuals: Victims of the Nazi Era, 1933-1945," fcit.usf.edu/holocaust/people/USHMMHOM.HTM.

[61] Eugen Kogon, *The Theory and Practice of Hell: The German Concentration Camps and the System Behind Them*, trans. Heinz Norden (New York: Berkeley Books, 1950), 172.

[62] Joshua M. Greene, *Justice at Dachau: The Trials of an American Prosecutor* (New York: Broadway Books, 2003), 49.

cases the subject was placed between two naked women: they were supposed to nestle close to the subject to warm him up. All three were then covered with blankets. Consciousness returned earlier than with other methods of warming, such as using hot baths or blankets. The temperature rose rapidly in four of the experimental subjects who engaged in sexual intercourse. Additional experiments involving re-warming by one woman indicated that return to consciousness and re-warming occurred even more quickly compared to when two women were involved, possibly due to fewer inhibitions.[63] Himmler considered these experiments as entertaining and, on occasion, brought friends to view them.[64]

X. Mengele's Twin Studies

Twins, Dr. Josef Mengele's primary concern, were regarded as the ideal experimental subject. Twins were valued because of their potential in promoting multiple births, in order to create the "Master Race."[65] Mengele's twin studies were not simply about increasing fertility through multiple births but also about perfecting the replication of the ideal features of the desired Aryan race: blue eyes, blond hair and strong bodies.[66] To this end, Mengele tried to change the pigmentation of eyes by injecting them with substances such as methylene blue. The procedure did not cause any permanent change in eye color but did cause considerable pain, vision damage and on occasion death.[67] Mengele was also believed to have experimented with sexuality among his twin subjects:[68] Several twin survivors believe that Mengele had twins mate although no twins have elaborated on what they knew about this. Some female twins were, however, sterilized and some males castrated. Rumors suggest that Mengele wanted to use twins' sperm to impregnate German women to see if they would also bear twins and to see if male twins who had intercourse with female twins would again bear twins.[69] At the end of 1944, a new block was being built in Auschwitz for experiments with artificial

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[63] Cohen, 87.

[64] Lord Russell of Liverpool, *The Scourge of the Swastica* (London: The Military Book Club, 1954), 186-187.

[65] Edwin Black, *Nazi Nexus: America's Corporate Connections to Hitler's Holocaust* (Washington D C: Dialog Press, 2009), 66-74.

[66] Posner and Ware, 31-32.

[67] Ibid., 34.

[68] Lucette Matalon Lagnado and Sheila Cohn Dekel, *Children of the Flames: Dr Josef Mengele and the Untold Story of the Twins of Auschwitz* (New York: William Morrow and Company, Inc, 1991), 70-71.

[69] Lifton, 357-359.

insemination, for the greater population of Germany; but the evacuation of Auschwitz prohibited their implementation.

XI. The Value of this Experimentation

Referring to these experiments as research credits them with some scientific validity. There is however, considerable doubt as to whether any research conducted on starving prisoners living under appalling concentration camp conditions and without consistently following appropriate medical standards is of any value. In addition, some of the activities of camp doctors under the guise of research, and later testified to by survivors, raise images of sheer morbid curiosity rather than science.

At the Nazi doctor's trial following the war commencing on October 25, 1946, none of those charged with the most heinous of these programs expressed remorse or regret: they remained convinced of the value and normalcy of their actions.[70] Their research appeared, to them, to have achieved the highest goals of purifying and removing degeneracy from the superior German Aryan race and they believed they should be honored for their achievements rather than criminalized.[71] Estimates suggest that between 200 and 350 German doctors, including university professors and lecturers, had been direct participants in research, while hundreds or perhaps thousands had stood silently by.[72] Among these doctors, the power of ideological conviction, combined with selfish achievement motivation, clearly outweighed the humanitarian underpinnings of their Hippocratic Oath.

XII. The Aftermath of the Nazi Medical Experiments

The so-called medical experiments conducted in the camps in association with many of the top research facilities in Germany at the time were horrendous. They have, however, stimulated a process of developing and refining ethical guidelines for research on human subjects that commenced shortly after the war and is still in progress. While this in no way justifies their occurrence, it is, at least, one optimistic outcome of these disastrous events.

Debates around issues related to the medical experiments of the Nazi era are, however, difficult. Using the "Nazi analogy" is a persuasive argument and tends to result in moral bulldozing.[73] In the medical world, a lack of un-

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[70] Spitz, 266.

[71] Ibid.

[72] Cornwell, 357.

[73] Arthur Caplan, "The Relevance of the Holocaust in Bioethics Today," in *Medicine, Ethics, and the Third Reich: Historical and Contemporary Issues*, ed. John J. Micahalczyk, 3-12 (Kansas City: Sheed and Ward, 1994), 6.

derstanding of Nazi medicine results in the "Nazi analogy" being a powerful force preventing careful examination of the merits and demerits of current medical developments such as cloning, or the use of stem cells, or assisted dying. It is only in recent decades that bioethicists have analyzed the ethical issues raised by the brutal experiments in the camps and the eugenics and euthanasia programs.[74] The German medical community in particular has been reluctant to confront its role in the Nazi era: Mitscherlich[75] was rejected by German medical bodies for editing the documents produced at the 1946-1947 Doctor's Trial at Nuremberg. Of 422 articles on Nazi Medicine published between 1966 and 1979, only two originated in Germany.[76] The reluctance of post-war scientists to examine the Nazi experiments and to dismiss them as irrelevant has led to a disregard for their implications for our current medical and scientific activities.[77] Exposing the extent and horror of the Nazi era is important if a balanced view of current medical developments can be obtained in relation to the faulty science underlying Nazi ideology. This is important because what took place in Germany was grounded not only in racism, as occurs in many current day conflicts and genocides, but also in science and medicine. Nazi racism was implemented using scientific and engineering technology administered by doctors and other health care providers.

XIII. Consequences of Not Examining Nazi Medicine after 1945

Our unwillingness to examine Nazi medicine in the decades following the end of World War II might have contributed to the ability of scientists to proceed with research that was, on occasion, questionable. For example, Jay Katz reports that the mustard gas experiments conducted by the U.S. armed forces between 1950 and 1970 continued patterns of abuse and neglect where subjects were recruited through lies and half-truths for experiments using chemicals known to cause debilitating long-term effects.[78] Similarly, Katz asserts that the Tuskegee Syphilis studies conducted between 1932 and 1972, by the U.S. public health service allowed for the monitoring of the natural history of untreated syphilis from its inception until death in 400 African-Americans, de-

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[74] Michael Grodin, "Historical Origins of the Nuremberg Code," in *Medicine, Ethics and the Third Reich: Historical and Contemporary Issues*, ed. John J. Michalczyk, 199- 209 (Kansas City: Sheed and Wade, 1994).

[75] Mitscherlich and Mielke.

[76] Henry David, Jochen Fleischhacker, and Charlotte Hohn, "Abortion and Eugenics in Nazi Germany," *Population and Development Review* 14 no. 1 (1998): 82.

[77] Jay Katz, "The Concentration Camp Experiments: Their Relevance for Contemporary Research with Human Beings," in *Medicine, Ethics and the Third Reich* ed. John J. Michalczyk, 73-86 (Kansas City: Sheed and Ward, 1944), 73.

[78] Ibid., 74-78.

nying them treatment. Katz further reports that as recently as 1994, consideration was given to the use of Alzheimer patients – who were unable to give consent – in research that would expose them to greater than minimal risk. As he elucidates, these studies share a common disregard of the human subjects' interests for the noble, scientific purpose of alleviating the pain and suffering of others. Nazi doctors might well have used the same argument. It need be noted, however, that while these questionable research instances have occurred in the decades since the end of World War II, these are nowhere near equivalent to Nazi era experiments and are not in any way representative of North American research in general.

XIV. A Code of Medical Research Ethics

What is most remarkable is that these studies were conducted long after a medical code of research ethics emerged from the ashes of the Holocaust. The Nuremberg Code of 1947, emerging from the Nuremberg trials, had as its first and most significant clause that the voluntary consent of human subjects in research is absolutely essential.[79] Remarkably, the 1964 World Medical Association Declaration of Helsinki removed this requirement and emphasised the importance of the scientific research instead. Later versions of the code, in 1975, 1983 and 1989, did once again include informed consent but this was listed as principles 9, 10 or 11 respectively.[80] As George Annas points out, judges and lawyers devised the Nuremberg Code, while physicians developed the Helsinki Code for their own guidance.[81] In conflict here is the principle of doing the best for the individual versus the broader population good. As Katz mentions we are now more concerned with the science of medicine than the art of healing.[82] In 1982, the World Health Organization together with the Council for International Organization of Medical Sciences (WHO/CIOMS) developed further guidelines, which, to an extent, may replace the requirement for individual consent with an independent impartial perspective review of all protocols. A 1992 version from this same body continued moving away from an individual rights approach to a prior group review approach.[83] To compound the problem, the Nuremberg Code, the Helsinki declaration and the WHO/CIOMS guidelines are

[79] Ibid., 82-83.

[80] Ibid.

[81] George Annas, "The Changing Landscape of Human Experimentation: Nuremberg, Helsinki and Beyond," in *Medicine, Ethics and the Third Reich: Historical and Contemporary Issues*, ed. John J. Michalczyk, 106-114 (Kansas City: Sheed and Wade, 1994), 107.

[82] Katz, 82-83.

[83] Annas, 111.

advisory only: they have no legal standing in most countries and do not carry any ability for sanction of researchers who disregard them.[84]

Economic pressures are currently forcing doctors to make research related decisions based on economic constraints, including lucrative sources of research funding and pharmaceutical companies' interests, and not necessarily in the best interests of patients – pressure that might well lead physicians down a wrong path.[85] Michael Grodin also emphasises that the fundamental relationship between physician and patient must not become subordinate to the needs of the state, as it did in Nazi times. As Katz notes, medical ethics should never allow research experiments on persons whose lives the state considers expendable including those in prisons, serving as soldiers or in hospitals or similar institutions.[86]

Drawing analogies between present actions and Nazi Holocaust behavior arouses strong emotive reactions and may result in the moral argument discounting any possibility of logical analysis as to when, where and why some lives might be terminated. Dónai O'Mathúna notes that James Watson (winner of the shared Nobel prize for discovering the structure of DNA; the first director of the Human Genome Project) believes that society needs to eliminate defective genes. Such thinking might justify embryo selection, abortion and infanticide as well as gene altering techniques.[87] Debates about the ethics of such actions continue; while many countries allow for abortion on some grounds, and embryo selection in particular circumstances, emotional and religiously based arguments abound decrying each of these possible steps and making constructive development of guidelines for the appropriate use of these techniques difficult. O'Mathúna further notes that prenatal caregivers and women worldwide have long accepted the value of routine prenatal screening with the intention of terminating some pregnancies. Even infanticide – which is, emotionally, perhaps the most difficult to accept of the three methods – needs consideration with regard to when, where and if it should be supported. According to O'Mathúna, Prof. John Harris, a member of the British Medical Association ethics committee, notes that there is widespread acceptance of infanticide in some countries and questions the difference between aborting late term fetuses and infanticide. The acceptability of giving lethal injections to

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[84] Ibid., 122.

[85] Michael A Grodin, George J Annas, and Leonard H Glantz, "Medicine and Human Reich: A Proposal for International Action," in *Medicine, Ethics and the Third Reich:Historical and Contemporary Issues*, ed. John J. Michalczyk, 199- 209 (Kansas City: Sheed and Wade, 1994), 198.

[86] Katz, 74-78.

[87] Dónai P. O'Mathúna, "Human Dignity in the Nazi Era: Implications for Contemporary Bioethics," *MBC Medical Ethics* 7, no. 2 (2006): 1-16.

patients with terminal and debilitating or painful illnesses is also currently debated in many countries with varying degrees of approval of this action.[88] Seen as merciful by some it runs contrary to the religious or moral beliefs of others. While we have the technological ability to implement many such actions, we currently still lack the guidelines that determine when, how and under what circumstances such actions are acceptable. The importance of discussing and determining ethical guidelines for the implementation of such actions remains a challenge for today's world.

Distinctive in almost all of these situations, however, is the requirement for patient consent for any of these procedures, which is in stark contrast to the practices of the Nazi era that imposed forced experimentation and killing. These sensitive issues reinforce the importance of maintaining the requirement of informed consent in all research and clinical practice medical guidelines. Unfortunately, informed consent is also open to abuse. To be truly ethical, informed consent should be both evidence-based and unbiased by the traditional superior doctor-inferior patient hierarchy that is commonly prevalent in both society and in medical care.[89] Yet not all doctors are fully aware of the most up-to-date evidence underlying their advocated practices, and not all provide information to their patients in a manner that is truly non-coercive, thereby diminishing the high moral grounds underlying the requirement to obtain informed consent for procedures.

Whether we examine childbearing today, matters of life and death, or Nazi medicine, it appears that lessons from the Nazi Holocaust have yet to be learned.

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[88] Ibid., 7.

[89] Beverley Chalmers, *Family-Centred Perinatal Care: Improving Pregnancy, Birth and Postpartum Care* (Cambridge: Cambridge University Press, 2017).

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The Rhetorical Biopower of Eugenics: Understanding the Influence of British Eugenics on the Nazi Program

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Abstract

The relationship between the British and Nazi eugenics movements has been underexamined, largely because of the more obvious ties between the American and Nazi programs and the lack of a state-sponsored program in Britain. This article revisits this gap to reinsert the British eugenics movement into the historiography of the Nazi program by way of their shared rhetoric. To do this, I employ Foucault's concepts of biopower and power/knowledge, arguing that biopower exists in rhetorical constructions of power and identity, which the eugenics movements employed at national and individual levels to garner support and participation, particularly from women. The article is not an exhaustive account of the rhetorical overlaps between the two movements, but rather serves as a model of how one might understand eugenics as a rhetoric of biopower.

Key-words: *eugenics; Nazis; British; biopower; power/knowledge; class; feeblemindedness; race*

The foundations of the Nazi eugenics program are largely attributed to two sources: Francis Galton's writings on eugenics and the American eugenics movement, which established the world's first eugenics sterilization law in Indiana in 1907. The American influence on the Nazi program is well-documented in works like James Q. Whitman's *Hitler's American Model* (2017) and Edwin Black's *War Against the Weak* (2012). However, there has been considerably less work on the British influence on the Nazi program, beyond the influence of Charles Darwin and Francis Galton.[1] This oversight is a product of neglecting the field of German eugenics prior to the rise of the Third Reich; focusing on Nazi doctors who referenced the American program on numerous occasions; and discounting the British movement because

[1] See Richard Weikart, *From Darwin to Hitler: Evolutionary Ethics, Eugenics, and Racism in Germany* (New York: Palgrave Macmillan, 2004).

it never resulted in legislation mandating forcible sterilization, despite political campaigns and related legislation that were considered foundational for a nationalized program. In other words, the British eugenics movement was a program that nearly was, and for that reason, it should be examined as an influence on the Nazi program, despite having been previously downplayed or overlooked.

The British eugenics movement's efforts were considerable, mobilizing the intelligentsia and politicians alike to actively campaign against the continuation of a so-called undesirable class of society. Their focus on class does not negate any racialized biological view – such is apparent in nineteenth-century descriptions and marginalization of the Irish, Africans, and Indians, among others. Rather, their concentration on class, imagined in racialized terms and therefore blurred with race, is part of a larger rhetorical strategy to gain support for the eugenics movement that ultimately classified non-Aryan, working-class, and "feebleminded" as unfit and part of a very broadly constructed underclass. In her study of Victorian eugenics, Angelique Richardson rightly notes that "early British eugenics was primarily a matter of rhetoric and representation;" this rhetorical approach, one that combined scientification with nationalism, was used in the first decades of the twentieth century as well.[2] Comparing the rhetoric used by British and Nazi eugenics offers an insight into the British influence on the Nazi program; more than that, it offers a broader understanding of the political and social power of language.

As noted by Daniel J. Kevles, the success of eugenics "depended on the authority of science,"[3] authority best understood through Michel Foucault's concepts of biopower and power/knowledge, which allow for a clear understanding of eugenics as power and offers insight into the transference of eugenics thinking between countries. Biopower, as described in *The Will to Knowledge*, is the "power to *foster* life or *disallow* it to the point of death [...] Such a power has to qualify, measure, appraise, and hierarchize."[4] Biopower, then, scientifically classifies and regulates the individual body to strengthen the national body: it includes a range of measures such as public hygiene and fertility campaigns, which lay the foundations for eugenics, an example of biopower that Foucault discusses.[5] Functioning within biopower is power/

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[2] Angelique Richardson, *Love and Eugenics in the Late Nineteenth Century: Rational Reproduction and the New Woman* (Oxford: Oxford University Press, 2003), xvii.

[3] Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (New York: Alfred A. Knopf, 1985), 101.

[4] Michel Foucault, *The History of Sexuality Volume 1: The Will to Knowledge,* trans. Robert Hurley (New York: Vintage Books, 1990), 138, 144.

[5] Ibid., 148-149.

knowledge, which is simultaneously national and individual. At the national level (and using the common translation of the term), Foucault theorizes that power exists because of the knowledge that supports it, and knowledge exists because of the power that (re)produces it.[6] However, when considered in its original French, *pouvoir/savoir*, the meaning is complicated and is seen as more localized: as Gayatri Spivak notes, *pouvoir* has an element of "'can-do'-ness," which requires a more nuanced translation of the concept: "if the lines of making sense of something are laid down in a certain way, then you are able to do only those things with that something that are possible within and by the arrangement of those lines. *Pouvoir/savoir*, being able to do something, only as you are able to make sense of it."[7] The ordinariness of this relationship allows the power/knowledge relationship to exist on multiple levels: as produced and reproduced by official entities (government, science, etc.) and as practiced by ordinary people within the framework of their understandings of their positions and themselves – which allows for production and repression as products of power/knowledge.[8]

Using Foucault's conceptualization of biopower and power/knowledge, this article analyzes eugenics rhetoric, meaning the language used to propose and implement policies, as demonstrating how biopower and power both have a direct and reciprocal relationship with the (re)production of knowledge and that knowledge has a relationship to a biological "can-do-ness" that is an internalized understanding of produced knowledge and which regulates the body itself. In other words, the language used to advocate for and implement eugenics functions at the state level of biopower through rhetorical mechanisms understood as power/knowledge, and at the individual level through the internalization of such nationalism that dictates how one uses one's body.

I. The power/knowledge of classification

Scientific classification functions as a state-level power/knowledge: the status given to scientific authority allows for the creation of knowledge (i.e. classification of types, species, etc.), which then perpetuates its authority. Within the framework of biopower through power/knowledge, scientific classification must take on a managing of bodies as a population-level interest: this comes through the public health measures that use the act of classifying

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[6] Michel Foucault, *Discipline and Punish: The Birth of the Prison,* trans. Alan Sheridan (New York: Vintage Books, 1995), 27-28.

[7] Gayatri Chakravorty Spivak, "More on Power/Knowledge," in *Rethinking Power,* ed. T. E. Wartenberg, 149-173 (Albany: State University of New York Press, 1992), 158.

[8] Ibid., 159.

in order to justify managing bodies – which is seen throughout the eugenics movements in Britain and Nazi Germany. The rhetoric itself is based on categorization of difference that creates a knowledge about bodies that reinforces this difference: thus created, this knowledge then produces the biopower of managing bodies that further creates knowledge about managing bodies. Rhetorically, this is achieved through language that embodies difference, authority, and national interests.

For British eugenics, such rhetoric exists in the scientification of class, which derives its power/knowledge from philosophical and policy-based discussions of class and welfare that are appropriated by the scientific community to create an authoritative and biological classification of difference, which then allows for the further justification of proposed interventions from the scientific community. This rhetoric has roots in Thomas Malthus's claims that society need not consider all men equal but rather weigh their value to society: "a man who is born into a world already possessed, if he cannot get subsistence from his parents on whom he has a just demand, and if the society does not want his labour, has no claim of *right* to the smallest portion of food, and, in fact, has no business to be where he is. At nature's mighty feast there is no vacant cover for him."[9] Malthus's rhetoric taps into earlier theories of inheritance and contemporary theories of biological determinism, appealing to the rising authority of scientific claims that sought a place in Britain's political and social arenas. His concept of usefulness is tied to class: although he notes the need for upper and lower classes as motivating factors so "man could hope to rise, or fear to fall in society," he argues that "the middle parts of society are most favourable to virtuous and industrious habits, and to the growth of all kinds of talent;" thus, "our best grounded expectations of an increase in the happiness of the mass of human society, are founded in the prospect of an increase in the relative proportions of the middle parts."[10] His disregard for unproductive or unwanted members of society indicates a clear eugenics argument even before the theory was formalized by Galton and introduces a class-based argument regarding such productivity.

Behind all these ways of describing the poor was Malthus's rhetoric of utility, which laid much of the groundwork for thinking about eugenics in terms of usefulness and fitness. Not surprisingly, Malthus's work influenced both Darwin and Galton's thinking about the social impact of a population unchecked, particularly in light of changing welfare policies.[11] Galton, how-

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[9] Thomas Malthus, *An Essay on the Principle of Population, or a View of its Past and Present Effects on Human Happiness* (London: T. Bensley, 1803[2]), 531.

[10] Ibid., 594.

[11] Marouf A. Hasian, Jr., *The Rhetoric of Eugenics in Anglo-American Thought* (Athens, GA: The University of Georgia Press, 1996; 2017), 16-20.

ever, went much further than Malthus: not satisfied with a natural process to control the population, he proposed that "the aim of eugenics is to bring as many influences as can be reasonably employed, to cause the useful classes in the community to contribute *more* than their proportion to the next generation."[12] As in Malthus's treatise, the pivotal concept is usefulness to community, but examined through a scientific lens that likens human reproduction to animal breeding. He describes favoring "superior breeds" which "are partly personal, partly ancestral" and looking for "energy, brain, morale, and health" and a "thriving family [...] defined or inferred by the successive occupations of its several male members in the previous generation, and of the two grandfathers."[13] Galton affirmed the contemporary belief that class was hereditary, which was perpetuated by others who also connected poverty to moral and physical degeneracy, thus justifying eugenic claims.

Galton's coining of the term eugenics, meaning "well born," aligns health, adaptability, and class as synonymous and as hereditary, thereby encouraging a medicalized and biologically-determined view of class, which, for Galton, could only be altered via processes implemented before birth (i.e. positive eugenics). Using evidence that favored a middle-class society, Galton was able to perpetuate his scientific authority through research that was dictated by his own class authority and merely reinforced the existing prejudice against the lower classes. Referring to the lower classes as the "residuum" of natural processes (and therefore less human than the middle classes), Galton introduced a stratification that perpetuated the legitimacy of the middle class and biologically segregated the lower classes.[14] Such rhetoric provided a foundation for the Eugenics Education Society (EES), established in 1907, which sought to address the spread of the residuum that represented the most degenerate of the working class, through "the control of their excessive fertility, which it held that they were insufficiently responsible to manage themselves."[15] Thus, the EES was able to legitimize its existence and recommendations through claims of scientific knowledge regarding reproduction, thereby arguing for control of fertility.

Using the same power/knowledge of class, eugenicists extended rhetorical biopower to race, relying on a blurring of concepts that perpetuated so-called biological differences. As perpetuated by the white, middle-class

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[12] Francis Galton, "Eugenics: Its Definition, Scope, and Aims,"*The American Journal of Sociology* 10, no. 1 (1904): 3.

[13] Francis Galton, *Inquiries into Human Faculty and its Development* (London: Macmillan, 1883), 324, 326.

[14] Francis Galton, *English Men of Science: Their Nature and Nurture* (London: Macmillan, 1874), 23.

[15] Richardson, *Love and Eugenics in the Late Nineteenth Century*, 29.

intelligentsia, eugenics reinforced its position of power through a knowledge generated by and about the very groups that were advocating for it. Thus, issues of race and "feeblemindedness" could be exploited using the same rhetoric seen in discussions of class, and the conflation of class and race became a deliberate technique to make such connections, particularly at the end of the nineteenth century. Eugenicists argued that British losses during the Boer Wars were evidence of its degeneracy that they attributed to the proliferation of the poor, the influx of foreigners to British soil, and the moral and physical degeneracy of both, which impacted British purity either through physical proximity to the preferred white middle class or through inter-marriage.[16] Such arguments about degeneracy were coupled with views of the poor as racially different to that of the middle class.[17] This racialization of class was repeatedly couched in scientific rhetoric as a means of promoting nationalism and arguing against social welfare policies, despite Darwin's attempts to distinguish race as biologically determined and class as socially and culturally determined.[18] As noted by Angelique Richardson, "The fluidity of the concept of race" meant "racial language was readily used to distinguish groups of varying social as well as ethnic backgrounds."[19] This blurring, however, was not accidental, nor simply a product of shifting meaning; rather, it signaled an othering that extends to all those deemed inferior to a white, middle-class English society, or, as Galton phrased it, the contrast between "high races" and "persons of lower natural stamp."[20] The national imperative, as articulated by Galton and others, was a concern for the development of the genetically superior for the greater good, at the cost of individual liberties and through biopower.

This nationalist rhetoric was framed within scientific concepts of species survival. In discussing the British losses during the Second Boer War, eugenicist Karl Pearson claimed the British were defeated "by a social organism far less highly developed and infinitely smaller than our own [... and] our soldiers [lost] the power of adapting themselves to change of environment."[21] Pearson's evolutionary language maintains British superiority but acknowledges the evolutionary failings of its soldiers, introducing the possibility of improving this military stock. Through this distinction, he argues that "the struggle

[16] See Karl Pearson, *National Life: From the Standpoint of Science* (London: Adam and Charles Black, 1901).

[17] Ibid., 22-23.

[18] Deborah A. Logan, *Harriet Martineau, Victorian Imperialism, and the Civilizing Mission* (New York: Routledge, 2016), 244 n. 4.

[19] Richardson, 24-25.

[20] Galton, *Inquiries into Human Faculty and its Development*, 330.

[21] Pearson, 9-10.

of existence among nations will not necessarily be settled in favour of the biggest nation, nor in favour of the best-armed nation, nor in favour of the nation with the greatest material resources."[22] Britain, then, cannot rely on these strengths alone, what he terms "the flesh, blood, and sinews of a nation" that need to be brought under a "complex nervous system [...] to make it a homogeneous, highly-organized whole."[23] This corporeal language of uniformity and adherence to a common goal, led by the thinking scientific community, speaks clearly to British nationalism.

Science, argues Pearson, is what will preserve the nation. Science functions "to show us what national life means, and how the nation is a vast organism subject as much to the great forces of evolution as any other gregarious type of life" and "to develop our brain-power by providing a training in method and by exercising our powers of cautious observation [...] to prepare for and meet the difficulties of new environments."[24] Such claims to scientific authority are couched in languages of inclusion but are actually a thinly disguised rhetoric of exclusion, whereby the fitness of the British nature will come at the cost of individual liberties and diversity. This distinction is perhaps clearest in Pearson's proposal to train scientific scouts to become observers of society's adaptations and to identify the weaknesses – presumably a system of spies to report inferiority. Thus, Pearson, using imperialism framed by scientific justification, argues both for the spread of white males to colonized countries and for politicians to "insure [*sic*] that the fertility of the inferior stocks is checked, and that of the superior stocks encouraged [...] the statesman has to hold the balance between the strong social feelings upon which are based the external success of the nation and the crude natural check to the unlimited multiplication of the unfit upon which the internal soundness of the nation depends."[25] For Pearson, the threat to the British nation is external and internal, requiring an act of promoting white superiority and middle-class superiority that ultimately aligns the lower classes with non-Aryan races.

Pearson uses science to both advocate for national eugenics policies and to instill a nationalistic pride that encourages a betrayal of individuals in favor of a national good. Such rhetoric is evident in essentially all eugenic writings, but perhaps no more so than in Robert Reid Rentoul's well-known (though controversial) *Race Culture; Or, Race Suicide?* (1906). Rentoul's use of "race suicide," the fear that unchecked reproduction would

[22] Ibid., 11.

[23] Ibid.

[24] Ibid., 34, 35.

[25] Ibid., 48, 59-60.

lead to the end of a race or nation, focuses on a power/knowledge that advocates for reproductive control by the medical community based on medico-scientific claims of inherited mental deficiencies defined by these same medical professionals – in essence, affirming their authority through self-generated knowledge. Thus, Rentoul touts medical authority over individual identities that groups them into categories of degeneracy simply because of this very authority, justified by the medicalization of social behaviors that are aligned with mental inferiority. He claims that "there are many thousands of mentally unsound persons in this country who would not be classed by lawyers as insane, and who therefore could not be legally certified by physicians."[26] As such, the medical profession must establish a classification of degeneracy that includes "criminals, neurotics, erotics, inebriates, drug *habitués*, kleptomaniacs, drunkards, borderland cases, 'failures in life,' and children who are mentally backward, mild epileptics, those suffering from severe chorea or migraine," a group which Rentoul contends will "propagate a degenerate stock."[27] This grouping of mental and physical ill health with social deviance offers insight into how eugenicists blurred scientific and medical lines to create a class of difference that could ultimately include any individuals that were deemed unfit to become part of this underclass that required regulation.

Rentoul's rhetoric of difference relied on a fear of these very boundaries contaminating those deemed fit, thereby further blurring distinctions and reinforcing the need for authoritative measures to ensure the health of the nation. In his metaphorical description of race suicide, he relies on medical language to further his claim for intervention. He writes:

> We may compare race culture and race suicide to a river, at first pure, clear, and health-giving. We begin to foul the pure condition by adding gross impurities to it. Day by day, hour by hour, and year after year we add diseased humanity – the children begotten by the diseased, idiots, imbeciles, epileptics, the insane, deformed, and those contaminated by venereal and other diseases. All these contaminating influences go on permeating, causing more disease, so converting the river into a cesspool, until it, ever widening and deepening, overflows, saturates and inoculates everything within its reach.[28]

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[26] Robert Reid Rentoul, *Race Culture; Or, Race Suicide? (A Plea for the Unborn)* (London: The Walter Scott Publishing Co., 1906), ix.

[27] Ibid.

[28] Ibid., 7.

This catch-all medicalization of difference allowed for British eugenicists to merge class, race, and mental health as threats to the national species. As noted by Mark Jackson, how Rentoul and other eugenicists "mobilized support for their policies rested heavily both on their identification of the feeble-minded as a class and race apart and on their ability to exploit middle-class anxieties about the multiple social, political, and moral threats posed by the lower classes."[29] Feebleminded, though a class unto itself, was conflated "with the supposedly promiscuous, parasitic, and impoverished criminal classes [which] guaranteed that both state and charitable interventions were almost exclusively directed at feeble-minded children and adults from the working classes."[30] Seen as neither productive nor physically fit, those deemed feeble-minded were classified as the underclass of British eugenics and as dangerous to British fitness as the lower classes and other races. Defined as being "on the borderland of imbecility," they were pitied and condemned as "a greater danger to the State, than the absolutely idiotic: these at least have the care and comfort of the asylum."[31] This statement reveals the real danger of the feeble-minded: they were not isolated from society and therefore could contaminate the waters described by Rentoul.

Feeblemindedness was imagined in the same Darwinian terms as the lower classes and so-called inferior races. Mary Dendy, an educator and fierce proponent of eugenics and segregation of those deemed intellectually deficient, claimed feeblemindedness demonstrated "instances of reversion to an earlier and less developed type of humanity [...] It is as though, when the higher faculties have dwindled, the lower, or merely animal, predominate in an unusual degree."[32] Adapting the authority of scientific theories, Dendy was able to stoke fears of national degeneration through the strong tendencies of the feebleminded to procreate and pass on their genetic inferiority. Dendy's rhetoric was so powerful that it was integrated into a 1912 Private Members' Bill, the "Feeble-Minded Control Bill," and was repeatedly evoked in Parliamentary discussions on the 1912 Mental Deficiency Bill, which would later become the Mental Deficiency Act of 1913.[33] These Bills (and the eventual Act) sought to segregate those deemed to have mental or moral deficiencies

[29] Mark Jackson, *The Borderland of Imbecility: Medicine, Society, and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000), 131.

[30] Mark Jackson, "'Grown-up Children:' Understandings of Health and Mental Deficiency in Edwardian England," in *Culture of Child Health in Britain and the Netherlands in the Twentieth Century,* eds. Marijke Gijswijt-Hofstra, and Hilary Marland, 149-168 (Amsterdam: Rodopi, 2003), 154.

[31] "The Borderland of Imbecility," *The British Medical Journal* 2, no. 1770 (1894): 1264.

[32] Mary Dendy, *The Problem of the Feeble-Minded* (London: John Heywood, 1908), 4, 7.

[33] Jackson, *The Borderland of Imbecility*, 212, 217.

and were supported by the EES and members of the medical community.[34] The final version of the act created medico-scientific categories of mental deficiencies (idiots, imbeciles, feeble-minded persons, and moral imbeciles) and allowed for state intervention by way of institutionalization.

Although proponents of the bill made efforts to distance themselves from the EES in this final version, claiming that the bill "does not represent any experiment in eugenics [...] It is a bill based on practical experience," opponents challenged this view.[35] Josiah Wedgewood, one of three MPs to vote against the legislation, claimed, "It is a spirit of the Horrible Eugenic Society which is setting out to breed up the working class as though they were cattle."[36] Joining Wedgewood in his opposition, MP Hugh Cecil warned that scientists "are apt to get fancies – you really can hardly call them by a more respectable name – and to press those fancies with a total disregard to the feelings of individuals and with the most ruthless indifference to the sufferings they cause."[37] Whether Cecil was referencing the existing eugenics programs in the United Stated or a general fear of what science could do is unclear; however, his rhetoric addresses a major concern regarding eugenics and its discourse: the establishment of authority based on knowledge produced by that very authority – power/knowledge in its most explicit form in the history of British eugenics.

The passing of the Mental Deficiency Act serves as a direct connection between British eugenics biopower and that of the Nazi eugenics program. Whereas British eugenics shifted from class and race to feeblemindedness, the Nazi eugenics program, aimed at *Lebensunwertes Leben* ("life unworthy of life"), focused first on those with physical or mental disabilities and then extended to a racialized eugenics that targeted non-Aryans. While Nazi sterilization laws were modeled after the American eugenics program, the language to describe the need for such laws has roots in the British eugenics rhetoric of the late Victorian and Edwardian periods.[38] Much like British eugenics, such rhetoric predates the formal proposal, or, in the case of the Nazis, implementation, of a eugenics program, but nevertheless creates the culture for such a proposal to be made. The defining factors of these groups

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[34] Edward J. Larson, "The Rhetoric of Eugenics: Expert Authority and the Mental Deficiency Bill," *The British Journal for the History of Science* 24, no. 1 (1991): 49.

[35] Ibid., 57.

[36] Quoted in Jayne Woodhouse, "Eugenics and the Feeble-Minded: The Parliamentary Debates of 1912-14," *History of Education* 11, no. 2 (1982): 133.

[37] Quoted in Larson, 58.

[38] For more on the American influence on the Nazi sterilization program, see (for instance) Egbert Klautke, "'The Germans Are Beating Us at Our Own Game': American Eugenics and the German Sterilization," *History of the Human Sciences* 29, no. 3 (2016): 25-43.

were couched in a scientific rhetoric that both emulated British eugenics and embodies power/knowledge as biopower. In the 1920 book that coined the term "life unworthy of living," *Die Freigabe der Vernichtung Lebensunwerten Lebens* (*The Permission to Destroy life Unworthy of Life*), the authors, lawyer Karl Binding and psychiatrist Alfred Hoche, made claims to scientific authority in their justification of killing those deemed "incurable idiots." Hoche argues, "the physician has no doubt about the hundred-percent certainty of correct selection [and] proven scientific criteria" of his actions regarding the killing of "a mentally dead person."[39] The claim to authority is defined by criteria that are created by the very people using this authority, thus perpetuating that authority: couched in claims of certainty, questioning the doctor's authority on this account would be to question a doctor's authority as a doctor.

Binding and Hoche's argument for such killing is framed by victim-blaming the individuals they seek to eliminate. They ask rhetorically, "Is there human life which has so far forfeited the character of something entitled to enjoy the protection of the law, that its prolongation represents a perpetual loss of value, both for its bearer and for society as a whole?"[40] This introduction of value as a criteria for determining life echoes the language of "life unworthy of life," which situates people as having or not having worth, and positions the discussion of life as one of value both to itself and to another life – that of the national body or *Volkskörper*. Such phrasing returns us to a Malthusian rhetoric of utility, which had a "hold on the popular imagination" of Germany throughout the nineteenth century and certainly influenced the Nazis' utilitarian view of life.[41] Moreover, the implementation of a sterilization and eventual euthanasia policy of those with mental disabilities, signed into law six months into Hitler's Chancellorship (in July 1933), moves the power/knowledge rhetoric into the action of biopower and the active controlling of bodies in order to maintain political power.

Such policies extend to other uses of scientifically-justified rhetoric, which predates the Nazi policies but justify their creation. The Malthusian-Darwinian-Galtonian theory of social usefulness was adopted in Germany well before the Nazi regime rose to power by zoologist and doctor Robby Kossmann in 1880. Evoking Darwin, Kossmann argues that "the human state [...] must reach an even higher state of perfection, if the possibility exists in it,

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[39] Quoted in Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986; 2000), 47.

[40] Quoted in Edwin Fuller Torrey and Robert H. Yolken, "Psychiatic Genocide: Nazi Attempts to Eradicate Schizophrenia," *Schizophrenia Bulletin* 36, no. 1 (2010): 27.

[41] Ernest Benz, "Escaping Malthus: Population Explosion and Human Movement, 1760-1884," in *The Oxford Handbook of Modern German History,* ed. Helmut Walser Smith, 195 (Oxford: Oxford University Press, 2011).

through the destruction of the less well-endowed individual, for the more excellently endowed to win space for the expansion of its progeny [...] The state only has an interest in preserving the more excellent life *at the expense of the less excellent*."[42] Here Kossmann imagines species survival as related to the need for space, or what will be called *Lebensraum*, a term that first emerged in Oscar Peschel's 1860 review of *On the Origin of Species* and that became political policy in Weimar and Nazi Germany.[43] Living space, framed by a rhetoric of science and politics, allowed for policies that support expansion at the cost of individuals outside (and also inside) the national body. In other words, the claim to space regarding German racial survival justified policies that restricted the individual lives of others. Such rhetoric included the expansion of German land beyond its defined boundary, as introduced by Friedrich Ratzel in 1897, and the need for "the nation and people [to] be pure and racially strong," a call back to Pearson's response to Britain's defeat in the Boer Wars.[44] Hitler's adaptation of *Lebensraum* included concerns with space within the Germany borders, a fear that an unchecked population would lead to a "crowding of too many people into an inadequate *Lebensraum* [which] leads to difficult social problems. People are now gathered into work centers that do not resemble cultural sites so much as abscesses on the body of the people – [a] place where all evils, vices, and sicknesses appear to unite. They are above all hotbeds of blood-mixing and bastardization, using ensuring the degeneration of the race."[45] Again, the rhetoric echoes Pearson's situating of individual life as part of and influencing the nation and Rentoul's image of the muddied waters of society, drawing on fears of contamination that would undermine the health of the national body.

Claims for national health justified the power of scientific and medical discourse to ensure this health, which allowed for the creation of further knowledge to expand the powers of this very discourse. Thus, classificatory systems derived from biological claims of authority, based largely on what was seen in Britain, became central to the Nazi eugenics rhetoric. The creation of the Nuremberg Laws, for instance, has roots in the same biological classification seen in early British eugenics regarding class distinctions; when situated historically as a response to the economic crisis of the 1930s, these

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[42] Robby Kossmann, "Die Bedeutung des Einzellebens in der Darwinistischen Weltanschauung," quoted in Weikart, 78.

[43] Michael Heffernan, "Fin de Siècle, Fin du Monde?: On the Origins of European Geopolitics; 1890–1920," in *Geopolitical Traditions: A Century of Geopolitical Thought,* eds. Klaus Dodds, and David A. Atkinson, 26-51 (London: Routledge, 2000), 45.

[44] David M. Crowe, *The Holocaust: Roots, History, and Aftermath* (Boulder: Westview Press, 2008), 99.

[45] Adolf Hitler, *Hitler's Second Book: The Unpublished Sequel to Mein Kampf*, ed. G. L. Weinberg; trans. Krista Smith (New York: Enigma Books, 2006), 26.

roots are even more pronounced. Moreover, the shift to expand eugenics from those deemed mentally deficient to include Jews (and eventually others) demonstrates the deliberate blurring of biological difference to justify the segregation and extermination of any group deemed unfit by the dominating party. Again, power (eugenics as policy) is determined by the very knowledge (eugenic claims to a science of difference) that justifies its existence and recreates this knowledge (the expansion of such claims of difference). The Nuremberg Laws, then, continued and expanded the eugenics rhetoric that empowered the medical and legal communities. The Laws, which controlled the sexual and marital activity of Jews and Germans, prohibiting the mixing of "races," categorized Jewishness as strictly biological (dismissing conversion or religious activity) and traced back Jewish blood through heritage lines, modeled after Galton's own work. Creating such hereditary hierarchies and divisions justified policies and the power to regulate them, which allowed for the creation of further hierarchies – such as the *Untermensch*, with connections to Galton's "residuum" – and the perpetuation of this power that continues to create knowledge to justify itself.

II. The "Can-do-ness" of Mothers

The perpetuation of such power comes from authority creating its own knowledge and individuals internalizing their own abilities or "can-do-ness" within this knowledge. Thus, the success of eugenics propaganda relied on individual buy-in to perpetuate the hegemony it created. As a regulatory operation carried out on bodies, eugenics biopower was best situated at the individual level in its appeal to women and their "privileged relation to biopower due to their procreative roles as mothers."[46] Thus, many eugenics measures brought the nationalistic rhetoric to the individual by way of the reproductive body, appealing to both the individual (female) body's obligation to the national body and to the desire of many women, particularly in Britain, to be more involved in the politics of the nation. Biopower embodied through this "can-do-ness" creates a type of testifying knowledge from individuals tasked to participate in the national eugenics agenda; this knowledge, of course, is simply reframed from the power/knowledge of the eugenics movement and thereby only reinforces existing knowledge and power. In other words, as much as women believed they were contributing to the national good, they were simply adhering to the existing power/knowledge that was already dictating their actions and beliefs. Rhetorically, then, the appeal to women as mothers needed to persuade people to take individual responsibility while

[46] Chloë Taylor, "Foucault and Familial Power," *Hypatia* 27, no. 1 (2012): 213.

still adhering to a rhetoric of collectivity and national good for the fit of the nation.

To do this, the British eugenics movement adopted the term "racial instinct," understood to mean the sexual drive *and* imperative to procreate with a member of one's own race, which included national, ethnic, class, and mental health distinctions, i.e. an all-encompassing concept of race that ultimately meant what eugenicists deemed to be fit. Caleb Williams Saleeby, a medical doctor and outspoken supporter of eugenics, wrote several guides aimed at parents, but primarily women, to emphasize the importance of racial instinct. In his 1915 publication, *Parenthood and Race Culture: An Outline of Eugenics*, he explains, "Woman is Nature's supreme instrument of the future. The Eugenist is therefore deeply concerned with her education, her psychology, the conditions which permit her to exercise her great natural function of choosing the fathers of the future, the age at which she should marry, and the compatibility between the discharge of her incomparable function of motherhood and the lesser functions which some women now assume."[47] The rhetoric Saleeby employs suggests eugenics to be a means of empowering women, whereby their decisions and actions dictate the future of the nation. However, his language also reveals a biological imperative that is dictated by eugenics discourse: such a role of selecting a partner and nurturing a child are biological and therefore natural to women – to go against such instinctual practices would be unnatural and therefore unfit for society. In other words, women's empowerment in eugenics rhetoric is only in their ability to maintain the status of fitness by the very standards set out by eugenicists, thereby demonstrating the biopower that controls the everyday activities.

The repeated appeals to women's role in the British eugenics movement resonated with a number of educated women, resulting in women advocating for other women to join the cause and fulfill their national duty. By 1914, women made up nearly half the membership of the EES, and a number of them were regularly appealing to women through a claim to "mothercraft," or the education of women on their roles as mothers.[48] Framed within medical discourse and supported by a number of women doctors, mothercraft shifted from practical parenting advice to the mother's obligation to the nation. In Elizabeth Sloan Chesser's *Woman, Marriage, and Motherhood* (1913), pitched, in part, as her medical advice to women, she includes a chapter entitled, "Motherhood and Eugenics," which is bookended by chapters that discuss moral degeneracy and motherhood. This rhetorical decision of

[47] Caleb Williams Saleeby, *Parenthood and Race Culture: An Outline of Eugenics* (New York: Moffat, Yard, and Company, 1909; 1915), xv.

[48] Greta Jones, "Women and Eugenics in Britain: The Case of Mary Scharlieb, Elizabeth Sloan Chesser, and Stella Browne," *Annals of Science* 51 (1995): 482.

chapter placement emphasizes the eugenic imperative to mothers in a recruiting rhetoric and warns of the potential dangers of not adhering to eugenic motherhood. This chapter focusses primarily on justifying eugenics, with only a single paragraph dedicated directly to the role of motherhood within the eugenics agenda. That role, as nurturer, is imagined as central to the nation and its future: "the home is the heart of life, the cradle of the race, the unit of the State, and it is upon the mothers of the race that the character of future generations will to a large extent depend [...] The eugenist is fundamentally concerned with woman as mother."[49] The exaltation of motherhood reinforces traditional Victorian values but offers women a stronger sense of purpose that turns motherhood into a political act: to be a good, eugenic mother was to shape the nation.

Not surprisingly, such rhetoric did not sit well with women who advocated for more direct involvement in politics (such as voting) or the higher education of women. Addressing these concerns, Saleeby offered "Eugenic Feminism," which advocated for both physical and foster motherhood, extolling women as "Nature's supreme organ of the future" and suggesting that most feminism aligns with eugenic interests.[50] Although Saleeby does not dedicate a chapter to Women's Suffrage, he does note his support: "I believe in the vote because I believe it will be eugenic, will reform the conditions of marriage and divorce in the eugenic sense, and will service the cause of [...] 'preventive eugenics,' which strives to protect healthy stocks from the 'racial poisons,' such as venereal diseases, alcohol, and, in a relatively infinitesimal degree, lead."[51] This statement describes the focus of the rest of the book, which appeals to feminists' concerns regarding the legal status of women, gender equality in the home, and women's opportunity to reach their potentials, and which Saleeby imagines as biological and therefore eugenic. As noted by Cecily Devereux, "his Eugenic Feminism was at least partly a deceptive rhetorical strategy seeking to draw middle-class women's rights activists *back* to home and duty, albeit with the vote and a markedly increased cultural value as progenitors of future generations."[52] Still, it appealed to many feminists because of their purported importance as tied to their white, middle-class identities. In other words, feminists saw their importance elevated through something that was seen as biological and stable, allowing for a continued importance and political role by accepting the eugenic imperative. These ap-

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[49] Elizabeth Sloan Chesser, *Women, Marriage, and Motherhood* (London: Cassell, 1913), 212.

[50] Caleb William Saleeby, *Woman and Womanhood: A Search for Principles* (London: Mitchell Kennerley, 1911), 25.

[51] Ibid., 24.

[52] Cecily Devereux, *Growing a Race: Nellie L. McClung and the Fiction of Eugenic Feminism* (Montreal: McGill-Queen's University Press, 2005), 43.

peals to women granted them a self-importance that was used to further the power/knowledge of the eugenics movement. In embracing the rhetoric of eugenics, they were reaffirming the need for its existence and the manuals they produced that further supported that existence.

Nazi eugenics relied on a similar appeal to women through motherhood, elevating "the motherly spirit," as Erna Günter phrased it, "the source of all that is eternal."[53] As with the British eugenics movement, that motherly spirit was extended beyond physical motherhood to surrogate or "spiritual mothers," those women who could not bear children, but could still serve the nation by caring for and educating children or by forming bonds with women in the borderlands.[54] Much like the British rhetoric, all women were imagined through the lens of motherhood, whether physical, spiritual, or eventual. However, the importance of women to Nazi eugenics was much more explicit in their rhetoric and actions because theirs was state-sponsored and not merely advisory, as was the case in Britain. Thus, the rhetoric had tones of revering women, as seen above; at the same time, the rhetoric evoked a national imperative. A member of the *NS-Frauenschaft* (Nazi Women's Group) asserted, "marriage is not merely a private matter, but one which directly affects the fate of a nation at its very roots."[55] This rhetoric, much like that of the British eugenics movement, situated women as "the central figure if not the head of the family. Woman as mother and housewife ruled over a small kingdom of her own."[56] Even more than with British eugenics, this rhetoric created a false sense of power: the household kingdom only existed in adherence to and in support of the Nazi eugenics program. Thus, women's power only extended as far as the Nazis allowed it. Such restrictions are notable in the classification of unmarried women as *Staatsangehöriger* ("subjects of the State"), a classification shared initially with Jews and the restrictions to employment and higher education opportunities that began in 1936.[57] The exception to this categorization was the single woman who agreed to participate in the *Lebensborn* program and produce Aryan children – but this required state inference with motherhood itself, reinforcing a biopower that creates mothers.

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[53] Erna Günter, "Wir Frauen im Kampf um Deutschlands Erneuerung," *Frauen Warte* 2, no. 17 (1934): 507, trans. Randall Bytwerk. Calvin German Propaganda Archive.

[54] Leila J. Rupp, "Mother of the 'Volk:' The Image of Women in Nazi Ideology," *Signs* 3, no. 2 (1977): 374; Elizabeth Harvey, *Women and the Nazi East: Agents of Witnesses of Germanization* (New Haven: Yale University Press, 2003), 31.

[55] Quoted in Jill Stephenson, *Women in Nazi Germany* (New York: Routledge, 2013), 28.

[56] Rupp, 369.

[57] Robert N. Proctor, "Nazi Biomedical Policies," in *When Medicine Went Mad: Bioethics and the Holocaust,* ed. A. L. Caplan, 32 (Totowa: Humana Press, 1992).

Such classification of unmarried women was an act of biopower that was countered with physical rewards for reproductive mothers. The Nazi party valued "the *four-child family* ideal," and beginning in 1939, Hitler established the Honor Cross of German Motherhood, with delineations of bronze for four children, silver for six, and gold for eight.[58] In describing the award, Reich Physician Gerhard Wagner noted that "the prolific German mother is to be accorded the same place of honor in the German Volk community as the combat soldier, since she risks her body and her life for the people and the Fatherland as much as the combat solider does in the roar and thunder of battle."[59] This rhetoric appealed to women's sense of duty and the unity of the nation as all in a war to secure the health of the national body. The physical embodiment of biopower through the medal was extended to gestures that reinforced the status of these women: Nazi youth were commanded to "show his respect for her through the obligatory salute of all members of the youth formations of the party."[60] This gesture, paired with the medal, embodied the rhetoric of biopower and created knowledge through objects and signals that reinforced the militarism of eugenics. At the same time, however, the visual representation of fertility was a means of shaming those women who were unable (or unwilling) to reproduce as many children as possible. Thus, the Honor Cross of German Motherhood was a means of controlling female bodies by way of displaying their biological capabilities, thereby mandating the continuation of their reproduction and perpetuating the biopower of Nazi eugenics.

III. Conclusion

Comparison of British and Nazi eugenics rhetoric reveals not only the British influence on the Nazi program, but also the proliferation of eugenics as biopower, understood through how power/knowledge functions to create and support biopower. Their shared rhetoric demonstrates how biopower can be constructed rhetorically to assert power over physical bodies, even when not, strictly speaking, employed by the state, as is the case for much of British eugenics. The difference between the eugenics programs – and one reason why the Nazi movement was so expansive and effective – was the movement from rhetorical biopower to actual biopower, which the British eugenics movement failed to achieve beyond the Mental Deficiencies Act of 1913. The British

[58] Ibid., 32.

[59] Quoted from the *Völkischer Beobachter,* Dec. 25, 1938, in George L. Mosse, *Intellectual, Cultural, and Social Life in the Third Reich*, trans. Salvator Attanasio (Madison: The University of Wisconsin Press, 1966), 45.

[60] Ibid., 46.

eugenics movement muddied the rhetorical and eugenics water by shifting the argument of what constituted unfitness. The shift from the lower classes to so-called inferior races was workable because of existing policies marginalizing both groups, but the further shift to feeblemindedness undermined the previous categorizations. Feeblemindedness existed in the middle and upperclasses (though believed to be in less degree), which required addressing multiple inferior groups simultaneously without a political mandate – an approach that led to little success for the British eugenicists. Conversely, the Nazi eugenics program employed a scaffolded approach to their rhetoric and eugenic policies, marginalizing one group through first language and then policies, and then moving quickly to the next. The effect was the solidification of biopower, so that it was easier to build upon existing policies and strengthen the medico-scientific discourse that allowed for the existence of such biopower. Juxtaposing the rhetoric of these two movements demonstrates how rhetoric functions within power/knowledge and the creation of biopower that begs for further consideration of the continued used of biopower in eugenics-based rhetoric today.

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Eugenics between Darwin's Era and the Holocaust

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Abstract

Heredity and reproduction have always been matters of concern. Eugenics is a story that began well before the Holocaust, but the Holocaust completely changed the way eugenics was perceived at that time. What began with Galton (1883) as a scientific movement aimed at the improvement of the human race based on the theories and principles of heredity and statistics became by the beginning of the 20th century an international movement that sought to engineer human supremacy. Eugenic ideas, however, trace back to ancient Greek aristocratic ideas exemplified in Plato's Republic, which played an important role in shaping modern eugenic social practices and government policies. Both positive (encouragement of the propagation of the fit, namely without hereditary afflictions, i.e. socially acceptable) and negative (institutionalization, sterilization, euthanasia) eugenics focused on the encouragement of healthy and discouragement of unhealthy reproduction. All these practices were often based on existing prejudices about race and disability. In this article, we will focus on the rise of eugenics, starting with the publication of Origin of Species *to the Holocaust. This examination will be multidisciplinary, utilizing genetics, legal history and bioethical aspects. Through this examination, we will discuss how provisional understandings of genetics influenced eugenics-based legislation. We will also discuss the rise of biopolitics, the change of medical ethos and stance towards negative eugenics policies, and the possible power of bioethical principles to prevent such phenomena.*

Key-words: *Eugenics; Darwin's era; Holocaust; race; heredity; Mendel's laws; forced sterilization; euthanasia; interracial marriage; immigration laws; biopolitics; medical ethics*

I. Introduction

The eugenics movement was an international movement that rose to prominence in an era of economic and social recession between 1900-1940, established socio-political beliefs and shaped government policies.[1] Social and political prejudices, nationalism, nativism, race and racial differences were often reflected in the "scientifically" based eugenic beliefs. Purity of the race and race inferiority ideas considered today unacceptable were common during this period.[2] It should be mentioned that in Europe during the early years of the 20th century the word race was often conceived as a synonym to "nation" in a context of nationalistic morale. Prominent medical schools, universities, and even high schools, developed curricula and established chairs for scientific fields, such as racial anthropology, and courses with elements of racial eugenics.

The nature of the majority of eugenic theories was deterministic. Eugenicists believed that almost all diseases, conditions and addictions were inherited and therefore eugenic practices, if applied, would eliminate disease and inherited conditions from the population, including communicable diseases such as tuberculosis or syphilis, as well as lifestyle habits that result to addiction such as alcoholism. As far as cancer is concerned it has long been recognized that an inherited predisposition to neoplasms exists, presenting as a higher-than-normal risk of certain patterns of cancer within families for many generations. An example is retinoblastoma, a rare malignant neoplasm that develops in the eyes of young children. The inheritance of retinoblastoma has been documented in the scientific literature since the first half of the 20th century and has led to "practical eugenics" guidelines, such as prohibition of future childbearing in parents of a child with retinoblastoma, sterilization of children survivors of retinoblastoma and procreation discouragement.[3]

Before and in the early 20th century, it was not known that Mendel's laws of inheritance could not be applied to complex functions, characteristics and behavioral traits, such as intelligence, mental illness or criminality. Often the characterization "defective and degenerate" was given both to criminals and people with mental disabilities.[4] This simplistic approach to the nature or nurture debate ignored the multigenic and multifactorial nature of complex characteristics and dysfunctions as well as epigenetic inheritance and the im-

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[1] Philippa Levin, *Eugenics: A Very Short Introduction* (Oxford: Oxford University Press, 2017), 1.

[2] Ibid., 42

[3] Carl V. Weller, "The Inheritance of Retinoblastoma and Its Relationship to Practical Eugenics," *Cancer Research* 1, no. 7 (1941): 517-535.

[4] Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Cambridge, MA: Harvard University Press, 2004), 33.

pact of environmental factors on human development, health and disease. In the 1930s, the eugenic movement in Britain was criticized both from a genetic and social point of view (class prejudices and racism) and rejected often by earlier supporters.[5,6]

Inheritance and transmission of physical and social human characteristics is an old question which is often reformulated in accordance with the scientific and social beliefs of the time. The modern eugenics movement was originally inspired by Darwin's theories and the emerging science of Mendelian genetic principles, applied to human populations, although the manipulation of human reproduction may be traced back to ancient Greek aristocratic ideas exemplified in Plato's *Republic*.[7]

II. Social origins

In Britain, unchecked human reproduction, especially of the poor, was a matter of concern since the 18th century when Thomas Malthus predicted that human population growth would surpass the earth's capability to produce food, resulting in environmental decline and social chaos.[8] Malthus' ideas brought controversy at that time between conservative Europeans, who propagated the godsent and inevitable nature of the widespread poverty and social misery, and liberal Americans such as U.S. presidents Thomas Jefferson and James Madison who thought that equal opportunities combined with migration in new fertile lands in a republic could solve the social problems of the Old World.[9]

The conservative idea that social chaos will result if there is mixture of the aristoi (wealthy aristocrats, literally "the best ones") and the kakoi (poor people of humble origin, literally "the bad ones") originated at least as early as the 6th century BC when there was social turmoil in Greek cities, as the aristocrat poet Theognis of Megara attests.[10] In a passage of Theognis, there is clearly mentioning of "blackening of citizens' generation"[11] if there is no

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[5] See John Burdon Sanderson Haldane, *The Causes of Evolution* (London, New York: Longmans, Green and Co., 1932), especially chapter "Natural Selection," 83-110.

[6] Pauline M. H. Mazumdar, "Reform Eugenics and the Decline of Mendelism," *Trends in Genetics* 18, no. 1 (2002):48-52,

[7] David J. Galton, "Greek Theories on Eugenics," *Journal of Medical Ethics* 24, no. 4 (1998): 263-267.

[8] Levin, *Eugenics*, 3.

[9] David R. McCoy, "Jefferson and Madison on Malthus: Population Growth in Jeffersonian Political Economy," *The Virginia Magazine of History and Biography* 88, no. 3 (1980): 259-276.

[10] Mark A. Holowchak, "Jefferson's Platonic Republicanism," *Polis* 31, no. 2 (2014): 369-386.

[11] Theognis, "Elegiae," in J. M. Edmonds, *Elegy and Iambus, Volume I* (Cambridge, MA. Harvard

selection of mating in humans like in livestock, an idea that the idealist philosopher Plato incorporated in the *Republic*.[12] Plato proposed selection of couples for childbearing to produce offspring with "good" characteristics and called it εὐγονία (eugonia, Republic 8.546a), as well as sterilization of individuals with "bad" characteristics (5.460b7-5.460c8) and euthanasia of individuals with corporal and psychic disorders (3.410a1-5).[13,14] Aristotle also starkly advocated exposing deformed infants despite the fact that they have already developed 'sensation and life,' but he had a different stance towards abortion distinguishing between 'lawful and unlawful abortion' depending on whether the fetus is a sensible, living being, i.e. 'able to move on its own' and therefore 'ensouled'. [15] It is true that Plato discusses abortion – and probably also infanticide – only in his ideal state, with regard to the class of the guardians and not in real life; only in such an ideal state there has to be control over breeding – at least for the guardians. Measures like abortion and, maybe, infanticide could be used if control failed.[16] In early 19th century, Thomas Jefferson heavily criticized Plato's eugenic ideas in several letters to his friends, favoring instead a democratic educational system of equal opportunity for all citizens so that the most intelligent and moral citizens may be justly selected for the most important levels of governance.[17] Jefferson was a Republican, an Enlightenment scientific empiricist, and a self-professed Epicurean.[18]

After a century of political and nationalistic turmoil, as well as the reshaping of societies by industrial revolution, in the beginning of the 20th century certain social circles were ready to accept eugenics based on their concern about biological degeneration due to the propagation among people with undesirable characteristics (birth rate declining in upper/middle class, low among the cultured and civilized and high among mental defectives and immigrants). Immorality (criminality, pauperism, alcoholism, and prostitu-

University Press, London, William Heinemann Ltd, 1931), 191-192.

[12] Ibid.

[13] Ibid.

[14] Christos Yapijakis, "Genetics and Ancient Greek Philosophers: From Myth to Science," in *Hybrid and Extraordinary Beings. Deviations from 'Normality' in Ancient Greek Mythology and Modern Medicine*, eds. Panayiotis N. Soukakos, Ariadne Gartziou-Tatti, and Minas Paschopoulos, 269-280 (Athens: Konstantaras Medical Books, 2017).

[15] Evangelos D. Protopapadakis, *From Dawn till Dusk: Bioethical Insights into the Beginning and the End of Life* (Berlin: Logos Verlag Berlin GmbH, 2019), 35.

[16] Ibid., 34.

[17] Holowchak, "Jefferson's Platonic Republicanism."

[18] Christos Yapijakis, "Ancestral Concepts of Human Genetics and Molecular Medicine in Epicurean Philosophy," in *History of Human Genetics*, eds. Heike L. Petermann, Peter S. Harper, and Suzanne Doetz, 41-57 (Dordrecht: Springer, 2017).

tion) and poverty were considered inherited biological characteristics. This was an amalgam of idealistic philosophical beliefs associating class, intelligence, inheritance, race beliefs, prejudices and fecundity. The British Eugenics Education Society focused on this. The common belief was that feeble-mindedness was common both to the lower classes and the pauper due to inbreeding habits (according to the British) or due to the fact that feeble mindedness and other social dysfunctions were inherited as Mendelian recessive characters (USA). Moreover, in the USA, immigrants from South and Eastern Europe were "paupers" meaning that they possessed defective genes. Prevention of procreation was proposed because "inherited" feeble-mindedness was believed to be the basis of criminality and pauperism.[19] Countries with high immigration rates (USA, Canada, Britain) used eugenics to control immigrants (racially, mentally, intellectually).

The eugenic movement was well-accepted and became an international movement rooted in ideologically-influenced science aimed at influencing culture. Scientists collaborated and exchanged findings and opinions at symposia and conferences, while novels were written and science fiction films were produced, raising eugenic issues.[20]

III. Emerging Eugenics

In the early 19th century Darwin's *Origin of Species* brought the question of inheritance and natural selection as well as the scientific interest in heredity and transmission of characteristics again to the forefront. In Britain, Sir Francis Galton[21] initiated this movement by coining the term eugenics[22] in 1883[23] and introducing the term "nature-nurture.[24] Although he had read Plato's *Republic*,[25] and most probably the

[19] Garland E. Allen, "The Eugenics Record Office at Cold Spring Harbor, 1910-1940: An Essay in Institutional History," *Osiris* 2 (1986): 225-264.

[20] Films were produced by the Eugenics society of Britain (1924) and the American eugenic film company (Birth 1917), as well as by independent producers (e.g. *Married in Name Only*, 1917); see Levin, *Eugenics*.

[21] Sir Francis Galton (1822-1911), British polymath, explorer, anthropologist, and eugenicist known for his pioneering studies of human intelligence.

[22] The word 'eugenics' derives from the Greek 'εὐγενής,' consisting of 'εὖ' (good) and 'γένος' (breed).

[23] Nicholas W. Gillham, "Sir Francis Galton and the Birth of Eugenics," *Annual Review of Genetics* 35 (2001): 83-101.

[24] According to this theory either nature (inherited ability) or nurture (upbringing) determines who we are. See Francis Galton, *English Men of Science: Their Nature and Nurture* (London: Macmillan & Co, 1874).

[25] Karl Pearson, *The Life, Letters, and Labours of Francis Galton* (Cambridge: Cambridge University Press, 1930), 312.

term eugenics was inspired by Plato's eugonia, Galton did not favor negative eugenics like the idealist philosopher, but rather promoted positive good breeding. As Richard Barnett notes, "Negative eugenics aimed to eliminate, through segregation or sterilization, those deemed physically, mentally, or morally undesirable," while "Positive eugenics encouraged the reproduction of the intelligent, the healthy, and the successful, and tended to be voluntaristic in tone."[26]

Galton became the founder and first president of the Eugenics Education Society (1907), a small but influential society focused on education and popularization of eugenics. Intrigued by *The Origin of Species* and based on his studies (pedigrees and offspring of prominent men, twin studies, anthropometrics, psychometrics, race and population measurements and biometry),[27] Galton supported the idea that nature and not nurture is the critical factor, physical and behavior character traits, intelligence, talents and abilities (*talent and character*) are inherited, measurable and subject to natural selection, thus the human race could be improved, exactly as animal breeds, by "selective (good) breeding" and elimination of undesirable characteristics. According to his theory, if parents belong to a "better," "superior" breed the children will exhibit exceptional characteristics.[28] Darwin had previously discussed these matters in his book *Descent of Man*, that was published in 1871. Darwin concurred that, unlike other animals, humans alone impede their own evolution through intervening to keep the weak alive and propagating; however, he thought that the instinct of human sympathy was too noble to deny.[29]

The initial confrontation of the popular mind against Galton's eugenics program as being an affront to God and nature became within a generation a wise scientific advancement to a significant percentage of the Anglo-American public, supported by Platonic, spiritual and idealistic theories.[30]

The emerging science of Mendelian genetics after the rediscovery of Mendel's laws in 1900 was originally applied in a simplistic and mechanistic way to human populations but with a plethora of misconceptions according to current knowledge (the concept of the gene itself, recessive and dominant alleles, variation, genotype-phenotype correlation, genetic mechanisms, complex diseases, genetics with multiple genes and environmental contribution etc.). Some of the misconceptions

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[26] Richard Barnett, "Keywords in the History of Medicine: Eugenics," *The Lancet* 363, no. 9422 (2004): 1742.

[27] Francis Galton, *Natural Inheritance* (London, Great Britain: Macmillan, 1889); in 1884 Galton set up Anthropometric Laboratory in London's International Health Exhibition that performed tests on volunteers (head size and reaction time, sight, hearing, and color sense).

[28] Francis Galton, *Hereditary Genius: An Inquiry into its Laws and Consequences* (London, Great Britain: Macmillan and Co, 1869).

[29] Charles Darwin, *The Descent of Man, and Selection in Relation to Sex* (New York: D. Appleton and Co, 1871), 162.

[30] Cathy Gutierrez, "Unnatural Selection: Eugenics and the Spirit World," *Studies in Religion* 47, no. 2 (2018): 263-279.

regarding human traits' inheritance derived from the fact that what was true for simple traits in plants and animals was not applicable to complex, multifactorial and heterogeneous human characteristics and disorders (intelligence, psychiatric disorders, cancer), thus beliefs about the universal applicability of Mendelian genetics to the inheritability of traits and dysfunctions such as tuberculosis, criminality, and feeble-mindedness did not pan out scientifically.

The United States also pioneered the eugenics movement and was very closely related to the British movement (1906 foundation of the Eugenics Committee, 1910 Eugenics Record Office in Cold Spring Harbor Laboratory). The American movement was centered on feeble-mindedness and social failure along with degeneration.[31] The leading eugenicists were Charles Davenport, Harry L. Laughlin and Henry G. Goddard. Davenport[32] was responsible for establishing Mendelism in the United States. He believed in eugenic intervention (eugenics is the science "of improvement of the human race by better breeding, by prevention of reproduction of the "unfit" and preponderance of the "fittest" marriages)[33] and that unrestricted immigration was a threat to the quality of the population.[34] What was considered to be an inherited trait such as "thalassophilia" (love of the sea) and "nomadism" (love of nomadic lifestyle) and other inconsistencies that seem absurd or even ridiculous today were in the context of the scientific knowledge of the time.[35]

Leading figures of this era, amongst others were Harry H. Laughlin[36] known for his ideas on eugenic sterilization,[37, 38] Henry H. Goddard[39] known for his study

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[31] Mazumdar, "Reform Eugenics."

[32] C. Davenport (1866-1944) was a prominent Biologist, Director of the Station of the Study of Experimental Evolution in Cold Spring Harbor, N.Y., Professor of Zoology at Harvard, founder of the Eugenics Record Office in 1910 at Cold Spring Harbor, NY.

[33] Charles B. Davenport, "Report of Committee on Eugenics," *Journal of Heredity* 1, no. 2 (1910): 126-129; C. B. Davenport, "Research in Eugenics," *Science* 54, no. 1400 (1921): 391-397.

[34] Allen, "The Eugenics Record Office."

[35] Mark S. Lubinsky, "Scientific Aspects of Early Eugenics," *Journal of Genetic Counseling* 2, no. 2 (1993): 77-92.

[36] H. Laughlin (1880-1943) was an educator and sociologist.

[37] Philip K. Wilson, "Harry Laughlin's Eugenic Crusade to Control the 'Socially Inadequate' in Progressive Era America," *Patterns of Prejudice* 36, no.1 (2002): 49-67.

[38] Garland E. Allen, "The Social and Economic Origins of Genetic Determinism: A Case History of the American Eugenics Movement, 1900-1940 and its Lessons for Today," *Genetica* 99, nos. 2-3 (1997): 77-88. Use of pedigrees on "manic-depressive insanity" and mental ability demonstrating inherited scholarship or feeble-mindedness; see Allen, "The Eugenics Record Office."

[39] Henry H. Goddard (1866-1957) was a psychologist who pioneering the introduction of intelligence testing in the USA, and introduced this test to a School (New Jersey Home for the Education and Care of Feebleminded Children in 1908).

The Kallikak Family[40] and the special importance he gave to the relation of mental deficiency with morality and criminality.[41]

Davenport and Laughlin were among the scientists who influenced most of the American eugenics policies and legislation[42] (especially compulsory sterilization legislation and restrictions on immigration). They believed that feeble mindedness was a recessive Mendelian trait (inherited) and the result of "misfit" marriages ("backward" immigrants).[43] All three believed that sterilization could reduce criminality.[44]

Germany was the third country to significantly contribute to the eugenics movement during the 19th and 20th centuries, focusing primarily on psychiatric disorders. Social transformation due to the fast industrialization of Germany at the end of 19th century was associated with social problems (rise in criminality, alcoholism, prostitution) and favored the rise of eugenics ideas especially ideas concerning race hygiene. The economic crisis of 1929 also favored the application of eugenics measures such as colonies for the feeble-minded and a law plan for sterilizations, which was ultimately not accepted. At that time a crucial distinction began to emerge between positive and negative eugenics, with both of them supporting the popular concept of social hygiene.[45]

In East Asian countries like Japan negative eugenic programs were implemented under the influence of Plato's *Republic* as a good paradigm of the "ideal state,"[46] while in several Latin American countries including Brazil the positive version of eugenics was more popular.[47]

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[40] The study describes two branches of a family who's the progenitor fathered a child out of marriage with a "feeble-minded" woman and then married an upright Quaker woman and fathered other children. Both families lived "in practically the same region and in the same environment" preponderance of inheritance (nature). The descendants of the first relation (Kakos) were decadent whereas the legitimate children flourished (kalos). Henry H. Goddard, *The Kallikak Family: A Study in the Heredity of Feeble-mindedness* (New York: MacMillan Co, 1912).

[41] T. Caulfield, and G. Robertson, "Eugenic Policies in Alberta: From the Systematic to the Systemic," *Alberta Law Review* 35, no.1 (1959): 59-79.

[42] In 1922 a "model sterilization law" was drafted by Laughlin on order to solve the legal problem of involuntary sterilization, which contradicted the constitutional right to due process of law. Moreover, Laughlin supported the Johnson-Reed Immigration Act of 1924 providing to Congress statistical data and the results of intelligence tests for immigrants on Ellis Island; see John P. Jackson, Jr., and M. Nadine Weidman, "Race, Racism and Science: Social Impact and Interaction," *History: Reviews of New Books* 34, no. 4 (2006): 133.

[43] Allen, "The Eugenics Record Office."

[44] Caulfield and Robertson, "Eugenic Policies in Alberta."

[45] Barnett, "Keywords in the History of Medicine."

[46] T. Sasaki, "Plato and Politeia in Twentieth-Century Politics," *Études Platoniciennes* 9 (2012):147-160; Y. J. Chung, "Better Science and Better Race? Social Darwinism and Chinese Eugenics," *Isis* 105, no. 4 (2014): 793-802.

[47] Lima Nisia Trindade, "Public Health and Social Ideas in Modern Brazil," *American Journal of*

German and American Eugenic Societies collaborated closely.[48,49] In Germany, the term *Rassenhygiene* (Race Hygiene), a politically enhanced version of the term of eugenics, was widely used. German Eugenics was rooted in social Darwinism, and, utilizing existing racial ideology, it was concerned about the fitness of German population.[50] The prominent German eugenicist Hans F. K. Günther was inspired by the Platonic myths about the origins of humans whose constitution included gold, silver, copper and iron, and on the divine prophecy that the state would perish when its rulers would be of copper and iron race (*Republic* 3.415a-c), therefore he concluded: "Only men of pure blood should philosophise! Plato must have acquired in some way the awareness of a reality which we, trained in racial research (eugenics), have to accept as true: the fact that through the Sophists men of a Levantine (Oriental) nature have usurped the power of the Hellenic spirit, while the Nordic (Aryan) soul of Greekness died."[51] Similarly, for the Nazi theoretician, Alfred Rosenberg the concept of race was not based on scientific knowledge or observation but in the apprehension of its idea by intuition in a Platonic way ("the race is the soul of the people seen from the outside"). Rosenberg believed that "true politics is eugenics" and that the Platonic methodology of negative eugenics could serve as a guide to the "racial hygiene" of the German population and create a homogeneous "Aryan people of pure blood" by cleansing "sub-human beings."[52]

The German Society for Racial Hygiene was founded in 1905 (among the founders were Alfred Ploetz,[53] and Ernst Rudin[54] who in 1932 is elected Presi-

Public Health 97, no. 7 (2007): 1168-1177.

[48] Stefan Kühl, "The Cooperation of German Racial Hygienists and American Eugenicists before and after 1933," in *The Holocaust and History. The Known, the Unknown, the Disputed and the Reexamined*, eds. Michael Berenbaum, and Abraham J. Peck, 134-151 (Bloomington and Indianapolis: Indiana, University Press, 1998).

[49] American eugenicists visited Germany after 1933 in order to examine eugenic sterilization processes and the advances of German sterilization Courts; see Garland E. Allen, "The Eugenics Record Office."

[50] Paul J. Weindling, *Health, Race and German Politics between National Unification and Nazism, 1870-1945* (Cambridge: Cambridge University Press, 1989).

[51] Simona Forti, "The Biopolitics of Souls: Racism, Nazism, and Plato," *Political Theory* 34, no. 1 (2006): 9-32.

[52] Ibid.

[53] Alfred Ploetz (1860-1940) German physician, biologist and eugenicist with strong interest in the improvement of the german population. He coined the term racial hygiene (Rassenhygiene); see Levin, *Eugenics*.

[54] Ernst Ruedin (1874-1952) German psychiatrist, eugenicist, expert on racial hygiene in Nazi Germany, considered by many, the founder of psychiatric genetics. Jay Joseph and Norbert A. Wetzel, "Ernst Rüdin: Hitler's Racial Hygiene Mastermind," *Journal of the History of Biology* 46, no. 1 (2013):1-30.

dent of the International Federation of Eugenic Organizations).[55] The Society advocated the principles of eugenics (the isolation of the feeble-minded, the restriction of "unfit" marriages, the control of "bad" immigration) of the time. Eugen Fischer was also a prominent eugenicist, especially concerned for "racial purity" and degeneration due to mixing with inferior races.[56] Among his projects and in collaboration with Charles Davenport, he conducted a study on "mixed children" which they studied at the International Federation of Eugenics Organizations (IFEO). There was a strong collaboration with the American Eugenics Society. In 1929 Fischer was asked by Davenport to become chairman of the committee on racial crosses of IFEO.[57]

German eugenicists also believed that recessive factors were important for everyone's inherited traits, both physical and behavioral. A German sterilization law passed in 1933, and, according to it, people with mental deficiency, schizophrenia, manic-depressive disorder, hereditary epilepsy, hereditary chorea (Huntington's chorea), hereditary blindness, hereditary deafness, severe hereditary deformities, and severe alcoholism should be sterilized.[58] A related euthanasia program began in 1939.[59]

Nazi eugenics measures were the implementation of the eugenic beliefs since the Third Reich followed the ideal of the Platonic state.[60] Almost one third of the Society members (prominent German physicians and geneticists such as Fritz Lenz, Alfred Ploetz, Gerard Wagner, Otmar von Verschuer, Ernst Rudin) later joined the Nazi party and participated in euthanasia and sterilization programs.[61]

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[55] Benno Muller-Hill, *Murderous Science: Elimination by Scientific Selection of Jews, Gypsies, and Others in Germany, 1933-1945* (Oxford University Press, 1988), 9.

[56] Eugen Fischer (1874-1967) German professor of medicine, anthropology, ethnology and eugenics, director of the Kaiser Wilhelm Institute of Anthropology, Human Heredity, and Eugenics (1927-1942), and appointed by A. Hitler rector of the Frederick William University of Berlin (1933). In 1908, he started studying Rehoboth population. He analyzed in 1908 around three hundred children (called "Rehoboth bastards") of mixed-race origin (Dutchmen and Khoikhoi African women in German Southwest Africa) and he concluded that these mixed-race unions produce "inferior" races; see Eugen Fischer, *Die Rehobother bastards und das Bastardierungsproblem beim menschen; anthropologische und ethnographiesche studien am Rehobother bastardvolk in Deutsch-Südwest-Afrika, ausgeführt mit unterstützung der Kgl. Preuss* (Jena: G. Fischer, 1913).

[57] Muller-Hill, *Murderous Science*, 8.

[58] 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): e0007; William E. Seidelman, "Lessons from Eugenic History," *Nature* 337, no. 6205 (1989): 300.

[59] Robert N. Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge, MA, and London: Harvard University Press, 1988), 41.

[60] Forti, "The Biopolitics of Souls;" J. Bannes, *Hitlers Kampf und Platons Staat; eine Studie über den ideologischen Aufbau der nationalsozialistischen Freiheitsbewegung* (Berlin: W. de Gruyter, 1933); A. Gabler, *Platon und der Fű hrer* (Berlin and Leipzig: W. de Gruyter, 1934).

[61] R. D. Strous, "Hitler's Psychiatrists: Healers and Researchers Turned Executioners and Its

IV. Legal eugenic framework before the Holocaust

i. Eugenic sterilization

Sterilization was accepted and practiced before the early 20th century in many countries [see Table I], in penitential and psychiatric asylum inmates.[62] It was aimed at the feeble minded, people with cognitive disabilities, epilepsy, hereditary diseases or diseases considered to be hereditary at the time (deafness and muteness, schizophrenia, alcoholism, moral delinquency) but it was also sometimes racially or class oriented (North Carolina and California, Virginia, underprivileged and poorly educated whites e.g. *Buck v. Bell*).[63,64]

Sterilization of mixed-race Germans was proposed in the 1920s by Fischer,[65] who was later one of the judges in Berlin's Hereditary Health Court, providing the Nazis with plenty of ideas on ensuring the purity of Aryan race.

Eugenic sterilization was accepted by the medical community, although some scientists were skeptical about its effectiveness to reduce hereditary defects. The Catholic Church was against sterilization.[66] In Britain, sterilization was never legalized because such a law was not supported by the British Medical Association, British Catholics, and the Labor movement.[67]

Laws were proposed in many countries (Poland, Romania, Britain, the Netherlands, China, Australia, and France) but the first law for involuntary sterilization was enacted in 1907 in the United States[68] "to prevent procreation of confirmed criminals, idiots, imbeciles and rapists." In 1927, a second law was passed,[69] concerning those "afflicted with hereditary forms of

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Relevance Today," *Harvard Review of Psychiatry* 14, no. 1 (2006): 30-37.

[62] 1899 inmates at Jeffersonville Reformatory, Indiana; see Levin, *Eugenics*, 62.

[63] Ibid., 66.

[64] Ann Harrington, *Mind Fixers* (New York, London: W. W. Norton & Company Independent Publishers, 2019), 61-63.

[65] Proctor, *Racial Hygiene*, 41.

[66] Levin, *Eugenics*, 69 (1930 papal decree, *Casti Connubii*).

[67] Ibid., 69.

[68] In the US State of Indiana followed by California, Connecticut, and Washington (1909), Iowa, Nevada, and New Jersey (1911), New York (1912) although in some states the law was barely used. In some other countries it was not legalized but practiced. Moreover, sterilization was used discretely for the prevention from procreating of the feeble-minded and cognitive disabled (e.g. epilepsy, hereditary deafness or muteness, schizophrenia, alcoholism, psychopathy); see Laura Mondt, "An Act to Prevent Procreation of Confirmed Criminals: The Origins of Sterilization in Indiana," *Historia* 20 (2011): 56-70.

[69] An act providing for the sexual sterilization of inmates in state institutions in certain cases; Act of March 11, 1927 ch. 241 (see Mondt, "An Act to Prevent Procreation").

insanity that are recurrent, idiocy, imbecility, feeble-mindedness or epilepsy" committed to state mental health institutions. Both laws targeted inmates of state institutions and not the general population. In 1924, Virginia signed into law SB 281, the "Eugenical Sterilization Act,"[70] concerning institutionalized people. A catalyst for the implementation of the above legislation in Virginia, but also for the adoption of corresponding legislation around the world at the time, was the trial of *Buck v. Bell*, 274 U.S. 200 (1927) by the United States Supreme Court.[71]

In Germany in the 1930s, a variety of eugenics laws passed concerning racial purity. In 1933, the German Reich government enacted the "Law for the Prevention of Offspring with Hereditary Diseases" (Sterilization Law) for those with "serious physical or mental defects of a hereditary nature" ("genetic blindness, hereditary deafness, manic depression, schizophrenia, epilepsy, congenital feeblemindedness, Huntington's' chorea and alcoholism"). In 1937 Adolf Hitler imposed the sterilization of the "*Rheinlandbastarde*," a derogatory term used by Nazis to refer to children who had one parent of German heritage and one parent of African descent.[72]

On the other hand, Greece, Netherlands, France[73] and Italy have never legislated for forced eugenic sterilization.

ii. Euthanasia

In the name of eugenics and science, a variety of laws were enacted throughout the world to euthanatize certain groups of people, such as the poor, criminals and those suffering from genetic and other health problems, in order to maintain a level of morality and a healthy society, as claimed by those who proposed this legislation.

[70] The purpose of the law was the lawful sterilization of people bearing undesirable hereditary features ("idiocy, imbecility, epilepsy and crime"). The law provided that no person involved in the sterilization process would be considered civil and criminally liable. The result of this legislation was the sterilization of 7325 people; see J. H. Landman, "The Human Sterilization Movement," *Journal of Criminal Law and Criminology* 24, no. 2 (1933): 400-408.

[71] Carrie Buck was a 17-year-old feeble minded woman in a state institution who was eventually sterilized. Characteristic is the judge's Oliver Wendell Holmes Jr. speech "Three generations of imbeciles are enough" in the US Supreme-Court. The judge claimed that Carrie Buck had to be sterilized for the good of society and so that not to have degenerate offspring. It also claimed that neither the due process clause nor the Equal Protection Clause in the 14th Amendment was violated ("Buck v. Bell, 274 U.S. 200 (1927)," U.S. Supreme Court, accessed July 25, 2019, https://supreme.justia.com/cases/federal/us/274/200/).

[72] Proctor, *Racial Hygiene*, 112-113.

[73] Although in France about 15,000 female inmates in psychiatric institutions have been sterilized without their permission; Lena Lennerhed, "Sterilisation on Eugenic Grounds in Europe in the 1930s: News in 1997 but Why?" *Reproductive Health Matters* 5, no. 10 (1997): 156-161.

In Germany, since the last decade of the 19th century the medical killing of people with an "unworthy life" was discussed very strongly. There were discussions about expanding euthanasia to other very diverse groups of people, criminals or those considered as criminals, and people with deformities, mental and genetic conditions, as well as based on racial origin and sexual orientation. On August 7, 1929, Adolf Hitler spoke about the killing of German families' infants who had physical defects, such as mental retardation or genetic diseases. Subsequently the criteria for euthanasia were extended to adults and eventually led to elimination of "disabled and mentally ill adults and the terminally ill."[74] The program of genetic euthanasia was named "Committee for the Scientific Treatment of Severe Genetically Determined Illness."[75] The euthanasia project, T4, followed, in order to relieve Germany of "disabled people." Fearing social outcry, the Nazis never officially proposed a law on euthanasia, however all its actions in this regard were carried out without legal formalities.[76]

German doctors at the Nuremberg trial, in order to justify their actions, argued that their practices were referring to American examples of euthanasia to exempt from "inferior elements." Also they emphasized that these actions were not initiated by Germany.

Moreover, in 1937, a poll in the United States showed that 45 percent of the population supported euthanasia for "defective infants."[77]

iii. Immigration law

Already in the 18th century, warfare, poverty, unemployment and the dream of a better life led waves of immigrants to foreign countries [see Table II]. The fear of the locals to the new immigrants, along with economic reasons, in combination with the eugenics movement, triggered the creation of a series of laws. Immigration restriction laws and nationality laws have existed since the 18th century in America, Europe and Australia. The above mentioned legislation mainly concerned migratory flow from Africa, Asia, Latin Ameri-

[74] Euthanasia is distinguished in voluntary and involuntary. In voluntary euthanasia the person has knowledge and consent to his killing. In contrast to involuntary euthanasia, the individual does not know (especially newborn children) or does not consent to his killing. Felipe E. Vizcarrondo, "Editorial Euthanasia and Assisted Suicide: The Physician's Role," *The Linacre Quarterly 80*, no. 2 (2013): 99-102.

[75] Proctor, *Racial Hygiene*, 186-187.

[76] Michael Berenbaum, and Abraham J. Peck (eds.), *The Holocaust and History*: *The Known, the Unknown, the Disputed, and the Reexamined* (Bloomington and Indianapolis: Indiana, University Press, 1998), 59, 243, and 315.

[77] Lars Grue, "Eugenics and Euthanasia – Then and Now," *Scandinavian Journal of Disability Research* 12, no.1 (2010): 33-45.

ca, Middle East (e.g. The Chinese Exclusion Act of 1882, which was a United States federal law), Southern and Eastern Europe (e.g. The Immigration Act of 1924, also known as The Johnson-Reed Act or National Origins Act, which was a United States federal law). Furthermore, the laws targeted specific groups of immigrants, like those who were considered to be poor and those who had been described as criminals and as "mentally or physically defective."[78]

iv. Interracial marriage

The idea of banning marriages for eugenic reasons has existed since ancient times. During the 17th century up to the 20th, there were laws that legitimized this very important and controversial issue of "miscegenation"– mixing of different racial groups. Many countries [see Table III], particularly the United States (e.g. Indiana Act of April 15, 1905 and the Cable Act, 1922) and in Europe (e.g. the Nuremberg Laws, September 15, 1935 and the Law for the Protection of the Hereditary Health of the German People, October 18, 1935), adopted so-called "eugenic marriage laws."[79] These laws had linked marriage licenses with medical examinations and their purpose was to prevent people from misery and to save future generations from great sorrow. Most of these laws remained in force until after the middle of the 20th century when they were abolished.

V. Bioethical aspects

The bioethical implications of the aforementioned historical, legal and scientific facts concerning eugenics between Darwin's era and the Holocaust concern mostly negative eugenics and especially its forms that could be considered criminal today as compulsive sterilization, abortion and institutionalization and euthanasia. Galton around 1890 promoted positive eugenics, mainly through the idea that society would be better if the gifted would be able to have larger families. There were several intellectuals who opposed even positive eugenics, like Gilbert Keith Chesterton,[80] but they were not able to with-

[78] United States, Congress, House. CHAP. 1134, *An Act to Regulate the immigration of Aliens into the United States*, loc.gov, accessed June 25, 2019 https://www.loc.gov/law/help/statutes-at-large/59th-congress/session-2/c59s2ch1134.pdf.

[79] Those who had been diagnosed as suffering from "venereal diseases" or some genetic disease were excluded from political marriage; see Paul A. Lombardo, "A Child's Right to Be Well Born: Venereal Disease and the Eugenic Marriage Laws, 1913-1935," *Perspectives in Biology and Medicine* 60, no.2 (2017): 211-232.

[80] "There exists to-day a scheme of action, a school of thought, as collective and unmistakable as any of those by whose grouping alone we can make any outline of history... It is a thing

hold the eugenics tide. However, "from the naive optimism that characterized Galton's work to the hideous atrocities of the Third Reich" there is a great distance.[81] Negative eugenics was condemned during the Nuremberg trials, while some positive eugenic practices, such as prenatal genetic diagnostic tests and the fast developing DNA manipulation techniques, are currently at the center of a heated bioethical debate. Today positive eugenics are strongly attacked by some critics, such as the disability movements' supporters,[82] for implicit or explicit discrimination against special human characteristics, or for offending rights like the right to an open future.[83]

Bioethically we are interested in three issues concerning the eugenics era. One is the connection of science and politics, namely the politicalization of biology or the biologicalization of politics. The second explores the change of medical ethos during the eugenics era and the Holocaust. The third is the question of whether the existing bioethical principles, expressed in medical codes (international and national) which advocate strict laws concerning treatment and research, could prevent the massive abuse of persons in the name of genetic, ethnic or racist genocide ordered by political authorities.

The gradually tightening tie of medical sciences with politics from Darwin's era forward is revealed at its peak by Hitler's own worlds when he appealed to 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."[84] In the same vein Rudolf Hess declared that National Socialism

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that can be pointed out; it is a thing that can be discussed; and it is a thing that can still be destroyed. It is called for convenience 'Eugenics' [...] it ought to be destroyed [...] I know that it means very different things to different people; but that is only because evil always takes advantage of ambiguity." Gilbert Keith Chesterton, *Eugenics and Other Evils* (London, New York, Toronto and Melbourne: Cassell and Company, 1922).

[81] Philip R. Reilly, "Eugenics and Involuntary Sterilization: 1907-2015," *The Annual Review of Genomics and Human Genetics* 16 (2015): 351-368.

[82] Ron Amundson, "Disability, Ideology, and Quality of Life: A Bias in Biomedical Ethics," in *Quality of Life and Human Difference Genetic Testing, Health Care, and Disability,* eds. David Wasserman, Jerome Bickenbach, and Robert Wachbroit (Cambridge: Cambridge University Press, 2005).

[83] Jurgen Habermas in his book *The Future of Human Nature* attacks genetic mechanics: "advances of genetic engineering affect the very concept we have of ourselves, as cultural members of the species of 'humanity' [...] they consist a wound in ethical self-understanding of the species, which is shared by all moral persons;" see Jürgen Habermas, *The Future of Human Nature* (Cambridge: Polity Press 2003), 39-40. The notion of 'open future' was introduced by Joel Feinberg; see Joel Feinberg, "The Child's Right to an Open Future," in *Who's Child? Children's Rights, Parental Authority and State Power*, edited by William Aiken and Hugh LaFollete, 124-153 (Totowa, New Jersey: Littlefield, Adams and Co., 1980).

[84] Jeremiah A. Barondess, "Care of the Medical Ethos: Reflections on Social Darwinism, Racial Hygiene, and the Holocaust," *Annals of Internal Medicine* 129, no. 11 (1998): 891-898.

was "nothing but applied biology,"[85] following so, according to Simona Forti, the eugenic methodology of Plato's "ideal state."[86] The discussion about biologicalization of politics leads us to the term *biopolitics*. Michel Foucault first, in the last years of his life, in his insistent effort to reveal the mechanics of power, defined *biopolitics* as "the growing inclusion of man's natural life in the mechanisms and calculations of power."[87] In *The History of Sexuality* he summarized the process by which life, at the beginning of the modern age, comes to be what is at stake in politics: "For millennia, man remained what he was for Aristotle: a living animal with the additional capacity for political existence; modern man is an animal whose politics calls his existence as a living being into question," thus introducing biopolitics' sovereignty.[88] Eugenics are a form of biopolitics where matters such as race and mental or physical health, the bare life of citizens, become the main interest of politics. Giorgio Agamben in *Homo Sacer* studies the connection of Sovereign Power and *bare life* or bodily human existence.[89] Agamben derives his concept of *homo sacer* or bare human life or biological life from Roman laws and social ethics, where it is defined as the life that "is included in the community in the form of being able to be killed."[90] These lives are the object of biopolitics that Agamben believes existed as a transformation of sovereign power from ancient times until the eugenics era where they made their appearance and led to a murderous peak during the Holocaust. Agamben believes that because biological life and its needs had become the politically decisive fact, we are able to "understand the otherwise incomprehensible rapidity with which twentieth-century parliamentary democracies were able to turn into totalitarian states."[91] And in these states "the sovereign is entering into an ever more intimate symbiosis not only with the jurist but also with the doctor, the scientist, the expert, and the priest."[92] There is a line "marking the point at which the decision on life becomes a decision on death, and biopolitics can turn into *thanatopolitics*."[93] This moving line between life or death decision circumscribes the

[85] Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Base Books 2000), 129.

[86] Forti,"The Biopolitics of Souls."

[87] Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, transl. Daniel Heller Roazen (Stanford, California: Stanford University Press, 1998), 119.

[88] Ibid.

[89] Ibid.

[90] Ibid., 82.

[91] Ibid., 122.

[92] Ibid., 122.

[93] Ibid., 122.

zone of *lives unworthy of being lived* (*Lebensunwerten Lebens*). The term was originally used in defense of the right to suicide, but according to Karl Binding it is essential, since it allows an answer to the juridical question: "Must the unpunishability of the killing of life remain limited to suicide [...] or must it be extended to the killing of third parties?"[94] For Agamben, it is obvious that "the concept of *life unworthy of being lived* is clearly not an ethical one [...]; It is, rather, a political concept."[95] In 1988, Francois Dagogner declared that "organisms belong to the public power: the body is nationalized," a statement that underlines the continuity of biopolitics in the post-Holocaust modern era and led Agamben to conclude that "in modern democracies it is possible to state in public what the Nazi biopoliticians did not dare to say."[96]

The second part of our bioethical investigation concerns the change of medical ethos through the wide acceptance of negative eugenics. For centuries from Hippocratic medicine on the leading principle of medicine was beneficence, a term covering the traditional medical values compassion, healing, relieving pain, and making lives of patients better. The mixture of healing with killing was unthinkable until negative eugenics appeared, marking a still existing change of paradigm in medical ethos that puts death (either as a political or personal decision as in the case of assisted suicide) in practitioner's armor among caring, healing and relieving. The "survival of the fittest"[97] that Darwin introduced for the animal evolution was erroneously accepted for the formation of human societies. Darwin disagreed with Galton's theory that "nature" is more important than "nurture."[98] The populist eugenics rhetoric and the flawed genetic determinism as an ungrounded scientism influenced the medical stance towards negative eugenics. Thousands of surgeons actively participated in procedures such as involuntary abortions and sterilizations. There was, of course, a different degree of medical participation among different countries.[99] In the U.S. eugenic policies were adopted earlier and taken further than in Britain [table I], and sterilization laws were legislated by several states in the world's most liberal immigration regime. Only Nazi

[94] Ibid., 137-138.

[95] Ibid., 142.

[96] Ibid., 165.

[97] Darwin borrowed the famous phrase in his *On the Origin of Species* from Herbert Spencer, a social thinker, who used it in his struggle against social welfare programs; see Reilly, "Eugenics and Involuntary Sterilization," 352.

[98] Galton named his research 'eugenics' one year after his half cousin's (Darwin's) death.

[99] For instance, the British Medical Association never accepted eugenic laws (see table I for different legalization of eugenics around the world).

Germany took it further more with a more ambitious and aggressive program.[100] German doctors were not only obedient but enthusiastic supporters of eugenic criminal activities of the Third Reich. They ranked prisoners as experimentation subjects or workers and sent those who were weak or became ill to the gas chambers. They used methods like injections of cultures of live tubercle bacilli, and they made premarital examinations, searching for Jewish blood. They participated in racial courts that considered the presence or absence of non-Aryan blood. "German medicine was not merely deflected from its traditional ethos but was invested in a perverse ideology of death and suffering."[101]

This observation brings us to the third part of our research, the question of the possible power of contemporary bioethical principles to prevent such a phenomenon. In the present, biomedical sciences equipped with principled bioethics supported by strict laws, conventions and universal declarations, seem inviolable from a new change of paradigm of medical ethics. After the Nuremberg Code the autonomous and non-coercive concept of informed consent has become the cornerstone of bioethics. Respect for autonomy, beneficence, non-maleficence and justice,[102] the famous four principles that are learned all over the world through bioethical education, are a strong instrument against a possible new abuse of patients or research subjects at least in the massive form that it took at the beginning of the 20th century. However, there remain coercive sterilization or abortion policies of curbing population growth sometimes of racist origin in several places on the planet.[103] Mixing of caring with killing in medical duties seems to be a legacy of the eugenics era. Pro-euthanasia legislation in several countries allow today the practitioners to exercise medical killing, introducing new trends in medical ethos. A heated debate about the right to conscientious objection of doctors is dividing the medical community as well as legislators. The advantage of current controversies over the ones we described here is that there exists today a stable and more or less universally accepted system of bioethical principles and the historic knowledge inherited by eugenics era and the Holocaust.

At last the horror of the Third Reich atrocities discredited eugenics and the word (although, not the concept) almost disappeared.[104] Eugenics, even

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[100] Randall Hansen, and Desmond King, "Eugenic Ideas, Political Interests, and Policy Variance. Immigration and Sterilization Policy in Britain and the U.S.," *World Politics* 53, no. 2 (Jan., 2001): 241.

[101] Barondess, "Care of the Medical Ethos," 895.

[102] Tom Beauchamp, and James Childress, *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2009).

[103] Reilly, "Eugenics and Involuntary Sterilization."

[104] For example, the UK-based journal *Annals of Eugenics* in 1954 changed its title to *Annals of Human Genetics*; see Barnett, "Keywords in the history of medicine."

renamed, remains still of strong influence, in genetic engineering, enhancement, infanticide, euthanasia, etc. practices that are defended mainly by the utilitarian rationale in contemporary bioethics.

Our investigation revealed Holocaust's negative eugenics theory not as an exception in international eugenics of the previous period, i.e. not an exceptionalism in theory, but in the extreme form and intensity of practices exhibited by the Nazis. The huge difference was the special interest on extinction of the Jewish people and the vast legalization of massive euthanasia practices. This observation does not underestimate the Holocaust as an exemplary (if not unique) appearance of evil in human history, but intends to draw attention on the incubation of the serpent's egg[105] in democracies, through far-right conservative political ideas, flawed scientism and absence of deeper bioethical education of scientists based on historical facts of the eugenics era that led to the Holocaust.

[105] The *Serpent's Egg* is a 1977 drama film written and directed by Ingmar Bergman. The title is taken from a line spoken by Brutus in Shakespeare's *Julius Caesar*: "And therefore think him as a serpent's egg / Which hatch'd, would, as his kind grow mischievous; / And kill him in the shell." "The Serpent's Egg (film)," Wikipedia, accessed November 5, 2019, https://en.wikipedia.org/wiki/The_Serpent%27s_Egg_(film)#cite_note-1).%20%E2%80%9CSerpent%E2%80%9D%20in%20the%20title%20means%20fascism.

Tables

Table I: Sterilization Laws in North America, Europe and Australia before the Holocaust

Country/State	Legislation	Target group
US/Indiana[1]	1. An act to prevent procreation (1907). 2. An act to provide for the sexual sterilization of inmates in state institutions in certain cases (1927). 3. Act of March 3, 1931 (ch. 50). 4. Act of 1935 (ch. 12).	1. Confirmed criminals, idiots, imbeciles and rapists housed in state institutions. 2. Individuals afflicted with hereditary forms of insanity that are recurrent (e.g., idiocy, imbecility, feeble-mindedness or epilepsy) who were committed to a state mental health institution. 3. Persons whose admission to feebleminded institutions. 4. Feebleminded.
US/Virginia	The Eugenical Sterilization Act, 1924.	People limited to state institutions "afflicted with hereditary forms of insanity that are recurrent" such as "idiocy, imbecility, feeble-mindedness or epilepsy."[2]
US/California	1. Sterilization Law, 1909. 2. Sterilization Law, 1913. 3. Sterilization Law, 1917.	1. People mentally ill and mentally deficient in state hospitals and institutions and prison inmates (especially sex offenders). 2. People from the general population "afflicted with hereditary insanity or incurable chronic mania or dementia to all those suffering from perversion or marked departures from normal mentality or from disease of a syphilitic nature." Also the State Lunacy Commission was set up and had the power to decide and order sterilization.[3]
US/New York	New York Sterilization Law, 1912. The law was declared unconstitutional in 1918 and the sterilizations stopped.	"Inmates of State hospitals for the insane, State prisons, reformatories, and charitable institutions, and rapists, and confirmed criminals in penal institutions."[4]
Canada/Alberta	The Legislative Assembly of Alberta, Canada, enacted the Sexual Sterilization Act, 1928.[5]	The law stipulated that "mental defectives" would be sterilized without their consent. Moreover, the law created a Eugenic Board, which provided advice on who should be sterilized.
Sweden	Sterilization Law of 1934 passed by the Swedish Parliament.	"Sterilization without the consent of the patient was now permitted in cases of mental illness, feeble-mindedness, or other mental defects."[6]

[1] "Eugenic Sterilization in Indiana," *Indiana Journal Law* 38, no. 2 (1963): 275-189.
[2] Jacob Henry Landman, *Human Sterilization: The History of the Sexual Sterilization Movement* (New York: Macmillan, 1932), 84.
[3] About 20,000 people were sterilized until 1964 in the state of California, an act of violation of human rights. The laws did not include self-notification procedures for people who would be sterilized, neither the possibility of questioning the mandate nor the opportunity of being heard by a judicial body (Stern, Alexandra Minna, "Eugenics, Sterilization, and Historical Memory in the United States," *História, Ciências, Saúde-Manguinhos* 23, no. 1 (2016): 195-212.
[4] Alexander R. Denis, and Ronald L. Numbers, *Biology and Ideology from Descartes to Dawkins* (Chicago - London: The University of Chicago Press, 2010), 182.
[5] Dominique Clément, "Human Rights Milestones: Alberta's Rights Revolution," in *The Search for Equality and Justice: Alberta's Human Rights Story*, eds. Dominique Clément, and Renée Vaugeois, 17-57 (Edmonton: John Humphrey Centre for Peace and Human Rights, 2012).
[6] Stephanie Hyatt, "A Shared History of Shame: Sweden's Four Decade Policy of Forced Sterilization and the Eugenics Movement in the United States," *Indiana International & Comparative Law Review* 11, no. 2 (1998): 475-503.

Norway	Parliament passed a law on voluntary sterilization, 1934.	The law passed for eugenic, social and economic reasons and targeted people with hereditary diseases. Sterilization for eugenic reasons took place in Norway[7] several years before its legalization in 1934.
Denmark	Law on Sterilization, 1929.[8]	Mentally ill.
Germany	Law for the Prevention of Offspring with Hereditary Diseases, 1933/Law for the Protection of Hereditary Health, 1933 (Gesetz zur Verhütung erbkranken Nachwuchses).	Sterilization of those who "suffered" from a "hereditary disease" and more specifically: "1. Congenital mental deficiency, 2. Schizophrenia, 3. Manic-depression, 4. Hereditary epilepsy, 5. Hereditary St. Vitus' Dance (Huntington's Chorea), 6. Hereditary blindness, 7. Hereditary deafness, 8. Serious hereditary physical deformity."[9]
United Kingdom	There was no law on eugenic sterilization in UK. However, there was a type of policy in this direction: • The National Association for the Care and Control of the Feeble Minded,[10] 1896. • The Eugenics Educational Society in 1907 was founded on the initiative of Francis Galton.[11] • UK birth control clinic,[12] 1921.	Those groups were aiming to avoid births of "mentally defective" and "feeble-minded" children.
Australia[13]	Mental Deficiency Bills, 1926, 1929, 1939.	• Sterilization[14] of "inefficient" people such as "slum dwellers, homosexuals, prostitutes, alcoholics, as well as those with small heads and with low IQs." • The Aboriginal population.

Table II: Immigration Laws in North America, Europe and Australia before the Holocaust

Continent	Law	Content
US	The original United States Naturalization Act of March 26, 1790.	Provided the conditions to grant United States national citizenship; For granting nationality the immigrant had to be a "free white person of good character."[15, 16]

[7] Alain Drouard, "Concerning Eugenics in Scandinavia: An Evaluation of Recent Research and Publications," *Population: An English Selection* 11 (1999): 261-270.
[8] Denmark was the first country in Northern Europe which passed a law on sterilization. See Drouard, 261-270.
[9] 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): e0007.
[10] Nikolas Rose, *The Psychological Complex. Psychology, Politics and Society in England 1869–1939* (London: Routledge and Kegan Paul, 1985), 104.
[11] Graham J. Baker, "Christianity and Eugenics: The Place of Religion in the British Eugenics Education Society and the American Eugenics Society, c.1907-1940," *Social History of Medicine : The Journal of the Society for the Social History of Medicine* 27, no. 2 (2014): 281-302.
[12] Caitriona Beaumont, "Moral Dilemmas and Women's Rights: The Attitude of the Mothers' Union and Catholic Women's League to Divorce, Birth Control and Abortion in England, 1928–1939," *Women's History Review* 16, no. 4 (2007): 463-485.
[14] Victor H. Wallace, "The Eugenics Society of Victoria (1936-1961)," *The Eugenics Review* 53, no. 4 (1962): 215-218.
[14] Ross L. Jones, "Eugenics in Australia: The Secret of Melbourne's Elite," *The Conversation*, 2011, https://theconversation.com/eugenics-in-australia-the-secret-of-melbournes-elite-3350
[15] Rudolph J. Vecoli, "The Significance of Immigration in the Formation of an American Identity," *The History Teacher* 30, no.1 (1966): 9-27.

US	Page Act of March 3, 1875.	Ensured that the migration of people from China, Japan and any Asian country must be free and voluntary. The law also banned the immigration of women into the US for prostitution and the immigration of those who have been convicted "in their own country of felonious crimes other than political."[17]
US	The Chinese Exclusion Act of 1882.	The first major federal immigration law aimed at a particular category of people banned the immigration of Chinese workers to the United States and anyone who is considered a "lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge"[18] Also, immigration from Africa, Asia, Latin America and the Middle East was restricted.
US	The Immigration Act of 1891.	This act forbade paupers, the insane, those with a contagious disease or those who have been convicted of a felony from immigrating to the US. Also, upon arrival of migrants to the US, there was strict control over their personal data.[19]
US	The Immigration Act of 1903 also called the Anarchist Exclusion Act.	The law stated (Sec. 2) "that the following classes of aliens shall be excluded from admission into the United States: All idiots, insane persons, epileptics, paupers, professional beggars; persons afflicted with a loathsome or with a dangerous contagious disease; persons who have been convicted of a felony or other crime or misdemeanor involving moral turpitude; polygamists, anarchists, prostitutes, and persons who procure or attempt to bring in prostitutes or women for the purpose of prostitution and also any person whose ticket or passage is paid for with the money of another."[20]
US	The Immigration Act[21] of 1907.	The law stated (Sec. 2) "That the following classes of aliens shall be excluded from admission into the United States: All idiots, imbeciles, feeble-minded persons, epileptics, insane persons, and persons who have been insane within five years previous; paupers; persons likely to become a public charge; professional beggars; persons afflicted with tuberculosis or with a loathsome or dangerous contagious disease; persons not Defective persons. comprehended within any of the

[16] Linda K. Kerber, "The Meanings of Citizenship," *The Journal of American History* 84, no. 3 (1997): 833-854.
[17] Ronald H. Bayor, *The Columbia Documentary History of Race and Ethnicity in America* (New York: Columbia University Press, 2004), 275-276.
[18] Patrick J. Hayes, *The Making of Modern Immigration: An Encyclopedia of People and Ideas*, Vol. 1 (Santa Barbara, CA: ABC-CLIO, 2012), 323.
[19] "FIFTY-FIRST CONGRESS. SESS. II. CH. 550, 551. 1891," Library of Congress, accessed July 15, 2019, https://www.loc.gov/law/help/statutes-at-large/51st-congress/session-2/c51s2ch551.pdf.
[20] "FIFTY-SEVENTH CONGRESS. SESS. II. CHS. 1011, 1012. 1903," Library of Congress, accessed June 25, 2019, https://www.loc.gov/law/help/statutes-at-large/57th-congress/session-2/c57s2ch1012.pdf.
[21] In 1907, the United States and Japan signed a Gentlemen Agreement according to which US would not forbid the entry of Japanese immigrants, and Japan would not issue passports for Japanese immigrants except for certain categories of businessmen ("FIFTY-NINTH CONGRESS. SESS. II. CH. 1134. 1907." Library of Congress, accessed June 25, 2019, https://www.loc.gov/law/help/statutes-at-large/59th-congress/session-2/c59s2ch1134.pdf).

		foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such mental or physical defect being of a nature which may affect the ability of such alien to earn a living; persons who have been convicted of or admit having committed a felony or other crime or misdemeanor involving moral turpitude; polygamists, or persons who admit their belief in the practice of polygamy, anarchists, or persons who believe in or advocate the overthrow by force or violence of the Government of the United States, or of all government, or of all forms of law, or the assassination of public officials; prostitutes, or women or girls coming into the United States for the purpose of prostitution or for any other immoral purpose; persons who procure or attempt to bring in prostitutes or women or girls for the purpose of prostitution or for any other immoral purpose." Also, Article 39 of the law provided for the creation of the U.S. Immigration Commission, better known as the Dillingham Commission, to investigate the problems caused by immigration and its effects in the US. Moreover, it was forbidden for Asians to enter the US through the state of Hawaii and doubled the head tax to $4 per person.
US	The Immigration Act of 1917, also known Literacy Act and Asiatic Barred Zone Act.[22]	This law prohibited immigration into the United States for those involved in prostitution, and those who were "idiots, imbeciles, epileptics, alcoholics, poor, criminals, beggars, any person suffering attacks of insanity, those with tuberculosis, and those who have any form of dangerous contagious disease, aliens who have a physical disability that will restrict them from earning a living in the United States..., polygamists and anarchists, those who were against the organized government or those who advocated the unlawful destruction of property and those who advocated the unlawful assault of killing of any officer" and those "born in the Asiatic Barred Zone," with the exception of the Japanese and the Filipinos. Additionally, the entry head tax was raised to $8 and a series of Literacy Tests had been introduced, but because of poverty, illiteracy and language ignorance, many failed. Moreover, immigrants were subjected to medical examinations to determine their physical and mental health.
US	The Emergency Quota Act, also known	A system of percentages was defined, lim-

[22] The Public Health Service (PHS), whose duties included the medical inspection and certification as it disembarked on the Ellis island, adopted and promoted eugenic practices "to help stem the flood of "inferior stock" represented by the new immigrants. "SIXTY FOURTH CONGRESS. SESS II. CHS. 27-29. 1917," Campus Library, Serving University of Washington Bothell and Cascadia College, accessed June 25, 2019, http://library.uwb.edu/Static/USimmigration/39%20stat%20874.pdf.

	as the Emergency Immigration Act of 1921, the Immigration Restriction Act of 1921, the Per Centum Law and the Johnson Quota Act.[23]	iting the wave of immigrants mainly from southern and eastern Europe, as they thought they were not able to assimilate to US culture. The law restricted the number of new immigrants per year to 3 percent of the number of residents from that country already in the US in 1910.
US	The Immigration Act of 1924, also known as The Johnson-Reed Act or National Origins Act was a United States federal law.[24]	The law restricted the number of new immigrants per year to 2 percent of the number of residents from that country already in the US. The aim of the law was to limit the number of so-called "New Immigrants" coming from Southeast European countries, such as Italy, Greece, Hungary, Poland, and the exclusion of the Asian tribes.[25] "Older immigrants" coming from countries in western or northern Europe such as Britain and Scandinavia were not impacted.
US	The Immigration Act of 1929.	This law fully established the percentages of the previous law of 1924 and limited the number of migrants to 150,000 people per year. According to the law "The annual quota of any nationality for the fiscal year beginning July 1, 1929, and for each fiscal year thereafter, shall be a number which bears the same ratio to 150,000 as the number of inhabitants in continental United States in 1920 having that national origin (ascertained as hereinafter provided in this section) bears to the number of inhabitants in continental United States in 1920, but the minimum quota of any nationality shall be 100."[26]
Europe (United Kingdom)	Aliens Act,[27] 1905.	The law restricted immigration for: • someone who "does not have means to support himself and/or dependents." • "a lunatic or an idiot." • "a convicted criminal."
Europe (United Kingdom)	British Nationality and Status of Aliens Act (Aliens Restriction Act),[28] 1914.	The target group included mainly the "enemy aliens", but there were several bans in the law for immigrants in general.
Europe	Aliens Act,[29] 1919.	The target group included mainly the "en-

[23] Hayes, 331-332.

[24] The law was replaced in 1965 by the Immigration and Naturalization Act of 1965, also known as the Hart-Celler Act, which established a new immigration policy based on family reunification and the advent of skilled labor in the United States ("SIXTY – EIGHTH CONGRESS. SESS I. CHS. 185, 190. 1924," Campus Library, Serving University of Washington Bothell and Cascadia College, accessed June 25, 2019, http://library.uwb.edu/Static/USimmigration/43%20stat%20153.pdf).

[25] Racial discrimination was due to the fact that the nations of northern and western Europe were believed to have been overtaken by the nations of southern and eastern Europe at various points, such as education, traditions and physical characteristics. Migrants from Southeast Europe were characterized as biologically inferior, poor in IQ TESTS and characterized by poverty, alcoholism and inaction, which were considered to be of genetic origin ("SIXTY – EIGHTH CONGRESS. SESS I. CHS. 185, 190. 1924," Campus Library, Serving University of Washington Bothell and Cascadia College, accessed June 25, 2019, http://library.uwb.edu/Static/USimmigration/43%20stat%20153.pdf.

[26] "SEVENTIETH CONGRESS. SESS. II. CH 690. 1929," Library of Congress, accessed August 24, 2919, https://www.loc.gov/law/help/statutes-at-large/70th-congress/session-2/c70s2ch690.pdf.

[27] The law enacted in order to protect Britain from "undesirable immigration" while encouraging immigration which was beneficial to Britain ("Aliens Act, 1905 [5 EDW. 7. CH. 13]," Legislation.gov.uk, accessed August 24, 2019, https://www.legislation.gov.uk/ukpga/1905/13/pdfs/ukpga_19050013_en.pdf).

[28] The law laid down very strict conditions for aliens wanted to immigrate to Britain. The monarch gained authority to restrict immigration to Britain in times of "national danger or great emergency" ("British Nationality and Status of Aliens Act 1914, CHAPTER 17," Legislation.gov.uk, accessed August 24, 2019, http://www.legislation.gov.uk/ukpga/Geo5/4-5/17/enacted).

(United Kingdom)		emy aliens" and those who did not have enough money and were at risk of charging the public funds, but there were several bans in the law for immigrants in general
Europe (Sweden)	Deportation Act, 1914.	Allowed deportation of: • Roma, • Criminals, • Workforce immigrants.[30]
Europe (Sweden)	Aliens Act, 1927.[31]	Severe restrictions on: • Gypsy immigrants, • Workforce immigrants, • Criminals, • Poor.
Europe (Germany)	The Nuremberg Laws September 15, 1935, The Reich Citizenship Law (Reichsbürgergesetz).	The law was both anti-Semitic and racist in nature and revoked the citizenship of German Jews. In accordance with Article 2 (1) of the Act: "A citizen of the Reich is that subject only who is of German or kindred blood and who, through his conduct, shows that he is both desirous and fit to serve the German people and Reich faithfully."[32]
Australia	The Immigration Restriction Act 1901 of the Parliament of Australia.	The law was enacted by the Parliament of Australia to ban certain categories of migrants from entering Australia in order to maintain the large proportion of Europeans living in Australia. Specifically, in the law it is stated:[33] "The immigration into the Commonwealth of the persons described in any of the following paragraphs of this section (hereinafter called "prohibited immigrants") is prohibited, namely: (*a*) Any person who when asked to do so by an officer fails to write out at dictation and sign in the presence of the officer a passage of fifty words in length in a European language directed by the officer; (*b*) any person likely in the opinion of the Minister or of an officer to become a charge upon the public or upon any public or charitable institution; (*c*) any idiot or insane person; (*d*) any person suffering from an infectious

[29] The law included "stringent and wide" terms. There were specific ports for the expulsion of immigrants. Also, all immigrants over 16 had to register with the police. Aliens who already lived in Britain were deported if they were arrested for a criminal act. Deportation was allowed if the Home Secretary judged this was "conducive to the public good". It was forbidden for foreigners to work in specific positions, such as "master, chief officer, or chief engineer of a British merchant ship" and public services. Ten (10) years of imprisonment was imposed for immigrants who participated in "any act calculated or likely to cause sedition or disaffection." Also medical examinations were required. "Aliens Restriction (Amendment) Act 1919, CHAPTER 92 9 and 10 Geo 5," Legislation.gov.uk, accessed August 24, 2019, http://www.legislation.gov.uk/ukpga/Geo5/9-10/92.

[30] Christer Gerdes, and Eskil Wadensjö, "Post-enlargement Migration and Adjustment in a Receiving Country: The Case of Sweden," in *Labor Migration, EU Enlargement, and the Great Recession*, eds. Martin Kahanec, & Klaus F. Zimmermann, 123-138 (Berlin, Heidelberg: Springer, 2016), 123.

[31] The law was aimed at the protection of "Nordic race" from immigrants for eugenic and economic reasons. Moreover, when the WWI ended, immigration policy became more stringent and the Swedes wanted to "control immigration of people who do not to our benefit allow themselves to meld with our population." Pontus Rudberg, *The Swedish Jews and the Holocaust* (New York: Routledge, 2017).

[32] Pheng Cheah, David Fraser, and Judith Grbich, *Thinking Through the Body of the Law* (New York: New York University Press, 1996), 66.

[33] "IMMIGRATION RESTRICTION, No. 17 of 1901," Australian Government: Federal Register of Legislation, accessed July 11, 2019, https://www.legislation.gov.au/Details/C1901A00017.

		or contagious disease of a loathsome or dangerous character; (*e*) any person who has within three years been convicted of an offence, not being a mere political offence, and has been sentenced to imprisonment for one year or longer therefor, and has not received a pardon; (*f*) any prostitute or person living on the prostitution of others; (*g*) any persons under a contract or agreement to perform manual labour within the Commonwealth: Provided that this paragraph shall not apply to workmen exempted by the Minister for special skill required in Australia or to persons under contract or agreement to serve as part of the crew of a vessel engaged in the coasting trade in Australian waters if the rates of wages specified therein are not lower than the rates ruling in the Commonwealth."

Table III: Interracial Marriage Laws in North American, Europe and Australia before the Holocaust

Continent	Law	Content
US	Virginia, [34] 1691 and Virginia 1924 (SB 219) "The Racial Integrity Act."[35]	All interracial marriages were forbidden by punishing whites who were in exile.
US	Maryland, 1664 (The British colonial law) and Maryland 1692.	Maryland passed the first British colonial law, which banned the marriage between white people and slaves. According to this law, any woman who married a black man and any children who may emerge from this union would be considered slaves. However, the law did not include provisions for a white man marrying a black woman.[36]
US	Oregon Law passed in 1862 and an Act to Prohibit the Intermarriage of Races, 1866 (Oregon).	Prohibited the marriage between white people and those with a quarter or more of "Negro blood."[37]
US	Connecticut, 1895, An Act Concerning Crimes and Punishments.[38]	The marriage of "epileptics, imbeciles, and the feebleminded"[39] was prohibited. The law criminalized even relations and cohabi-

[34] Wolfe Brendan, "Racial Integrity Laws (1924–1930)," *Encyclopedia Virginia*, Virginia Humanities, (Feb. 2009), accessed July 10, 2019, https://www.encyclopediavirginia.org/racial_integrity_laws_of_the_1920s.

[35] The law banned the interracial marriage for eugenic purposes and defined the white person as the one "who has no trace whatsoever of any blood other than Caucasian." The law was abolished in 1967 following the case Loving v. Virginia. See Kevin R. Johnson, *Mixed Race America and the Law: A Reader* (New York: New York University Press, 2003), 53, 64, 238.

[36] Christopher Tomlins, *Freedom Bound: Law, Labor, and Civic Identity in Colonizing English America, 1580–1865* (New York: Cambridge University Press, 2010), 459.

[37] Allan K. McDougall, Lisa Philips, and Daniel L. Boxberger, *Before and After the State: Politics, Poetics, and People(s) in the Pacific Northwest* (Vancouver, Toronto: UBC Press, 2018), 112.

		tation of "affected couples."[40]
US	Indiana Act of April 15, 1905.	Banned marriage to people with "mentally deficient", "transmissible disease" and "habitual drunkards."[41]
US	Congress passes the Cable Act, 1922.	Weddings between white and African American people, as well as between Indians and Asians were prohibited.[42]
Canada	There was no law against interracial marriage.	There was a strong social outcry against interracial marriage despite the lack of interracial marriage laws.
Europe (Germany)	The Nuremberg Laws, September 15, 1935, Law for the Protection of German Blood and German Honour (Gesetz zum Schutte des deutscen Blutes und der deutscen Ehre).	The law was a result of Nazi and anti-Semitic theory and mentioned in Sections 1 and 2: 1. "Marriages between Jews and citizens of German or some related blood are forbidden. Such marriages [...] are invalid, even if they take place abroad in order to avoid the law. 2. Sexual relations outside marriage between Jews and citizens of German or related blood are forbidden."[43]
Europe (Germany)	Law for the Protection of the Hereditary Health of the German People, October 18, 1935.	New requirements for marriage were introduced under this law such as a certificate of fitness to marry. These certificates were not administered to "those suffering from hereditary illnesses and contagious diseases" [44] and those attempting to marry against the Nuremberg Laws.
Australia	The Aboriginals Ordinance 1918.	Marriage restriction between Indigenous women and non-Indigenous men to avoid reproduction of "genetically inferior offspring"[45]

[40] Following the Connecticut law, some 30 states adopted similar laws, such as Minnesota and Kansas (1903), Ohio and New Jersey (1904), Indiana and Michigan (1905) and Arizona (1913). According to this law "mental or physical defects" of parents would be transferred to their offspring, who was undesirable and was considered as a burden on society. See Laura L. Lovett, "Mark A. Largent. Breeding Contempt: The History of Coerced Sterilization in the United States. New Brunswick: Rutgers University Press. 2008," *The American Historical Review* 114, no. 3 (2009): 776-777.

[41] Lawrence B. Goodheart, "Rethinking Mental Retardation: Education and Eugenics in Connecticut, 1818–1917," *Journal of the History of Medicine and Allied Sciences* 59, no. 1 (2004): 90-111.

[42] Philip R. Reilly, "The Surgical Solution: A History of Involuntary Sterilization in the United States," *The American Historical Review* 97, no. 3 (1992): 944-945.

[43] Samuel M. Dike, "State Laws Regulating Marriage of the Unfit," *Journal of the American Institute of Criminal Law and Criminology* 4, no. 3 (2013): 423-425.

[44] Michael C. LeMay, and Elliott Robert Barkan, *U.S. Immigration and Naturalization Laws and Issues: A Documentary History* (Westport: Greenwood Press, 1999), 135-136.

[45] Cheah, Fraser, and Orbich, 66.

[46] Wayne Morrison, *Criminology, Civilisation and the New World Order* (London: Routledge, 2006), 80.

[47] Nina N. Lemieux, *Australian Eugenics from 1900 to 1061* (PhD Diss, The University of Texas at Austin, 2017), 12.

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III. The Holocaust and the social role of the professions

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Professional Ethics in Three Professions during the Holocaust

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Abstract

Modern scholars and bioethicists continue to learn from the Holocaust. Scholarship and history show that the authoritarian Nazi state limited and steered the development and power of professions and professional ethics during the Holocaust. Eliminationist anti-Semitism drove German professions and many professionals to join in policies and programs of mass deportation and ultimately genocidal mass murder, while also excluding many professionals (including most Jewish professionals) from paid work. For many physicians and other medical professionals, humane and truly ethical practices were limited by constrained professional autonomy and coercive state laws. Education and research in natural sciences were distorted by applications of racist eugenic policies and practices. In law schools and legal professions, professionals were rewarded as judgmental enforcers of state policies, often working with limited independent agency and in the public sphere. Mass harm and mass crimes were therefore perpetrated in accordance with Nazi laws and policies, incorporating professions and professionals into destructive practices, along with other occupational groups.

Key-words: *bioethics; holocaust; professional ethics; independent agency; public sphere*

I. Introduction

Bioethics has a tradition of learning from the Holocaust,[1] especially with respect to medical ethics,[2] the limits of research with human subjects,[3] and the immorality of eugenics.[4] Since the Holocaust, the Nuremburg Code has been created, endorsed, and built upon by internation-

[1] Arthur L. Caplan, *When Medicine Went Mad: Bioethics and the Holocaust* (Totowa, NJ: Humana Press, 1992).

[2] Arthur L. Caplan, "The Meaning of the Holocaust for Bioethics," *The Hastings Center Report* 19, no. 4 (1989): 2-3.

[3] Sheldon Rubenfeld, and Susan Benedict, *Human Subjects Research after the Holocaust* (Dordrecht: Springer International Publishing, 2014).

[4] Arthur L. Caplan, Glenn McGee, and David Magnus, "What Is Immoral About Eugenics?" *British Medical Journal* 319, no. 7220 (1999): 1284-1285.

al and national actions, as has the 1964 Helsinki Declaration condemning medical abuse of human experimentation.[5] Horrifying mass crimes, including genocide, human experimentation, and euthanasia, perpetrated by the authoritarian National Socialist (Nazi) regime, were rationalized using racist and anti-Semitic ideologies which were deeply rooted in German biology, medicine, sciences, and public attitudes.[6]

Many Nazi-era scientists and physicians supported persecution of racialized groups, such as Jews and Roma, by advancing ideologies. This came to public attention in the post-war Nuremberg trials.[7] While eugenics had widespread and international public support around the time of the Holocaust in many nations,[8] the Nazi Germans took eugenic theories to extremes in both science and medicine.[9] Policies based on eugenics allowed unethical practices, from sterilization to murder, based on national and local law,[10] which were enacted and operationalized without successful opposition from medical, scientific, or legal professions.[11] A Nazi version of "medical ethics" was reinforced by teaching physicians their obligations to their profession and to the Nazi German state.[12] Obligations to individual people under Nazi medical ethics was subjugated in favor of actions based on an eliminationist anti-Semitism that supported an authoritarian regime.[13]

Bioethics has grown to serve as a system of checks and balances for unethical medical practice since the Holocaust, and it has a respected tradition of considering the ways that social and cultural contexts influence the practice of health care and research.[14] Bioethics has incorporated the scholarship

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[5] Michael H. Kater, *Doctors under Hitler* (Chapel Hill: University of North Carolina Press, 1989), 6.

[6] Christopher Hutton, *Race and the Third Reich: Linguistics, Racial Anthropology and Genetics in the Dialectic of Volk* (Cambridge; Malden, MA: Polity, 2005), 17-33.

[7] Caplan, The Meaning of the Holocaust for Bioethics," 2-3.

[8] Alison Bashford, and Philippa Levine, *The Oxford Handbook of the History of Eugenics* (New York: Oxford University Press, 2010), 1-23.

[9] Patricia Heberer, "Science," in *The Oxford Handbook of Holocaust Studies*, eds. Peter Hayes, and John K. Roth, 39-53 (Oxford: Oxford University Press, 2010).

[10] Michael J. Bazyler, *Holocaust, Genocide, and the Law: A Quest for Justice in a Post-Holocaust World* (New York: Oxford University Press, 2016).

[11] Telford Taylor, "The Legal Profession," in *The Holocaust: Ideology, Bureaucracy, and Genocide: The San José Papers*, eds. Henry Friedlander, and Sybil Milton, 133-140 (Millwood, NY: Kraus International Publications, 1980).

[12] Florian Bruns, and Tessa Chelouche, "Lectures on Inhumanity: Teaching Medical Ethics in German Medical Schools under Nazism," *Annals of Internal Medicine* 166, no. 8 (2017): 591-595.

[13] Daniel Jonah Goldhagen, *Hitler's Willing Executioners: Ordinary Germans and the Holocaust* (New York: Alfred A. Knopf, 1996).

[14] Arthur Kleinman, Renée C. Fox, and Allan M. Brandt, "Introduction: Bioethics and Beyond,"

of leading philosophers and social scientists, including works encouraging the teaching of non-biomedical topics to medical students.[15] One important and interesting combination of bioethics and the Holocaust is to explore the roles, behaviors, and conditions for professions and professionals during the first half of the twentieth century.[16] We learn from "sociological bioethicists" that people and groups motivated or constrained by bioethics, including medical and legal professionals, have obligations to work towards the common good through the pursuit of social justice in addition to protecting individual rights.[17]

Individual and human rights during the Holocaust were not subject to systematic protection by either international organizations or by respected professional organizations. Jews, including Jewish professionals, were subject to systematic discrimination and eventually the loss of all rights under German law.[18] After the Holocaust, international human rights law grew substantially, in part to fill this void.[19] During the Holocaust, Nazi power over professions (and professionals) redirected, coerced, and transformed scientific, medical, and legal goals, expenditures, and practices. This transformation sometimes involved disguising policies of persecution and later genocide with pseudo-scientific fictions and with "double-speak," in which propaganda and policy claimed "racial hygiene" as a primary goal of science, medicine, law, and education.[20] Grotesquely, physicians were employed in "medical killing" and other forms of systemic harm, violating bioethical principles, including autonomy, beneficence, justice, and non-maleficence.[21] Coercive transformations of information and education also impacted scientific and legal professions and professionals.

Professional autonomy and ethical practice are hallmarks that can be affected by the environment within which professionals must practice.[22] During

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Daedalus 128, no. 4 (1999): vii.

[15] Renée C. Fox, "Is Medical Education Asking Too Much of Bioethics?" *Daedalus* 128, no. 4 (1999): 1-25.

[16] Renee C. Fox, and Judith P. Swazey, "Examining American Bioethics: Its Problems and Prospects," *Cambridge Quarterly of Healthcare Ethics* 14, no. 4 (2005): 361-373; Renée C. Fox, Judith P. Swazey, and Judith C. Watkins, *Observing Bioethics* (New York: Oxford University Press, 2008).

[17] Renée C. Fox, "Moving Bioethics Towards Its Better Self: A Sociologist's Perspective," *Perspectives in Biology and Medicine* 59, no. 1 (2016): 46-54.

[18] Ingo Müller, *Hitler's Justice: The Courts of the Third Reich* (Cambridge, MA: Harvard University Press, 1991), 115-119.

[19] Bazyler, 235-288.

[20] Deborah Dwork, and R. J. Van Pelt, *Auschwitz, 1270 to the Present* (New York: Norton, 1996).

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

[22] Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York:

the Holocaust, many types of working people were severely limited by authoritarian Nazi laws, policies, and practices. Professionals often worked collectively toward unethical, and retrospectively criminal, purposes, perpetuating and rewarding tasks that clearly included abuses of human populations, often in the name of pseudo-scientific racial theories.[23] Especially after 1939, professionals during the third *Reich* were obligated to subscribe to eugenic and authoritarian systems of professional ethics, often delivered through lectures by Nazi Party loyalists.[24]

Many German professions, strained by economic challenges and stresses on a growing labor pool, quite readily welcomed Nazi seizure of power.[25] Consequently, the Nazi regime routinely denied autonomy, agency, and the rewards of ethical professional work not only to medical and allied health professions but also to professions in the natural sciences and law.

Disempowering acts included but were not limited to evolving anti-Jewish policies that preceded the Holocaust, such as a 1926 NSDAP (Nazi) draft law that banned Jewish professional practice in a Thuringian regional Party Program.[26] In the context of authoritarian rule during the Third Reich, professions and professionals of all sorts were subject to totalitarian and terrifying influences of fascist government policies and practices, rather than to the humanistic ideals of professional ethics that are now the center of professional pride. This is not in any way meant to justify unethical and harmful professional practice or to minimize the possibility of free will or even the obligation of ethical dissent, but simply to emphasize the extreme contextual and historically specific challenges that Nazi fascism created for professional ethical practices.

During the Holocaust, many professionals and professions collectively collaborated and acted in ways that supported state violence and crime, concluding with the catastrophe (Shoah) that we have since learned to define as medically sanctioned genocide. Indeed, ethics themselves were decreed by authoritarian and anti-Semitic actions, including state-sponsored curricula, lectures, and texts that included inhumane demands for a complete "solu-

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Atherton Press, 1970); Eliot Freidson, *The Professions and Their Prospects* (Beverly Hills CA: Sage Publications, 1973); Andrew Delano Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (Chicago, IL: University of Chicago Press, 1988).

[23] Heberer, 39-51.

[24] Bruns, and Chelouche, 591-595.

[25] Konrad H. Jarausch, "The Perils of Professionalism: Lawyers, Teachers, and Engineers in Nazi Germany," *German Studies Review* 9, no. 1 (1986): 107-137.

[26] Peter Longerich, *Holocaust: The Nazi Persecution and Murder of the Jews* (Oxford: Oxford University Press (OUP), 2010).

tion to the Jewish Question in Europe" that involved mass murder.[27] In these respects, the policies and practices of the Nazi German state did not allow anything like the significant degree of professional autonomy that characterizes our modern medical, scientific, or legal professions and professionals.[28] While this does not implicate or exculpate any specific individuals or groups, it does reinforce the finding that professional work has been and can be strongly influenced by its environment.[29]

II. Medical Professions: Limited Professional Autonomy

All professions, including biomedical ethics, were subject to Nazi eugenics and a program of deception. The exclusion of Jews from the German Health System involved the implementation of a "racial hygiene" paradigm in medicine,[30] and the expansion of scientific racism through eugenics.[31] In Germany and German-occupied nations, persecution followed a series of steps, from identification (such as of Jews with stars), documentation (such as allowing forced removal and latter historical tracing), isolation and ghettoization, and ultimately mass murder (genocide). Nazi authorities harnessed scientists and physicians to fuel Germany's war machine and to implement racialist policies.[32]

Prior to the creation of death camps, the Nazis established deceptively named "euthanasia" policies of direct medical killings by means of medicalized decisions carried out by medical professions. "Medical killing" was rationalized as "life unworthy of life" and involved five gross and criminal violations of both medical ethics and human rights: coercive sterilization, killing "impaired" (disabled) children, killing "impaired" adults, concentrated killings of "impaired" people, and mass murder in death camps.[33]

"Medicalized killing" perversely reversed a doctor's ethical obligations, substituting criminal murder of persecuted groups for the ancient obligations to heal and to do good. According to Robert Jay Lifton, "Nazification" of the

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[27] Bruns, and Chelouche, 591-597.

[28] Henry Friedlander, *Origins of Nazi Genocide: From Euthanasia to the Final Solution* (Chapel Hill, NC: The University of North Carolina Press, 1995); Henry Friedlander, and Sybil Milton, *The Holocaust: Ideology, Bureaucracy, and Genocide: The San José Papers* (Millwood, NY: Kraus International Publications, 1980).

[29] Abbott, *The System of Professions: An Essay on the Division of Expert Labor*.

[30] Longerich, 52-69.

[31] Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (New York: Knopf, 1985).

[32] Heberer, 42-44.

[33] Lifton, 30-51.

German medical profession meant extending the "euthanasia" first practiced on persecuted groups into the context of mass murder in death camps. These applications of racist biomedical ideologies meant that Nazi doctors took roles in Auschwitz and other locations of genocide that included supervising murders by gas and lethal injections, directing the crematoria, and keeping order during the human "selection" processes, where some people were permitted to live as enslaved laborers in the camps while most others were murdered, often gassed and incinerated *en masse*.[34]

While it is not fair to assume that *all* medical professionals had a choice in these matters, and while there has been debate around the idea that all professionals were *forced* to collaborate with Nazi policies, it has been established that many professionals and professional associations were *willing* collaborators and offered themselves to the Nazi regime.[35] National Socialism was considered an opportunity for many aspiring and working professionals. Not all medical professions or professionals, however, were compliant with Nazi policies nor complicit in the mass crimes committed in Nazi German and occupied territories. Indeed, physicians in Holland resisted co-optation in the early 1940s, and consequently one hundred of them were sent to concentration camps, providing an example (among others) of organized resistance to both Nazi policies and fascist policies more generally.[36]

The German medical profession, which had been a location of movements for public health and social justice in the mid-1800s, gradually reduced "editorial comment" on public health or social justice at the beginning of the 20th century, focusing more on "technical" and medical discussions.[37] By the early 1930s, Jewish contributions to medical and other sciences were being removed and replaced with anti-Semitic, eugenic, and other racial theories that condemned large groups as unfit, unequal, and/or eugenically 'diseased.' Doctors supported eugenic policies sooner, and in larger numbers, than most other professions in Germany. During the Holocaust (1933-1945), 31-40% of German physicians were members in the Reich's Physicians' League, an adjunct Nazi Party organization; thus demonstrating how the medical profession welcomed members of the 'racial hygiene' movement.[38]

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[34] Lifton, 5.

[35] Konrad H. Jarausch, "The Crisis of German Professions 1918-33," *Journal of Contemporary History* 20, no. 3 (1985): 397-398.

[36] Kater, 54-73.

[37] Gert H. Brieger, "The Medical Profession," in *The Holocaust: Ideology, Bureaucracy, and Genocide: The San José Papers*, eds. Henry Friedlander, and Sybil Milton, 141-150 (Millwood, NY: Kraus International Publications, 1980).

[38] Michael H. Kater, *The Nazi Party: A Social Profile of Members and Leaders, 1919-1945* (Cambridge, MA: Harvard University Press, 1983); Kater, *Doctors under Hitler*, 12.

"Hereditary Health Courts" were established nationally by Nazi law in mid-1933 and operationalized early in 1934. Their role was to select people and groups for involuntary sterilizations, based on decisions among groups including two physicians and one district judge with ties to the Nazi Party.[39] Physicians were legally obligated to report people who could be "hereditarily sick," sterilizing large numbers that were projected to exceed 410,000 in only a few years. The process, like many others, was reinforced by law and aggressive policing.[40]

Lifton observed that Nazification of the medical profession and of German medical practices during the Holocaust enabled a horrific transition from sterilization to direct medical killing. Both ideological zeal and systematic terror aided this Nazification process. Authorities like Berlin faculty member Rudolf Ramm encouraged each doctor to "cultivate genes" and serve the *Volk* as a "biological soldier." Selecting those considered unfit for sterilization or murder was considered "merciful" and an "obligation" that superseded individual rights. Nazi public "euthanasia" programs were modeled after programs to create a genetically select defense squad (*SS*) force. New medical associations replaced older ones; a younger generation of bureaucratic and Nazi-influenced professionals pushed out older professionals who were subject to pre-Nazi ideologies. Gerhard Wagner, chief Reich physician, helped promote "people's medicine" that was distrustful of both academic medicine and pure science.[41]

Jewish doctors in Germany were subject to oppressive regulations from the start of Nazi rule in 1933, but on August 3, 1939 all remaining Jewish physicians had their medical licenses nullified by a "Fourth Amendment" to the Nuremburg Laws. Adding to exclusionary practices, German doctors were discouraged from referencing Jewish authors in scientific papers (any Jewish references were required to be in a separate list of Jewish sources) and "Aryan" doctors were discouraged from seeing Jewish patients. This "purification" and "racial hygiene" was promoted despite shortages of medical providers. In academic medicine and in education more generally, Jewish scholars and others who challenged authorities were persecuted from above by differential treatment from authorities and from below by militant behaviors on the part of the National Socialist Student League, which organized violent protests. German academics who opposed the regime, including Karl Saller, a prominent anthropologist, were subject to sanctions, including prohibition from teaching.[42]

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[39] Lifton, 25-29.

[40] W. W. Peter, "Germany's Sterilization Program," *American Journal of Public Health* 24, no. 3 (1934): 187-191.

[41] Lifton, 30-39.

[42] Ibid., 39.

"Positive eugenics," such as encouraging large Aryan families, and "negative eugenics," such as sterilization and eventually "euthanasia," were combined as elements of the Nazi biomedical vision. Physicians were part of special commissions tasked with "approving" marriages based on Nuremberg racial statutes, an authority and practice formalized by the 1935 Physicians' Law. Doctors were also active in criminal and positive eugenics through a "Spring of Life" (*Lebensborn*) program that administered welfare and other forms of assistance to SS officers who parented "racially valuable" children. This program's medical director, Gregor Ebner, publicly applauded both positive and negative measures.[43]

Propaganda including stereotypes of Jewish people and others who were represented as subhuman or vectors of diseases polluting society were used to distort genetics and to rationalize this genocidal form of eugenics. How could medical professionals, trained in science and obligated to ethical care, ignore these distortions and engage in harmful practices? Lifton's interviews with Nazi doctors and consideration of perpetrator psychology are the basis for the idea that Nazi doctors "doubled" their "medical selves" into good people in bad situations, acting as individually autonomous people-who-could-do-evil, victimizing humans while unconstrained by medical ethics and ethical requirements. Numbed, split, perhaps dissociated from their "other" selves, Lifton suggests that these medical practitioners made Faustian bargains and did "dirty work." Much as a soldier rationalizes killing for the sake of future peace, Nazi doctors killed for false future ideals of racial "progress."[44]

The most horrifying cases of medical collusion with Nazi crimes, which were prosecuted and found criminal after the war, have been well-documented. The International Military Tribunal (IMT) Trials at Nuremberg were followed by twelve more Nuremburg trials, starting with "The Doctors Trial" which started on October 25, 1946, less than four weeks after the IMT judgements were issued. In "Case number 1" (*US vs. Karl Brandt et al.),* 23 Nazi physicians were tried for war crimes and crimes against humanity. Defendants included Brandt, who was Hitler's personal doctor, and Dr. Herta Oberheuser, who worked as a doctor at the Ravensbruck camp and was the first female defendant at Nuremberg. While only 16 of these 23 were found guilty, Brandt was hanged and others received prison sentences of 10-20 years.[45] In a second case with only one defendant, Marshal Milch was tried and found guilty of crimes against humanity that included slave labor and medical experiments. Resected legal historian

[43] Ibid., 43-44.

[44] Ibid., 418.

[45] Bazyler, 92-93.

Michael Bazyler notes that Milch served only seven years of a life-in-prison sentence.[46]

If we examine the almost 90,000 physicians in Nazi Germany, we see that only 350 people in the medical profession were found to be closely involved with the most infamous and cruel medical crimes after the war.[47] It is difficult to estimate how many in Germany or in other occupied nations were collaborators, bystanders, or actively resisted eugenics or genocide. Professionals were, for the most part, unable to or unwilling to resist authoritarian rules in any organized fashion until after the genocidal "war against Jews" had decimated the European continent.

In addition to physicians, many nurses were also involved in medical harm, including unethical experimentation, in all sorts of roles, from SS to forced laborers.[48] During hidden and malicious medical and other war crimes, where were the ethics of famous German medical leaders who inspired earlier generations from around the world? This version of "the German question"[49] is hard to answer, but one reviewer of professional literature shows that "no opinions" were widely expressed about Nazi "actions" in German medical editorial circles at the time. While Jewish medical professionals were excluded from professional practice, state-approved "Aryan practitioners" usually put the goals and orders of the Reich above any individual responsibilities or ethical obligations to universal or public human health.[50] Is there a standard of historical research that helps classify Nazi-era medical professionals as perpetrators, collaborators, or bystanders? Historical documents clearly show that mass harm was done by large numbers of professional biomedical practitioners. The larger goal of the Nazi state was eliminationist genocide, which involved "ordinary" people.[51] It appears now that biomedical professionals in Germany did not, for the most part, stop or even slow this process. While not all people or professionals acted in a similar or ethical manner, the net result was a long period of harm, injustice, and ultimately eliminationist genocide, reinforced by willing and "ordinary" people in all kinds of occupational groups.[52]

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[46] Ibid., 93.

[47] Brieger, 43.

[48] Susan Benedict, and Cathy Rozmus, "Nurses and Human Subjects Research During the Third Reich and Now," in *Human Subjects Research after the Holocaust*, eds. Sheldon Rubenfeld, and Susan Benedict, 87-98 (Dordrecht: Springer International Publishing, 2014).

[49] Ralf Dahrendorf, *Society and Democracy in Germany* (Westport, CT: Greenwood Press, 1979).

[50] Brieger, 141-146.

[51] Goldhagen, 80-129.

[52] Ibid., 181-202.

III. Natural Sciences: Distorted by Eugenics

During the Holocaust, all academic disciplines, including the natural sciences, were subject to coercion and influence from the state, skewing subjects towards "German" national (eugenic) goals and away from "Jewish" influence. Science and medicine are described as "enabling agents of the Holocaust" in a world where Nazi dictatorship "muzzled dissent and discouraged alternative opinions."[53] Like Einstein, many prominent scholars were compelled to emigrate, leaving space for new and sometimes pseudo-scientific endeavors. While many legitimate natural sciences and scientific professionals were publicly and officially respected during the Holocaust, professionals who conducted "Nazi science" were beholden to the ideologies and material demands of their authoritarian, fascist state. "Nazi scientists" were obligated to serve Nazi leadership and policies under duress from Nazi law; they worked in fields well beyond military sciences and with theories that included geography, demography, and planning, in addition to eugenic genetics and "racial hygiene."[54]

In the context of Nazi science, some pseudo-scientific theories were also promoted. For example, "World Ice Theory" in physics was a form of pseudo-science promoted to rationalize the demotion of more credible and established theories, like Einstein's physics, associated with Jewish scientists.[55] *Gleichschaltung* (synchronization) of national and scientific policies resulted in the segregation of "German" and "Jewish" physics by "Aryan physicists" Stark and Leonard.[56] As with many aspects of Nazi persecution and propaganda, deceptive language manipulation was used to control organizations and groups in society.[57]

Even with the promotion of certain pseudo-sciences, scientists and science during the Nazi era and the Holocaust did not work illogically or singularly pursue irrational theories. Basic and applied chemistry and physics, along with engineering and demography, were systematically required for the war effort and for massive operations, including population transfers. Objective

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[53] Heberer, 43.

[54] Longerich, 80-85.

[55] Heberer, 42.

[56] Alan Beyerchen, "The Physical Sciences," in *The Holocaust: Ideology, Bureaucracy, and Genocide: The San José Papers*, eds. Henry Friedlander, and Sybil Milton, 151-163 (Millwood, NY: Kraus International Publications, 1980).

[57] Henry Friedlander, "The Manipulation of Language," in *The Holocaust: Ideology, Bureaucracy, and Genocide: The San José Papers*, eds. Henry Friedlander, and Sybil Milton, 103-113 (Millwood, NY: Kraus International Publications, 1980).

scientific practices were used for barbaric and political ends, both against international enemies and "internal" threats; a genocidal war against Jewish populations required innovation and applied sciences. Development, application, and popularization of eugenic biology was a major part of this effort.[58]

"Eugenics" was developed as a science of "good births." The term itself was coined in 1883 by British naturalist Francis Galton. "Racial hygiene" was later developed in 1895 by Alfred Ploetz. Ploetz, following a focus on artificial selection by Biologist Ernst Haeckel, advocated an unjust and ultimately catastrophic view of "health" through persecution, including segregation and selections of populations deemed diseased, dangerous, and/or degenerate. For Ploetz, selection of marriage partners and killing of babies was part of the goal of eugenic practices, which mimicked those of Spartan warriors.[59] Less draconian eugenic advocates, especially in Germany but also internationally, advocated the mobilization of scientific eugenic practices to control what was perceived as a cycle of decay through three objectives: discover (presume) hereditary characteristics contributing to social problems, develop biomedical solutions to the problems, and create public health campaigns (including propaganda) to combat these dangers. In Nazi Germany, eugenic theories grew into an industrially destructive practice that perpetrated genocide through the Holocaust, scapegoating Jewish and other "dangerous" or "polluted" populations (following anti-Semitic tropes) in attempts to "eliminate root causes" of social problems.

In 1920, Karl Binding and Alfred Hoche published a barbaric text, "The Destruction of Unworthy Life." In this text, only those vigorously working and maximally producing should live in and as part of Germany. This text offered a "solution" to the internal conflicts in Germany that were magnified by economic troubles after the World War I. Popular opinion held, and many Germans were shocked into believing that German leadership had allowed the loss of a "winnable" World War I. Hitler echoed theories presented by Binding and Hoche in his book *Mein Kampf*, and operationalized eugenics (and euthanasia) once the Nazis took power. The first Nazi social program was the Law for the Prevention of Hereditarily Ill Offspring (1933), followed by the Law against Dangerous and Habitual Criminals. These policies promoted sterilization and other forms of persecution, limiting intergroup marriage. As noted above, regulations initially designed for elite troops (the *SS*) were used as a model for medical and social regulation of the entire German population.[60]

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[58] Bashford, and Levine, 5-21.

[59] Dwork, and Van Pelt, 118.

[60] Ibid., 119.

Biologist Ernst Haekel had suggested that "artificial" selection of human individuals and groups should aid natural selection to remove and destroy those "unworthy" of life – what we would now call "ethnic cleansing." Extension of a German and international eugenics movement into promoting active euthanasia was realized through Nazi policies and law. Sterilization and killing large numbers of people was "science-based" Nazi policy, reinforced by propaganda and education to stigmatize and scapegoat Jewish, disabled, Slavic, Roma, and other populations deemed a "threat" to idealized nationals (Volk) and "races." Racist pseudo-science thus guided policies, practices, and professional work under authoritarian government. Anthropology was transformed into "German Anthropology" and established on a larger scale to support the science of human difference and the uniqueness and superiority of German (*volkish*) national and Aryan culture.[61] Sociology and history were "transformed" as well.

Professional ethics were twisted to serve eugenic theories and euthanasia, based on Hitler's interpretation of the writings of Alfred Ploetz. "Scientific" conclusions about people who were disabled or about ethnic groups including Jewish people fueled popular prejudice and rationalized systemic harm to humans and later genocide. Scientists followed research trajectories that clearly reinforced this process. For example, respected geneticist and German pathologist Otmar von Verschuer became Director of a newly founded Institute for Hereditary Biology and Racial Hygiene at the University of Frankfurt in 1935. He published a 1937 text describing genetic origins of diseases and was widely respected and well-funded for clinical studies of twins that supported genetic theories.[62]

Ploetz and others supported expansion of racial hygiene education in German medical schools, writing often on "Jewish issues," placing a "racial biology" of Jews in the context of his research in hereditary pathology. Soon, after he was a late joiner to the Nazi party in 1940, his published "Primer to Racial Hygiene" in 1941, which called for a "complete solution to the Jewish Question."[63]

Unlike our world of modern bioethics, there were few regulations on scientific research. When biological "materials" for eugenic research became scarcer after 1941, pathologist Verschuer turned to his former student and assistant, the infamous and cruel Dr. Josef Mengele, who became head physician of Auschwitz. Mengele thereafter provided his collaborator with human skeletons and body parts, blood samples and other "biological material" for research, including twins whom Mengele had infected with typhus.[64] This

[61] Hutton, 18-24.

[62] Heberer, 39-41.

[63] Ibid.

[64] Ibid.

"Nazi science," among many others, has become one of the major reasons for the advancement and codification of modern and biomedical ethics for scientific research with human subjects.[65]

While medical experimentation on prisoners was not the only crime undertaken by Nazi science, it has become one of the most infamous. Without giving every brutal example, we can review some of the categories of unethical human medical experimentation by Nazi scientists. First, some experiments were designed to help German military personnel endure dangerous conditions, such as high altitudes in damaged aircraft. Second, many experiments involved testing pharmaceutical drugs and other treatments for injuries and illnesses on prisoners. Third, combining unethical ends and means, were experiments like those inducing disease by Dr. Josef Mengele and eugenic trials using forced sterilization.[66] These distortions of science and research methods, including practices found to be criminal by international courts, violated almost any version of biomedical ethics, illustrating a lack of medical and scientific autonomy, not to mention the central scientific norms of universalism and disinterestedness.[67]

Scientific professionals, along with engineers and many other professionals, were subject primarily to central governmental control. From the outset of Nazi rule, in the name of management of economic and other amplified "crises" facing the nation, racial ideologies were used to "reprofessionalize" those involved in sciences and other professions, including the educational systems, the selective pipelines to the professions, and most forms of professional practice. In the longer run, by the end of the 1930s and the war, an ironic result of this process was "deprofessionalization," wherein people and associations previously focused on truth and progress had been "recast" into obedient roles, void of ethical reflection and determined largely by an authoritarian and genocidal government.[68]

IV. Legal Professions: Limited Agency under Authoritarian Rule

The Nazi assault on Jewish and other groups during the Holocaust was conducted based on newly established dictates in German law.[69] National and local laws empowered racist, corrupted, and xenophobic "criminal justice sys-

[65] Caplan, *When Medicine Went Mad*, 1-32.

[66] Heberer, 51-52.

[67] Robert King Merton, and Norman W. Storer, *The Sociology of Science: Theoretical and Empirical Investigations* (Chicago, IL: University of Chicago Press, 1973).

[68] Jarausch, "The Perils of Professionalism," 107-137.

[69] Doris L. Bergen, *War and Genocide: A Concise History of the Holocaust* (Lanham: Rowman & Littlefield, 2016), 69-98.

tems" that included legal, courts, and "corrections" systems.[70] These systems were themselves staffed by police and military forces,[71] along with the designers and employees of concentration, transit, and extermination camps.[72] This section will explore the lawyers and other legal professionals working in the courts; many scholarly authors and texts noted herein more fully describe the actions and motivations of the other and varied occupational groups serving in the police, military, and penal systems.

The workings of the German legal system before, during, and after the Holocaust are important and well described by Ingo Müller.[73] In Germany, law students are selected and begin their studies immediately after high school. After state examination they take obligatory clerk roles. In contrast to courts in Britain and the United States, German courts, which worked at three levels and sometimes with specialty courts, are presided over by stable panels of judges and without juries. With more judges involved, the careers of many German jurists do not flow from public or private legal practice into the judiciary, but rather start with judicial roles that can begin immediately after law school, more akin to a civil servant position in the United States.

While there were many Jewish professionals in German society and in legal professions in the years leading up to the Holocaust, accounts of Jewish influence in German and European, especially professional, life do not often include accurate data. Providing facts and challenging Nazi stereotypes of professionals can improve our understanding of history. In the case of the German Weimar republic, exaggerated descriptions of Jewish representation, power, and influence have been grossly misleading. In fact, the percentage of Jews in the nation declined from 1.2% in 1871 to 0.76% in 1930. While Hitler and Hans Luther, German Ambassador to the US, suggested that over 50% of government workers were Jewish, the actual statistic was less than 1% of *all* government employees.[74] In the field of law, Jews were indeed *over-represented* due to restrictions in other professions; 22% of about 19,500 members of the bar in Germany were of Jewish background. Nazis ranted against the powers of more politically involved Jewish attorneys – especially labor leaders – rather than against the less Jewish judiciary. Jewish employment in civil service was declared illegal in April of 1933; thereafter thousands of attorneys were harassed, discriminated against, and often deprived of their right to practice for "racial" reasons. Persecution of legal professionals who

[70] Müller, 46-84.

[71] Goldhagen, 203-282.

[72] Dan Stone, *Concentration Camps: A Short History* (Oxford: Oxford University Press, 2017), 1-10.

[73] Müller, 27-198.

[74] Ibid., 59-67.

supported political opposition or stood up against Nazi policies such as the annexation of Austria were also disbarred, all this without any consideration of professional autonomy.[75]

Research supports the proposition that the German legal profession helped Nazis take and retain power during the Holocaust. Unlike the medical profession, there was no need to invent scientific racism or eugenics, only to support and incorporate its harmful implications. The Weimar judiciary supported the idea that the loss of the World War I was a "stab in the back" from criminal "enemies within" the German nation. Weimar judges were part of a movement to discern "friend" of the state from "foe," advancing the notion, embraced by Hitler and fascism, of an ongoing national German struggle. From 1919-1920, in the wake of the Russian revolution, this involved resisting a German civil war, executing hundreds without trial, and sentencing thousands of revolutionary socialists for treason.[76]

Anti-Semitism was hardly a new legal topic in the 1930s. During the peak of the inflation crisis in 1923, while eastern regions formed coalitions with communists and French troops occupied western regions, Hitler and storm trooper militias marched and carried out the "beer hall *putch*," for which Hitler was brought to trial in February 1924. This Munich trial displayed the power of the radical right, and the court failed to admonish those calling out "a Jew government" of criminals. Hitler and associates were minimally sentenced to a very comfortable imprisonment and given early parole. Historians show that lawyers, among others, drifted towards support for Nazi power even before 1933.[77] Weimar trials showed German courts openly expressing anti-Semitism, taking sides with Nazi actions and aggressions against social democratic groups. Despite limitations on German militarization in the Treaty of Versailles, courts upheld rapid growth in militias by referring to a "national emergency," prosecuting thousands of pacifists and republicans who objected to the regrowth of a heavily re-militarized state as treasonous.[78]

Legal professionals supported Nazi authoritarianism and the Holocaust, from the Reichstag Fire Trial that helped the Nazis consolidate power until the collapse of the regime and the Nuremburg trials. In March and April of 1933, at once threatened and empowered by the new Nazi leadership, the German Federation of Judges expressed confidence in and servility towards the new government. Judges enabled the "Law for Restoration of the Professional Civil Service" to remove thousands of Jews and other "unreliable" jurists and officials. Some judicial associations disbanded or "coordinated"

[75] Longerich, 38.

[76] Ibid., 10-21; Müller, 12-26.

[77] Jarausch, "The Crisis of German Professions 1918-33," 379-398.

[78] Müller, 52-54.

with those patrons more sympathetic to Nazi power, one delegate noting the limits of "narrow professionalism." Right wing German nationalists subsumed the judiciary, as well as the political leadership. Subsequent concern from national judicial leadership was limited; Supreme Court Judge Erwin Bumke expressed few legal concerns with national policies beyond issues of pensions.[79]

Nazi power and rule under Hitler essentially amounted to twelve years of martial law.[80] A German state of emergency and thus suspension of all personal rights during the Third Reich was in effect from the publication of the Reichstag Fire Decree on February 28, 1933 until war's end in May 1945. The legal profession, lawyers, and the force of law were subsequently limited to and agents of the Nazi state. The scope of unjust and eugenic laws would expand with war and eliminationist anti-Semitism, affecting populations and conflict throughout Europe and driving migrations around the world.[81]

Racial and cultural persecution, while focused on anti-Semitism and culminating in genocide, was not limited to anti-Jewish measures. Racial and other forms of persecution against non-Jewish and mixed groups evolved from 1933 and were intensified by the police in 1936-1937. Prior to organized expulsion, forced migrations, and mass murder, persecuted groups included people of non-European origin and mixed ancestries, Roma (Sinti) cultures, people labeled "asocial" and/or disabled, and people identified as LGBT. The centralization of police forces helped increase "preventive detention" and "preventive crime-fighting," based on regulations from "Criminal Biology." Guidelines for the identification of "asocials" included begging and alcoholism. Concurrent regulations were issued and helped authorities round up and persecute men identified as homosexual, of mixed national or ethnic origin, or otherwise deemed a threat to "racial hygiene."[82]

Radicalization of anti-Semitic policies followed Hitler's party rally in 1937, leading to more active measures to remove Jewish populations and culture from a toxically racialized German nation. New anti-Jewish measures in 1938 included prohibitions of Jews from the auction and weapons trades and the loss of tax privileges for Jewish religious associations.[83] The annexation of Austria soon meant persecution of a larger Jewish population, accelerating the exclusion of Jews from the economy and magnifying the crisis of Jewish voluntary and forced emigration.

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[79] Ibid., 39-41.

[80] Bazyler, 3-13.

[81] Deborah Dwork, and R. J. Van Pelt, *Flight from the Reich: Refugee Jews, 1933-1946* (New York: W. W. Norton, 2009).

[82] Bergen, 70-73.

[83] Longerich, 133-150.

Lawyers and legal professions inside of Germany had limited independent agency in the context of authoritarianism and sweeping anti-Semitic segregation during the 1930s and institutionalized eliminationist anti-Semitism during the war. Throughout the Holocaust, many local populations anticipated the anti-Semitic intention of Nazi law and policies even before they were enacted, barring Jews from public facilities and from professions even before national mandates. Daniel Goldhagen explains that many judges and other legal professionals were predisposed to anti-Semitic actions under Weimar leadership. They began purges of Jews early in 1933 just after the Nazis took power, and a Berlin court soon allowed this even in the absence of a special law to this effect.[84]

German anti-Jewish policies involved at least two specific aims: producing "social death" of Jews and removing Jewish presence and influence from German dominion. This was done through terror and other forms of violence, using anti-Semitic and vituperative propaganda, assaults upon Jewish bodies, and legal/administrative separations of Jews from non-Jewish Germans. An unsystematic and punitive series of exclusionary laws from 1933-1935 were consolidated in the Nuremburg laws of September 1935, which defined Jewish "blood" in order to "purify" the nation (defined by the people or *Volk*) and "the race." Identification (by genealogy or heritage, not belief) and definition of Jewish individuals was a first stage in Germany's war against Jews that was required for subsequent stages of expropriation and emigration, ghettoization, and annihilation.[85] Negative eugenics was associated with scientific racism in both Nazi ideology and in German law.[86]

Holocaust-era judges and courts were rarely constrained by what we now consider professional ethics. From the early 1930s, Nazi courts ramped up prosecution of political opponents and forgave uses of excessive force by police and the military. After outlawing communist and social democratic political parties, along with other associations, members of groups which opposed the Nazis were successfully tried – often for treason – and either driven into exile or subject to incarceration in concentration camps. At the same time, amnesty was granted for many actions and crimes committed based on "zeal for the National Socialist (Nazi) cause."[87]

During the Third Reich, Nazi jurisprudence witnessed a decline of autonomous law that involved law schools and professors. Cloaking Nazi crimes,

[84] Goldhagen, 164-202.

[85] Bazyler, 7-13.

[86] Philippa Levine, *Eugenics: A Very Short Introduction* (New York: Oxford University Press, 2017).

[87] Longerich, 52-89.

writings by newly employed "professionals" were used by judges and the state to rationalize punitive verdicts and legal interpretations. Only three months after taking power, on April 7, 1933, 120 of all 378 (31.5%) of all German law professors were dismissed for being Jewish. Newly vacant positions were soon offered to colleagues with "nationalist orientations," without regard to prior standards that included objectivity and autonomy. Carl Schmidt concisely summarized the Nazi judiciary and legal standard: every interpretation must be a National Socialist interpretation.[88]

Authoritarian law, judgement, and principle in this context was designed to protect the state against individuals, rather than individual rights against state powers. Müller states that law students thus learned to protect German society by eliminating "degenerate" or "otherwise lost" individuals, purging "inferiors" through principles of "protective law."[89] New "standards also changed criminal trials into evaluations of personality types rather than specific criminal actions or behaviors.

Many of the defendants who were tried at the Nuremburg trials were lawyers and judges. Wielding threats from the military and police agencies and with control over heavy industry, Nazis had used terror and fear to control the German legal system, preventing any systematic check on Nazi persecution and its many misuses of power. Telford Taylor, Counsel for the Prosecution at the International Military Tribunal overseeing the Nuremburg trials, describes the German legal profession as having four parts: private practitioners, the judiciary (a relatively large group of lawyers and part of civil services), government lawyers, and private corporate lawyers. The proportion of the legal professional working in the latter types of work (who all depend on the government) was much greater in Germany (~75%) than in other nations (~25% in the USA), making it much easier for government, especially an authoritarian one, to exercise power over the profession. In addition, German judges did not often achieve prominence or offer dissenting views, rather they were more like civil servants. In Taylor's view, the overcrowded bar was divided, conservative, jealous of the military, and frequently anti-Semitic.[90]

Taylor also notes that the German legal system and bar association crumbled rapidly after Nazis took power in 1933, centered around the National Socialist Bar Association, whose membership ballooned. Jewish lawyers were banned in the spring of 1933 by the Law for the Restoration of Civil Service, with a short-lived exemption for Jewish WWI veterans, and, as in the medical profession, Jewish professionals were forced out of the profession. Hitler's

[88] Müller, 41-45.

[89] Ibid., 59-67.

[90] Taylor, 136-139.

singular authority was cemented by 1934 with the Rohm purge, and the news championed the fact that judges were only subject to orders from the Fuhrer, eliminating any pretense of independent judgement. By the start of the war in 1939, all Jews were removed from legal protections entirely.[91]

At the end of the Nuremburg congress in September 1933, a special session of parliament had created the Reich Citizenship laws, limiting German citizenship to people of "kindred" blood. To "protect" this racialized and exclusionary concept of a national blood line, the Law for the Protection of German Blood and German Honor was also passed, forbidding intermarriage and sexual intercourse between people who were defined as Jews and citizens of German "kindred" heritage. To administer these and other anti-Jewish laws, supplementary laws using counts of grandparental religious identifications were used to create classifications of mixed (*Mischlings:* two Jewish grandparents) and fully Jewish individuals (3+ grandparents, 2 grandparents and a Jewish spouse, or post-law converts).[92]

On December 21, 1935, a supplementary decree clarified the inter-group marriage prohibitions and criminalized more types of relations, introducing a concept of "alien blood" that was thereafter defined as referring to anyone of "Gypsie" or "Negro" heritage. Jewish life was made more difficult in August 1938 by forcing mandatory middle names (Israel and Sarah) and passport demarcations. This same month, another decree completed exclusion of legal practices by Jews.[93]

Ethnic cleansing and pressures to migrate were expedited by these and other subsequent laws passed prior to the onset of war. Hitler made the first public governmental announcement threatening Jewish Europeans was made on January 30, 1939 in a speech to the German parliament. Thereafter, German invasions of neighboring nations incited war and expanded the scope of German law, requiring the ministry of Justice to recruit new and transnational lawyers. Anti-Jewish laws would consequently apply in Austria and large parts of Poland, France, and other nations, some of which were ruled by puppet regimes.[94]

In occupied territories, including what Snyder calls the "blood lands" of eastern Europe,[95] two new sets of laws were created and administered by civilian administrations. First, law was designed to and lawyers sought to quell

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[91] Ibid., 137-138.

[92] Bazyler, 9-11.

[93] Ibid., 12.

[94] Ibid., 14-21.

[95] Timothy Snyder, *Black Earth: The Holocaust as History and Warning* (New York: Tim Duggan Books, 2015).

underground resistance. Second, sets of laws addressed the "management" of transportation and ghettoization of large Jewish populations in Poland and adjacent nations. Laws against resistance included a "Night and Fog" decree that allowed "disappearances" of enemies in detention and public shootings of blacklisted individuals as "examples." Post-war Nazi law has been subject to less research, but those studies that exist show that Jewish and other "foreign people" or aliens were subjected to "special laws" during Polish and other occupations. In these new rules, lawlessness became permissible, allowing systemic terrorism against persecuted populations and facilitating corruption and profiteering during the stages of forced removal and genocide.[96]

Tragically, "extermination" during the Holocaust was authorized by law, including both large-scale killing of Soviet civilians and virulently anti-Semitic genocide. For example, liability for killings in the mass shootings in Operation Barbarossa in June 1941 was removed by the Barbarossa Jurisdiction Order, leaving militias and civilians free to commit mass killings, including those by "murder squads" (*Einsatzgruppen*). Uses of poison gas, first used in "euthanasia" programs of people with disabilities, were expanded into systemic genocidal attacks in 1942, first with mobile killing vans and later through death camp gas chambers.[97]

Laws and the legal profession in Germany also created the systems of concentration and extermination camps. From the outset, Nazi "prison reform" was less "economical" than designed to create military-like discipline and demand work, reducing diet at the same time.[98] 1923 principles that included humane justice were replaced in 1934 by principles that included severe discipline and order. Prison populations rapidly increased, which created crowding. History records more harsh discipline and extensions of prison systems, leading to beatings, starvation, and humiliation, well before the creations of ghettos and the extermination camps that have stained our history.

The legal heroes of the Holocaust were those who coined, adopted, and used the new term for barbaric mass murder, "genocide." Raphael Lemkin remains first and foremost among these heroes.[99] In charging war criminals with war crimes, Nuremburg lawyers, including Taylor, Robert Jackson, Benjamin Ferencz, and many others, adapted and incorporated Lemkin's term of genocide, developing new structures for important international legal traditions.

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[96] Bazyler, 21-31.

[97] Ibid., 25.

[98] Müller, 85-89.

[99] Raphael Lemkin, "Genocide as a Crime under International Law," *The American Journal of International Law* 41, no. 1 (1947): 145-151; Raphael Lemkin, and Steven L. Jacobs, *Lemkin on Genocide* (Lanham, MD: Lexington Books, 2012).

The December 1948 international convention against genocide was central to this process. Not only does this convention and subsequent law create important preventive rules, human rights, and responses to injustice for all nations, it also addresses related crimes and criminal categories, including conspiracy, incitement, attempted genocide, complicity, and crimes against humanity.[100]

V. Conclusion

In the context of the Holocaust, it is not surprising to find that authoritarian government and eliminationist anti-Semitic policies both affected many professions and limited the potential autonomy and power of bioethics. Professional autonomy was restricted by Nazi-era laws and practices, taking to extremes the medical and scientific applications of eugenics, supporting policies of mass murder later defined as genocide. While not all professionals and associations were continually complicit or active in the destructive state policies and actions, the fact remains that professionals and those principles we now consider professional ethics and bioethics did not and often could not realize powers necessary to restrain or to successfully prevent harm to human health and mass crimes associated with eliminationist genocide.

The coercive and destructive force of the Holocaust were also apparent after the war, both in the statistics of genocide and the post-war conditions for Jews and other professionals in Germany and Europe.[101] Narrative and witness accounts from survivors, as well as from war crime trials, have painstakingly elaborated the many inhuman, genocidal, and unethical actions and policies which harmed European, and ultimately world populations. To describe the Holocaust as simply a distortion or absence of bioethical behavior is insufficient, but we can certainly conclude that a lack of humane bioethics was part of the tragic evolution of this genocide. Lucie Adelsberger, a respected Jewish physician who worked during the Holocaust and an Auschwitz survivor, wrote after liberation and reflection, "To be a physician was a farce as soon as one became an unwilling minion of the Gestapo."[102] For most Holocaust-era professionals, to work at all in Germany or German-occupied areas was to engage in practices that now appear to mock widely accepted principles of bioethics.

While the evolution of professional ethics after the war is a topic beyond our scope, it is notable that the reconstruction of Jewish life in Germany has

[100] Bazyler, 69-152.

[101] Leni Yahil, *The Holocaust: The Fate of European Jewry, 1932-1945* (New York: Oxford University Press, 1990); Yehuda Bauer, and Nili Keren, *A History of the Holocaust* (New York: Franklin Watts, 2001), 499-542.

[102] Lucie Adelsberger, and Arthur Joseph Slavin, *Auschwitz: A Doctor's Story* (Boston: Northeastern University Press, 1995).

included many contradictions and complications, for professionals and for all members of societies. While two-thirds of European Jewry was murdered and others fled to new nations, remnants of Jewish communities have endured, despite sometimes difficult conditions. Jews in Germany passed through temporary structures known as displaced persons camps, reconsolidated, worked to become represented again, and some now serve as functionaries in new German administrations.[103] If we seek lessons after the Holocaust, we can find two important consequences: the development of international law (including genocide prevention) and the global growth and ongoing development of professional ethics in many professions, including medicine, science, and law. In reviewing and discussing issues of Holocaust-era professional ethics, we can continue to honor the memories of the millions who were harmed and killed during the Holocaust and the World War II, including Holocaust-era resistors and survivors.[104]

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[103] Y. Michal Bodemann, *Jews, Germans, Memory: Reconstructions of Jewish Life in Germany* (Ann Arbor: University of Michigan Press, 1996).

[104] Henry Greenspan, *On Listening to Holocaust Survivors: Beyond Testimony* (St. Paul, MN: Paragon House, 2010); Ruby Rohrlich, *Resisting the Holocaust* (New York; Oxford: Berg, 1998): 1-18.

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Normalizing Evil: The National Socialist Physicians Leagues

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Abstract

The National Socialist Physicians League (or NSDÄB), was a professional medical organization founded upon the same ideologies that shaped the broader National Socialist agenda. Despite the vast historical and ethical literature focused on physician involvement in Nazi atrocities during the Holocaust, little attention has been paid to the NSDÄB. However, the establishment of this group is important to understanding the forces shaping physician participation in the Nazi party. Physicians often look to professional medical organizations as a source of moral guidance; thus, ideologies of racism and the active harassment of ethnic or racial minority groups by this professional organization may have contributed to the establishment of this behavior as not only permissive but normal. This article will explore how this organization contributed to normalizing, desensitizing and legitimizing behavior that could not be justified by any normative theory of professional medical ethics.

Key-words: *National Socialist Physicians League; Professional Ethics; Bioethics; Holocaust*

I. Introduction and background

This article will focus on the National Socialist Physicians League (Nationalsozialistischer Deutscher Ärztebund, or NSDÄB), a professional medical organization founded upon the same ideologies as the broader National Socialist agenda. The organization's alliance with and close association to the Nazi party is apparent in its early formative policy. Despite the vast historical and ethical literature focused on physician involvement in Nazi atrocities during the Holocaust, little attention has been paid to the NSDÄB. However, the establishment of this group is important to understanding the forces shaping physician participation in the Nazi party. This article will

explore how this organization contributed to normalizing, desensitizing and legitimizing behavior that could not be justified by any normative theory of professional medical ethics. This work draws from secondary source analysis and primary source materials obtained through archival research in order to examine the ways in which this organization played a role in actively promoting the Nazi party and normalizing radically eugenic ideologies within the medical community. Archival documents show various ethical transgressions perpetrated by the NSDÄB, which sought to aggressively alienate and abuse non-Nazi physicians. Although members described the early NSDÄB as a 'pacifist' organization there are numerous disturbing personal accounts from members that tell of how early in the organization's history it began to terrorize non-Nazi doctors collectively.[1]

Prior to and during the Second World War, the Third Reich had attempted to skew traditional patient-centered medical ethics towards notions of utilitarianism (appealing to the greater good) and public health. Policies were created that reoriented patient-centered medical ethics and instructed physicians that individual patients were not their concern. According to these policies, aggregate concerns for the *Volk*, or the people, were to be the focus of the physician.

> The primary concern of physicians should be the healthy people who had the most to contribute to the Volk, and not the care of the sick, the weakly, and the useless who are only preserved in an artificial world, such as the artificial world of the mental hospital.[2]

This idea of physician obligation to the *Volk* and the concept of "the weakly, and the useless [...] preserved in an artificial world," are critical components of the eugenic ideology.[3] Eugenic ideologies were, in fact, extremely formative in shaping medical norms at this time, not only in Germany but internationally.[4]

II. Eugenics and National Socialism

Eugenics first took a stronghold in North America. There, vasectomy was implemented as a means of involuntary sterilization in penal institutions at the

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[1] Françoise Bayle, *Croix gammée contre caducée les expériences humaines en Allemagne pendant la deuxième Guerre mondiale* (Neustadt, 1950).

[2] Robert Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge: Harvard University Press, 1988), 42.

[3] Ibid.

[4] Daniel Kevles, *In the Name of Eugenics* (Cambridge: Harvard University Press, 1998).

beginning of the twentieth century. By 1920, twenty-five states had compulsory sterilization laws for those labeled criminally insane and "inferior."[5] A combination of factors, including the cultural changes associated with the Industrial Revolution, resulted in marriages at a relatively older age and producing fewer children. At this time, Darwin's canonical work, *The Origin of Species*, was rediscovered, introducing the concepts of evolution and natural selection, along with increased understanding about heredity. In other words, science now understood that parents passed traits on to their offspring. These ideas were bolstered by so-called "scientific proof" in the work of Francis Galton, who began to trace the genealogy of the families of reputable men/geniuses, as well as so-called "degenerate families" to show that parents passed both desirable and undesirable traits on to children.[6] This meant that eugenic ideology took hold at the perfect moment in history: there was a perceived crisis, made visible by newly employed vital statistics, while at the same time there existed a new understanding of heredity, natural selection and evolution.[7]

Beyond that, Francis Galton and others believed that man could perfect evolution. The technologies of the industrial revolution made many believe that mankind could use science and technology to master all. Humankind did not need to wait to improve through natural selection; men could master and accelerate this process. "What nature does blindly, slowly and ruthlessly, man may do providently, quickly and kindly."[8]

Importantly, Galton and others who believed in the science of eugenics and claimed to understand Darwin's theories feared that society had created an artificial environment that was supporting the weak – those that would not have survived natural selection. Part of perfecting evolution would have to involve correcting this social error and stopping the weak from procreating.[9]

The eugenics movement was also intimately linked to racism.[10] When eugenics arrived on the scientific scene, ideas of racial medicine were still prevalent. Physicians believed that the races were biologically different and that some (generally non-white individuals) were predisposed to disease.[11] They believed that there were both superior and inferior races and that these racial differences determined not only the behavior but also the disease susceptibility of individuals. The racist ideas of biological inferiority that were built

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[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid., 12.

[9] Ibid.

[10] Proctor.

[11] Ibid.

into eugenic ideology were apparent in Nazi rhetoric and propaganda. Hitler's enthusiasm for eugenics is well-established and can be seen incorporated into *Mein Kampf*. In fact, the invocation of medical rhetoric was one of the ways in which the Nazis successfully legitimized and justified their treatment of Jewish, gypsy, and other populations. As an example, they aligned Jewish people with disease vectors, using medicine to rationalize anti-Semitism by explaining how the Jewish population was biologically predisposed to disease and disorder. It also contributed to the devaluing of the Jewish population, now understood as diseased and in need not only of special treatment but also of segregation (quarantine) for society's protection.

However, the application of eugenics was not limited to propaganda; rather, the Nazi regime understood eugenics as a government responsibility. It was the government's responsibility to ensure the success of its population by ensuring proper breeding and health; this practice was often termed "applied biology."[12] This vision of government work – one aligned with eugenic ideology – meant that physicians were easily drawn into the work of National Socialism. They saw the early eugenic policies of the party as an important application of internationally accepted medical science. Beyond being grounded in science, government work also offered German physicians steady and reliable employment. The promise of professional success (and the framing of government work as medical) was a powerful motivator for physicians during the pre-war years, who were already suffering professionally due to an economic downturn. The Wall Street crash of 1929 and resulting depression were felt across the world, including in Germany, where the impact was even more significant due to reparations being paid after the Great War. Physicians were not immune to the failing economy, and many German doctors suffered economically.[13]

III. Nazi doctors

Physicians joined the Nazi party in greater numbers than any other professional group, and many were in positions of relative power. More than 38,000 physicians joined the Nazi Party, which represented almost half of all German physicians.[14] During this same period, the average income of a German physician rose from only 9,300 marks in 1933 to over 15,000 marks in 1938.[15] During the war 7% of all physicians were members of the SS, which is compar-

[12] Ibid.

[13] Alexa R. Shipman, "The German Experiment: Health Care without Female or Jewish Doctors," *International Journal of Women's Dermatology* 1, no. 2 (2015): 108-110.

[14] Proctor.

[15] Berg M. Cocks, *Medicine and Modernity: Public Health and Medical Care in Nineteenth and Twentieth Century Germany* (Cambridge: Harvard University Press, 1997).

atively high in comparison with the less than 0.5% of the general population who were members.[16] Physicians were involved in many of the atrocities committed during the Second World War, including forced sterilization, institutionalized killing (Child Euthanasia, T4 Program, Wild Euthanasia, Operation 14f13, The Final Solution), medical experimentation, and more.[17]

i. Professional Medical Associations

Moving beyond the overall numbers of individual physicians who joined the party, it is also critical to recognize the communal acceptance of National Socialism within the medical community. Professional medical groups were vocal supporters of Hitler. In 1933, Dr. Alfons Stauber, head of Germany's two major professional associations (including the German Medical Association) wrote to Hitler with emphatic support. He wrote that the Association "welcomes with the greatest joy the declaration of the Reich Government [...] with the promise to faithfully fulfill our duty as servants of the people's health."[18] As Proctor has shown, the support of key professional medical groups was critical to the creation of the *Gleichschaltung* (coordination or Nazification) of German medicine. Among the most important components of *Gleichschaltung* was the *Nationalsozialistischer Deutscher Ärztebund*, or NSDÄB.[19]

ii. Nationalsozialistischer Deutscher Ärztebund

The NSDÄB was a professional medical organization founded in 1929 by Dr. Leonardo Conti.[20] Leonardo Conti was already a member of the National Socialist Workers Party (NSDAP) at that time and would become a member of the SS only a year later. Conti would go on to hold many high-ranking positions of power within the Nazi leadership hierarchy. Many other prominent Nazi physicians were members and went on to contribute to racist policy formation and to take an active role in Nazi wartime atrocities. In total, roughly 2,500 physicians or 6% of the physician population in Germany joined the NSDÄB during the first year.[21] This organization began independently and would later be formally absorbed into the Nazi Party.[22]

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[16] Proctor.

[17] Ibid.

[18] Proctor, 70.

[19] Ibid.

[20] Bayle.

[21] Proctor.

[22] Bayle.

The power of this group is evidenced in the speeches and writings of Adolf Hitler himself. Not only were eugenic ideologies foundational to *Mein Kampf*, Hitler also specifically addressed their value in an early speech to the NSDÄB, in which he proclaimed that while he could implement his policies without the assistance of other groups, physicians were vital. Hitler urged doctors to become his guardians of the racial hygiene of the Reich, saying "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?"[23] The support was reciprocal; these physicians viewed themselves as "biological soldiers" who conceptualized the State as their primary "patient."[24]

The NSDÄB listed one of its primary calls to be the promotion of racial hygiene, racial science and eugenic knowledge; it also aimed to provide the Nazi party with "[...] experts in all areas of public health and racial biology."[25] These largely eugenic goals were in line with the Nazi party. The organization's alliance with and close association to the Nazi party can also be seen in its early formative policy. As an example, the first official charter of the NSDÄB expected adherence to the values and worldview of National Socialism. In the early years, the organization did not yet require party membership. However, this changed in subsequent charters when party membership was mandatory. After Hitler's rise to power, large numbers of practicing physicians joined the NSDÄB. In fact, membership rose from 2,786 in January 1933, to 11,000 members later that same year, and eventually over 42,000 members in 1942.[26] The group also had an official journal, *Ziel und Weg*, which spread its communal views across Germany.

NSDÄB's influence did not stop with the practicing medical community in Germany. In 1935, the organization inaugurated a chapter of the NSDÄB for medical students in German medical schools.[27] This fact points to the far-reaching nature of this organization. Although membership was supposedly optional, those who did not join were suspect and often abused or mis-

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[23] George J. Annas, and Michael A. Grodin, *The Nazi Doctors and the Nuremberg Code* (New York: Oxford University Press, 1992), 64.

[24] Michael A. Gordin, Erin L. Miller, and Jonathan Kelly, "The Nazi Physicians as Leaders in Eugenics and 'Euthanasia,'" *American Journal of Public Health* 108, no. 1 (2018): 53-57, 53.

[25] Proctor.

[26] Paul Weindling, *Health Race and German Politics between National Unification and Nazism, 1870-1945* (Cambridge: Cambridge University Press, 1989).

[27] Michael H. Kater, *Doctors under Hitler* (Chapel Hill: The University of North Carolina Press, 2000).

treated.[28] After Leonardo Conti took leadership of NSDÄB in 1933, he began an organized program of terrorizing those who did not hold the ideas and values of National Socialism and the Nazi Party.[29]

Although members described the early NSDÄB as pacifist, it engaged in active harassment. In fact, there are numerous, disturbing accounts telling of how the organization began to terrorize non-Nazi doctors collectively.[30] In March of 1933, the NSDÄB began an organized campaign to remove Jewish physicians from the medical profession. As part of this campaign, many Jewish doctors were bullied and brutalized by NSDÄB members.[31] Thus, this organization played a sinister role in actively promoting the Nazi party and its specifically racist ideology within the medical community by aggressively alienating non-Nazi physicians. Since physicians look to professional medical organizations as a source of moral guidance, the racism and active harassment of ethnic/racial groups by that organization may have established this behavior as not only permissive but perhaps normalized.

An example of the type of organized harassment and brutality occurred on April 1, 1933, when members of NSDÄB (and uniformed members of SA), took Jewish doctors from their bed in the early morning hours, beat them, and drove them to an isolated area for further abuse.[32] Here, the Jewish physicians were made to run at gunpoint, while the NSDÄB members laughed and mocked them. They took turns beating them, then left them without care for 24-48 hours. All of the victims were physicians, and some were elderly (80 years of age). The harassment and abuse were the continuation of what had begun a few days earlier when Jewish doctors were invited into NSDÄB member's offices under the pretext of a consultation, and were then driven to the woods, beaten, and abandoned.[33]

Clearly, from an ethical perspective, there is no justification for such behavior by anyone towards any fellow human being as it violates basic ethical principles of respect and bodily integrity. This ethical wrongdoing seems to be aggravated by two crucial considerations: First, that human abuse was conducted by medical professionals and members of a national medical association. Normative conceptions of professional medical ethics aim to benefit persons in need, not to terrorize and bully politically ostracized groups. This leads us to the next point – that these medical professionals

[28] Bayle.

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

abused their peers. Indeed, the fact that they lured Jewish professionals with the pretext of consultation attests to the professional daily interactions they had with their Jewish counterparts and the respect they pretended to have towards them. Membership in a profession includes respect for other members of that group based on mutual training, expertise, and shared community. The abuse of fellow medical professionals represents an abuse of trust and a fracturing of the professional medical community at its core level.

The NSDÄB was a powerful and influential organization that was included as one of only ten options on an internal Nazi statistical survey in 1939, alongside other organizations such as the SS, the SA, and others.[34] By 1933, the leader of the NSDÄB represented centralized and concentrated authority. The Führer of the league was not only that but also the head of the Reich Physician's Chamber, the Hartmannbund, the German Medical Association, the Expert Committee for Public Health, and the Association of German Health Insurance Physicians. The same leader was also in charge of three national offices: Public Health, Racial Policy, and Genealogical Research.[35] The consolidation of power underscores the influence of this group, which extended to medical literature coordinated by the NSDÄB.[36]

The NSDÄB's power is also apparent at the end of the war when it was seen as significant enough to warrant severe penalties by liberators and to be included as one of the forty-five groups dissolved along with the Nazi party.[37] Furthermore, some of the members who were in leadership positions achieved high ranking within the Nazi hierarchy, telling of their influence. Dr. Leonardo Conti, the founder of the NSDÄB, became Ministerialrat and was put in charge of health services at the Olympic games in Berlin and later became the SS-Gruppenführer and SS-Obergruppenführer.[38] Another member, Dr. Walter Gross, was the Founder and Leader of the Information Office for Population Policy and Racial Hygiene and later the leader of Racial Policy Office of the NSDAP until the end of the war.[39] Dr. Kurt Blome, who served as second in command of the NSDÄB, became the SA-Gruppenführer, receiving the Gold Party Badge before becoming the SA-Sanitätsgruppenführer.[40]

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[34] Arolsen Archives, *Survey of Security Staff-SS Members*, 5.1.0, 1939.

[35] Proctor.

[36] Ibid.

[37] Arolsen Archives, *Control Council Proclamations Laws Ordinances: Directive 38*, 6.1.1. (English Version), 1945; Arolsen Archives, *Control Council Proclamations Laws Ordinances: Law no. 5*, 6.1.1 (English Version), 1945.

[38] Bayle.

[39] Ibid.

[40] Kater.

Within the practice of healthcare, professional ethics is often drawn from and justified by the ethical codes that have been published and espoused by professional medical institutions, associations, and organizations. These include documents developed by national and international organizations such as Physicians for Human Rights, the American Medical Association, the World Medical Association, and the National Institutes of Health, as well as both domestic and international law and policy. For many physicians, these professional medical organizations are formative and authoritative in their understanding and practice of medical professional ethics, perhaps to a greater extent than the esoteric bioethics literature. Therefore, even for bioethicists, it is essential to include these codes in discussions of professional medical ethics. Furthermore, these codes permit analysis and reflection on the ways in which medical professionals (or those in power) choose to represent their own collective morality.

While these professional medical organizations can and should serve as educators in the moral development of physicians and aide in solving ethical dilemmas that may be encountered during medical practice, physicians' reliance on these organizations may be problematic. As shown here, professional medical organizations have historically been heavily influenced by political ideologies, religion, and popular social values, which shape their policies, missions, and codes. These influences inform the physicians who may look to them for moral guidance.

The NSDÄB was ruthless in its abuse of Jewish and non-Nazi doctors. The organization and broader *Gleichschaltung* of German medicine were forceful in pushing eugenic and National Socialist ideologies on both practicing doctors and medical students. Beyond that, those in command held positions of power and authority within the Nazi organizational structure, often complicit with medical atrocities or the creation of policies that permitted them. This organization was undoubtedly powerful in normalizing, desensitizing and legitimizing behavior that could never be justified by any normative theory of professional medical ethics.

IV. Conclusion

Almost seventy years after the end of the Second World War, the German Medical Association recognized the role that it played in the Holocaust and issued a formal apology. This apology was published as a declaration on May 12, 2012, wherein the delegates of the Physician's Congress unanimously declared a public and formal apology.

> We acknowledge the responsibility for the medical crimes committed under the Nazi Regime and regard these events as a warning for the present and the future [...] We pay our respects to all

> the victims, those still today and those who have already died, as well as their descendants and ask for their forgiveness.[41]

This apology addresses the misinformed belief that the most serious human rights violations originated from the political authorities at the time, and instead takes responsibility for the role of the physicians themselves. The declaration was made from a meeting held in Nuremberg, and states:

> The crimes were simply not acts of individual doctors, but rather took place with the substantial involvement of leading representatives of the medical association and medical specialist bodies as well as considerable representatives of university medicine and renowned biomedical research facilities.[42]

According to this declaration, German physicians were guilty of scores of human rights violations.[43] While some estimate that only 350 doctors are known to have specifically committed medical crimes, the proliferation and power of Nazi ideology within the professional community means that the majority of those 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.

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[41] Arthur Gale, "A Milestone in Medical History: German Medical Association Finally Apologizes for Atrocities Committed by German Physicians Under the Nazis," *Missouri Medicine* 110, no. 6 (2014): 486-488.

[42] Ibid., 486.

[43] Ibid.

Arolsen Archives. *Control Council Proclamations Laws Ordinances: Directive 38*, 6.1.1 (English Version). 1945.

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Medicine and State Violence

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Abstract

During the last decades, in different places and under different circumstances, some physicians and other health professionals have supported state violence. The Holocaust is a prime example for how doctors can cooperate with the state to plan, give ideological support to and implement violent policies. As a consequence of the Industrial Revolution, people gained access to health promotion and health protection, not as an achievement of the welfare state, but as a tool necessary to maintain healthy and more productive workers. Gradually, all social strata, employees and their relatives gained access to health coverage. Physicians as a group increased in number and changed the structure of their profession by establishing a symbiotic relationship with the state. Between the state and the medical class, different models of cooperation can be distinguished. In general, we can affirm that with the implementation of a public health system, greater interdependence among the state and the medical class was established. In the case of authoritarian or totalitarian regimes, the support of the medical class for violent policies depends on the degree of previous cooperation. National Socialist Germany and the Soviet Union are two striking examples of totalitarian states in which strong public health systems and subsequent close cooperation between the medical class and the state can be observed. In both countries, violent state policies were quickly accepted and integrated into medical practice. Practices such as forced sterilization, murder of patients or experimentation with prisoners were prevalent under National Socialism. The abuse of psychiatry as tool for exerting power was common in the Soviet Union. South American dictatorships constitute examples of totalitarian states with weak previous cooperation between the medical class and the state, as they did not have strong public health systems. In those countries, support for state violence can be found, such as participation of health care professionals in torture or abduction of babies, but cooperation was not as strong as in Nazi Germany or the Soviet Union. In other cases in which no strong previous relationship existed between medicine and the state, authoritarian regimes were not accompanied by medical support for violence, such as in the case of the Rwandan genocide or in Cambodia, where doctors were persecuted and murdered based on their membership of the bourgeois class.

Key-words: *Holocaust; T4 Aktion; medical experiments; political abuse of psychiatry; torture; state violence*

I. Introduction

State violence is defined as the use of force committed or authorized by members of government institutions against an individual or group.[1] Over the last decades, in different places and under different circumstances, some doctors and other health professionals have supported State violence. The Holocaust represents an example of how physicians can cooperate with the system to plan, provide ideological support and implement state violence policies.

Medicine and industrialized medicalized murder can be understood as the core of the Holocaust. Never before and never after the Nazi period has there been a symbiotic relationship between the state and the medical class of a level which permitted a regime to execute violence through physicians. Doctors supported and were protagonists of the ideology that justified the Holocaust.

Because the Holocaust represents the singular example of cooperation between the state and medical class, the relationship between state violence and medicine can be better explained in other instances if a framework for comparing these situations to the Holocaust is established.

II. The relation between medicine and state after the Industrial Revolution

Before the Industrial Revolution the right to health was individual, with almost no intervention by the state. Only the wealthier classes had access to medical care, while the most underprivileged lacked it or had to obtain it in charity hospitals.

The Industrial Revolution caused enormous social, economic and demographic changes. Cities became overpopulated and their inhabitants often suffered from diseases and epidemics. Workers' health began to be valued as a necessity to increase labor performance since a healthy employee would produce more and faster. As a result, labor mutual insurances and sanitary coverage for workers started to emerge. Sanitary coverage was provided then, and for the first time, by labor mutual (an insurance company owned by the policy holders), employers or the state. It is important to stress the economic vision in the creation of health promotion and protection systems. This point of view, even though modified, influences the foundation of all the current sanitary systems. It was not until the nineteenth century, when microbiology and

[1] It can be affirmed that almost any country, in its recent history, has committed some sort of state violence. Under the rule of law, citizens have the tools to denounce this violence and obtain justice and reparation, while in the authoritarian states, this rules are limited or inexistent. This topic is unmanageable in the format of this article. That is why I will focus on some examples that can illustrate the argument.

epidemiology were developed as scientific and medical fields, that collective and preventive health became important. Models of health care assistance resulted from different political reforms and changes. In those countries with more developed industrial systems and with more interventionist types of government, health coverage which tried to be universal/global was established.

Thereafter, the small medical classes started to increase in number and develop. The doctors became a large and influential collective who played an essential role in economics, due to their responsibility for maintaining workers' health.

It is a paradox that the free market increased the administrative activities of the state, due to the bureaucratization of the health system.[2] It can be said that, with the implementation of a public health system, interdependence between the state and medical class was created. Once a symbiotic relationship between the medical profession and the government was established, it can be easier to garner support from the medical class for the policies enacted by a totalitarian regime.

In the event that a state becomes authoritative or totalitarian, medical class support for violent policies depends on the degree of previous cooperation and the development of the administrative apparatus in relation to public health.

III. Violence in democratic, authoritarian and totalitarian states

State violence is usual but not exclusive to authoritarian and totalitarian regimes. It should be understood as an act of power in which there are two subjects: the victim and the victimizer (either a group or an individual). Violence is legitimized in dictatorships, becoming the axis in the relationship between society and the state.[3] When there is a totalitarian shift, purges are usually produced against doctors that are critics of the new system.[4, 5] In the case of those who work in the public sector it is often enough to just issue a cease

[2] George Rosen, "Industrialism and the Sanitary Movement (1830-1875)," in *History of Public Health* (Baltimore: John Hopkins University Press, 1993), 168-269.

[3] About relationship between physicians and dictatorships: Esther Cuerda, "Medicina y Totalitarismos," in *El Delirio Nihilista: Un Ensayo Sobre los Totalitarismos, Nacionalismos y Populismos*, eds. Fernando Navarro, Gonzalo Sichar, and Esther Cuerda, 413-441 (Málaga: Utima línea, 2018).

[4] Javier Angulo, Juan José Gómiz, Esther Cuerda Galindo, and Matthis Krischel, "Urology during the Civil War and under Franco's Regime in Spain," in *Urology under the Swastika*, eds. Dirk Schultheiss, and Friedrich H. Moll, 76-93 (Davidsfonds Uitgeverij, 2017).

[5] Matthis Krischel, "German Urologists under National Socialism," *World Journal of Urology* 32, no. 4 (2014): 1055-1060.

order against them; for those who do not belong to the public structure, it is possible to expel them through complementary actions. In addition to the exclusion of professionals there is the promotion of those who are related to the new government. In other words, doctors who oppose the new regime are repressed whereas those who concur with the new ideology are promoted. In this way, the totalitarian state controls certain aspects of society through the medical class.[6]

These changes come with a diminishment of civil rights and liberties. A totalitarian regime provides theoretical and active frameworks that facilitate unethical medical acts. Nevertheless, these acts can also be committed within well-established democracies. The state violence acts in which doctors may be implicated are:

- Murder of sick and disabled people
- Counseling and direct participation in torture and executions
- Counseling on hunger
- Help and care denial
- Medical experiments
- Psychiatric abuse
- Forced sterilization
- Document forgery
- Theft of newborns
- Organ trafficking

IV. Doctors and state violence: Symbiosis

In case of a totalitarian shift, it is easier for the state to exert programmed and legitimized violence through its medical staff in those countries that previously had an established and bureaucratized state health network.

The state-medical class symbiosis exists in a bidirectional relationship in which both groups obtain benefits. The medical class receives money, position and social prestige, while the state gains scientific reinforcement to legitimate its speech.[7]

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[6] About Language and Totaliarisms: Aram Aharonian, "El Lenguaje Totalitario," http://www.nodal.am/2015/12/el-lenguaje-totalitario-por-aram-aharonian/; Ranko Burgarski, "Lengua, Nacionalismo y la Desintegración de Yugoslavia," *Revista De Antropología Social* 6, no. 13 (1997): 14-27; Ramón Garrido Nombela, "Lenguaje y Genocidio," http://cvc.cervantes.es/lengua/esletra/esletra_04.htm; Andrés González Vela, "El lenguaje de los totalitarios," http://www.paginasiete.bo/opinion/andres-gomez-vela/2015/12/6/lenguaje-totalitarios-79255.html.

[7] Matthis Krischel, "Gleichschaltung und Selbstgleischaltung des Deutschen Urologie im Nationalsozialismus," in *Urologen im Nationalsozialismus*, eds. Matthis Krischel, Frizt Moll, Julia Bellmann, Albrecht Scholz, and Dirk Schultheiss, 23-39 (Berlin: Hentrich & Hentrich, 2011), 25.

Two examples of this close collaboration are Nazi Germany and the Soviet Union.[8] The sanitary health system was implemented in Germany long before the Nazis seized power, while in the Soviet Union it was created with the totalitarian state. Both regimes encouraged the creation of new medical faculties, promoted the public healthcare and nationalized the pharmaceutical industry. The Nazis had a biological global vision, while for the Soviets, Marxist theory accounted for the perception that all people were alike. The Soviet Union promoted the presence of women in universities, including medical faculties and hospitals. On the contrary, during the Nazi period women's roles were limited to motherhood and housework.

V. Euthanasia

A very specific and extreme form of State violence during the Nazi period is the wrongly called euthanasia program.[9] It was the first mass murder plan that targeted prisoners and finally, this terrible conceptual and chronological concatenation escalated into the Holocaust. It represents a euphemistic term to describe a, more or less, clandestine plan for elimination. Through this project, psychiatric patients and disabled people were murdered in Germany and the annexed and occupied territories. In 1939, doctors that were close to Hitler started organizing an operation to murder disabled children. They asked nurses and doctors to notify health authorities of the cases of children with severe intellectual or physical disabilities. In October 1939, the public health authorities encouraged the parents of disabled children to transfer them to pediatric clinics specially designed for their alleged care. Those were actually centers in which children were murdered by medicine or starvation. The first unit of special care was created in Brandenburg and there were nearly 30 more in Germany and Austria.[10]

The authorities decided to extend this program with a second phase and execute it on disabled adults who were in institutions. The plan was called *Aktion T4* and it included the opening of six facilities equipped with gas chambers. Very similar to the first phase of child euthanasia, forms were distributed

[8] Since the end of the ninteenth century German workers had health insurance. After the Russian Revolution, the Soviet government created, in 1918, the people's public health commissariat called "Narkomzdrav" with equal access to medical attention. Both systems were solid and strongly bureaucratized.

[9] Gotz Aly, *Los que Sobraban: Historia de la Eutanasia Social en la Alemania Nazi 1939-1945* (Barcelona: Planeta Barcelona, 2014), 22.

[10] Florian Steger, Andreas Görgl, Wolfrang Strube, Hans-Joachim Winckelmann, and Thomas Becker, "Transferred to Another Institution: Clinical Histories of Psychiatric Patients Murdered in the Nazi 'Euthanasia' Killing Program," *The Israel Journal of Psychiatry and Related Sciences* 48, no. 4 (2011): 268-274.

among the sanitation employees in order to have a record of hospitalized patients. Those who suffered from schizophrenia, epilepsy, dementia and other psychiatric and neurological illnesses had to report to the authorities. Law and medical squads were formed. They made evaluations of the forms that came into the Berlin office and decided on the outcomes of the patients. In January of 1940 the transfer of the selected patients to the facilities was set in motion. There, they were murdered by carbon monoxide intoxication. It was not until August 1941, when over 70,000 patients had already been murdered, that Hitler officially cancelled the euthanasia program. The program was decentralized and entered into a third phase in which patients continued to be murdered by a drug overdose or lethal injection in spite of the program's official cancellation.

The murder of patients, in which a large number of doctors and health personnel were involved, is an example of the state violence committed against an especially vulnerable group of citizens.

VI. Forced sterilization

Citizens with physical or psychological disabilities of possible hereditary origin such as schizophrenia, epilepsy, intellectual disability or alcoholism, were sterilized during the Nazi period. Over 300 special courts were established. They were comprised of a doctor who specialized in genetic diseases, a doctor who was part of the public health administration and a lawyer; together, they determined who should be sterilized. It is estimated that near 350,000-400,000 Germans were sterilized[11] in public hospitals and private clinics by urologists and gynecologists, which profited from these interventions performed against the patients' will. This also constitutes an act of organized violence by the state via a network of doctors and lawyers, which were the instrument of the biologist-political violence of the Nazi government.

In recent years, cases of forced sterilization – apart from the ones performed by Nazis – have been uncovered. In countries in which this has happened, such as Guatemala, Peru, and Canada, there exist non-legal documents that suggest these procedures occurred. Sterilizations are normally performed in indigenous communities, usually in public hospitals. The doctors often take advantage of childbirth and perform a tubal ligation without the women's consent. This is a form of state violence, specially performed

[11] Esteban González-López, "La operación T4: El Asesinato de los Enfermos en la Alemania Nazi," in *Cuando la Medicina no Cura: La Participación del Personal Sanitario en Torturas, Genocidios y Experimentos al Margen de los Códigos Eticos*, eds. Esther Cuerda Galindo, and Francisco López-Muñoz, 171-182 (Alicante: Delta, 2016), 174.

against women, but it is not legitimized, visible, nor does it have an official and bureaucratic apparatus like the one deployed by the Nazi regime.

VII. Psychiatric abuse as punishment

Institutional psychiatric abuses took place in the Soviet Union under a complete totalitarian repression. They were intended to eliminate several forms of citizen dissidence and other social behaviors that were unacceptable to the regime.[12]

The convictions could result in exile in some peripheral province or abroad or re-education in a work camp belonging to the *gulag*. Nevertheless, the Soviet regime considered another punishment much more subtle and effective; it condemned the prisoner to enter a psychiatric hospital due to combined ideological and pragmatic motives (Socialism is focused on the establishment of the ideal society, those who are against it must be mad;[13] people can be locked away forever and the government does not have to respond to their political convictions as they are the product of an ill mind and do not have to be taken seriously). At first, the only victims were political dissidents, but then the practice spread to anyone who was uncomfortable for the system such as religious people or nationalists. In the 1960s Professor Andrei Snezhnevsky from the Muscovite psychiatric school created his own diagnostic categories. These criteria allowed classifying political dissidents and people with social adaptation problems within the category of "mild schizophrenia" or "inactive schizophrenia" which enabled their reclusion in an asylum. Once they were confined, they received an overdose of neuroleptics for strictly punitive purposes. Most of the psychotropic drugs used in these practices were untested and not widely known or used.

One example of a psychotropic agent used for punitive purposes[14] is sulfozin (is a 1% elemental sulfur oily solution). This preparation was used for the treatment of schizophrenia before the introduction of antipsychotic agents in the 1950s and abandoned completely after. Sulfozin induced febrile

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[12] Ian Spencer, "Lessons from History: The Politics of Psychiatry in the USSR," *Journal of Psychiatric and Mental Health Nursing* 7, no. 4 (2000): 355-361.

[13] Different examples can be found in the Francoism: Communists should certainly have a psychiatric disorder. There was a research made with prisoners and the studies were published in: Antonio Vallejo Nájera, "Biopsiquismo del Fanatismo Marxista," *Revista Española De Medicina y Cirugía De Guerra* 3 (1938): 189-195; Antonio Vallejo Nájera, "Psiquismo del fanatismo marxista: Investigaciones Biopsíquicas en Prisioneros Internacionales," *Revista Española De Medicina y Cirugía De Guerra* 11 (1939): 53-58.

[14] Francisco López-Muñoz, and Cecilio Alamo González, "El Papel de los Médicos en la Tortura: La Psicofarmacología como Abuso de Poder," in *Cuando la Medicina no Cura: La Participación del Personal Sanitario en Torturas, Genocidios y Experimentos al Margen de los Códigos Éticos*, eds. Esther Cuerda Galindo, and Francisco López-Muñoz (Alicante: Delta, 2016), 209.

episodes that lasted several days, in addition to intense pain in the injection area. After these torture sessions, the "dissident-patients" ended up in a state of profound physical and emotional exhaustion.

Sending people to psychiatric institutions was beneficial for the regime in many ways. In case of being mentally ill, the prisoner did not have the right to trial or appeal; the sentence was not measured in years since the psychiatric pathology was considered chronic. The inmate was never cured from his or her illness and ended up dying from poor care or committing suicide.[15]

In the Soviet Union, psychiatry was used as an instrument for the abuse of patients, since there was no law that protected them until 1992. From the 1960s to the 1980s, psychiatric hospitals continued to be used to admit political dissidents.[16] Such is the case of the General Piotr Grigorenko, a metalworker who was considered a war hero after World War II and became General Commander of the Soviet Army. In 1961 he reported the totalitarian abuses of the Stalinist leaders; this led to his expulsion from the CPSU (Communist Party of the Soviet Union), deportation to Siberia and reclusion in different prisons and psychiatric hospitals. The psychiatrists from the Moscow Serbsky Forensic Psychiatric Institute diagnosed him with a personality disorder with "reformist ideas, overvaluation of his own personality, an intense affective component and the conviction of the righteousness of his actions."[17] Because of this diagnosis, he went through different psychiatric institutions from 1964 to 1976 as a *psikhuskha* (psychiatric prisoner). After his exile in the U.S.A. where it was proven that he did not have any mental illness, he became an important human rights activist, denouncing the psychiatric abuses by the Soviet government.

Some renowned psychiatrists actively participated in these programs, such as the so-called "mercenaries" of the Serbsky Forensic Psychiatric Institute. Although the vast majority did not actively participate, they did consent, and only a few resisted.

This system of institutionalized psychiatric abuse took place in the Soviet Union and in Romania. Some isolated cases have been found in other countries that also formed part of the Warsaw Pact, like Czechoslovakia, Hungary or Bulgaria,but there is no evidence that points to an institutionalized abuse system.

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[15] Semyon F. Gluzman, "Abuse of Psychiatry: Analysis of the Guilt of Medical Personnel," *Journal of Medical Ethics* 17 – Supplement (1991): 19-20.

[16] Burovski was a victim of this system. In 1971 he leaked 150 pages documenting the psychiatric abuse. https://static1.squarespace.com/static/57798b38414fb50acf42cc9b/t/57999a6bf7e0ab03ddd9d351/1469684460903/A+Manual+on+Psychiatry+for+Dissenters.pdf.

[17] Robert van Voren, "Political Abuse of Psychiatry: An Historical Overview," *Schizophrenia Bulletin* 36, no. 1 (2010): 33-35.

VIII. Doctors and state violence: Structural subordination

From the 1950s up to the 1990s Latin-American went through several dictatorships, which were justified as transitory, temporary and necessary to fight Marxism. They were also supported by the U.S.A.,[18] which played an essential role through two operations that were more or less clandestine: Condor Operation and the creation of the School of the Americas.

Condor Operation is the name given to the coordinated action plan and mutual support between the leaders of the dictatorial regimes in the South Cone with the participation of the U.S.A. during the 1970s and the 1980s.

Condor Operation officially involved the persecution, detention, interrogation with torture, transfers between countries, disappearance and death of people considered subversive or against the political and ideological thought of those regimes. It was established in 1975 by the leader of the Chilean DINA (National Intelligence Directorate) and leaders of military intelligence services from Argentina, Bolivia, Paraguay and Uruguay (all of the above were dictatorial systems). In 1992, the "Files of Terror" were found in Paraguay, which show that over 50,000 people were murdered, 30,000 disappeared and 400,000 were incarcerated.

The School of the Americas was an institution created under the protection, finance and control of the U.S.A. It was established in 1946 and was located, until 1984, in the Panama Canal. Its mission was to prepare the Latin-American nations to cooperate with the U.S.A. and keep a political balance to counteract the growing influence of Marxist organizations during the Cold War. In 1963, the first interrogatory behavior manual was written (now declassified and available for consultation).[19] It showed different suggested techniques and also included several practical recommendations. The manual explains how the interrogator needs to rely on the healthcare staff. Since 1966 this manual (KUBARK) was used in the school in Panama.

During the second half of the twentieth century there were military dictatorial regimes in South America, such as in Chile, Argentina, Brazil, Paraguay,[20] and Uruguay, where the repression was greatest. The difference with fascism and communism is that, while these totalitarian European regimes intended to establish a new order based in one ideology, the South-American dictatorships did not have one; they emerged as a counter movement against

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[18] Gregorio Martirena, "The Medical Profession and Torture," *Journal of Medical Ethics* 17 – Supplement (1991): 23-25.

[19] https://nsarchive2.gwu.edu/NSAEBB/NSAEBB27/docs/doc01.pdf.

[20] Alfredo Boccia Paz, Carlos Portillo, and Carlos Arestivo, *Médicos, Ética y Tortura en el Paraguay* (Paraguay: Editorial Arandurá, 2006).

communism. These dictatorships were based on the national security doctrine and aimed to generate a military action consensus around alarmism. At the same time, they hid the illegitimacy that surrounded them.[21]

The South-American dictatorships did not have previous solid administrative structures of public-health. Those political regimes were not totalitarian and were not able to control the whole society (including medicine and doctors). This lead to isolated cases of cooperation with the doctors to exert state violence. This can be defined as a structural subordination of medicine.[22] In this context, doctors become instruments for state violence in many different ways.

In dictatorships such as Argentina, Chile and Uruguay,[23] torture was but another instrument of the system. Centers for illegal detention were created and repression machinery was established and legalized through a state policy in which military and civil doctors actively participated.

As can be proven from many testimonies, the presence of a doctor was mandatory during the process of interrogations. In these cases, during the torture sessions, doctors would provide drugs to the victims to sedate, confuse, or agitate them. It has been confirmed that in Chile,[24] health personnel injected sodium thiopental to the detained before the interrogations. Doctors also indicated when to stop or resume the torture sessions, and even revived the tortured so they would not die.

Before torture	• Examining prisoners to certify them as being capable of withstanding torture • Overseeing the neglect of food, water, etc.
During torture	• Preventing death of a prisoner • Conducting unethical experiments • Took part in executions with medical methods

[21] Leonardo Senkmann, "Tortura y Participación Médica en la Represión durante la Última Dictadura Militar en Chile y Argentina: Una Comparación preliminar," in *Cuando la Medicina no Cura: La Participación del Personal Sanitario en Torturas, Genocidios y Experimentos al Margen de los Códigos Éticos*, eds. Esther Cuerda Galindo, and Francisco López-Muñoz, 323-337 (Alicante: Delta, 2016).

[22] Gregorio Martirena, *Uruguay, la Tortura y los Médicos* (Montevideo: Ediciones de la Banda Oriental, 1987), 27.

[23] Maxwell Gregg Bloche, "Uruguay's Military Physicians. Cogs in a System of State Terror," *Journal of the American Medical Association* 255, no. 20 (1986): 2788-2793.

[24] Alfredo Jadresic, "Doctors and Torture: An Experience as a Prisoner," *Journal of Medical Ethics* 6, no. 3 (1980): 124-127.

After torture	• Concealing evidence of torture thought the forging of documents and death certificates • Maintaining hygienic standards to prevent infectious disease from spreading to the prisons guards

In the detention centers the doctors had specific tasks such as providing orientation to the executioners.[25] There were many levels of preparation and numerous participants had received "anti-subversive fight courses" from international agents that had been trained in torture methods.

The death flights were performed during the Argentinean and Chilean dictatorships. These were clandestine flights in which the prisoners were thrown to the sea or to the interior of lakes and volcanoes. Previously, they were injected with a paralyzing substance; for that matter there was always a doctor in those flights. When the bodies were thrown out of the plane, the doctor would remain in the cabin claiming that their medical ethics would not let them toss a prisoner to a certain death.[26] More than 4,000 Argentines were murdered this way.

In Argentina, the medical knowledge was in the service of prisoner executions: for example, the intra-cardiac injections.

The legal medicine was subordinate to the government interests, with false death or birth certificates, false autopsy reports, or health certificates for the tortured. In Argentina, doctors were involved in newborn thefts. The pregnant prisoners that were in clandestine detention centers were moved to hospitals and maternity wards. There, they remained chained and hooded so they would not recognize the doctors or the place. On many occasions they had unnecessary C-sections with the intention of accelerating natural birth time. Once the baby was born, the mother was taken back to the detention center and the baby was given to a family related to the regime that had generally paid to obtain the newborn. The doctors, apart from participating in birth deliveries in subhuman conditions or performing unnecessary C-sections, also signed false birth certificates, changing the mother's name.[27] Some medical staff members were subject to repression, arbitrary dismissals, detention and abuse.

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[25] Horacio Riquelme, *Etica Médica en Tiempos de Crisis: Los Médicos y las Dictaduras Militares en América del Sur* (Chile: Ediciones Chile América CESOC, 2002), 61-72.

[26] Horacio Verbitsky, *El Vuelo 'una Forma Cristiana de Muerte': Confesiones de un Oficial de la Armada* (Buenos Aires: Sudamericana, 2004), 57.

[27] On the theft of babies and other acts committed during the Argentinean dictatorship: "Varios. Nunca más," Informe ICONADEP, http://www.desaparecidos.org/nuncamas/web/investig/articulo/nuncamas/nmas0001.htm.

Ethical responsibility cases have also been found among doctors: non-discriminatory treatments for the patients and victims of torture, or the denial to obey orders and denouncements to the authorities.

IX. The torture exception

Cambodia was a special case. During the Khmer Rouge's dictatorship, doctors were persecuted, incarcerated in reeducation camps or murdered for belonging to a bourgeois middle class.[28]

Torture is a practice that escapes any attempt at classification, association with the past or with a governmental regime. It is normally produced in dictatorships, totalitarian regimes and, although to a lesser extent, in democracies.[29] It is also independent from the sanitary structure of the country.

Torture has been prohibited but not yet discarded. It continues to survive as a disturbing presence that arises in conflicts, wars, colonies and returns in a voracious way in dictatorships and totalitarian regimes. It is an uninterrupted phenomenon as a clandestine practice in the shadow of sovereignty. In torture there exists a simultaneous exercise of sovereign power (torturer) with "biopower" (the possibility that the tortured is revived by the doctor).[30] For that matter, health professionals supervise the health state of the victim and give instructions on how to prevent his death.

Even though some states have declared torture as illegal, many continue to perform it outside their territories (on ships in international waters), distorting the language (calling it coercive interrogation) or torturing without leaving visible signs ("white" torture).

A paradigm shift occurred after 9/11; when the biggest western democracy enacted a state of exception which partially recognized and justified torture to prevent terrorism. This way, the immediate nexus that linked torture with totalitarian regimes disappeared.

X. The unique case of military doctors

It is a fact that some military doctors have been part of state violence.[31] In recent years in Iraq and Afghanistan military doctors have helped in the

[28] Alex Hinton, "Genocide, Categorical Certainty, and the Truth: Questions from the Khmer Rouge Tribunal," *The Journal of Analytical Psychology* 56, no. 3 (2011): 390-396.

[29] Daniel Rafecas, *El Crimen de Tortura en el Estado Autoritario y en el Estado de Derecho* (Buenos Aires: Ediciones Didot, 2015), 153.

[30] Donatella di Cesare, *Tortura* (Barcelona: Gedisa, 2016), 36-37.

[31] Maxwell Gregg Bloche, and Johnatan H. Marks, "Doctors and Interrogators at Guantanamo Bay," *The New England Journal of Medicine* 353, no. 1 (2005): 3-6.

design of the interrogations.[32] In Abu Ghraib doctors and psychiatrists used drugs during interrogations and rationed the prisoners' food. Other examples of non-ethical behaviors employed by physicians include: placing an intravenous catheter in a prisoner to pretend he died in the hospital, hiding injuries or forging certificates.[33]

From an ethical point of view,[34] the commission and/or concealment of acts of torture should never be justified by any health professionals – clinical, non-clinical, military, or non-military. As the Declaration of Tokyo states, "The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose."[35] The health personnel participation in torture should be subject to criminal justice, ethical reflection[36] and collective memory.

Nowadays some institutions provide training to groups (among them military doctors) considered to be of special risk in this subject. The purpose is to teach them how to identify risky behaviors in conflict situations. The reflection of other authors is to vindicate the civilian condition of military doctors in the exercise of their profession in the armed forces.

XI. Discussion

Totalitarianism acts as a unifying and explanatory-propagandistic element of change in the moral framing; it also represses any criticism that might arise against the new imposed justice. In totalitarian regimes, doctors sometimes sacrifice their patients' health for the sake of the state, the people, or the regime. They align with the totalitarian thinking and perform medical actions against sick people and citizens. This is what happened during the Holocaust and has continued throughout history.

Do ethics change in a totalitarian regime? Ethics help to distinguish between good and bad actions. Ethical relativism questions the immobility of the absolute principles of acts. It states that nothing is absolutely good or

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[32] Maxwell Gregg Bloche, and Johnatan H. Marks, "When Doctors go to War," *The New England Journal of Medicine* 353, no. 1 (2005): 6-8.

[33] Steven H. Miles, "Abu Ghraib: Its Legacy for Military Medicine," *The Lancet* 364, no. 9435 (2004): 725-729.

[34] Vincent Iacopino, and Stephen N. Xenakis, "Neglect of Medical Evidence of Torture in Guantanamo Bay: A Case Series," *PLoS Medicine* 8, no. 4 (2011): e1001027.

[35] World Medical Association, "Declaration of Tokyo," http://www.wma.net/en/30publications/10policies/c18/index.html.

[36] Robert J. Lifton, "Doctors and Torture," *The New England Journal of Medicine* 351, no. 5 (2004): 415-416.

bad, but that the validity of an action can be interpreted within a determined context that provides it with concrete connotations.[37] According to this way of thinking the murder of children with disabilities in ancient Sparta could not be judged as something morally wrong since, according to the values and traditions of this civilization, it would have been wrong to let them live. Using this paradigm, everything could be justified.

Ethics in medicine is filled with exceptions and special cases. It seems to follow a scheme of gray transition areas. There are many particular situations in which a doctor without sharing the purpose can perform certain acts and become an accomplice and collaborator of non-ethical actions. When a doctor cannot refuse to take part in such acts, the axiom would be: Reduce the wrong in case you cannot avoid it.[38]

Some doctors refused to participate in torture during South-American dictatorships. Paradoxically they did not refuse because of a humanist conception or awareness but because of political motives: if the executioner was to be tortured, they would have cooperated.

In the field of medical ethics, we need to accept a series of absolute values, following the thinking scheme of Kantian ethics.[39] Ethics is an evolving branch of philosophy in which the axioms accepted today can be judged tomorrow, but they need to be considered as part of a philosophy with no setbacks. Medical ethics as a code of standards that differentiates between what is right and wrong in the profession must not change under any totalitarian or authoritarian regime.

Some points to avoid a relationship between the state and the medical class that support violence and aggression can be proposed. Studying bioethics and the Holocaust is relevant for modern medicine in order to recognize the slippery steps and grey zones. Ethical values should be part of the comprehensive educational program of the Holocaust and be conveyed to health professionals at the different levels: college, postgraduate degrees or any type of curricular or extracurricular activities. Education of the general population is an important point and can be conducted using books, conferences and exhibitions. Institutions should provide training to groups considered to be of special risk to support state violence, such as police or the military. The purpose is to teach them how to identify risk behaviors.

Finally, independent legal structures to ensure human rights must be maintained. Independence of the justice system from executive and legisla-

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[37] Matthias Gotzemeier, "Relativismus," in *Enzyklöpedie Philosophie und Wissenschaftsheorie*, 564-565 (Stuttgart: J. B. Metzler, 2004).

[38] Henry Shue, "Complicity and Torture," *Journal of Medical Ethics* 43, no. 4 (2017): 264-265.

[39] Oswald Schwemmer, "Ethik," in *Enzyklöpedie Philosophie und Wissenschaftsheorie*, 592-599 (Stuttgart: J. B. Metzler, 2004).

tive branches of the government can ensure a strong structure to avoid unfair and unethical situations.

XII. Conclusions

State violence can appear in any political regime, including democracies, but it is far more frequent in dictatorships and authoritarianisms. Doctors can become a State´ s instrument of violence. If a totalitarian shift is produced, it is easier for a state-medical class symbiosis to be generated in those countries which have a well-established and bureaucratized sanitary structure. The lack of previous structure usually generates subordination from the medical class. Torture is a phenomenon that, due to its own characteristics and globalization can resurface in any conflict, or societal structure.

The ethics of sanitary, civilian or military acts must be an independent instrument from any form of government.

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IV. The Holocaust and medical education

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

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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 ascendency 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

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[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-academicians 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 Germany[11] 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 (*Rassen-hygiene*), 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]

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[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 postwar 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

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[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]

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[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 activities[52] 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 studies[53] 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

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[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 cruelty[60] 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]

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[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*

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[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 evidence[88] 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 mentors[91] 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 Annas[98] 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 Musem, 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.

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[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 inquiry[103] 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

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[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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Pertinent Today: What Contemporary Lessons Should be Taught by Studying Physician Participation in the Holocaust?

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Abstract

The participation of physicians in the atrocities of the Holocaust exposed vulnerabilities in medicine's moral commitment to patients' best interests that every health professional should recognize. Teaching about this history is challenging, as it is extremely complex and there are no common standards for what basic historical facts students in health professions training programs should learn. Nor is there guidance on how these historical facts can or should be related to contemporary ethical issues facing health professionals. To address these problems, we propose a set of core historical facts about health professional involvement in the Holocaust that every student in a health professional training program should learn. We then identify three ethical lessons from the Holocaust that are pertinent today as physicians struggle to maintain their moral compass and earn the trust of patients and the public: 1) The lesson of commitment to science; maintaining balance between reason and skepticism in the search for truth, (2) The lesson of clinical detachment; maintaining balance between necessary professional distance with a commitment to humanism and intimacy with patients, and 3) The lesson of competing loyalties; maintaining balance in upholding medicine's multiple responsibilities, including to individual patients and the larger community. Embedding these facts and lessons into the education of health professionals is challenging yet critically important. Today's physicians struggle with some of the same ethical tensions as did German physicians in the Nazi era, albeit in a much-attenuated fashion. Awareness of these tensions and taking active measures to maintain them in balance are necessary components of humanistic health care, which should be an integral part of health professional training programs.

Key-words: *Holocaust; medical ethics; health professional education; trust; scientific method; competing loyalties; professional detachment*

Some academic health centers host elective activities intended to teach health professional students, educators, researchers, and clinicians about the horrific medical crimes during the Nazi era. But only 16 percent of North American medical schools have any required curricular elements in this regard.[1] The degree of exposure and awareness of other health science students and faculty (nursing, pharmacy, dentistry and others) is unknown, though it is unlikely to be great. Outside of academic centers, awareness among health professionals of the complex factors that enabled Nazi medical abuses is likely even less.

"Never Again!" is a common message of Holocaust remembrance programs, including those focused on medical crimes. Presumably this reflects a concern that such events, or lesser versions of them, might recur if they are not remembered.[2] Indeed, there have been subsequent attempted genocides and other war crimes, including some led by medical professionals, and the threat of health professionals following a broken moral compass seems ever-present. In this article, we argue that teaching this history to health professional students is important because it can and should inform their understanding of three core ethical issues that remain as pertinent today as they were prior to and during World War II.

First, we briefly recount some key historical facts about medical participation in the Holocaust that we believe all health professional students should learn during their training [Table I].

By the end of medical training, all health professions students should be able to:
1) Describe the theory of eugenics and its relationship to racism.
2) Describe at least 3 socioeconomic factors that made the German medical profession of the 1930s especially prone to subverting the needs of individuals to the perceived needs of the German state.
3) Describe the Nazi program of forcible sterilization and its relationship to similar programs in the US.
4) Describe the child euthanasia and T4 programs and how they related to later programs of mass murder in the Holocaust.
5) Describe at least 2 rationales used by German physicians to justify unethical human experimentation on prisoners.

Table I

[1] Matthew K. Wynia, et al., "How Do U.S. and Canadian Medical Schools Teach about the Role of Physicians in the Holocaust?" *Academic Medicine* 90, no. 6 (2015): 699-700.

[2] Arthur L. Caplan, *When Medicine Went Mad: Bioethics and the Holocaust. Contemporary Issues in Biomedicine, Ethics, and Society* (Totowa, NJ: Humana Press, 1992).

These basic historical facts focus on understanding the professional and social factors that played critical roles when Nazi era physicians abandoned their professional commitment to respect human life and protect patients from harm, and they form a core set of historical learning objectives for all health professions students. Next, we present a perspective on three core ethical issues that continue to challenge physicians today and can be illuminated by understanding this history [Table II].

Students should have the opportunity to explore how these historical facts can illuminate contemporary ethical challenges facing health professionals, including:
1) The lesson of commitment to science – maintaining balance between reason and skepticism in the search for truth;
2) The lesson of clinical detachment – maintaining balance between necessary professional distance and a commitment to humanism and intimacy with patients; and
3) The lesson of competing loyalties – maintaining balance in upholding medicine's multiple responsibilities, including to individual patients and the larger community.

Table II: Lessons from the Holocaust Pertinent to Contemporary Ethical Challenges in Medicine

These ethical issues are complex. Using this history to explore them is admittedly difficult both for teachers and learners. Yet we propose that using this tragic history to better understand these issues can provide critical and powerful insights with a potentially lifelong impact for anyone entering the healing professions. Finally, we discuss several practical challenges and opportunities of integrating these lessons into the curriculum of health professional education and training.

I. Key historical facts that students should know

A great number of historical forces were involved in the origins of the Second World War, but most of these are not of special interest to health professionals. A history of the Nazi era that focuses on the roles of health professionals should highlight a few factors that are especially important for understanding the roles that health professionals played so that students can understand how to mitigate those factors in the future.

To start, students should understand that the German military required a large number of physicians to support their troops during World War I, but upon returning to civilian life many struggled to eke out a living in private practice due to Germany's severe post-war economic contraction. No longer valued as military officers, many physicians experienced a dramatic decrease in status and respect as they struggled to support themselves. While there

was a long-standing system of "sickness funds" that covered workers and their families, contracts to care for patients enrolled in these funds were difficult to obtain, and many physicians were excluded. As a result, physician unemployment soared, and many experienced great frustration and anxiety; some blamed Jews, Communists and Socialists for their plight, following a popular belief that these groups had "stabbed in the back" the prior German government, causing the loss of the war. Meanwhile, the Weimar republican government largely ignored physicians' complaints while increasing the number of workers covered by the sickness funds. This removed these workers and their families from the private market, further restricting physician economic opportunity.[3]

Many physicians joined the new National Socialist Physicians League, in part attracted by the Nazi focus on "race hygiene," eugenics and social Darwinism, which offered a view of physicians as potential national heroes who could use biological "science" as a political instrument to improve the nation and create a master race.[4] Beliefs about race hygiene and eugenics were also common in the US, Britain and elsewhere, but Hitler's urgent plea to 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..."[5] – was particularly effective. Students should also know that German physicians flocked to the Nazi party sooner and in greater proportion than any other profession.[6]

Under the Nazis, the goal of the medical profession was to help "heal" the state and rid it of "vermin," i.e. people deemed to pose a genetic threat to the larger community. An early step in this process was to implement a requirement that physicians report patient health data to state public health offices, genetic health courts and research institutes where decisions were then made to forcibly sterilize those assumed to have genetic traits that could pollute the German gene pool.[7] This reporting structure required physicians to set aside the ancient obligation of patient confidentiality in what physicians were told (and presumably believed) was a critical service to their

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[3] Michael H. Kater, "Professionalization and Socialization of Physicians in Wilhelmine and Weimar Germany," *Journal of Contemporary History* 20, no. 4 (1985): 677-701.

[4] Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 2000), 34.

[5] F. Bartels, "Der Ärzt als Gesundheitsführer des deutschen Volkes," *Deutsches Ärzteblatt* 68 – Supplement (1938) 4-9; cited in Robert N. Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge, MA: Harvard University Press, 1988), 64.

[6] Donald W. Light, "Values and Structure in the German Health Care Systems," *The Milbank Memorial Fund Quarterly. Health and Society* 63, no. 4 (1985): 615-647.

[7] Paul Weindling, *Health, Race, and German Politics between National Unification and Nazism, 1870-1945* (Cambridge; New York: Cambridge University Press, 1989), 549.

nation. It also distanced the reporting physician from direct responsibility for the resulting ”medical” decisions.

Of note, students should learn that eugenic policy was not unique to Nazi Germany. About 70,000 Americans were also forcibly sterilized between 1908 and the 1980's, through state laws, which were endorsed by the US Supreme Court in the infamous *Buck v. Bell* decision. This was based on ”scientific” assertions regarding economic, social, and racial “worthiness” that were supposedly genetic.[8] In Germany, the forcible sterilization law was very aggressively implemented through the creation of hereditary health courts, which comprised two physicians and one jurist and which typically passed judgment after only cursory review of written patient records. Ultimately, around 400,000 people were sterilized under this program. While some physicians attempted to protect their patients by falsifying reports to these courts, most simply complied. This program arose in the first six months of the Nazi era, well before the later pogroms and other terror-state tactics, so fear of reprisal for non-compliance presumably was low. Yet still there was a striking absence of resistance.[9]

The forcible sterilization program in Germany was the first step toward an eventual series of increasingly aggressive “euthanasia” programs, initially targeting newborns and children under the age of three who were perceived to be severely disabled, then expanding as the “T4 program” to target adults as well, including the mentally ill and “incurable,” i.e. those said to be experiencing “lives not worth living.” Soon included were the antisocial, the unproductive and eventually Jews, Roma, homosexuals, prisoners of war and other undesirables whose murder was required to cure the “disease” supposedly afflicting society.[10] About 300,000 people were killed in the T4 program, and at least another 5,000 people were killed in the so-called “child euthanasia” program.

These were the first mass murder programs implemented by the Nazis, preceding the Holocaust by more than five years. A large number of German physicians and scientists helped design and oversee the operation of these mass killings under the guise of euthanasia (an obvious misnomer, since the victims of these mass killing programs were not seeking a “good death”), and many more participated by sending individuals to killing centers to be murdered. Others performed inhumane and even lethal research on these “undesirables,” sometimes arguing that they were to die anyway. There is record of only a few individual physicians speaking out or resisting these actions,

[8] Proctor, 97.

[9] Victor W. Sidel, “The Social Responsibilities of Health Professionals. Lessons from Their Role in Nazi Germany,” *Journal of the American Medical Association* 276, no. 20 (1996): 1679-1681.

[10] Proctor, 177.

the majority of these being Jews or socialists who were swiftly eliminated.[11] There was virtually no organized resistance from academia or medical organizations – either in Germany or in any other country. Students should also learn that physicians actively contributed to the development of novel technologies involved in the medically-driven "euthanasia" programs, including specialized gas chambers and crematoria, which eventually were used in the creation of industrialized killing centers such as Auschwitz and Treblinka. Notably, a physician who trained in the T4 program was for a time the commandant of the Treblinka killing center.

Finally, students should know that the Nazi experience is certainly not the only historical instance of physicians disgracing the profession. In fact, the Nazis were arguably inspired by "scientific racism" among physicians in the US and Britain, and especially by anti-miscegenation and forced sterilization programs in many American states.[12] Nazi Germany was also not the only place where medical research subjects were abused; it has occurred repeatedly in the United States, before and since the Nazi experience.[13] Even in recent years, physicians have actively supported and in some cases been the leaders of other genocides, for example in Syria, Haiti, Bosnia, Albania, Rwanda, and Argentina.[14] Physician involvement in human rights abuses, such as torture, facilitation of executions and abuse of medicine for political purposes, remains distressingly prevalent.[15,16]

On learning these facts of history, students today often struggle to comprehend how physicians could ever repeat these errors and again desecrate their profession. Yet some do, suggesting that this history or its lessons are not always learned, or, if learned, are not applied to contemporary challenges. If we are to succeed in helping students apply their (perhaps newfound) knowledge of this history to contemporary medicine, we will also need to be clear about the core lessons from this history that remain important today.

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[11] Michael H. Kater, *Doctors under Hitler* (Chapel Hill and London: The University of North Carolina Press, 1989), 74-84.

[12] James Q. Whitman, *Hitler's American Model: The United States and the Making of Nazi Race Law* (Princeton, NJ: Princeton University Press, 2017).

[13] Henry K. Beecher, "Ethics and Clinical Research," *New England Journal of Medicine* 274, no. 24 (1966): 1354-1360.

[14] Jeremy Hugh Baron, "Genocidal Doctors," *Journal of the Royal Society of Medicine* 92, no. 11 (1999): 590-593.

[15] British Medical Association, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (London: Atlantic Highlands; NJ: Zed Books, 1992).

[16] Nicholas Casey, "Trading Lifesaving Treatment for Maduro Votes," *New York Times,* March 17, 2019, https://www.nytimes.com/2019/03/17/world/americas/venezuela-cuban-doctors.html.

II. What are the core lessons of this history for today's health professionals?

The lessons of the Holocaust pertinent to the medical profession have been considered previously with some misleading if not erroneous conclusions. For example, Wynia and Wells have already shown that one should not think that the evils of Nazi medicine and science were due to German medicine being primitive or underdeveloped; that the trial of the Nazi doctors at Nuremburg and the resulting Nuremberg Code led directly to modern codes of medical research ethics; and that strongly-worded ethical codes are sufficient protection against the medical profession once again abandoning its core commitment to protect patients.[17]

However, if these are not the core lessons from this history for health professionals, what then are the lessons that should be learned from this tragic legacy? This question is not merely academic or philosophical in nature. It carries a great deal of pragmatic importance. Any effort to bring the lessons of medical involvement in the Holocaust into contemporary medical curricula will need to come with clear application to challenges facing medicine today, not just learning objectives focused on knowing historical facts, as important as those facts are [Table I].

We propose that there are three core issues in contemporary medical professionalism and ethics [Table II] that should be explored with students through their engagement with the tragic historical facts noted above. We acknowledge that there are many other lessons from the participation of physicians in the Holocaust that remain pertinent today, many of which are specific to a given perspective, such as medical research or public health practice. Yet the three core lessons described below and in Table II apply broadly and universally to the health professions and we consider them to be critically important to embed into the education and training of all aspiring health professionals.

Lesson 1: The proper calibration of scientific skepticism

Medicine bridges the gap between science and society.[18] The Physician Charter for Medical Professionalism in the New Millennium states in part, "Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold sci-

[17] Matthew K. Wynia, et al., "Light from the Flames of Hell: Remembrance and Lessons of the Holocaust for Today's Medical Profession," *Israeli Medical Association Journal* 9 (2007): 186-188.

[18] Royal College of Physicians, "Doctors in Society. Medical Professionalism in a Changing World," *Clinical Medicine* 5, no. 6 – Supplement 1 (2005): S5-S40.

entific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience."[19] Scientific standards preclude accepting a theory as fact before there has been sufficient rational experimentation. Absent objective observation there is not science, only faith garbed in pseudoscience. The acceptance of a theory – and implementing radical social policies in accord with the theory – because it just "seems right" is a violation of the principles of science. The Nazi implementation of public policy based upon the theory of Social Darwinism absent reasoned observation – and even in the face of evidence disproving it – is an example of such abuse of science, one with heinous consequences. The current American anti-immigration controversy provides several examples of public policy at variance with objective evidence, such as the discredited notions that immigrants bring disease or are more likely to commit crimes, as well as a reminder of the racist history of American immigration policy.[20]

Conversely, rejection of well-reasoned science on grounds of scientific skepticism is also a breach of scientific standards. A pernicious misuse of the scientific method is to reject well-established science because "it's just a theory."[21] Recent decades' debate over teaching evolution and today's public dialogue regarding climate science are reminders that objective observations can be ignored in favor of preconceived ideology[22] reflecting a dangerous misuse of scientific skepticism.[23]

Increasingly, the public gets information on science from a growing number of non-scientific sources.[24] Rogue medical journals and ideologically biased blogs overload the public with information of dubious scientific validity that is then redistributed and amplified on social media platforms. The information may become common knowledge absent any basis in truth. This appears to be the situation of the anti-vaccination movement, which thrives in the face of overwhelming scientific evidence against it. Physicians must

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[19] Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, "Medical Professionalism in the New Millennium: A Physician Charter," *Annals of Internal Medicine* 136, no. 3 (2002): 243-246.

[20] Daniel Okrent, *The Guarded Gate: Bigotry, Eugenics, and the Law that Kept Two Generations of Jews, Italians, and Other European Immigrants out of America* (New York: Scribner, 2019).

[21] Peter Godfrey-Smith, *Theory and Reality: An Introduction to the Philosophy of Science* (Chicago: University of Chicago Press, 2003).

[22] John Cook, et al., "Rational Irrationality: Modeling Climate Change Belief Polarization Using Bayesian Networks," *Topics in Cognitive Science* 8, no. 1 (2016): 160-179.

[23] Lawrence Torcello, "The Ethics of Belief, Cognition, and Climate Change Pseudoskepticism: Implications for Public Discourse," *Topics in Cognitive Science* 8, no. 1 (2016): 19-48.

[24] Paul Hitlin, et al., "The Science People See on Social Media," Pew Research Center, https://www.pewresearch.org/science/2018/03/21/the-science-people-see-on-social-media/.

evolve new strategies to regain the public's trust in the scientific foundation of medicine and strengthen their role in bridging the gap between science and society.[25]

As humanistic scientists, physicians have a moral duty to defend the scientific method and prevent social misuse of science through either premature acceptance of an unproven hypothesis or rejection of a well-substantiated one. As we have learned from the Holocaust, abuse of pseudoscientific theories can harm people, sometimes with horrific consequences.

Lesson 2: Empathy and detachment during medical training

Despite the need to frequently witness and sometimes even to cause pain and suffering in the course of medical practice, compassion and empathy toward patients are prerequisites to strong clinical relationships. It is perhaps inevitable that, in the course of training, medical students learn to tamp down their empathetic responses to human suffering. In fact, studies regularly demonstrate that the empathy of aspiring physicians declines through the course of medical education and training.[26] Concurrently, "clinical detachment" increases as students are exposed to the objectivity of medical science and as they adopt it as a protective mechanism against emotional overload.

But the history of Nazi physicians shows – in the most extreme way possible – the terrible cost of becoming so distant from patients that one can consign people to suffering and death with no remorse. Teaching about this history provides a unique opportunity to openly discuss the careful balance that practicing physicians must strike between personal empathy and professional distance. There must be a caring patient-doctor bond that is strong enough to overcome the pressures of malicious authority and the clinician's myriad competing interests and loyalties. But there must also be limits on the physician's intimacy with patients, lest emotional attachments themselves become competing interests and compromise clinical objectivity. Effectively caring for patients suffering with distress, pain, advancing disease and death requires some distancing, but it must not quash empathy. An equilibrium of empathy and detachment is necessary for physicians to be fully functional and retain their humanity.[27]

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[25] Richard J. Baron, et al., "Mistrust in Science – A Threat to the Patient-Physician Relationship," *New England Journal of Medicine* 381, no. 2 (2019): 182-185.

[26] Melanie Neumann, et al., "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," *Academic Medicine* 86, no. 8 (2011): 996-1009.

[27] Christine Montross, *Body of Work: Meditations on Mortality from the Human Anatomy Lab* (New York: Penguin Press, 2007).

Lesson 3: The challenge of competing loyalties

Perhaps the most compelling, and most complex, contemporary lesson from physician participation in the Holocaust is the need for physicians to balance their multiple and sometimes competing roles. A physician's commitment to an individual patient's best interest exists concurrent with loyalty to the best interests of other patients, to the larger community, to the health institutions and clinics where they practice, and sometimes to legitimate personal, political or commercial obligations that come with taking on other roles, such as citizen, parent, spouse, or employee. Physicians need to maintain their primary responsibility to patients while concurrently being responsive to other interests, including, for example, the need to serve as responsible stewards of the resources entrusted to them.

Though it is tempting to say, "the patient always comes first," the reality of navigating the challenge of competing loyalties is not that simple. Instead, we have criteria embedded in professional codes of ethics to help us wrestle with circumstances when it may be appropriate to, for example, breach patient confidentiality. Health professionals should always feel a bit uncomfortable when asked to act as agents of the government or for the sole sake of the community, even when it is well justified, and especially when it means potentially harming an individual. But sometimes it is justified, and that is what makes this such a complex and difficult lesson to learn.

Ethical codes in medicine are intended to create a set of explicit, reciprocal responsibilities based on mutual trust between the profession and society and reflected in mutual trust between individual patients and physicians. In Nazi Germany, trust between patients and physicians was only possible within the Aryan culture of Nazism. All others were abandoned.

It must be noted that American medicine in the early- to mid-20th century was similarly exclusionary. African Americans, Jews, Catholics and other minorities were discriminated against as patients and as professionals.[28,29] Much has improved since the end of World War II, a great deal of this directly in response to the recognition of human rights and the value placed on them following the Holocaust. But mistrust based on mistreatment persists. Some of this is the shameful legacy of generations of exploitation, institutionalized racism, and professional disrespect of the poor and minorities,[30] and some is a

[28] Vijaya Rao, et al., "Why Aren't There More African-American Physicians? A Qualitative Study and Exploratory Inquiry of African-American Students' Perspectives on Careers in Medicine." *Journal of the National Medical Association* 99, no. 9 (2007): 986-993.

[29] Edward C. Halperin, "The Rise and Fall of the American Jewish Hospital," *Academic Medicine* 87, no. 5 (2012): 610-614.

[30] Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on*

reflection of today's persistent health care inequities across gender, ethnicity, socioeconomic and other lines.[31]

Medicine has become much less authoritarian and more respectful of individual autonomy. Yet public confidence in American medicine has dramatically eroded in recent years.[32] A recent report from the Pew Research Center finds that only 74 percent of Americans have a mostly positive view of medical doctors and only 57 percent believe doctors care about the best interests of their patients all or most of the time.[33] Patients need to be confident that their health and well-being is their physician's primary concern, not the physician's income or productivity, the bottom line of the health system that employs the physician, or the demands of government and regulators.

In summary, physicians today are exposed to many of the same influences as were German physicians during the Nazi era, albeit in a greatly attenuated fashion, in part because these pressures reflect intractable dynamics inherent to the complex roles of healers in society. In the end, gaining and maintaining trust between patients and physicians depends in large part on physicians learning how to balance their responsibilities to individual patients and the larger community. Exploring the history of Nazi medicine can put a very sharp point on these necessary and difficult conversations.

III. Using the history of the Holocaust to teach these lessons

There is a growing gap in public knowledge of the Holocaust. A 2018 study found that 41 percent of Americans and 66 percent of millennials said they had not heard of the Auschwitz concentration and extermination camps. In the US, 22 percent of millennials have not even heard of the Holocaust.[34] The youngest Holocaust survivors are approaching the end of their lives, leaving dwindling opportunities for in-person encounters and direct testimony. Currently only 11 states have mandates for Holocaust education in K-12 public

Black Americans from Colonial Times to the Present (New York: Doubleday, 2006).

[31] Frederick J. Zimmerman, et al, "Trends in Health Equity in the United States by Race/Ethnicity, Sex, and Income, 1993-2017," *Journal of the American Medical Association Network Open* 2, no. 6 (2019): e196386-e196386.

[32] Robert J. Blendon, et al., "Public Trust in Physicians – U.S. Medicine in International Perspective," *New England Journal of Medicine* 371, no. 17 (2014): 1570-1572.

[33] Cary Funk, et al., "Trust and Mistrust in Americans' Views of Scientific Experts," Pew Research Center, August 2, 2019, https://www.pewresearch.org/science/2019/08/02/trust-and-mistrust-in-americans-views-of-scientific-experts/.

[34] Conference on Jewish Material Claims Against Germany, "New Survey by Claims Conference Finds Significant Lack of Holocaust Knowledge in the United States," http://www.claimscon.org/study/.

schools.[35] As the Holocaust recedes from public awareness, it is increasingly important for academic institutions, including health professions training programs, to integrate this history and its lessons into the curriculum.

In medical training, Holocaust-related education is in competition for curricular time with a host of other required topics. Exacerbating this challenge is the fact that the history of health professional involvement in the Holocaust is both complex and emotionally charged; it cannot be presented quickly, and it requires time to debrief and discuss. Moreover, the teaching of any history of medicine has been dwindling in health professional education.[36] As a practical matter, we accept that required courses that focus directly on Holocaust-related topics are unlikely to flourish in today's medical training programs. Instead, the focus should be on building Holocaust-related themes into existing curricula.

There is also a dearth of teaching modules that address Holocaust-related medical topics. Those that do exist, such as the travelling *Deadly Medicine: Creating the Master Race* exhibit of the US Holocaust Memorial Museum,[37] are designed for focused and time-consuming attention which, as noted, seems unlikely to materialize in most schools. Establishing clear core standards for educational content, as we propose, can help with integration of these lessons into the existing curriculum, especially if the standards address key lessons from this history that can be directly applied to challenges facing the profession today, as ours do.

To implement these standard educational objectives, it will also be necessary to develop faculty sufficiently grounded in both bioethics and the history of health professional involvement in the Holocaust and provide them with ideas and tools for embedding the lessons within existing bioethics education. Some examples of creative approaches include a conscious effort to reference the rationale for avoiding eponymous labels on medical conditions associated with Nazi physicians, such as Reiter, Asperger and Wegener. Discussions of the care of patients with developmental disabilities and mental health issues can and should include reference to the murder and inhumane treatment that Nazi physicians perpetrated on patients with these conditions. Teaching the scientific method and research ethics should include examples of the misuse of the scientific method to promote social policy such as the Nazi aggressive implementation of social Darwinism.

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[35] Anti-defamation League, "Why We Need Legislation to Ensure the Holocaust is Taught in Schools," https://www.adl.org/blog/why-we-need-legislation-to-ensure-the-holocaust-is-taught-in-schools.

[36] Philip A. Mackowiak, et al., "The Case for Medical History in Physicians' Education: A Survey of What Physicians and Physicians-in-Training Think," *The American Journal of Medicine* 130, no. 4 (2017): 494-497.

[37] United States Holocaust Memorial Museum, "Deadly Medicine: Creating the Master Race," https://www.ushmm.org/information/exhibitions/traveling-exhibitions/deadly-medicine.

In sum, teaching the lessons of the Holocaust in health professional education is critically important to the development of an ethically responsible and humanistic health professional workforce, and some of the core challenges that faced physicians during the Holocaust are still with us today. But this teaching will not occur without conscious efforts by academic leaders to develop both competent faculty and a consistent and effective curriculum. This will require institutional and leadership commitment to education on Holocaust-related bioethics, and it will require greater clarity regarding the exact historical facts that need to be covered and the ways in which this history can – indeed must – resonate with and inform our deliberations on ethical challenges facing health professionals today.

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Visiting Holocaust: Related Sites in Germany with Medical Students as an Aid to Teaching Medical Ethics and Human Rights

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Abstract

Many doctors and nurses played a key role in Nazism. They were responsible for the sterilization and murder of people with disabilities. Nazi doctors used concentration camp inmates as guinea pigs in medical experiments that had military or racial objectives. What we have learnt about the behaviour of doctors and nurses during the Nazi period enables us to reflect on several issues in present-day medicine (research limitations, decision making at the beginning and the end of a life and the relationship between physicians and the State). In some authors' opinions, the teaching of the medical aspects of the Holocaust could be a new model for education relating to professionalism, Human Rights, Bioethics and the respect of diversity. Teaching Medicine and the Holocaust could be a way of informing doctors and nurses of violations of ethics in the past. Moreover, a study trip to Holocaust and medicine related sites has strong pedagogical value. Visiting Holocaust related sites, T4 centres and the places where medical experiments were carried out has a special meaning for medical students. Additionally, tolerance, anti-discrimination, and the value of human life can be both taught and learned through this curriculum. The following article recounts our experiences of organizing and supervising a study trip with a group of medical students to some Holocaust and medicine related sites in Berlin and Hadamar (Germany). The study tour included lectures at universities in Düsseldorf and Berlin.

Key-words: *Holocaust; Bioethics; Nazi doctors; Professionalism; Human Rights*

I. Teaching Medicine and the Holocaust

During the Nazi period, many doctors played key roles as perpetrators of countless criminal acts,[1] which included the forced sterilization and the extermination of people with mental and physical disabilities,[2] medical experiments with no regard for the subjects[3] and mass extermination of Jews, Sinti Roma, Gypsies and homosexuals. These atrocities performed by physicians were exposed during "The Doctor's Case," one of the Nuremberg Trials, which led to the creation of the Nuremberg Code, an international bioethical regulation meant to govern human research.[4]

Analysis of the actions carried out by Nazi doctors[5] offers a valuable tool for providing insight into the ethical dilemmas which modern-day doctors and nurses may experience in their working lives, including research limitations, beginning or end of life decisions, and the influence of economic and political issues on their work.[6] Knowledge of the past reinforces the importance of the present emphasis on bioethical values in the training of health professionals.[7] We believe that the curricular content for the teaching of future doctors has to be supplemented with resources related to Medical Humanities, and we realize that the Holocaust would allow us to teach students ethical values. Visiting the historical sites and reading testimonies of the victims in the same places where those tragic events happened add a special significance to the learning experience.

In 2011, the Universidad Autonoma de Madrid, Spain, announced a call to faculty members to create elective courses concerning Human Rights and the combating of all forms of discrimination. These elective subjects were designated as complementary curricula included in the European Higher Education Area (EHEA). We submitted the project: "The Holocaust: Lessons for

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[1] Arthur L. Caplan. "How Did Medicine Go So Wrong," in *When Medicine Went Mad: Bioethics and the Holocaust*, edited by Arthur L. Caplan (Totowa, New Jersey: Humana Press, 1992), 61-78.

[2] Susan Bachrach, "In the Name of Public Health – Nazi Racial Hygiene," *New England Journal of Medicine* 351, no. 5 (2004): 417-418.

[3] Paul Weindling, "Peak Years, 1942 to 1944," in *Victims and Survivors of Nazi Human Experiments. Science and Suffering in the Holocaust,* ed. Paul Weindling, 69-108 (London: Bloomsbury, 2015).

[4] Michael A. Grodin, "Historical Origins of the Nuremberg Code," in *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation,* eds. George J. Annas, and Michael A. Grodin (New York-Oxford: Oxford University Press, 1992), 134-135.

[5] Joel Geiderman, "Physician Complicity in the Holocaust: Historical Review and Reflections on Emergency Medicine in the 21st Century, Part I," *Academic Emergency Medicine* 9, no. 3 (2002): 224-229.

[6] Tessa Chelouche, "Medicine and the Holocaust – Lessons for Present and Future Physicians," *Medicine and Law* 27, no. 4 (2008): 794-801.

[7] Shmuel P. Reis, Hedy S. Wald, Paul Weindling, "The Holocaust, Medicine and Becoming a Physician: The Crucial Role of Education," *Israel Journal of Health Policy Research* 8 (2019): 55-61.

Medicine" and after receiving approval, we have been teaching the course for the last 7 years. There are eight modules in the course:[8]

- Historical frameworks (1918-1945).
- A workshop on how to analyze written and audio-visual documents.
- The role of doctors and nurses in Eugenics and the so-called Euthanasia program.
- Jewish doctors in ghettos and camps.
- Nazi doctors in concentration and extermination camps.
- Medical experiments in camps.
- The medical and psychological consequences faced by Holocaust survivors/ Traces of the Nazi period in Medicine today.
- Lessons from the Holocaust for present day Medicine.

Each module lasts two hours and includes a lecture with audio-visual content. The methodology encourages active participation and debate. Every week, each student prepares a written assignment on one of the five case studies presented, based on documents that include testimonies of victims, statements made by Nazi doctors and descriptions of ethical dilemmas.[9] On completion, the students upload their finished work onto the online learning platform, Moodle®. In the last module, "Lessons from the Holocaust for present day Medicine," we encourage students to search modern media for any examples that illustrate recent breakdowns of ethical values. The aim of this activity is for students to be aware that the events discussed in class could, in fact, happen again.

The students' evaluation of the course has been very positive in all cases. Every year the university conducts a student satisfaction survey. Out of a maximum mark of 5, the average rating for all the university subjects (2014-2018) was 3.74 and the score for *The Holocaust: Lessons for Medicine* was 4.57. In the comments section, students stated that the classes gave them a more humane perspective on medicine, they realized the importance of learning from history, and that the subject is related to current events. We conducted a survey of our students' opinions on some bioethical issues before and after the 2014, 2015, and 2016 classes. The results showed our course is a contributor to upholding and developing professional values.[10]

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[8] Esteban González-López, Rosa Ríos-Cortés, *The Holocaust: Lessons for Medicine*, https://afly.co/9r32.

[9] Tessa Chelouche, and Geoffrey Brahmer, "Casebook on Bioethics and the Holocaust. Israel National Commission for UNESCO," http://www.unesco-chair-bioethics.org/wp-content/uploads/2015/09/Casebook-on-Bioethics-and-the-Holocaust.pdf.

[10] Esteban González-López, and Rosa Ríos-Cortés, "Medical Students' Opinions on Some Bioethical Issues Before and After a Holocaust and Medicine Course," *Israeli Medical Association Journal* 21, no. 4 (2019): 298.

II. Visiting Holocaust-related sites with medical students

Visiting authentic sites related to Medicine and the Holocaust creates a unique learning experience, far different from classroom study. Being present at the very places where awful medical experiments and actions took place has a particular meaning for medical students. Teaching and learning about Bioethics during a visit to Holocaust related sites has a huge impact on students and the way in which they understand medical ethics.[11] We organized two study trips (2013 and 2014) to Krakow and Auschwitz,[12] as well as a study trip to Holocaust and Nazi related sites in Germany, with the collaboration of two German universities.

III. Description of the study trip to Holocaust related sites in Germany

We applied for and were awarded a scholarship from the German Academic Exchange Service (DAAD) to design a study tour for a group of 15 medical students and two professors to various Holocaust and medicine related sites in Germany. The study tour (4th-12th July 2017) included lectures at two universities (Heinrich Heine University at Düsseldorf and Berlin-Charité University), and a visit to the Memorial for the "*Euthanasia*" victims at Hadamar, accompanied by German medical students and their professors.

i. Heinrich Heine University (Düsseldorf)

Our trip started in the campus of Heinrinch Heine University, visiting historical buildings such as the old church and the old pulmonary diseases pavilion. The students had the opportunity to learn about the organization of the hospital in the 19th century. Professor Matthis Krischel delivered a lecture entitled: *Coming to terms with the past? Nazi medical crimes and their historical reflections in Germany*. The aim of the lecture was to consider how medical crimes committed by Nazi doctors have influenced present day medicine in Germany and all over the world.

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[11] Anthony S. Oberman, Tal Brosh-Nissimov, and Nachman Ash, "Medicine and the Holocaust: A Visit to the Nazi Death Camps as a Means of Teaching Medical Ethics in the Israel Defence Forces Medical Corps," *Journal of Medical Ethics* 36, no. 12 (2010): 824-825.

[12] Esteban González-López, Rosa Ríos-Cortés, "Visiting Holocaust and Medicine-related Sites with Medical Students as an Aid in Teaching Medical Ethics," *Israeli Medical Association Journal* 18, no. 5 (2016): 257-260.

ii. Memorial to Victims of the Nazi Regime[13] *(Düsseldorf)*

On the ruins of the former Nazi police headquarters, a memorial has been built for the remembrance of victims of Nazism that included people with disabilities. We had a guided visit to the exhibition*: "Düsseldorf's children during the Nazi Regime"* which illustrates the stories of youth during the Nazi era in Düsseldorf. It was very shocking for the students to learn how propaganda can be used to create supporters of a totalitarian regime.

iii. Hadamar Memorial Museum (Hadamar)

The Hadamar State Psychiatric Hospital[14] was one of the five killing centers located in Germany, the others being Brandenburg, Bernburg, Graefeneck, and Pirna-Sonnenstein. At these sites doctors carried out the killing of 70,273 people with mental or physical disabilities. 10,072 people were murdered in Hadamar.

In October 1939 Hitler charged his Secretary Philip Bouhler, and his personal doctor, Karl Brandt, with the responsibility of carrying out what he called "*mercy killings*." This was known as the *T4 Aktion*, after the Berlin office on the 4th Tiergarten Strasse, where criminal decisions were taken. Patients were transferred by bus (the so-called *Grey Buses*) to the killing centers where they were taken to gas chambers. Carbon monoxide was used to end their lives. The corpses were burnt and the ashes were sent to their relatives. Doctors were tasked with organizing the killings, checking the clinical records, opening the gas valves and signing false death certificates that stated death was due to common causes such as pneumonia, heart failure or appendicitis. Some corpses and organs were used for medical research.[15]

The killing of people in the gas chambers in the camps of Nazi-occupied Poland was key to the implementation of the so-called "*Final Solution of the Jewish problem*." Doctors, their assistants and equipment were transferred to the death camps that included Auschwitz-Birkenau, Treblinka, Chelmno, Sobibor and Belzec. Dr. Irmfried Eberl[16] is an example of the utilization of Nazi doctors in the State Racial policy. He was in charge of the Brandenburg killing facility

[13] https://www.duesseldorf-tourismus.de/en/art-culture/museums-and-more/museums/memorial-to-victims-of-the-nazi-regime/.

[14] George Lilienthal, "Regional Psychiatric Clinic of Hadamar," in *How Healing Becomes Killing. Eugenics. Euthanasia. Extermination*, eds. Ursula Ghering-Münzel, Marci Regan Dallas, and Ira D. Perry (Houston: Holocaust Museum Houston, 2007), 81.

[15] Yehuda Bauer, "Aktion T4/ 'Euthanasia,'" in *Mass Murder of People with Disabilities and the Holocaust*, eds. Brigitte Bailer, and Juliane Wetzel, 19-24 (Berlin: Metropol Verlag & International Holocaust Remembrance Alliance, 2019).

[16] Rael D. Strous, "Dr. Irmfried Eberl (1910-1948): Mass Murdering MD," *Israeli Medical Association Journal* 11, no. 4 (2009): 216-218, 217.

and the first commander of the extermination camp in Treblinka. The murder of Jews started with the killing of disabled people in Germany and Austria, and the role of Nazi doctors was pivotal in the development of these actions.

Hitler decided to stop the *T4 Aktion* in 1941 after protests from the Catholic and Protestant Churches. However, the murder of people with other medical conditions continued, using methods including administering overdoses of drugs such as morphine, scopolamine and barbiturates or starving the victims.

Hadamar was also the final destination of civilians who experienced disorientation following air raids, German soldiers suffering from stress as a result of the war, and forced laborers from the Soviet Union and Poland who developed tuberculosis.

Today Hadamar[17] is a hospital that cares for psychiatric patients, as well as a museum, a memorial and a place of remembrance. We visited the remnants of the killing center (gas chamber, dissection room, and crematorium), the former bus garage for the so-called "*Grey Buses,"* the permanent exhibition, and we attended a workshop given by a member of the staff. At the end of the tour, we paid tribute to the victims.

A visit to a memorial located in an old killing centre is an occasion to reflect on the value of human life and think about how doctors collaborate with governments. Our students in their future practices may encounter situations in which they will be asked to obey laws that go against their ethical values. This portion of our trip helps prepare them for the possibility of such a situation.

iv. Topography of Terror[18] *(Berlin)*

The exhibition is located in the historic site where many central institutions of the Nazi state such as the Secret State Police Office (GESTAPO) and a prison were housed. They were the places where many criminal decisions were made. Our visit focused on the Nazi terror policy in Germany and its occupied territories. The group spent time, during the guided visit, considering the information on the exhibition's panel dedicated to the killing of disabled people, the "so called" *T4 Aktion*.

v. House of the Wannsee Conference[19] *(Berlin)*

On January 20, 1942, a meeting of high-ranking SS functionaries and members of the Reich government took place in a magnificent villa in Berlin's Wannsee

[17] Gedenkstatte Hadamar, "Hadamar Memorial: Memorial to the Victims of the Nazi-'Euthanasia'-Crimes," http://www.gedenkstaette-hadamar.de/webcom/show_article.php/_c-914/_nr-1/i.html.

[18] Topographie des Terrors, "Topography of Terror Documentation Center," https://www.topographie.de/en/topography-of-terror/.

[19] Haus der Wannsee Conferenz, "Der historische Ort / Die Gedenkstätte," http://www.ghwk.de/?lang=gb.

district. Here the final details of the so-called "*The Final Decision to the Jewish Question*" were put together. Specifically, the deportation of European Jews to the ghettos and the concentration and extermination camps in Eastern Europe.

It was profoundly striking to visit a very quiet and beautiful place where a group of individuals took no more than one and a half hours to decide the sad fate of millions of people. We visited the exhibition and afterwards had a meeting and workshop with Dr. Elke Gryglewski, Deputy Director of the House of the Wannsee Conference Memorial and Educational Site. The topic was: *How does Germany deal with its own past and how does the memory of the victims and the acknowledgment of its own history play a central role in the German psyche in the present day?*

vi. Museum of the History of Medicine at Charité[20] *(Berlin)*

The Museum of the History of Medicine is located in the former building of the Pathological Institute in the Charité-School of Medicine. The exhibition shows several stages in the history of medicine and houses an impressive collection of human parts used for teaching in the faculty. The Director of the Museum, Professor Dr. Thomas Schnalke, gave us a lecture on German medicine before the Nazi era. Germany was the country where medicine in the nineteenth and twentieth centuries made distinguished advancements. However, at the same time, it was the place where medicine showed its darkest face.

Walking to the museum, located in the University of Berlin-Charité Campus, we had the opportunity to talk to the students about the German doctors who were expelled from their positions in the University because they were Jews or political opponents or both.[21] For example, Dr. George Grosscurth[22] who, as a member of the German Resistance, was imprisoned and executed. There were others such as Dr. Herman Stieve, Professor of Anatomy in Charité, who conducted research using the corpses of 184 prisoners, mostly women, murdered by the Nazis. He studied the influence of stress on the female reproductive system.[23] Here two different approaches are demonstrated, Dr. George Grosscurth who decided to resist the Nazis and Dr. Stieve took advantage of the situation.[24]

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[20] Berliner Medizinhistorisches Museum der Charité, https://www.bmm-charite.de/en/index.html.

[21] Charité Memorial Site, "Exclusion and Forced Displacement at the Charité: Persecuted Colleagues 1933–1945," https://gedenkort.charite.de/en/people/.

[22] See https://www.gdw-berlin.de/en/recess/biographies/index_of_persons/biographie/view-bio/georg-groscurth/?no_cache=1.

[23] Andreas Winkelmann, and Udo Schagen, "Hermann Stieve's Clinical-anatomical Research on Executed Women during the 'Third Reich,'" *Clinical Anatomy* 22, no. 2 (2009): 163-171.

[24] Sabine Hildebrant, "The Women on Stieve's List: Victims of National Socialism Whose Bod-

vii. Museum of Otto Weidt's Workshop for the Blind[25] *and the Silent Heroes Memorial Center*[26] *(Berlin)*

It is important to note that despite the possibility of horrendous repercussions and punishments, some ordinary German men and women, during the National Socialist era, helped persecuted people such as Jews, prisoners of war and political opponents. Otto Weidt was the owner of a small factory that manufactured brushes and brooms. During World War II, he employed mainly blind and deaf Jews. They were protected because the Nazis considered these goods essential for the war effort. Today, Otto Weidt's old factory is a small snug museum, where visitors can see the artifacts made by the workers, together with images of people saved and their rescuers, the machinery, and the rooms used to hide the persecuted. Close to Otto Weidt's factory is the Silent Heroes Memorial Center, dedicated to ordinary people who decided to hide Jewish people during the Nazi era. These "silent heroes" provided Jews with fake identity cards, food and accommodation, and as a consequence, put themselves in great danger. They looked upon these Jews only as human beings who needed help. The exhibition contains the biographies of 241 German "silent heroes." Our students were tasked with searching for information on the helpers using the exhibition's computers and display panels.

vii. Sachsenhausen Concentration Camp[27] *(Berlin-Oranienburg).*

Located in Oranienburg, a town on the outskirts of Berlin, the camp was built in 1936 as a concentration camp for political opponents. More than 200,000 people were housed in this prison and became casualties of forced labor, punishments and hunger.

We visited the museum, the historic ruins and, in particular, the permanent exhibition "Medical Care and Crime – The Infirmary of Sachsenhausen Concentration Camp." Our guide was Dr. Astrid Ley, Deputy Head of the Sachsenhausen Memorial and curator of the exhibition. The exhibition is situated in the old infirmary, which was the ward where medical experiments took place. It is a large exhibition with display panels and artifacts giving

ies Were Used for Anatomical Research," *Clinical Anatomy* 26, no. 1 (2013): 3-21.

[25] See http://www.museum-blindenwerkstatt.de/en/first-of-all/.

[26] See https://www.museumsportal-berlin.de/en/museums/gedenkstatte-stille-helden/. Recently the Silent Heroes Memorial Center has been moved to the German Resistance Memorial Center Foundation https://www.gdw-berlin.de/en/home/.

[27] See https://www.sachsenhausen-sbg.de/en/.

visitors an insight into the different uses of the site during the Nazi era. Medical help was provided by the inmate doctors and their assistants, whilst the SS doctors only supervised some facets of care. The inmate doctors tried to care for people to the highest moral and professional standards, but with very limited resources.

We had the opportunity to see display panels and objects related to the Nazi Racial Policy which disclosed the eugenic measures inflicted on homosexuals, the disabled, and Sinti-Roma people. In one of the exhibition rooms, one of our students read the testimonies of Mr. Salomon Feldberg,[28] a victim of hepatitis research carried out by Dr. A. Dohmen. He was one of the 11 Jewish boys who were transferred from Auschwitz to Sachsenhausen to be used as guinea pigs in identifying the pathogens that caused the disease. Nazi doctors injected the boys with infected serum, and performed blood tests and liver biopsies on them.[29]

Our visit continued to other places in the concentration camp, such as the remnants of the gas chamber and the memorial to the victims. We also paid tribute to the 200 Spanish people who were deported to Sachsenhausen as political prisoners because of the parts they played in resisting the Nazis.

ix. Memorials and places of remembrance (Berlin)

Close to the Brandenburg Gate, memorials dedicated to the victims of Nazism and the Holocaust have been erected.

a. Memorial to the Murdered Jews of Europe[30]

This Memorial honors and remembers the six million Jewish victims of the Holocaust. It is an innovative monument consisting of 2,700 concrete slabs (the so-called *Field of Stelae*). At one end of the monument is the Memorial Center and the exhibition related to the genocide of European Jewish people. The display panels showing family portraits give victims an identity. This is a place to warn future generations to avoid any kind of discrimination and to protect Human Rights. We completed a guided tour of the open-air monument and the exhibition, after which we attended a workshop delivered by a member of the Memorial's staff.

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[28] See http://hernandobry.com/wp-content/uploads/2017/11/salomon-feldberg.pdf.

[29] Astrid Ley, and Günther Morsch, "Medical Experiments in Sachsenhausen Concentration Camp," in *Medical Care and Crime, The Infirmary at Sachsenhausen Concentration Camp 1936-1945*, eds. Astrid Ley, and Günther Morsch, 338-361 (Berlin: Metropol, 2007).

[30] See https://www.stiftung-denkmal.de/en/memorials/the-memorial-to-the-murdered-jews-of-europe.html.

b. Memorial to the homosexuals persecuted under the National Socialist regime[31]

Homosexuals were one of the groups that suffered from Nazi oppression, because they were considered as "socially aberrant." Their organizations were banned when Hitler came to power. They were treated with extreme brutality, deported to concentration camps, sterilized and became victims of medical experiments attempting to identify the best method of changing their sexual orientation. Here we remembered the gay victims of Nazism and read the testimony of Mr. Otto Giering, a victim of compulsory castration.[32]

c. Memorial and information point for the victims of National Socialist "Euthanasia" killings[33]

On the historical site of the office of the *T4 Aktion*, a memorial was built to honor the disabled people murdered by the Nazi doctors. The killing of thousands of people with disabilities or classified as "socially undesirable" was the first systematic and medically supported crime carried out by the National Socialist regime. An easily accessible outdoor exhibition, without any fences or barriers presents information on the history of the so-called Euthanasia facilities, as well as on the victims, perpetrators and opponents. Here we read the testimony of Mr. Martin Bader,[34] a German shoemaker who suffered from Parkinson's disease; designated a "useless eater" to use the Nazi jargon. He was transferred to Grafeneck where he was murdered in the gas chamber. It is important to recognize that behind every number there is always a person.

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[31] See https://www.stiftung-denkmal.de/en/memorials/memorial-to-the-homosexuals-persecuted-under-the-national-socialist-regime.html.

[32] Astrid Ley, and Günther Morsch, "Compulsory Sterilization and Compulsory Castration," in *Medical Care and Crime, The Infirmary at Sachsenhausen Concentration Camp 1936-1945*, eds. Astrid Ley, and Günther Morsch, 293-306 (Berlin: Metropol, 2007).

[33] See https://www.stiftung-denkmal.de/en/memorials/memorial-and-information-point-for-the-victims-of-national-socialist-euthanasia-killings.html.

[34] Helmut Bader, "The Voice of the Victims and their Families: The Case of Martin Bader," in *Silence, Scapegoats, Self-Reflection. The Shadow of Nazi Medical Crimes on Medicine and Bioethics*, eds. Etienne Lepicard, Volker Roelcke, and Sascha Topp (Göttingen: V&R Unipress, 2014), 107-108.

d. Memorial to the Sinti and Roma of Europe, murdered by the National Socialist regime[35]

The next stop of our visit to the memorials of Holocaust victims was the monument for Sinti-Roma people killed by the Nazis. Sinti-Roma were seen by the Nazis as "asocials" and "racially inferior." They were victims of persecution and genocide by the Nazis and their collaborators in German-occupied Europe. They were deported, or murdered in their hometowns, or in ghettos, concentration camps or killing centers. Some estimates calculate that as many as 500,000 men, women and children were persecuted for being "Gypsies" and became victims of National Socialism. Sinti and Roma were also victims of medical experiments in Auschwitz and in some other camps.[36] At the memorial, we read the testimony of Mr. Hans Hoellenrainer,[37] a victim of salt-water medical experiments in Dachau concentration camp (Germany) and listened to the Romanni Anthem "Gelem, Gelem."[38]

x. Additional visits

In order to gain a better understanding of recent German History, we visited the East Side Gallery[39] independently. Also, we arranged a guided visit to the Berlin Wall Memorial.[40] As our trip lasted only seven days, the Professors encouraged the students to visit some other historical places and museums in Berlin such as: the Bundestag, the Pergamon and Bode Museum, DDR Museum, Stasi Museum, and the Royal Palace and Gardens in Potsdam, in their own time.

IV. Comments

Following the international recommendations for visiting Holocaust related sites,[41] we provided the students with educational material on the places to

[35] See https://www.stiftung-denkmal.de/en/memorials/sinti-and-roma-memorial.html.

[36] Paul Weindling, "Targetting Victims: Gypsies," in *Victims and Survivors of Nazi Human Experiments. Science and Suffering in the Holocaust*, ed. Paul Weindling (London: Bloomsbury, 2015).

[37] See http://nuremberg.law.harvard.edu/transcripts/1-transcript-for-nmt-1-medical-case?seq=10657.

[38] See https://en.wikipedia.org/wiki/Romani_anthem.

[39] See http://www.eastsidegallery-berlin.com/data/eng/index-eng.htm.

[40] See https://www.berliner-mauer-gedenkstaette.de/en/.

[41] European Union Agency for Fundamental Rights, "Discover the Past for the Future. The Role of Historical Sites and Museums in Holocaust Education and Human Rights Education in the EU." http://fra.europa.eu/en/publication/2010/discover-past-future-role-historical-sites-and-museums-holocaust-education-and; International Holocaust Remembrance Alliance, "Guidelines for Study Trips to Holocaust-Related Authentic and Non-Authentic Sites," https://www.holocaustremembrance.com/node/141; Council of Europe, "European Pack for

visit including concentration camps, historical sites, memorials and places of remembrance, as well as transcripts of victims' testimonies. Each of our visits always included a pedagogical activity such as a lecture or a workshop. The students were asked to personalize the victims and not merely think of them as a name or number. That is why, when viewing some of the exhibits in Berlin, we encouraged students to focus on an artifact or a photo, and try to imagine the life the owner had. We would like to make some suggestion to teachers who decide to visit Holocaust-related sites. It is essential that students are prepared emotionally and psychologically for the trip. It is also vital to meet every day before and after visiting each site. This enables the students to talk about their impressions and emotions, and thus express their feelings.

V. Conclusion

We would like to say that we achieved all the goals we set for the program, additionally enhancing collaboration between German universities and our university. Our students had the opportunity to share impressions of some of the visits with German students. They socialized and talked to each other about their experiences and about the education systems in each other's countries. A follow-up activity for the Spanish students was designed by the Professors, using and sharing books, movies and other documents and resources related to Nazism and the Holocaust. Students were invited to share their experiences with their classmates. This has proved to be more powerful than any account given by the Professors.

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A Human Paradox: The Nazi Legacy of Pernkopf's Atlas

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Abstract

Eduard Pernkopf's Atlas of Topographical and Applied Human Anatomy is a four-volume anatomical atlas published between 1937 and 1963, and it is generally believed to be the most comprehensive, detailed, and accurate anatomy textbook ever created. However, a 1997 investigation into "Pernkopf's Atlas," raised troubling questions regarding the author's connection to the Nazi regime and the still unresolved issue of whether its illustrations relied on Jewish or other political prisoners, including those executed in Nazi concentration camps. Following this investigation, the book was removed from both anatomy classrooms and library bookshelves. A debate has ensued over the book's continued use, and justification for its use has focused on two issues: (1) there is no definitive proof the book includes illustrations of concentration camp prisoners or Jewish individuals in particular, and (2) there is no contemporary equivalent to this text. However, both points fail to address the central importance of the book, not simply as part of anatomy instruction, but also as a comprehensive historical narrative with important ethical implications. Having encountered a first edition copy, these authors were given a unique opportunity to engage with the text through the respective humanities lenses of history, ethics, and narrative. In doing so, an instructive and profound irony has surfaced: Nazis, including Pernkopf, viewed specific groups of people as less than human, giving rise to unthinkable atrocities perpetuated against them. However, these same individuals became the sources for the creation of the Atlas, which served as the model for primary instruction on the human form for more than half of the twentieth century. In this article, we recount the difficult and somewhat opaque provenance of this book, engage the ethical questions surrounding both its creation and its use, and ultimately propose a pedagogical methodology for its continued use in medical education.

Key-words: *human anatomy; medical humanities; narrative analysis; ethics; holocaust; history of medicine*

"Yet you, my creator, detest and spurn me, thy creature, to whom thou art bound by ties only dissoluble by the annihilation of one of us. You purpose to kill me. How dare you sport thus with life? Do your duty toward me, and I will do mine towards you and the rest of mankind. If you will comply with my conditions, I will leave them and you at peace; but if you refuse, I will glut the maw of death, until it be satiated with the blood of your remaining friends."
Mary Shelley, *Frankenstein*

I. Introduction

Eduard Pernkopf's *Atlas of Topographical and Applied Human Anatomy* (hereinafter "the Atlas") is a four-volume anatomical atlas published between 1937 and 1963 and is generally believed to be the most comprehensive, detailed, and accurate anatomy textbook ever created.[1] Over the fifty years following its creation, the book was widely translated and frequently used in anatomy education in medical schools throughout the world.[2] However, inspection of the forty-one illustrations of the particularly problematic second volume of the Atlas, which was created at the University of Vienna in 1941 during the National Socialist period, appears to have revealed signatures by the artists using Nazi symbols.[3] In 1988, research conducted by David J. Williams, Professor of Medical Illustration at the School of Veterinary Medicine at Purdue University in Indiana, revealed that not only was Pernkopf a member of the Nazi party, but the primary illustrators, Erich Lepier, Ludwig Schrott, Karl Endtresser, and Franz Batke, were all active members of the Nazi party as well.[4] This raised further questions about whether individual cadavers depicted within the book were victims of the Nazi regime of which Pernkopf and many of his colleagues were a part.

A formal investigation into the creation of the book and the identity of the subjects depicted in it was subsequently undertaken by the University of Vienna in 1997 at the behest of individual medical professors in the U.S. and Canada, as well as Yad Vashem (The Holocaust Martyrs' and Heroes' Remem-

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[1] Sabine Hildebrandt, "How the Pernkopf Controversy Facilitated a Historical and Ethical Analysis of the Anatomical Sciences in Austria and German: A Recommendation for the Continued Use of the Pernkopf Atlas," *Clinical Anatomy* 19, no. 2 (2006): 91-100; Garrett Riggs, "What Should We Do about Eduard Pernkopf's Atlas?," *Academic Medicine* 73, no. 4 (1998): 380-386; Chris Hubbard, "Eduard Pernkopf's *Atlas of Topographical and Applied Human Anatomy*: The Continuing Ethical Controversy," *The Anatomical Record* 265, no. 5 (2001): 207-211; Demetrius M. Coombs, and Steven J. Peitzman, "Medical Students' Assessments of Eduard Pernkopf's Atlas: Topographical Anatomy of Man," *Annals of Anatomy* 212 (2017): 11-16.

[2] Michel Atlas, "Ethics and Access to Teaching Materials in the Medical Library: The Case of the Pernkopf Atlas," *Bulletin of the Medical Library Association* 89, no. 1 (2001): 51-58.

[3] Daniela Angetter, on behalf of the Senate Project of the University of Vienna, "Anatomical Science at University of Vienna 1938-45," *The Lancet* 355, no. 9213 (2000): 1454-1457.

[4] Hildebrandt, 93.

brance Authority).[5] These individuals made three requests to the University of Vienna:

> (1) There should be an official investigation by outside experts to determine who the subjects portrayed in the Pernkopf atlas were and how they died; (2) If the subjects are in fact, or could possibly have been, victims of the Nazis, there should be a public commemoration to the victims by the institutions and organizations concerned; (3) The book should continue to be published with an acknowledgment in every future edition documenting the history of Pernkopf and commemorating the victims.[6]

The Senate Project of the University of Vienna ultimately concluded that Lepier had repeatedly signed his name with a swastika, but the 'double S' attributed to Endtresser and the 'double S lightning bolt' rune attributed to Batke, could have been simply idiosyncrasies of handwriting and not intentional signs of Nazi allegiance.[7]

Questions remained, however, surrounding the identity of the thousands of individuals whose bodies were assigned to the University of Vienna's Institute of Anatomy during the Nazi regime. A bombing of the Institute at the end of World War II destroyed a number of documents that could have been used to determine the identity of these individuals.[8] Consequently, of the many cadavers received by the Institute, only 1,377 could definitively be said to have been executed citizens, including eight Jewish individuals. While not conclusive, the Senate Project further offered that it is reasonable to assume models for the Atlas's illustrations probably came from those 1,377 prisoners, though none were conclusively found to have been victims of Nazi concentration camps.[9] Moreover, the Atlas contains approximately 350 illustrations that are not dated and thus, it is not known whether they, too, depict victims of the Nazi regime.[10] The University of Vienna further agreed that, going forward, the following statement should be included as an insert in the front of each copy of the Atlas:

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[5] Angetter, 1454.

[6] Howard Israel, and William Seidelman, "Nazi Origins of an Anatomy Text: The Pernkopf Atlas," *JAMA* 276, no. 20 (1996): 1633.

[7] Angetter, 1456.

[8] Ibid., 1454.

[9] Ibid., 1455, 1456.

[10] Ibid., 1456.

> [...] Currently, it cannot be excluded that certain preparations used for the illustrations in this atlas were obtained from (political) victims of the National Socialist regime. Furthermore, it is unclear whether cadavers were at that time supplied to the institute of Anatomy at the University of Vienna not only from the Vienna district court but also from concentration camps. Pending the results of the investigation, it is therefore within the individual user's ethical responsibility to decide whether and in which way he wishes to use this book.[11]

Despite the fact that Yad Vashem has indicated a desire for the book's continued use, printing of the text ceased in 1994,[12] and its official use is now all but banned in classrooms, giving rise to difficult questions of how to reconcile the text's unequivocal utility with its horrifying origin. This debate has typically centered on whether the book should be banned or continued to be published and used with little inquiry into *how* it should be used, and under what pedagogical circumstances. Below, we recount the difficult and somewhat opaque provenance of this book, engage the ethical questions surrounding both its creation and its use, and ultimately propose a pedagogical methodology for its continued use in anatomical instruction, specifically advancing that the book is a valuable part of a medical humanities approach to anatomy instruction.

II. The Anatomy of an Anatomical Atlas

In recounting the ethical debate surrounding Pernkopf's Atlas, authors generally begin with a biography of Pernkopf himself, detailing his rise in the faculty at the University of Vienna and his affiliation with the Nazi party. While valuable, this approach conflates the biography of the author with the story of the book itself. It further, and all-too-easily, provides readers with an identifiable villain in this narrative at whose feet we can lay blame for the atrocities that gave rise to the creation of the Atlas. This approach, however, discourages the kind of reflection that is the book's true and current value. The story of Pernkopf's Atlas is, in many ways, the history of contemporary medicine and, so, this is where we will begin.

For the first half of the 19th century, medical and scientific theory was shaped by Parisian "hospital medicine."[13] Its reliance on "correlating external

[11] Atlas, 53.

[12] Andrew Yee, et al., "Ethics Considerations in the Use of Pernkopf's Atlas of Anatomy: A Surgical Case Study," *Surgery* 165, no. 5 (2019): 862.

[13] Nicholas Jewson, "The Disappearance of the Sick-Man from Medical Cosmology," *Interna-*

symptoms with internal lesions" through autopsy gave rise to "pathological anatomy" as the "all-pervading research technique of Hospital Medicine"[14] and thus, medicine, generally. This method of research was also a method of learning as the study of medicine developed into a process of "observation and investigation."[15] The ideal places for such observation and investigation were "large hospitals in which a great number of sick people could be tended and treated" and so emerged the concept of the "teaching hospital."[16]

Beginning in the middle of the 19th century, a cultural shift led by the University of Vienna ushered in a new age of medicine and shifted the center of medicine's intellectual and academic activity away from France to Austria-Hungary and Germany, and particularly towards German laboratories.[17] Much as the French model had made hospitals an indispensable part of medical instruction, the German model suggested that a clinical laboratory was a necessary component to the ideal medical college.[18] This gave rise to a third medical epoch, aptly named "laboratory medicine."[19] In retrospect, a number of ethnically German scientists could be credited for this shift, such as Theodor Schwann, Ignaz Semmelweis, Rudolf Virchow, Robert Koch, and Friedrich Loeffler, to name just a few. By the turn of the 20th century, and with the decline of the French influence in medicine, the dominance of Germany in the field of medicine was solidified.

Although the rise of the practice of routine post-mortem autopsy is often attributed to French medicine, it was the Viennese pathologist Karl von Rokitansky, who brought the practice from France to the Vienna General Hospital in the mid-19th century and is credited for performing as many as 30,000 autopsies during the course of his life.[20] In contrast to medical centers in Europe and North America, the practice of dissection was utterly unrestricted at Vienna General Hospital and led to the founding of the Second Vienna Medical School.[21] The availability of bodies for autopsy is credited with the international prestige accorded to the institution.[22]

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tional Journal of Epidemiology 38, no. 3 (2009): 622-633.

[14] Ibid., 625.

[15] J. Büttner, "The Origin of Clinical Laboratories," *European Journal of Clinical Chemistry and Clinical Biochemistry* 30 (1992): 586.

[16] Ibid.

[17] Jewson, 625; Sherwin Nuland, "Chapter 9: The Germ Theory Before Germs," in *Doctors: The Biography of Medicine.* (New York: Random House, Inc., 1988), 241.

[18] Büttner, 587.

[19] Jewson, 625.

[20] Fernando De Campos, "The Dawn of Modern Pathology," *Autopsy Case Reports,* 6, no. 1 (2016): 3.

[21] Ibid.

[22] Ibid., 4.

In addition to the prominence of German Laboratory Medicine and the University of Vienna in particular, the success of anatomical dissection, for centuries, has rested on the overlooked exploitation of disvalued populations as the source of the individual cadavers necessary for study.[23] Indeed, the bodies depicted in Andreas Vesalius's *De Humani Corporis Fabrica* (1543) were those of executed criminals.[24] As multiple authors have noted previously, in Vienna the practice of using the bodies of executed prisoners in the instruction of anatomy was centuries old dating back to 1404.[25]

It was against this backdrop that anatomist Eduard Pernkopf rose to prestige. Prior to the 1938 *Anschluss* (the annexation of Austria by Nazi Germany), The University of Vienna School of Medicine's Anatomy Institute was comprised of two separate departments: First and Second Anatomy. Eduard Pernkopf had been appointed Director of Second Anatomy in 1929 and first began work on the Atlas as a manual to assist in his own teaching of human dissection.[26] In 1933, with the rise of Hitler, Pernkopf formally joined the Nazi party and the S.A. (Sturmabteilung, German "Assault Division"). A few weeks after the 1938 annexation, he was appointed Dean of the Faculty of the Medical School and combined the two anatomy departments. Within a month, he had requested that all University staff provide documentary proof of their Aryan ancestry and give an oath of loyalty to Hitler.[27] Two weeks later, all Jewish faculty – fully 78% of the Medical School faculty – were fired.[28]

As detailed by Sabine Hildebrandt, Pernkopf's first lecture as Dean of the Medical Faculty openly praised Hitler, embraced eugenics and race hygiene,

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[23] Coombs, 11-12.

[24] Ibid., 11; Nuland, "Chapter 3: The Reawakening: Andreas Vesalius and the Renaissance of Medicine," in *Doctors: The Biography of Medicine*; Dillon Arango, Patrick Grieffenstein, and James P. O'Leary, "Selected Anatomists: At the Boundary of Contemporary Ethics," *JAMA Surgery* 148, no. 1 (2013): 94-98.

[25] Angetter, 1454.

[26] Arango, et al., 96.

[27] Edzard Ernst, "A Leading Medical School Seriously Damaged: Vienna 1938," *Annals of Internal Medicine* 122, no. 10 (1995): 790.

[28] Ibid.; Gerald Weissmann, "Springtime for Pernkopf," *Hospital Practice* 20, no. 10 (1985): 142-168, noting a 1938 issue of *The Lancet* in which a letter, signed by 18 prominent physicians begged that "our colleagues in all countries [...] do all in their power, whether by public protest, by public or private assistance, to stand by any member of our profession who may suffer hardship under the new regime.", 163-164. Subsequent correspondence raised concern about the "undue competition" that could arise from the U.K. accepting too many "medical refugees from Central Europe." As one letter of April 23, 1938, notes, "[T]he prosperity so speedily attained by some refugees has done more than anything else to weaken the desire to help refugees as a class.", 164. Alternatives were proposed, including, "it would be better to send foreign refugees to the countries with large populations and few doctors, such as India, rather than admit them to overcrowded England.", 167.

and ended with a triple, *Seig Heil*, eliminating any ambiguity as to Pernkopf's allegiance.[29] He subsequently implemented a new curriculum in race hygiene within which instruction in anatomy was essential to understanding concepts of racial difference.[30] He further advanced theories of both positive and negative eugenics, some of which were directly adopted by the Nazis as justification for the Holocaust itself.[31]

As noted above, the history of anatomy's reliance on the bodies of executed prisoners is well established. However, with the rise of the Third Reich the demographics of those bodies increasingly comprised political dissidents and persons with mental illness who had previously been residents in psychiatric hospitals, such as Am Spiegelgrund, which was the site of the euthanasia of mentally and physically handicapped children under the Nazi regime.[32] Most of the victims, it is agreed, would have been those "executed at the Vienna district court and of others put to death at Gestapo execution chambers in Linz, Munich, and Prague."[33] Thus, while Pernkopf-the-individual was a man whose views we find repugnant and whose conduct we rightly disavow, Pernkopf-the-anatomist would not have existed but for the convergence of the disturbing history of anatomical study and the prominence of German laboratory medicine during the rise of the Nazi regime. This historical context is critical to any examination of the Atlas, especially as we consider its value and potential from a medical humanities, and specifically, narrative perspective.

III. Responding to Arguments

A number of arguments have been advanced exploring whether or not it is ethically permissible to continue to use Pernkopf's Atlas. Chief among them are: (1) that the Atlas lacks any contemporary substitute and is incomparably valuable in its instructional utility; (2) that the results of the Senate Project of the University of Vienna were inconclusive as to the source of the cadavers and thus, there is no definitive proof the bodies depicted in the text were obtained from executed prisoners, much less Jewish victims of the Holocaust; and (3) that the continued use of the Atlas honors the dead and provides comfort in so far as the victims depicted in its pages did not die in

[29] Hildebrandt, 93.

[30] Ibid.

[31] Ibid., 93: "It should be mentioned at this point that Pernkopf, in his rhetoric of 'negative selection,' spelled out the steps that led directly from biological theory and Rudulf Hess's (Hitler's deputy) 1934 mandate of National Socialism being 'applied biology' to the 'other means' of the Holocaust."

[32] Angetter, 1454.

[33] Israel, 1633.

vain. Below, we address each of these arguments individually, but ultimately find them unpersuasive.

i. The Atlas as Indispensable

As several authors have noted previously, part of the complexity of addressing Pernkopf's Atlas is its superiority among anatomical atlases. When *The New England Journal of Medicine* reviewed the 3rd edition of the book in 1990, they described it as an "outstanding book of great value to anatomists and surgeons" and "in a class of its own."[34] *JAMA* has also described it as in "a class among atlases."[35] Moreover, as scholars have noted, unlike much Nazi "research," the Atlas is "a rare example of Nazi medical scientists producing scientifically significant work."[36] While much of the data derived from Nazi research cannot be validated and was flawed in its foundational hypotheses and design, Pernkopf's Atlas has never been challenged for its validity, only lauded.[37] Garrett Riggs has described the Atlas as the "archetype of highly reliable data tainted by its association with Nazism."[38] Hildebrandt has remarked, "The Atlas is still one of the very best in terms of accuracy, showing levels of detail concerning fascia and neurovascular structures that are of direct relevance for the actual dissection process."[39]

Recently, Sharon Begley recounted the Atlas's indispensable utility in the performance of a complicated surgery performed by Dr. Susan Mackinnon.[40] Having been confronted intraoperatively with an inability to locate the saphenous nerve, Mackinnon consulted the Atlas, projecting the relevant text illustration on a screen in the operating room. She credits the illustration with her successful completion of the surgery.[41] However, Mackinnon was so disturbed by the Atlas's history, she questioned whether her reliance on it should have been made a part of the patient's

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[34] Richard Snell, "Pernkopf Anatomy: Atlas of Topographic and Applied Human Anatomy," *The New England Journal of Medicine* 323, no 3 (1990): 205.

[35] Malcolm Hast, "Pernkopf Anatomy: Atlas of Topographic and Applied Human Anatomy, Vol. 1: Head and Neck" [Book review] *JAMA* 263, no. 15 (1990): 2115.

[36] Hildebrandt, 92.

[37] Atlas, 54.

[38] Riggs, 382-383.

[39] Hildebrandt, 97.

[40] Sharon Begley, "The Surgeon Had a Dilemma only a Nazi Medical Text Could Resolve. Was It Ethical to Use It?" in *STAT* (2019), accessed August 20, 2019, https://www.statnews.com/2019/05/30/surgical-dilemma-only-nazi-medical-text-could-resolve/.

[41] Ibid.

informed consent process. How would a patient feel if she knew "her surgeons consulted a work of Nazi medicine to help" her?[42]

Over the years, some have suggested that the exceptionality of the book has been somewhat reduced by other methods of anatomy instruction. While Richard Snell lauds the work as being of great value, he also notes a number of aspects of the Atlas that are now outdated.[43] However, attempts to find a substitute have been largely unsuccessful. For example, Michel Atlas has responded previously to suggestions that The Visible Human Project could serve as an adequate substitute to the Atlas commenting that the male model in that project is, himself, an executed prisoner, a practice that has been condemned as deeply unethical by nearly the entire developed world.[44]

Moreover, and to the ultimate point of this article, the reliance on ostensibly less ethically problematic means of instruction results in a "missed opportunity to have a conversation about humans and humanity."[45] As Edzard Ernst has commented, medical schools have an ethical obligation to lead such discussions, particularly as they relate to the eugenics movement, because the medical profession played such an enormous role institutionally in "generating, popularizing, and implementing"[46] social Darwinist theories during the first half of the twentieth century.

ii. The Absence of Evidence as to the Origin of Subjects in the Atlas

The least persuasive of the arguments advanced for the continued use of the Atlas relies on, rather than rebukes, the lack of certainty regarding the origin of the bodies depicted in its pages and further notes that although Pernkopf was an ardent Nazi, there is no evidence that he participated in Nazi executions.[47] However, this argument, which attempts to find purchase in doubt, is unpersuasive. But for the air raid of February 7, 1945, which destroyed the death certificates – including causes of death (e.g. executed) and the location where the body was transferred after death – we would almost certainly find that the bodies depicted in the Atlas were predominantly victims of the Nazi Regime. Indeed, scholars have already speculated that the number of executed individuals transferred to the Anatomy Institute "must be higher than

[42] Ibid.

[43] Snell, 403.

[44] Atlas, 57.

[45] Ibid.

[46] Ernst, 789.

[47] Riggs, 381.

1377."[48] While we cannot know with certainty that these bodies were from victims of the Nazi regime, it seems we should proceed from the assumption that they *are* such victims given what we *do* know.

Between 1907 and 1932, there were fewer than 20 civilians executed per year in Germany. Between 1933 and 1945, there were at least 16,000 executions in German prisons (this figure obviously excludes executions in Nazi concentration camps). Most people were sentenced to death for political reasons.[49] Of those executed, the bodies of at least 1377 civilian prisoners, including eight Jewish prisoners, were assigned to Pernkopf's anatomy department. Further, as previously noted by Michel Atlas, there is concern that the Atlas contains material from children killed in Viennese hospitals. Between 1938 and 1945, some 7,000 bodies of fetuses, miscarriages, still births, and premature babies were delivered to the Institute.[50] The influx of bodies executed by the Nazis increased so much during Pernkopf's tenure that there were times when the executions had to be postponed because there was not sufficient room for the bodies at the Institute.[51] Importantly, the literature consistently demonstrates that anatomists were "an integral part of the system of capital punishment" during the Nazi regime.[52]

More recently, researchers have obtained the comments of individuals who survived World War II and worked in the Institute with Pernkopf. In 2007, Seyed Hossein Aharinejad and Stephen Carmichael interviewed three professors of the Institutes of Anatomy of the University of Vienna: Walter Krause, Alfred Gisel and Werner Platzer. Their remarks were chilling and include explicit admissions that "there were executed Jews among the bodies delivered to the Institute."[53] In addition to the bodies of Jewish people, Alfred Gisel, Emeritus Full Professor of Anatomy acknowledged that "bodies of executed Jewish people were used, these were people who had protested against

[48] Angetter, 1455: "The total number of people executed under the National Socialist regime could not be established because all the sources used for research – including the death certificates at the Vienna municipal cemetery offices, the lists form the Vienna assize court archives, the documentary archives of the Austrian resistance and the German army information office in Berlin – was incomplete. Hence, the true number of executed citizens must be higher than 1377."

[49] Angetter, 1455.

[50] Atlas, 53.

[51] Hildebrandt, 94.

[52] Heather Pringle, "Confronting Anatomy's Nazi Past," *Science* 329, no. 5989 (2010): 275.

[53] Seyed Hossein Aharinejad, and Stephen W. Carmichael, "First Hand Accounts of Events in the Laboratory of Prof. Eduard Pernkopf," *Clinical Anatomy* 26, no. 3 (2013): 299. Walter Krause, Emeritus Full Professor of Anatomy responded to questions as follows: "The bodies of executed people, also Jewish people, were delivered to the Institute of Anatomy in Vienna and they were used. So what? I am sure Jewish people were among these bodies, but who should know exactly and how can we estimate numbers?" at 299.

the NS regime and were then killed by National Socialists. Also, some were put on trial and then killed. [...] [B]eside Jews, there were also homosexuals and gypsies among the executed [and] people with different political ways of thinking from the National Socialists."[54]

Given what is known about the circumstances at the University of Vienna during the time the book was being created, it seems most judicious to proceed under the assumption that at least some of the drawings depict "victims of the Holocaust" including the cognitively disabled, homosexual persons, Romani, Jews, and those who were political dissidents during the Nazi regime. The fact that one cannot say this with certainty should provide little in the way of comfort.

iii. The "Salvage-Some-Good-From-The-Ashes" Defense

Garrett Riggs and Sabine Hildebrandt both have argued that the book may be a "fitting tribute to those who died for it."[55] This is what Riggs has called the "Salvage-Some-Good-From-The-Ashes" defense. Riggs specifically finds the "Good-From-The-Ashes" defense somewhat persuasive noting that "teaching, enlightenment, and enhancing patient care are noble ends" and that to acknowledge this does not "[diminish] the magnitude of past wrongs or [forget] those who were wronged."[56]

This argument, however risks that the past wrongs may simply fall out of the conversation as one necessarily prioritizes the "noble ends" of learning *over* the past wrongs. This rationalization, then, is question-begging in a conversation about whether the use of the Atlas can be ethically justified. Further, this argument seems to take as "given" points of debate which are, as yet, very much unresolved, such as whether prioritizing the "noble ends" of learning in the context of Pernkopf's Atlas treats the individuals contained in its pages as a means, rather than as ends in themselves. To do so would seem to disregard Kantian maxims about personhood, which comprises a core tenet of modern bioethics.

At the very least, the "Salvage-The-Good" defense requires close attention to the use of language. The people depicted in the pages of Pernkopf's Atlas did not die *for* this book, as Riggs describes. That sort of language suggests a deliberate undertaking, an intentional sacrifice for a greater good. People die for their country; they die for their children; they die for causes they believe in. They do not die *for* textbooks. The individuals depicted in

[54] Ibid., 301.

[55] Riggs, 385; Hildabrandt, 97.

[56] Riggs, 384.

the pages of Pernkopf's Atlas were murdered as part of a project of ethnic cleansing and eugenics. Their death was exploited by a man who sought to profit off the convenient increased body count and who not only ascribed to, but developed, perpetuated, and implemented policies in accordance with this genocide. We are concerned that such arguments invite sentimentality, romanticization, and oversimplification. If we choose to engage with this part of the human story, we surrender the privilege of doing so with euphemisms.

IV. The Limits of Principlism

Part of the flaw of the above frequently-proffered arguments is the framework on which they rest. Whether explicitly or implicitly, any "ethical analysis" of the use of Pernkopf's work relies on modern bioethical principles of research for justification or impermissibility of use. However, we argue this analysis is too limiting.

The end of World War II, the Nuremburg Trials, and the subsequent promulgation of the Nuremberg Code are often portrayed as having signaled a paradigm shift in the way scientists approach research participants. The ten paragraphs that comprise the Code begin by defining informed consent as the cornerstone of good research, stating that "voluntary consent of the human subject is absolutely essential." The Code continues on to condemn "force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion"[57] This ideal has been reiterated in the World Medical Association's Declaration of Helsinki (1964) which states that research that does not comply with the requirements of the declaration should not be accepted for publication.[58] The 1979 promulgation of The Belmont Report ushered in the formal age of principlism with its three principles of Respect for persons, Beneficence, and Justice.[59] Most recently, The Revised Common Rule sets forth the requirements for conducting research at institutions that receive federal funding. The Common Rule makes requirements of informed consent arguably the most important ethical consideration for a researcher.[60]

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[57] "Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10," Vol. 2, 181-182, para. 1. Washington, D.C.: U.S. Government Printing Office, 1949.

[58] World Medical Association, "World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research involving Human Subjects," *JAMA* 310, no. 20 (2013): 2191-2194.

[59] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," (1979), in U.S. Department of Health & Human Services, accessed August 20, 2019, https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html.

[60] U.S. Department of Health and Human Services. "The Revised Common Rule," 45 CFR 46

None of these codes, however, tell us what to do with research that has already been conducted. Beyond that question, it is worth pondering whether principlism is really what stands between us and our capacity for something as horrifying as the circumstances under which the Atlas was created. Research by Jachen Vollmann and Rolf Winau indicates that Germany, and Prussia before it, had one of the world's first research ethics codes.[61] In 1891, the Prussian minister of the interior established a policy forbidding the administration of tuberculin to prisoners with tuberculosis unless the patient consented.[62] Subsequently, in 1898, Dr. Albert Neisser of the University of Breslau tested a syphilis-prevention on a group of prostitutes. The vaccine was unsuccessful and several of the prostitutes contracted syphilis. After public outcry and the publication of a collection of 600 cases of unethical human subjects research, the minister of religious, educational, and medical affairs issued a directive to hospitals requiring consent for non-therapeutic research and barring research on individuals who were minors or who were incompetent to give consent.[63] Perhaps most notably, in 1931, three years before Pernkopf joined the SA, the Reich Minister of the Interior issued guidelines for research in Germany that expressly included requirements of informed consent in non-therapeutic research.[64]

This sequence of events is surprisingly similar to the fallout from the infamous 1966 publication by Henry Beecher in the NEJM in which he highlighted the multitude of ethics violations depicted in medical journal publications in the United States.[65] Beecher's article would eventually lead to Senate hearings on the Tuskegee syphilis experiments and the promulgation of The Belmont Report in 1979. The problem then, was not that the Nazis did not have codified principles for research ethics. The problem was that they simply did not follow them, or perhaps found them inapplicable to the particular kind of research they were doing or the research subjects they were using.

None of these ethical principles or codes could tell us what to do with a book like Pernkopf's Atlas. Having looked at this book, these codes seem wholly inadequate to the task. There is a heaviness to these texts that cannot be measured in ounces. It is deeply disturbing to leaf through its pages with the knowledge of its likely contents. To look at the emaciated faces depicted

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et seq. (2018).

[61] Jachen Vollmann, and Rolf Winau, "Informed Consent in Human Experimentation before the Nuremberg Code," *British Medical Journal* 313, no. 7070 (1996): 1445-1449.

[62] Ibid., 1445.

[63] Ibid., 1445-1446.

[64] Ibid., 1446.

[65] Henry Beecher, "Ethics and Clinical Research," *NEJM* 274, no. 24 (1966): 1354-1360.

in its illustrations is to quite literally look into the face of a history many of us would rather not think about. "Informed consent," the centerpiece of modern bioethics codes, is not really the fundamental ethical issue raised by the Nazi project. As if informing of risks and benefits and asking permission would somehow have mitigated the ethical problem both then – with the genocidal aims of Pernkopf and the Third Reich – and today – with our remaining question of "What now?"

We suggest that if we are to ethically engage with Pernkopf's Atlas, it will require us to fundamentally alter our understanding of what the book *is* and what the book *means*. The discussion is larger than whether the book belongs in an anatomy classroom or can ethically be used in instruction in anatomy. As the truth of the Atlas's story unfolds, the referent that is "Pernkopf's Atlas," the thing that is this book, has changed. To say that Pernkopf's Atlas is only an anatomy textbook, is no longer to say something that is true. It is so wholly incomplete as to be false. The framework of principlism fails; it is simply not large enough for Pernkopf.

V. Towards a Humanities Approach to Anatomy Instruction

Because we must consider whether Pernkopf's Atlas is ethically relevant, it is important to re-emphasize the sensitive nature of the discussion. If the debate is approached without hesitation, unease, or even with bold repugnance and opposition, we miss the point and the potential. It is largely because of the sensitive nature of the debate that we *should* proceed. To stop all use of the Atlas would be too irresponsible and would ignore the complexity of the issue. Therefore, there exists an obligation to think deeply about how to move forward appropriately.

The Atlas should not be removed from the anatomy classroom or the library shelves altogether. Instead, its treatment requires a much broader, more interdisciplinary approach, one which is not reliant solely on principlism, or even ethics, as construed narrowly. Rather the text and what to do with it invites conversations of narrative and history and a kind of completeness of understanding that is not accessible if the text is seen solely as an anatomical atlas. As the Atlas transitions back into the classroom for the purpose of instruction, medical humanities provides the only appropriate and responsible method for addressing it.

VI. Medical Humanities

Medical humanities is an interdisciplinary endeavor bringing together various disciplines within the humanities and social sciences to better understand, enrich, and inform health, disease and healing. In a clinical sense, it reminds us that

human beings are at the heart of medicine – they are people *with* injuries, *with* disease – *people* experiencing illness and suffering and death. In an academic sense, medical humanities teaches us about where we have been and how it all began. Hippocrates, Galen, Vesalius, Virchow, Harvey, Semmelweiss, and others help us understand what happened – how we got here and how to proceed. Medical humanities also encourages us to consider the complex nature of ethical issues in medicine so that through careful deliberation we might arrive at reasonable resolutions about how to act. Because we need to always remember that mere clinical facts are often not enough – the individual patient story is almost always begging to be realized – the various disciplines within medical humanities come together to ensure a more responsible and comprehensive, yet compassionate approach to medicine and healthcare in training and in practice.

In an attempt to define medical humanities, Howard Brody proposes a robust definition including three conceptions, which include 1) a list of disciplines, 2) a program of moral development and 3) medical humanities as a supportive friend. Each, according to Brody, is examined through the lens of a particular narrative so that we are reminded that "the conceptions of the humanities are linked to ways of living our lives and of addressing problems in the real world."[66] In other words, the narrative is not just a way to illustrate the conception, but presents as the essential core of the discipline. Ultimately, by proceeding under the assumption that the medical humanities involves three complementary narrative-based conceptions, we are bound to more fully "educate future health professionals who will adopt a more critical and reflective stance toward their work and toward the knowledge that informs it."[67]

This is precisely why we view the Atlas through the lens of medical humanities. Brody's first conception relies on the disciplines which comprise the medical humanities. Medical humanities operates within three core disciplines including literature, history, and ethics, and together these form the interdisciplinary lens through which we should view the Pernkopf debate. The complicated history of the text and its inherent, yet glaring ethical issues must be considered, but perhaps most importantly, the examination of the text from a literary point of view, as a form of narrative, or story, is essential. For this purpose, we subscribe to Kathryn Montgomery's conception of narrative and its relationship to story: "in using the word narrative somewhat interchangeably with story we mean to designate a more or less coherent written, spoken, or (by extension) enacted account of occurrences, whether historical or fictional."[68]

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[66] Howard Brody, "Defining the Medical Humanities: Three Conceptions and Three Narratives," *Journal of Medical Humanities* 32, no. 1 (2011): 5-6.

[67] Ibid., 7.

[68] Kathryn Montgomery-Hunter, Narrative, Literature, and the Clinical Exercise of Practical

One may argue that Pernkopf's Atlas alone does not constitute a narrative or story, yet the broader inter-textuality of the Altas among the laws, discourses, and science literature of the time reveals such a story. The genre of textbook becomes obsolete as it is seen through this new interdisciplinary lens, and this becomes a mandatory viewing. Thomas Murray continues that "while the differences among the genres are at least as interesting as the similarities, the one important thing that they share is their implicit or explicit contrast to the view that the substance of morality consists of the set of true propositions."[69] It is useful to proceed under this assumption.

VII. A Narrative Approach

Regarding Pernkopf's Atlas, it is our responsibility to critically and carefully examine what lies in front of us with what we know to be true, while also and perhaps most importantly realizing the *inevitable gaps* in our understanding. How we approach the gaps – how we identify the true moral particulars of *the story* – has the potential to help us construct a meaningful narrative and glean a new understanding. Subsequently, through the development of a more intense moral imagination, we begin to work toward a sense of empathy, or at least a comprehensive way of knowing as we engage in a thorough and more responsible form of pedagogy.

Martha Nussbaum suggests that "style itself makes its claims, expresses its own sense of what matters. Literary form is not separable from philosophical content, but is, itself, a part of content – an integral part, then of the search for and the statement of truth."[70] The form is in part shaped by the content and the content is of course essential to the form – each relies on and illuminates the other. It may not seem, at least initially, as if Pernkopf's Atlas has any real literary form. However, by either assigning it literary form, or at least by viewing it through a literary lens, we can begin to uncover and develop the story, making sense of what is otherwise unclear. While Nussbaum refers to novels for the majority of her work, applying her framework to the Pernkopf text, allows for the construction of the narrative, producing similar benefits. To begin, students and other users of the text should consider the following questions:

Reason," *The Journal of Medicine and Philosophy* 21, no. 3 (1996): 306.

[69] Thomas Murray, "What Do We Mean by 'Narrative Ethics?,'" in *Stories and Their Limits: Narrative Approaches to Bioethics*; ed. Hilde Lindemann, 3-17 (New York: Routledge, 1997), 6.

[70] Martha C. Nussbaum, *Love's Knowledge: Essays on Philosophy and Literature* (New York: Oxford University Press, 1990), 3.

- Who is speaking? Who are the characters and who is the author?
- What are the relevant (and perhaps irrelevant) points of view?
- Do the characters have personalities? Which parts of the personalities are appealing, and which are not. Why?
- What overall shape and organization does the text seem to have? Form?
- What type of degree of control does the author have over the material?
- What status is claimed for the voices?
- Does the text give pleasure? If so, at what cost (if any)?
- To what extent do particular people, places and contexts figure?
- How precise is the text concerning its subjects?
- How does the text treat the contradiction? What is the contradiction?
- Does the text offer explanations?
- What does the text in question seem to say, or show, about human life, about knowledge, about personality, about how to live?[71]

Different from the novel, when applying these questions to a text like Pernkopf's Atlas, students are not provided explicitly with the details. Rather, they have to put in the time and do the work, examining the text for purposes beyond identification of tendons or nerves. As they identify, evaluate, analyze, and apply the context to the existing gaps, students begin to construct a morally relevant, and useful, story. While all of Nussbaum's questions require consideration, there are two which seem to be the most significant to the transition from anatomy text to narrative. The first requires consideration of the contradiction, which exists in the very purpose of the text. The second addresses our treatment of the text, and its representation of human life and ultimately, how we should live.

The first question considers how the text treats the profound contradiction of its creation and prompts us to define that contradiction. The contradiction, of course, is that Pernkopf created an anatomical atlas, with an intent to represent the ideal human form, for the purpose of anatomy instruction in medical education. However, it is true that the Nazis, including Pernkopf, had only one narrow view of "human" with all others – Jewish, Homosexual, Disabled, Roma – viewed as less than human. And yet, it was *these bodies* that filled the pages of Pernkopf's Atlas and, thus, from which students have taken their instruction on the ideal form of the human for more than half of the 20th century. Herein lies the central paradox of Pernkopf. To truly engage with the

[71] Ibid., 32-35.

text in any ethically permissible manner requires the reader to consider how the text treats that contradiction, while identifying the relevant contextual details that can be added to the story to more clearly illustrate and define the contradiction.

The second question – what does the text in question seem to say, or show, about human life, knowledge, personality, and how to live – is ultimately what students must consider as they examine the full narrative. More specifically, what does the text say about human life, considering the author's position, the artists' allegiance, and the lives of those whose bodies are depicted? Who were they? What were their lives like? What were they resisting? How did they end up as anatomical subjects in a text created by Nazis? Further, what does the text tell us about knowledge in general and how that knowledge is obtained? To be sure, there are methods of obtaining knowledge that are ethically inappropriate. But what is our assignment when we find ourselves face to face with that knowledge? Students engage with it in an ethically appropriate and responsible manner, while also asking the difficult questions before determining how to move forward. Finally, we consider our own personalities and how they are formed by what we know and how we know it.

Once all of these things have been explored in-depth, we can begin to articulate what has been learned about how to live, even while remaining at odds regarding the ethical truths.[72] The goal of this kind of critical engagement is not to land on a single correct answer. Rather, the appeal of narrative exploration and construction is that it provides context so that we might learn from its various interpretations and consider carefully what it might be like to be someone very different from ourselves; someone with a very different story.

Re-framing the text into a fuller, more complete narrative, equips us to consider our responsibilities from an ethical point of view. Through expansion of our own moral imagination, and with the tools necessary to consider complex ethical questions, we begin to approach ethical decision making *in practice* more responsibly. Principlism remains a useful guide, but a shift toward a narrative approach to help us navigate the murky waters of the most complex ethical issues, as demonstrated by the utility of Pernkopf and the troubling paradox it presents, is required.

Reframing the analysis into one which values narrative allows us then to reframe the ethical debate into one whereby narrative supplies the essential elements absent from an archaic principled ethical analysis. Narrative

[72] Ibid., 203.

> [...] aims not at an explanation but at understanding. It moves us to ask: What happened then, and then what...? And whatever happens next in a narrative will follow intelligibly, though not by entailment, from what occurred before as the story unfolds. Narratives are normative in that they shape our perceptions and mold our moral sensibilities and practices. We relate to each other along the lines of stories we adopt and are adopted by. Stories that speak to us transform us and our ways with the world.[73]

Therefore, in terms of pedagogy, the artifact itself has value, but *only* within a much larger narrative context. The Atlas should not be used simply as an anatomy text – we see this as not only incredibly limiting from an educational perspective, but more importantly, morally irresponsible. Further, the text with an accompanying letter explaining Pernkopf's affiliation with the Nazi party is not sufficient. Rather, we envision an extensive, critical examination of and engagement with the text from historical, ethical, and literary perspectives: Specifically, a critical and reflective medical humanities approach.

VIII. Conclusion

The Holocaust is often portrayed as the consequence of a State gone mad, the brainchild of a ruthless dictator with a distorted vision of the ideal man and a genocidal project by which to achieve those ends. As Robert Proctor has noted however, this narrative incorrectly suggests that "Nazi racial policy [...] was imposed *on* [the scientific] community" when in fact, it "emerged from *within* the scientific community."[74] The risk of this inaccurate portrayal of the role of medicine in the Holocaust is a de-emphasis on the enormous power and responsibility of clinicians or to suggest that the various codes currently in place somehow insulate us from such atrocities ever occurring again. This is a difficult argument to make, though, when infamous research ethics violations such as the Tuskegee syphilis experiments continued not only after Nuremberg, but after Helsinki and other international guidelines on research.

According to philosopher Carl Elliott, bioethicists and doctors often use language in a way that simply describes the world, rather than considers its

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[73] Ron Carson, "The Moral of the Story," in *Stories and Their Limits: Narrative Approaches to Bioethics*, ed. Hilde Lindemann, 232-237 (New York: Routledge, 1997), 233.

[74] Robert N. Proctor, "Nazi Doctors, Racial Medicine, and Human Experimentation," in *The Nazi Doctors and the Nuremberg Code*, ed. George Annas, 17-31 (New York: Oxford University Press, 1992), 28.

content.[75] While it is important to collect the data and present the facts, this focus on *what* we say often results in detrimental misrepresentation, as has happened with the Pernkopf debate. Instead, the way the information is presented – the language used, and the style with which it is used – allows us to not just represent the narrative, but also to interpret it and create new meaning.[76] Pernkopf's Atlas is a work of art, both in the traditional sense and also as a form of literature. It is neither good nor bad. It is, rather, a very important narrative that requires critical and reflective examination so that it may serve to educate future healthcare professionals in a way that is consistent with our understanding of the value of the human condition, lest we not lose our understanding of who we are and where we come from.

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[75] Carl Elliott, *A Philosophical Disease: Bioethics, Culture and Identity* (New York: Routledge, 1999), 123.

[76] Ibid.

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Jewish Doctors' Challenges in the Death Camps: Ethical Dilemmas? Choiceless Choices? The Human Condition?

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Abstract

Most commentators have focused on ethical dilemmas and the idea that they were core to the actions of and decisions by Jewish doctors in SS concentration camps and ghettos during the Holocaust. While I recognize Jewish doctors did face ethical dilemmas, in this article, I shift my attention to include two other significant factors: choiceless choices, defined by the eminent Holocaust historian Lawrence Langer as "crucial decisions [that] did not reflect options between life and death, but between one form of abnormal response and another, both imposed by a situation that was in no way of the victim's own choosing," and the human condition, whereby decisions and actions were triggered by personal traits and past experiences in response to particular situations and circumstances. Inherent in all three factors is the tenaciousness of reality and how the abhorrent conditions, immorality, inhumanity and evilness cast a shadow over every moment of the Jewish doctor's life. My thesis is that decision-making was not one-dimensional but multi-dimensional. For the Jewish doctor every incident became a source of dread and tragedy. They were often not trained to treat some diseases or perform surgery and lacked experience to work in such conditions and cope emotionally and psychologically. I will attempt to show that how a person responds to an ethical dilemma is based on his or her own experiences and reasoning, and how they reacted to sudden and inexplicable incidents that threatened life or impacted survival induced abnormal actions and decisions. As Jewish doctors they were driven to be healers, to be normal, but they were forced by circumstances to kill or become perpetrators, acting abnormally. Tragically the abnormal became the norm. The Jewish doctors were professionally trained and culturally socialized to continue their roles as doctors. Nevertheless, they were human and were driven by the innate will to live.

Key-words: *ethical dilemmas; choiceless choices; human condition; Jewish doctors; survive; Hippocratic oath; life; death*

"How did I keep alive in Auschwitz? My principle is: myself first, second and third. Then nothing. Then myself again – and then all the others. This formula expressed the only principle which was possible for Jews who intended – almost insanely intended – to survive Auschwitz."[1]
Dr. Ena Weiss

I. Introduction

In traditional Judaism, a cardinal law "requires the physician to do everything in his power to prolong life, but prohibits the use of methods that prolong the act of dying."[2] This law remains a fundamental truth that dictates the reality of medicine as well as Jewish medical ethics. However, in the dark murderous days in the SS death camps in which every Jewish person was sentenced to death,[3] almost every moral code and set of values, personal and professional, was ignored or abandoned by a certain number of Jewish prisoners including doctors. A void existed between theoretical law and reality as Jewish doctors were forced to abandon their core personal and professional ethical values in order to survive. The shame and disgust they felt in view of this aberrant behavior is expressed in the surviving doctor's memoirs and diaries, such as in those of Gisella Perl, Louis Micheels, Miklos Nyiszli, and Elie Cohen.

Why a doctor made decisions or acted in a particular way under such excruciating conditions is known only to him or her. While their memoirs provide some answers, nonetheless questions remain regarding their actions or motivations. We should take a more balanced view of the doctor as a healer and as a normal human being. So, we need to continually ask questions. How should the Jewish doctor be viewed in the death camps in her role when treating patients and what should our expectations be regarding what decisions were made? Must we view the Jewish doctor purely as a physician weighing which decision entailed the lesser evil, or should we view the Jewish doctor as a person, a human being with an innate drive to survive? As a Jewish prisoner with common human strengths and weaknesses such as resilience, compassion and empathy in the former and a person of fallibility, weakness, frailty, imperfection and vulnerability in the case of the latter? Was an ethical dilemma present when there was no doubt of the outcome? Although we acknowledge most Jewish doctors attempted to honor the Hippocratic oath,

[1] Lawrence Langer, *Versions of Survival: The Holocaust and the Human Spirit* (Albany, NY: State University of New York Press, 1982), 72 (the quote in the abstract is also from the same page); also Ella Lingens-Reiner, *Prisoners of Fear*, trans. Ilsa Barea (London: Victor Gollancz Ltd, 1948), 118.

[2] Fred Rosner, "The Jewish Patient in a Non-Jewish Hospital," *Journal of Religion and Health* 25, no. 4 (1986): 31.

[3] At the Wannsee Conference on January 22, 1942 the date on which the Final Solution was resolved and all Jews were sentenced to death and all SS camps became death camps.

what was the power of other forces such as the natural instinct to stay alive? The answers to these questions are important because it allows us to debate upon what grounds and for what reason decisions were made and actions taken.

My contention is that the human condition and the drive to survive were innate and powerful forces that drove Jewish doctors to make the abnormal decisions they needed to make in order to live. Under the terminal circumstances it is understandable that on occasion prisoner doctors would do anything, even kill another human, to preserve their own life. I propose that the decisions made by doctors were not one-dimensional or merely the response to a difficult question of ethics; rather, they were made in response to a combination of factors: *ethical dilemmas, choiceless choices* and the *human condition*.

To compare any facet of life in the SS extermination camps during the Holocaust with so called "ordinary life" in the Western world is impossible. According to Fred Rosner, Professor of Medicine at Mount Sinai School of Medicine and an expert on Jewish medical ethics, "right and wrong, good and evil are absolute values that transcend the capricious variations of time, place and environment as well as human intuition or expediency."[4] Their situation was unique because the whole apparatus of Auschwitz was industrial murder on a grand scale without morality, ethics and, in particular, without conscience. To survive, the abnormal became the normal and humans became animal-like. By way of a well-planned and efficient operation the SS either murdered the Jews upon arrival at the camps or commenced a program of genocide that first stripped each Jewish prisoner of their identity and humanness and finally of their mind and life.

Before expanding on my thesis, the following are brief examples of types of challenges faced by three Jewish doctors:

> a. During roll call, when every tenth prisoner was executed and Dr. Albert Haas realized he was that next tenth prisoner, he switched places with a *Muselmänn* which in Auschwitz jargon was the name for a prisoner who had lost all hope and literally committed suicide by starving to death. He refused to work or obey orders such that he was beaten to death by SS guards and even at times by fellow prisoners. The prisoners had no regard or respect for the Muselmänn and despised them for their refusal to follow orders often meant all prisoners were punished. Haas acted to save his own life at the expense of his fellow prisoner. He was forced to act abnormally. He killed the Muselmänn. If he wanted to live, he had no choice but to take that action.

[4] Rosner, 318.

b. Dr Lucie Adelsberger, who worked in Birkenau, was forced to choose which patient was to receive medication and who would go without. Her decision was not made under threat to her own life, but medication was extremely scarce and her options were few. Her choices had consequences. Giving medication to one patient to save his or her life or to another to reduce his or her suffering caused the death or continued suffering of others. Her options were negligible since she could not rely on the benefits of triage due to the sheer number of patients and the grim shortages in medical supplies. Although her life was not threatened at the time, she was certain of her fate, sentenced to Block 11, the dreaded prison block where few came out alive, or execution if she refused to carry out orders.

c. Dr. Alina Brewda was allegedly observed having dinner, including wine, with some colleagues in her block. Patients under her care were sick and dying and all were malnourished. It is here Brewda had a choice. Either to share the food and beverage with the prisoners – particularly those in most need – or to feast on the food and wine with her colleagues. The importance of this decision is addressed further in the paper.

These same doctors were extraordinary by virtue of their acts of care and courage. Their position was enigmatic, since, on the one hand they were healers, yet on the other, according to Langer they were forced to make abnormal decisions to save the lives of others or to save their own life. The dilemma that confronted Adelsberger was different from that faced by Haas, yet both point to a common seed from which grew similar as humans. Regardless of any personal or professional ethics, human beings are driven by the human condition. This certainly was the case with Brewda, whose behavior appears selfish and abnormal, yet in Auschwitz it was normal. Thus, we have three cases, each of which represents a different scenario and separate responses according to the circumstances and conditions but which are each linked to a single factor: the intrinsic humanness of each person. Haas thought his life was threatened on a number of occasions and acted accordingly and, at times, not in the best interests of the prisoner. Despite his respect and commitment to the Hippocratic oath and his awareness of his obligations to patients, his actions on some occasions reveal he was driven by the will to live.

This brings up a range of perplexing feelings and thoughts about ethics, morality and the meaning of life. In the death camps every Jewish doctor was followed by the shadow of death and, paradoxically, frequently became the shadow of death that followed the Jewish prisoner. For example, sick prisoners were reluctant to report to the infirmaries and hospitals for fear of

being considered by both the Jewish and SS doctors as too weak to return to work and thus *selected*[5] for execution. The uniqueness of the situation in the case of the doctor was the torment of the decisions that had to be made between the lives of patients on the one hand and the survival of the doctor on the other. Decisions were made on the conditions and circumstances at any one time and according to the natural instincts and past experiences of the doctors. Conjecture and opinion by historians and survivors can distort reality. Primo Levi, a survivor of Auschwitz and highly respected scholar and philosopher specializing in matters of the Holocaust, particularly Auschwitz, states that only the worst of the prisoners survived.

> The 'saved' of the Lager were not the best, these predestined to do good; the bearers of a message... Preferably the worst survived, the selfish, the violent, the insensitive, the collaborators of the 'grey zones,' the spies. It was not a certain rule (there was none, nor are there certain rules in human matters), but it was, nevertheless, a rule... The worst survived – that is, the fittest; the best all died.[6]

Levi doesn't distinguish between the different types of survivors. Does he include the Hungarian Jews who arrived in the six months before Auschwitz was liberated? Or prisoners who worked as clerks in the Schreibstube (the administration office), gardeners or Jewish doctors? Labelling all survivors as the "worst" is arguably misleading.[7] According to the memoirs of survivors, the worst of the prisoners who survived were the Kapos (prominent prisoners who oversaw the blocks and work gangs) and Blockälteste (the block elders who were Kapos and in charge of prisoner blocks). I could find no evidence to suggest that Jewish doctors were violent or cruel, although some of their actions were inarguably not exemplary.

Literature addressing Jewish doctors and the Holocaust, particularly that written since the beginning of the 21st century, has emphasized ethical dilemmas as the main source of discord when making clinical decisions. It is paradoxical that in an effort to save a patients' life, suffering a high fever

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[5] Selections occurred mainly in the hospitals and infirmaries. The Jewish doctors were ordered to select a certain number of Jewish prisoners too sick to return to work to be executed. The executions were carried out by Phenol injections, firing squad, or through the gas chambers. The Jewish doctors would be given a number – 20 prisoners – and they selected the number required who were presented to a SS doctor who authorised the execution. This was one of the most onerous tasks of the Jewish doctor.

[6] Primo Levi, *The Drowned and the Saved*, trans. Raymond Rosenthal (London: Abacus, 1989), 62.

[7] I have no evidence who or what groups survived and Levi doesn't provide details or evidence of his accusations.

indicating typhoid, a doctor in the name of medical ethics would falsify medical records with the likely consequences of exposing hundreds of prisoners to the deadly disease. On one occasion Elie Cohen, the doctor of a block, suspected a prisoner with a high fever may have had typhus or malaria. Cohen decided to take a swab to the pathologist. The prisoners disagreed with his decision, aware they were potentially indirectly exposed to the virus. Upon returning Cohen discovered the sick prisoner had been murdered. Thus, Cohen faced his ethical dilemma by taking steps to save the patient, yet put at risk the lives of hundreds of prisoners. If a prisoner was found to have a fever, the policy of the SS was to murder the suspect prisoner and all block prisoners. The block was usually burnt to the ground. Did Cohen have the right to put the lives of hundreds of prisoners at risk to save one prisoner?

II. Moral Requirements

From a philosophical perspective, it is difficult to argue Jewish doctors were expected to act in accordance with a normal theory of ethics or standard of morality – be it utilitarianism/consequentialism, deontological or another framework. I would argue the label the theory of ethics befitting the abnormal actions of and decisions by the doctors as that of utilitarianism with the consequences of caring for the fate of the many as opposed to the few. This was not always the case for many decisions were made to benefit the self.

Collective consequentialism is a theory of pattern-based reasons and, according to Derek Parfit, the distinguished late 20th and early 21st century British philosopher, "it claims that you should play your part in the best pattern of action performable by your group, because it is your part in this best pattern."[8] This was the case when Cohen murdered and continued to kill individual prisoners to save members of his block. A doctor treating patients attempting to distribute scarce drugs would be considered virtuous; however, the decisions made could be colored by influencing factors such as nationality, or in such cases whether or not thepatient could pay for medication or bring their own medical supplies and medication. A doctor could be considered virtuous when dispensing drugs; however, in reality the drug was chosen not for the specific illness or injury but according to availability and access. Still, whatever the decision the doctor would have been aware that a life saved meant a life lost. The ethical theory of deontology based on the premise that the morality of an action is based on the action itself being right or wrong rather than consequences being good or bad. Good and evil, right and wrong, are definitive values that go beyond the unpredictable variations in time, circumstances and conditions as well as human belief or anticipation.

[8] Derek Parfit, *Reasons and Persons* (Oxford: Clarendon Press, 1987), 31.

Under every measure, and endorsed by two survivors of Auschwitz, imminent philosophers Primo Levi and Jean Améry, the circumstances facing the Jewish doctors and the prisoners were unique and beyond judgement. Another Auschwitz survivor testified:

> The camp had its own ethics, its own idea of right and wrong. It was the ethics of misery, boundless poverty and total humiliation of a human being. Thoughts seized, bodies suffered, souls died or fell into nothingness.[9]

Based on the above comments, the SS camp had abandoned ethics, goodness and decency, replacing them with their own standards, those of immorality, destructiveness and genocide. The Jewish doctors attempted to adhere to their own values that could normally be measured by reference to ethical theories and of course a code of medical ethics. Deontology suggests actions are good or bad according to a clear set of rules. Utilitarianism is a normative ethical theory that places the locus of right and wrong solely on the outcomes (consequences) of choosing one action over other actions. As such, it moves beyond the scope of one's own interests and moves beyond the self to the interests of others. The dominating factor when facing ethical dilemmas in the extermination camps was the perseverance of reality. Two cases can be compared which may appear the same at first, yet due to circumstances are different.

An actual case is that of Elie Cohen who was forced to make the decision between the life of one prisoner and four hundred prisoners including his own life and a hypothetical case[10], introduced by the British philosopher Dr. Bernard Williams, of Jim and Pedro, in which Jim is confronted with the ethical dilemma of killing one person or causing the death of twenty people.

In both cases it is a question of the execution of one prisoner to save the lives of many prisoners. In Cohen's case his life would have been lost along with the four hundred prisoners, however Jim's life is not in danger if he fails to carry out Pedro's orders. Although Cohen was aware that as a doctor he was crossing the line by taking a life, his actions were to save the lives of four hundred prisoners by killing one prisoner. Or to save the life of one prisoner and cause the death of four hundred prisoners. Saving four hundred prisoners, including the self, was a normative ethical action with the consequences of saving the life of the majority. Cohen knew the reality of his situation. He was certain one or four hundred prisoners were going to die. Jim, on the other hand,

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[9] Paul Rosenzweig, "Written Testimony of Document 0-3/437," *Yad Vashem Archives* (1948): 59.

[10] Christopher Woodward, "Pedro's Significance," *Southern Journal of Philosophy* 47, no. 3 (2009): 301-319.

is in a different position because his life is not threatened, he doesn't know any of the prisoners and has no attachment to them culturally or socially; he also doesn't know Pedro. In addition, he is not a doctor and has no allegiance to a sacred code of ethics. In reality, he doesn't know if Pedro will kill the rebels if he refuses to kill the prisoner. He also doesn't know if Pedro will kill the remaining prisoners even if Jim does kill the prisoner. Cohen's goal was to survive and to save the life of four hundred other prisoners. Jim could walk away because his own life was not threatened and he had no allegiance to the twenty native Indians. Nevertheless, according to Williams if Jim does nothing and Pedro kills the American Indians, Jim is responsible for killing the Indians. Jim is committed to a doctrine of negative responsibility. In this case Williams loosely equates consequentialism with *negative utilitarianism* saying "[...] if I am ever responsible for anything, then I must be just as much responsible for things that I allow or fail to prevent, as I am for things that I myself, in the more everyday restricted sense, bring about."[11]

The two cases demonstrate the complexity and intricacy of inconceivable ethical dilemmas. Both are ethical dilemmas with terrible consequences as a result of abnormal decisions and reliant on the human condition.

III. Ethical Dilemmas

The doctors' situation during the Holocaust was unique. The structure of the medical system in the camps was organized to ensure the Jewish doctors participated in every program and policy involving the treatment and the eventual death of Jewish prisoners. This involvement gave legitimacy to the actions and policies of the SS doctors. The master/servant relationship between the Jewish doctor and the SS doctor solidified and crystalized that association evidenced by the absence of freedom of choice or rights and living under the fear of death or torture for the slightest infringement. Associate Professor Karen Allen of Oakland University's Social Work program states there are three conditions that must be present for a situation to be considered an ethical dilemma:

> The first condition occurs in situations when an individual must make decisions about which course of action is best. Situations that are uncomfortable but that don't require a choice, are not ethical dilemmas [...] The second condition for an ethical dilemma is that there must be different courses of action to choose from.

[11] Steven Cahn, and Peter Markie, *Ethics: History, Theory and Contemporary Issues* (Oxford: Oxford University Press, 2016), 612.

> Third, in an ethical dilemma, no matter what course of action is taken, some ethical principle is compromised. In other words, there is no perfect solution.[12]

Allen's definition is acknowledged and applicable to most situations in which a decision must be made between two options, each of which entails an ethical compromise. It is, however, not a very useful way of understanding the decisions Jewish doctors were forced to make when decisions lay outside any usual considerations of an ethical dilemma. Their position was incongruous and absurd, yet it was reality. Factors, such as, death, torture, imprisonment, and loss of privileges that influenced and determined doctor's decisions and actions, were basically set in stone.

According to Dr Lingens-Reiner, a survivor of Auschwitz and author of *Prisoners of Fear,* as a result of her successful efforts to save a prisoner's life another prisoner was condemned to death:

> [...] by facing a great risk, I had achieved nothing. If I rescued one woman, I pushed another to her doom, another who also wanted to live and had an equal right to live. "We'll have to take another in her place." And for this I risked never seeing my child again! Was there any sense in trying to behave decently? It was difficult not to despair.[13]

The doctors were confronted with many tasks that compelled them at times to abandon beliefs, ethics, laws, customs, conduct and conventions. A doctor might participate in a selection, distribute scarce medications or carry out an abortion, all in the one day, tragically much of which led to the death of or increased suffering by patients. The most sacred tenet of the Hippocratic oath was to do no harm, yet a patient or prisoner died or suffered because of the decisions of a doctor.

Dr. Adina Blady Szwajger, a survivor of the Warsaw ghetto, recalls her dilemma when she learned that the children in her hospital were to be sent to Auschwitz. She was aware of the terrible suffering they would inevitably endure and made the decision to kill the infants and children before the Nazis could take them:

> I took the morphine upstairs. Dr Margolis was there and I told her what I wanted to do. So, we took a spoon and went to the

[12] Karen Allen, "What is an Ethical Dilemma?" *The New Social Worker*, *https://www.socialworker.com/feature-articles/ethics-articles/What_Is_an_Ethical_Dilemma%3F/.*

[13] Lingens-Reiner, 92.

> infants' room [...] so now I poured this last medicine into those tiny mouths... So, they lay down and after a few minutes – I don't know how many – but the next time I went into the room they were asleep.[14]

In her memoirs, Blady Szwajger infers that she had "no choice." Morally she thought it was the right thing to do. Philosophically, the theory of utilitarianism – of deciding what action will achieve the greatest good for the greatest number – would explain Blady Szwajger's decision. While we would not normally term choosing to kill children 'achieving the greatest amount of good,' Blady Szwajger was striving to create the least amount of harm by preventing a greater amount of suffering she felt certain the children would otherwise have to endure. Arguably, it is a complex case of facing not only an ethical dilemma but also the forces of the human condition of empathy, fear, anxiety, foreboding and other emotions. The fate and suffering of the children were uppermost in her mind. The case of Blady Szwajger is indicative of the complexity encountered when examining ethical dilemmas faced under extreme adversity and when the victims are facing a death sentence. Lingens-Reiner, recalls:

> In fact, in our situation normal principles of human and professional ethics broke down, because the problems we had to face were previously non-existent, and in dealing with them we did not know what to do.[15]

Albert Haas' response to a situation that falls into the category of an ethical dilemma occurred while he wasoperating on a fellow prisoner:

> I had a split-second decision to make [it]. Should I use some priceless Evipan on an apparently unconscious and dying man, or save it to barter for life sustaining favours? I decided to save it, and prayed that the man on the table would die before I began to cut. As a doctor in Gusen II, I had to make such terrible choices almost daily.[16]

Haas faced the dilemma of choosing between the self and the patient. He chose himself over the patient by withholding valuable Evipan that could relieve the pain and suffering of a patient during his last moments before death. He was

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[14] Adina Blady Szwajger, *I Remember Nothing More: The Warsaw Children's Hospital and the Jewish Resistance*, trans. Tasja Darowska, and Danusia Stok (London: Collins Harvill, 1990), 57.

[15] Lingens-Reiner, 12.

[16] Albert Haas, *The Doctor and the Damned* (New York: St Martin's Press 1984), 5.

well aware of what he was doing and why. Haas was anticipating his future, thinking of his survival. Although his life was not in immediate danger, under the horrendous conditions and circumstances, Haas, like most prisoners, had developed what Simon Baron-Cohen describes as a deep-seated self-centeredness.[17]

There were doctors who committed suicide rather than behave according to Hobbes' Law of Nature as did Haas and Blady Szwajger, or question their obedience to the Hippocratic Oath as did Lingens-Reine.

IV. Choiceless Choices

Dr Elie Cohen was the doctor in the "lunatics room" of his block and was ordered to keep the patients quiet. It was made plain to him by the *Blockarzt* (prisoner block doctor) on instruction from the *SS Schutzstaffel* (SS) that he and all the prisoners in his block would be executed if there were any further disturbances, particularly if prisoners attempted to escape. After consulting with Valentin, a fellow prisoner, Cohen saw no other option than to kill the next prisoner who, by creating a disturbance attracting the ire of the SS, posed a threat to Cohen's life and that of the other prisoners. Aware of the murderous intentions and history of the SS, Cohen sought the help of a fellow prisoner, Valentin, to kill the next offending prisoner:

> And [...] it's always the first step that counts. For a few weeks later, it happened again. But by that time, I had far fewer scruples about going upstairs again and saying to Valentin, 'Same old thing. We'll have to do it again.'And we did too, and that man died as well. It was quite simple, of course, for you just filled something on the deceased's cards. Pneumonia [...] anything you liked. For it was all a farce in that room. I kept a very neat chart for each patient, showing his temperature and even the medicines we were giving him. Or were not giving him, even though they were entered on his chart.[18]

The language Cohen uses, particularly "Same old thing [...] I kept a very neat chart for each prisoner,"[19] suggests his actions were mechanical and he had

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[17] Simon Baron-Cohen, *Zero Degrees of Empathy: A New Theory of Human Cruelty* (London: Allen Lane, 2011), 29.

[18] Elie Cohen, *The Abyss: A Confession*, trans. James Brockway (New York: WW Norton & Co., 1973), 88-89.

[19] Ibid., 89.

become emotionally disconnected. Cohen's position and circumstances were unlike Jim's in the Jim and Pedro case. Jim's life was not under threat. Jim had a choice to kill or not to kill the prisoner. Cohen was certain the SS would murder all of the prisoners including Cohen if he did not stop the prisoner from attracting unfavorable attention or attempting to escape. Pedro's response to Jim's decision was unknown. To ensure he lived, Cohen thought he had one choice- murder the disruptive prisoner- while Jim had two choices, both of which it was highly likely he would survive. The policy and history of the SS and the experience of Cohen as a witness to murderous events in the camp convinced him that to escape death abnormal action was needed. He was faced with no other choice but to kill and keep killing disruptive patients or any who attempted to escape. At the same time his decision had the consequences of saving hundreds of fellow prisoners. He was forced to act in a manner that was completely foreign and abnormal to his normal professional and personal standards. In terms of the moral philosophical theory of consequentialism, Cohen's actions focused on maximizing the overall good; the good of others as well as the good of himself.

It wasn't until after liberation that Cohen revealed the depth of his guilt and shame and the heavy burden he carried for his actions. Despite these misgivings he admitted, "That will to live, that forcing yourself to carry on, that survives. It just happens to be like that."[20]

Gisella Perl found herself in a similar position in which it became necessary for her to kill a baby to save her own life, the life of the mother and of many other pregnant women:

> 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 not hide him no longer. I knew 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.[21]

Perl clearly felt devotion to the child but knew the eventual fate of herself and the mother depended on the fate of the child. Perl decided to save pregnant women. As a victim of betrayal by Mengele which resulted in the

[20] Ibid., 84.

[21] Giselle Perl, *I Was a Prisoner in Auschwitz* (North Stratford, NH: Ayer Company Publishers, 1984), 82.

death of many pregnant women, Perl swore to save as many such women as humanly possible. According to her memoirs Perl's actions were founded on decisions that went beyond an ethical dilemma. Her decisions and actions to save her own life and that of the mother would be considered choiceless, albeit intertwined with reactions of revenge, resistance, survival and empathy and sympathy related to the human condition. Of course, Perl was confronted with ethical dilemmas in performing abortions and killing newborns; nevertheless, it was the act of betrayal by Mengele that resulted in the death of many pregnant women that drove her to obsessively seek out and abort the fetuses:

> I stood rooted to the ground, unable to move, to scream, to run away. But gradually the horror turned into revolt and this revolt shook me out of my lethargy and gave me a new incentive to live. I had to remain alive. It was up to me to save all the pregnant women in camp C from this infernal fate. It was up to me to save the life of the mothers, if there was no other way than by destroying the life of their unborn children.[22]

At the beginning of her memoir Lucie Adelsberger recounts her agony when faced with the dilemma of whether she should euthanize her invalid mother and save her from the clutches of the SS. Many children killed their elderly and sick parents to save them from the Nazis. Adelsberger felt unable to kill her mother because of who she was and because of her commitment as a doctor to do no harm. She arrived in Auschwitz in May 1943 and worked in the hospitals and infirmaries in Birkenau including the gypsy camp. Tragically, time, circumstances and experiences in the camp dramatically changed her philosophy on life. During the infamous Death March, Adelsberger was giving support to a young girl. They were both tiring, and she realized that she would not survive if she continued to allow the girl to hold onto her shoulder. Despite knowing that the young girl would be shot or beaten to death if she fell, Adelsberger released the girl's arm. Adelsberger survived the March. Did Adelsberger have another option that would save both her and the girl? This was not a case of an ethical dilemma but one of survival. Based on her strong will to live and her rationale at the time, Adelsberger believed she had no choice but to let the girl fend for herself.

[22] Ibid., 154.

V. The Human Condition

According to Hannah Arendt, the German-American philosopher and political theorist, the human condition[23] is an inherent part of humanity not dependent on race, color, gender, religion or social class but relating to an individual' search for pleasure, indulgence, security, safety, personal relationships and survival and an understanding and acceptance of hardship, suffering and the inevitability of death. To continue a more thorough examination of the human condition is far beyond the scope of this article. Suffice to say Arendt's theory emphasizes *vita activa* (the active life) and *vita contemplative* (the contemplative life) both of which are part of the human condition. In this article, focus is placed on the *vita activa*.

Olga Lengyel, a nurse who was considered a medical doctor in Auschwitz, revealed an occasion when she and her friend were faced with a decision between their own well-being, the wishes of a *Blocova*, the barrack or block chief in the women's camp, the *Califactorka,* the Blocova's personal maid, and the suffering and dying Jewish prisoners.

> The Califactorka signalled to us. 'I will make a deal with you,' she said in a low tone. 'Bring me a few aspirin tablets and I will give you a bit of plazki [potato pancake]. I have a bad pain in my ear, and I don't want to wait in line outside the infirmary.'[24]

Lengyel knew they faced a dilemma as aspirin was scarce in the camp. Irrespective of this, she acknowledged the issue for her and the friend was about personal gain. Both prisoners were aware they had other options, such as encouraging the Califactorka to stand in line with other privileged prisoners and obtain the pills. Alternatively, they could report the prisoner to the SS. Lengyel and her friend were hungry and the aroma of the plazki (potatoes) tormented their nostrils. They agreed to hand over the aspirin for the *plazki*, rationalizing that their actions saved the Califactorka's valuable time by her not having to stand in line. Lengyel expressed shame and felt the need to justify her actions saying, "But we were at Birkenau-Auschwitz, and we were starved."[25]

Dr Miklos Nyiszli worked for Josef Mengele as a pathologist and, unlike the majority of Jewish doctors, experienced far better living and working conditions. He had access to both modern medical equipment and unlimited

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[23] Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 7-21.

[24] Olga Lengyel, *Five Chimneys: A Woman Survivor's True Story of Auschwitz* (Chicago: First Academy Chicago Publishers, 1995), 111.

[25] Ibid., 111.

drugs and had a working relationship with Mengele and other SS doctors. Mengele on one occasion even called him "Mein Freund!"[26] His approach to his work was 'business as usual' and he took pride in doing excellent work for Mengele. He welcomed SS doctors who wanted to learn his techniques and skills. He also enjoyed the fruits of his labor:

> I drank some tea spiked with rum. After a few glasses I managed to relax. My mind cleared and freed itself of the unpleasant thoughts that had been plaguing it. A pleasant warmth penetrated me: the voluptuous effects of the alcohol, comforting as the caress of a mother's hand [...] The cigarettes we were smoking had also been 'Imported from Hungary.' In the camp proper a single cigarette was worth a ration of bread: here on the table lay hundreds of packages.[27]

Nyiszli took advantage of his position by sharing in the luxuries enjoyed by his colleagues, the SS doctors; he did not attempt to share his good fortune with his fellow prisoners. He appeared not to be shamed by his actions but reveled in his good fortune. Nyiszli had the opportunity to share his good fortune of food with his prisoner friends but it appears he didn't. He was roundly criticized by survivors. He so relished his access to rum and its comforts like 'the caress of a mother's hand' that the human condition appears to have played no small part in affecting his actions. He appears to have adopted the approach of *business as usual*.

VI. Conclusion

The issue addressed in this article is that the actions of and decisions by Jewish doctors in the SS camps cannot solely be considered ethical dilemmas. The doctors were well intentioned to do no harm and provide support to every prisoner, but the culture of abject evil, the purpose and structure of the camp system based on industrial murder, the shocking inhumane conditions of the camp and the master/servant relationship between the SS doctor and the Jewish doctor destroyed any hope of a Jewish doctor upholding or demonstrating strong ethical standards. The ideology of the camps from the beginning to the end was wholesale murder by unconscionable means which brought millions of Jewish people to the precipice of inhumanity. Degradation and humiliation stripped them of any chance of normalcy, of morality and ethics and, for most, any hope of

[26] Miklos Nyiszli, *Auschwitz: A Doctor's Eyewitness Account*, trans. Tibère Kremer and Richard Seaver (New York: Arcade Publishing 1993), 172.

[27] Ibid., 45.

survival. It is impossible to compare the standard of morality and ethics of Jewish doctors in the camps with that of contemporary medical practice. Although the responsibilities of physicians and their commitment to the sacred tenets of a code of ethics, such as the Hippocratic oath, may be similar, the circumstances of the Holocaust, compared to normal times are indescribably different. Thus, each action taken during the Holocaust must be examined individually within its context. Most decisions made and actions taken by the doctors were made under duress and were sudden and inexplicable. The circumstances were unique, the selections were endless and the consequences tragic and traumatic. At the epicenter of the Jewish doctor's life was suffering and death.

The indescribable inhumanity and evil of the camps underpin an enormous shift in the role of ethics, which were often replaced by the drive to survive under all circumstances and influenced by personal traits. For the Jewish doctor, as for the ordinary prisoner, it became a matter of the self. The memoirs repeatedly tell us that at times ethics became ancillary and the will to survive became the primary force that drove the prisoner – including the Jewish doctor.

While it perhaps bestows a sense of dignity and nobleness to regard the Jewish doctors as acting solely on the basis of ethical dilemmas, prepared to sacrifice their time, energy and lives for the sick and injured, they were human – ordinary people who wanted to survive and live and who possessed the same vulnerabilities, frailties, strengths and weaknesses as any normal person. This humanness is evident in the memoirs, diaries and testimonies of the doctors. Perl, Brewda, Vaisman, Adelsberger and many other Jewish doctors were extraordinary doctors aware of their professional responsibilities, but they were also capable of doing what it took to survive. Tragically, it could be argued that their behavior was at times unethical, immoral and in some cases unwillingly in co-operation with the Nazis. But judgement is impossible and should not be attempted.

Camps such as Birkenau-Auschwitz have become a microcosm of behavior when humans are subject to conditions of extreme adversity in which death is imminent. In truth, most Jewish doctors attempted to follow their sacred oath to do no harm, but in reality, to survive they were forced by misfortune, conditions and circumstances to at times abandon ethics, morality and values and make abnormal or choiceless choices and decisions founded on the human condition.

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Resistance, Medicine, and Moral Courage: Lessons on Bioethics from Jewish Physicians during the Holocaust

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Abstract

There is a perpetrator historiography of the Holocaust and a Jewish historiography of the Holocaust. The former has received the lion's share of attention in bioethics, particularly in the form of warnings about medicine's potential for complicity in human atrocity. However, stories of Jewish physicians during the Holocaust are instructive for positive bioethics, one that moves beyond warnings about what not to do. In exercising both explicit and introspective forms of resistance, the heroic work of Jewish physicians in the ghettos and concentration camps tells us a great deal about the virtues and values of medicine. In this article, we frame the stories of four of these Jewish physicians in ways that are instructive for contemporary medicine. By far, the most widely recognized and discussed figure is Viktor Frankl, whose work on hope and the meaning of suffering remains essential insofar as medicine inherently confronts disease and death. Less discussed in bioethics and medical humanities are the cases of Mark Dworzecki, Karel Fleischmann, and Gisella Perl. Dworzecki's efforts to encourage others in the Vilna Ghetto to document their experiences illustrates the power of narrative for the human experience and the notion of ethics as narrative in the face of suffering. Fleischmann's art underscores not only the importance of reflective practices for professionals as a form of simultaneous introspection and testimonial, but illuminates hope amid sheer hopelessness. This hope, which was comparatively implicit in much of Fleishmann's art, is explicated as a method by Frankl, becoming a form of therapy for both physicians wrestling with their professional work, and patients wrestling with their illnesses and diseases. Finally, Perl's resistance to Mengele's orders highlights the importance of moral action, not just reflective reaction. The experiences of each of these figures, while certainly located in the unique horrors of Holocaust Germany, portends lessons for today's physicians faced with moral distress and ethical dilemma in the face of suffering, interpersonal relationships, and socio-political conflicts that increasingly test the professed ideals of medicine. In this article we briefly tell the story of each of these physicians and connect the lessons therein to contemporary medical practice.

Key-words: *bioethics; historiography; holocaust; Jewish physicians; logotherapy*

I. Introduction

As a discipline, bioethics was born in reaction to moral wrongs. While the Nuremburg Code had generated some new clarity about ethics in medicine, this had not been institutionalized. By the early 1970s, building off of the momentum of a rising tide of individualism captured in the countercultural and civil rights movements, medicine finally began confronting long-practiced forms of paternalism. Within the clinical context, the prolonged forced treatment of patients was challenged in cases like Karen Ann Quinlan[1] and Dax Cowart,[2] while in the research context, the abuses discovered in research such as the Tuskegee Syphillis Study[3] and the hepatitis studies at the Willowbrook State School[4] provoked horrified recollections of Nazi experiments. Sociologist Charles Bosk has called these and similar events, "essentially contested total social conflicts" not only because of how loud and pervasive the public outcry, but because the resulting discourse shook the foundations of social institutions.[5] Bioethics emerged from these watershed moments as a field intently focused on what *not* to do, how not to repeat the mistakes and abuses of the past.

The origin story of bioethics also helps explain why its focus on the Holocaust period has centered nearly entirely on Nazi atrocities, with scant attention paid to Jewish physicians of the period who salvaged moral sensibility and professional virtue. Indeed, there is a perpetrator historiography of the Holocaust and a Jewish historiography of the Holocaust. The former is important in its warnings about medicine's potential for complicity in human atrocity. The latter, however, is an important narrative in its own right, where stories of Jewish physicians in the ghettos and concentration camps are instructive for a positive bioethics – one that moves beyond warnings about what not to do. In exercising both introspective and implicit forms of resistance, the heroic work of these physicians tells us a great deal about how to carry out the virtues and values of medicine.

Any attempt to extrapolate insights that are relevant to contemporary life from the unprecedented horror of the Holocaust must take great care to

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[1] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (New York: McGraw-Hill, 2011), 9.

[2] Ibid., 23.

[3] Brian P. Hinote, and Jason Adam Wasserman, *Social and Behavioral Science for Health Professionals* (Lantham, MD: Rowman and Littlefield, 2017), 249.

[4] Ibid., 248.

[5] Charles L. Bosk, "Bioethics, Raw and Cooked: Extraordinary Conflict and Everyday Practice," *Journal of Health and Social Behavior* 51, Supplement (2010): S134.

offer sufficient respect for the incomprehensible magnitude of that horror. Analogies to the Holocaust evoke strong emotional reaction, but the features of Nazi Germany and its genocide rarely can be cleanly or uncontroversially mapped onto contemporary phenomena. Worse, such analogies can undermine the scale of the tragedy and cheapen the memory of the dead. As Arthur Caplan wrote, "to use the Nazi analogy with abandon is to abandon history."[6] At the same time, it also is dangerous to suggest that, in its incomparability, the Holocaust cannot teach us about our lives today. In this piece, the lessons we extrapolate from history are meant to inform our present context, not to compare it.

This article connects the work of historians on Jewish physicians during the Holocaust to bioethical concerns; specifically, it frames the stories of four Jewish physicians during the Holocaust in ways that are instructive for issues of both professional and clinical ethics: Mark Dworzecki, Karel Fleischmann, Viktor Frankl, Gisella Perl. While Frankl is widely known and read, the others have equally important stories to tell. The inherent disease, death, and suffering which confront medicine involve, nearly by definition, moral distress and ethical dilemmas that challenge its professed ideals. Thus, while the experiences of each of these figures are certainly located in the unique horrors of Holocaust Germany, they nonetheless portend lessons in professional and clinical ethics for physicians today.

II. Background: Finding our Way to a Positive Ethics

In *Ethics: An Essay on the Understanding of Evil*, Alain Badiou confronts the epistemic foundations of the modernist ethics project that underpin its ostensibly moral focus on human rights in the wake of twentieth century genocides. He writes, "[...] according to the modern usage of ethics, Evil – or the negative – is primary: we presume a consensus regarding what is barbarian [...]."[7] Accounts of how the Holocaust informs ethics in medicine have had precisely this character; they have overwhelmingly focused on atrocity, of how Reich physicians could be complicit, etc. To be sure, these are important and productive questions. Franklin M. Littell asks, for example, "What kind of medical school trained Mengele and his associates? What departments of anthropology prepared the staff at Starsbourg University's 'Institute of Ancestral Heredity?'"[8] In quoting Littell, Zygmunt Bauman draws our attention

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[6] Arthur Caplan, *Am I My Brother's Keeper: The Ethical Frontiers of Biomedicine* (Bloomington, IN: Indiana University Press, 1997), 78.

[7] See Alain Badiou, *Ethics: An Essay on the Understanding of Evil*, trans. P. Hallward (New York: Verso Press, 2001), 8.

[8] Quoted in Zygmunt Bauman, *Modernity and the Holocaust* (Ithaca, NY: Cornell University

not just to the complicity of physicians, and a woefully inadequate system of education that produced them, but to the broader complicity of a science that separates itself from humanism.

Today, nearly all medical schools include at least some formal training in bioethics and some boast quite robust programs in these areas. Yet the inclusion of ethics in curricula have largely netted rules about how *not* to tread on the rights and liberties of patients and research subjects. At best, this provides a baseline for avoiding transgression. The notions of moral obligation inherent in an ethics that is focused exclusively on why not to harm another is, ironically enough, founded on precisely the sort of tenuous "ethic of sameness" that served as an ontological foundation for the Holocaust and other genocides. If finding value in others requires identifying what is common between us, it yields an ethics that is paradoxically able to catalyze the most abject abuses.[9] When ethics requires sameness, those who can be sufficiently defined as dissimilar easily come to warrant no moral consideration. Emmanuel Levinas (1975) worried precisely about this sort of negative ethics:

> My responsibility for the other man, the paradoxical, contradictory responsibility for a foreign liberty – extending, according to the Talmud (Sotah 37b), even to responsibility for his responsibility – does not originate in a vow to respect the universality of a principle, nor in a moral imperative. It is the exceptional relation in which the Same can be concerned with the Other, without the Other's being assimilated to the Same, the relation in which one can recognize the inspiration, in the strict sense of the term, to bestow spirit upon man.[10]

Bauman notes something similar in observing how modernist interpretations of the call to "love thy neighbor as thyself" are rather insidious: "He deserves love if he is so much like me in so many important ways that I can love myself in him. She deserves it yet more if she is so much more perfect than I am that I can love in her the *ideal* of my own self."[11]

Certainly, we have witnessed important attempts at authentic engagement with the narratives of Others in clinical medicine. While these also fre-

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Press, 1989), 29.

[9] Badiou; Bauman.

[10] Emmanuel Levinas, "Ideology and Idealism," in *Modern Jewish Ethics*, ed. Martin Fox, 121-138 (Athens, OH: Ohio State University Press, 1975), 245.

[11] Zygmunt Bauman, *Does Ethics have a Chance in a World of Consumers* (Cambridge, MA: Harvard University Press, 2008), 31.

quently are reduced to abstract sets of best practices for doctor-patient communication, they contain at least the seed-thought that ethical relationships require a positive engagement in ways that cannot be prescribed by trans-subjective rules and, in turn, that medical ethics does not reduce to proscriptions against harm. Similarly, contemporary discussions of professionalism in medicine often call back Greek notions of virtue that, again, often get reduced to sets of acceptable or unacceptable behaviors. Nonetheless at its core the idea of virtue points toward an ethics focused on what it means to be a human in relationships with others that cannot be reduced to warnings about how not to hurt them. The doctoring performed by the four figures profiled in this article show us this sort of deeply human ethics, one that does not just advocate refrain from harm, but that reaches out to the Other, to us all.

Though with notable exceptions on which we will draw in this article, historiography of Jewish resistance, or even agency, during the Holocaust is dwarfed by the focus on the exploits of Nazis. There has been some reporting of Jewish militancy in the 1943 Warsaw Ghetto Uprising. However, stories of resistance by Jewish physicians in the ghettos and concentration camps have received comparatively scant attention. It was made abundantly clear in the Doctors' trial (Nuremberg, 1946-1947) that Nazi physicians played a major role in perpetuating the Holocaust. Hitler made this explicit as early as 1933, speaking to a group of physicians: "I cannot do without you for a single day, a single hour. If not for you, if you fail me, then all is lost."[12] But while the history of Nazi medicine is full of important warnings about how physicians should not behave, we turn to a comparatively small but important Jewish historiography to provide a positive counterbalance that can fill in the negative space of proscriptive ethics.

Elie Wiesel refused to allow his experiences during the Holocaust to dehumanize or embitter him and he taught, "to invent hope when there is none, to call upon love and faith in the world which lacks both."[13] Yet everywhere in medicine there is negativity, burnout, deprofessionalization, bureaucratization, and commodification that seem to draw physicians ever further from human connection to their patients. It is a profession poised for dehumanization and bitterness and, at the same time, one that cannot be itself without humanism and compassion. So many of the physicians working in the ghettos and camps maintained a deeply human connection to their work and to others, despite unimaginably inhuman conditions. Adina Szwajger who worked

[12] Quoted in Daniel Okrent, *The Guarded Gate: Bigotry, Eugenics, and the Law that Kept Two Generations of Jews, Italians, and other European Immigrants out of America* (New York: Scribner, 2019), 364.

[13] Nadine Epstein, *Elie Wiesel: An Extraordinary Life and Legacy* (Simsbury, CT: Mandel Vilar Press, 2019), 114.

in the Warsaw Ghetto put this profound struggle succinctly, writing, "It may sound silly, but somewhere underneath, I still felt myself to be a doctor."[14]

Each of the figures profiled below helps raise important questions: How can one maintain a sense of self or identity personally and professionally amidst circumstances constantly assaulting these? What helps to raise us out of despair? What is altruism and what is its role in ethics and medicine? How far must a physician be committed to altruism under personal threat? And how do we protect the unprotected? Dworzecki, Fleishmann, Perl, and Frankl explored these questions in a context of unprecedented horrors that cannot be compared to the challenges of contemporary medicine today. Yet the notions of ethics and humanism that found expression in these four figures under incomparable conditions nonetheless offers insights for professionals in medicine and health care encountering challenges to professional and personal commitments, disruptive forms of institutionalization and commodification, scarcity of resources, daunting social injustices and inequality that manifest through who falls victim to disease, and the grief associated with illness and death.

III. Humanism amidst Inhumanity

Ross Halpin suggests that there are two common threads which run through Jewish medicine in the ghettos and concentration camps.[15] The first concerns the cornerstone of the Jewish attitude towards life best expressed in *Deuteronomy* 30:19, "I call Heaven and Earth to witness against you this day, I put before you life and death, blessing and curse. Choose life so that you and your offspring would live." The second thread centers around the juxtaposition of the earlier successes of Jewish physicians to the horrors of Nazi Germany. The stories of Jewish physician resistance in this section reflect precisely this struggle against death and towards life, to recover and maintain their identities as physicians, and to find and express hope.

As with all historical narrative, the story of Jewish resisters remains incomplete. Hundreds who acted with great courage are known; yet there are likely thousands who resisted in unknown ways. Similarly, no account we could give of Dworzecki, Fleishmann, Frankl, and Perl could sufficiently catalogue their contributions, let alone fully tell their stories. We therefore select only aspects of their experiences that we believe contain insights for contemporary medicine.

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[14] Adina Blady Szwajger, *I Remember Nothing More: The Warsaw Children's Hospital and the Jewish Resistance* (New York: Pantheon, 1991), 136.

[15] Ross Halpin, "Jewish Doctors: A Place in Holocaust History," in *Jewish Medicine and Healthcare in Central Eastern Europe*, eds. Marcin Moskalewicz, Ute Caumanns, and Fritz Dross 237-248 (Switzerland: Springer International, 2019), 240.

i. Dr. Mark (Meier) Dworzecki: Documentary as Resistance and Reflection

Dr. Mark Dworzecki (1908-1975) was instrumental in the emergence of a Jewish history of the Holocaust. He not only documented his own experiences in the Vilna Ghetto and slave labor camps, but also urged other prisoners to do the same.

In Vilna, where Dworzecki was responsible for children's health, he covertly documented the atrocities. In 1943, he was first imprisoned in Estonia, and thereafter was frequently relocated. Ultimately, he was incarcerated in seven different German concentration camps before he escaped from the Death March of 1945. In Paris, between 1945 and 1949, he wrote about the Holocaust for *The Survivors Press*, before going to Israel where he worked diligently to establish a Chair of Holocaust Studies at Bar Ilan University. This was the first of its kind and Dworzecki served as the inaugural faculty in that role, teaching Holocaust studies. Among his works, *Mahanot Hayehudim B'Estonia*, "is considered to be an authoritative source on the Nazi camps in Estonia and is used as a reference in current texts and encyclopedias of concentration camps."[16]

Dworzecki provided important witness, but his work also underscores the power of the documentary as an active form of resistance and reflection, beyond simply a passive cataloging of events. This is a methodology now deployed to physicians in training around the world, where medical schools and residency programs increasingly promote reflective writing about the profession as a means of making sense of one's experiences. Dworzecki saw his own work in precisely this light. Boaz Cohen writes, "As a physician, Dworzecki saw the Holocaust as a radical attack on the medical profession and its values. He juxtaposed the German medical profession and its complicity in The Final Solution with the heroic work of Jewish doctors in the ghettoes and camps... [he] regarded his writings almost as an affirmation of humanity in the face of bestial inhumanity."[17]

Motivated by his need to document events as a way of capturing not only the essential humanism of medicine, but the ethical responsibility of physicians to maintain it even in the face of unprecedented tragedy, Dworzecki conducted extensive research and published widely on medical issues during the Holocaust. In 1948, he dedicated an original poem entitled *Help Me Tell what I Have Seen* to, "the chroniclers in the ghettoes, concentration camps, cellars, and attics..., the remnants," an excerpt of which reads:

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[16] Boaz Cohen, "Dr. Meir (Mark) Dworzecki: The Historical Mission of a Survivor Historian," *Holocaust Studies: A Journal of Culture and History* 21, no. 1-2 (2015): 34.

[17] Ibid., 25.

And deep inside I cry a prayer
Do not silence the Survivors before they pass on their heritage
That heritage that is both a curse and a blessing
It is our sacred mission and our calling.[18]

Importantly, Dworzecki specifically documents resistance by doctors, describing how they risked their lives in the dual struggle against explicit Nazi violence and the epidemics of disease inherent to life in the ghettos and camps. In his memoirs from the Vilna Ghetto experience, Dworzecki commends the physicians who created a public health system, "designed to stymie the Nazi's genocidal mission for as long as possible and vigilantly maintain this organization under increasingly dire circumstances."[19] In *Kampf Far Gesund In Ghetto Vilna,* Dworzecki points out that Jewish physicians in the ghetto, "started their struggle for the health of the ghetto population, every day waiting for death..., convinced that to protect the ghetto against epidemics meant to preserve it from early annihilation."[20] In 1946, Dworzecki wrote that doctors during the Holocaust, "took up a special place, knowing how to preserve the human image amid the agonies of the ghetto and to instill hope and comfort in hearts until the last moment."[21]

Vilna, as was the case with most other ghettos, was eventually liquidated and the inhabitants were deported to concentration camps. But in capturing how Jewish physicians were able to withstand the Nazis inhumane overcrowding, exposure, and starvation, Dworzecki's work illuminates the commitment of physicians to public health. Dworzecki shows us medicine's role in social justice, a medical ethics that looks beyond the interpersonal relationships of private clinical moments.

At the same time that he praised fellow prisoner-physicians, he reflected critically on the ethics of his own actions, some of which enabled him to survive while other physicians died. He wrote, "perhaps you were false to me – my Con-

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[18] Ibid., 26.

[19] McKenna Longacre, Solon Beinfeld, Sabine Hildebrandt, Leonard Glantz, and Michael A. Grodin, "Public Health in The Vilna Ghetto as a Form of Jewish Resistance," *American Journal of Public Health* 105, no. 2 (2015), 294.

[20] Steven P. Sedlis, "The Establishment of a Public Health Service in The Vilna Ghetto," in *Jewish Medical Resistance in the Holocaust*, ed. Michael A. Grodin, 148-154 (New York: Berghahn Books, 2014), 153.

[21] Quoted in Miriam Offer, "Coping with the Impossible: The Developmental Roots of the Jewish Medical System in the Ghettos," in *Jewish Medicine and Healthcare in Central Eastern Europe Shared Identities, Entangled Histories. Religion, Spirituality and Health: A Social Scientific Approach,* eds. Marcin Moskalewicz, Ute Caumanns, and Fritz Dross, 261-277 (Switzerland: Springer International, 2019), 264.

science – while being tortured... Perhaps you sold me for the price of staying alive."[22] He similarly reflected on how the Holocaust had forced confrontation with the "beast in man," which referred not only to the Nazis, "but also to those of their victims who had failed the test."[23] He ultimately reassured himself that he did not violate his ethical standards and explored moments when he risked his life to save other prisoners. But the unsettled character of this internal dialogue demonstrates the power of reflection for personal growth and its value for medicine as it confronts ethical ambivalence.

As a prisoner and later as a free man, Dworzecki's writings posed questions not only about his own behavior under stress, but of what he called "the world of the apathetic – the world of our neighbors in Europe, the world of the Poles, Lithuanians, the Russians and the Ukrainians, the Estonians, the French, the Belgians"[24] He saw his historiography as calling out for "sociological and moral research" that would examine the attitude of those neighbors and explicitly called for investigating the both active and passive complicity of Christian churches.[25] In other written reflections, he focused on the behavior of Jews under Nazi occupation and in the free world. Dworzecki's work was so respected that he was the only university faculty member to be included in the Yad V'Shem Circle.[26] But his work includes special lessons for medicine and medical ethics – about reflexive documentary as an act of professional virtue – to which we will return in the final section of this article.

In the first two decades after the war, the study of Jewish medicine during the Holocaust was led by the survivor physicians, with Dworzecki chief among them. After his death in 1974, as well as the passing of other physician-survivors, there was a noticeable decline in this important area, lessons from which remain significant for contemporary medicine.

ii. Dr. Karel Fleischmann: Art as Hope amidst Hopelessness

Like Dworzecki, Dr. Karel Fleischmann struggled both to document the horrors around him and to make sense of them. Rather than historical documentary, however, Fleischmann turned primarily to art.

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[22] Quoted in Daniel S. Nadav, *Medicine and Nazism* (Jerusalem: Hebrew University Magna Press, 2009), 101.

[23] Boaz Cohen, "Setting the Agenda of Holocaust Research: Discord at Yad Vashem in the 1950s," in *Holocaust Historiography in Context: Emergence, Challenges, Polemics and Achievements*, eds. D. Bankier, and D. Michman, 255-292 (New York: Berghahn Books, 2008), 271.

[24] Ibid., 275.

[25] Ibid.

[26] Dan Michman, "Is there an Israel School of Holocaust Research?" in *Holocaust Historiography in Context: Emergence, Challenges, Polemics and Achievements*, eds. D. Bankier, and D. Michman, 37-66 (New York: Berghahn Books, 2008), 43.

Fleischmann (1897-1944) was born in Klatovy, in the Austro-Hungarian Empire. He studied painting and drawing in Prague while in medical school and also wrote poetry and prose. In 1937, he published a series of lithographs and he was a founder of the "Linie" (The Line) Avant-Garde Artists Association. As a physician, he practiced dermatology in Ceske, Budejvice. Unlike Dworzecki, he did not survive the Holocaust, but was murdered in the crematoria of Auschwitz in 1944.

On April 18, 1942, Fleischmann was deported to what was known as Terezin (to the Czechs) and Theresienstadt (to the Nazis), which housed both a ghetto and concentration camp. As the Assistant Director of the Health Department, he had oversight for the welfare of elderly prisoners. Upon arrival in Terezin, Fleischmann found the medical conditions in the ghetto infirmary to be deplorable. He saw so much human suffering: "hunger, fear, overcrowding, sickness, deportation, brutality and murder."[27] After long days looking after the health of the prisoners, "Fleischmann often worked at night to capture in his artwork the horrors of what he saw during the day: the constant struggle of Jewish children, adults, the invalid, and the elderly to survive."[28] In his poem, *Transport*, he describes Jews leaving for the death camps and ends the poem in Hebrew, "Baruch Atah" adapted from the Book of Job 1:21. This verse, which reads in full, "The Lord has given, the Lord has taken, blessed be the name of the Lord," has been recited by Jews for centuries at the approach of death and by relatives at their time of loss.

Fleischmann was among the most renowned of the many artists in Terezin. Nora Levin writes, "More than death, they feared that the world would never know what they were enduring, and worse, that they would not be believed."[29] Though he perished, Fleischmann's art survived to tell his story. Where Dworzecki wrested meaning largely from acts of writing, Fleischmann largely used art as a means of documenting his observations.

Beyond a methodological contribution, however, in Fleischmann, we can see how hope is inherent in art. Fleischmann's clandestine creative endeavors were dangerous; had his work depicting the horrors of Terezin been discovered, he would have been tortured and likely murdered. Despite the circumstances, his early Terezin art and poetry reflects a measure of optimism. At the bottom of a painting of children walking, each with a backpack, he wrote a poem about survival:

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[27] Leonard J. Hoenig, Tomas Spencer, and Anita Tarsi, "Dr. Karel Fleischmann: The Story of an Artist and Physician in Ghetto Terezin," *International Journal of Dermatology* 43, no. 2 (2004): 131.

[28] Ibid.

[29] Quoted in Mary S. Costanza, *The Living Witness: Art in the Concentration Camps and Ghettos* (New York: The Free Press, 1982), xiii.

One of us
Will teach the children to sing again
To write on paper with a pencil
To do sums and multiply,
One of us
Is sure to survive.[30]

By 1944, however, there was no longer a shred of optimism in his writing: "[Terezin] is a splendid terror. It is a struggle of white corpuscles against fever. It is an enormous field hospital next to the front, disturbed by the din of battle taking place nearby... Whither does time gallop like a madman for those candidates for death."[31]

And yet this represents a profound paradox. Art fundamentally reaches out with meaning and humanity, implicitly full of hope, even if it is ostensibly about despair. In medicine, a discipline essentially constructed to battle against death, yet faced daily with its inevitability, recovering hope from hopelessness is a significant act of medical humanism.

iii. Dr. Viktor Frankl: The Meaning of Suffering

Dr. Viktor Frankl (1905-1997) is the most recognized and widely read physician-survivor. Frankl was a neurologist and psychiatrist who founded logotherapy. He survived Terezin, Auschwitz, Kaufering, and Turkheim. In both Terezin and Auschwitz, he was revered as a healer and protector.

Soon after Frankl arrived in Terezin, Fleischmann appointed him head psychiatrist. Frankl established a multi-disciplinary group, deemed the "Assault Squad," to engage despondent prisoners, particularly those expressing suicidal thoughts. Fighting despondency among prisoners possessing every reason to be wholly despondent is existentially charged work. While Fleischmann's resistance to hopelessness was implicit in his art, Frankl spent his remaining years explicating it as a life-philosophy and a clinical therapy.

Inspired by the paradoxes he confronted, Frankl initially wrote, *Man's Search for Meaning*, while in Terezin and protected the manuscript in his coat when he was transported to Auschwitz. When the coat, with the manuscript, was taken from him, he was despondent. However, he found in the inner pocket of his new coat the words of *Shema Yisroel*, the prayer of faith affirming the Jews faith in God. This galvanized his faith that the Holocaust would one day end and he would rewrite his book. After liberation, Frankl completed a re-write of his seminal book in just nine days. To date, *Man's Search for*

[30] Ibid., xvi.

[31] Nadav, 63.

Meaning has been translated into more than two dozen languages and has sold over ten million copies.

From these and other lessons in hope, Frankl's approach was to help prisoners find something to live for, something unique to that individual – whether it was to be a father to a hidden child or to complete some unfinished scientific research. The notion of purpose became central for him; to help his fellow prisoners save themselves from an existential void in which nothing else was possible became his primary act of medicine.

In *Man's Search for Meaning*, Frankl recounts several stories that demonstrate the importance of purpose and faith in the future. As one goes, his senior block warden, a well-known composer, confided in him about a dream he had in February of 1945:

> I would like to tell you something, Doctor. I have had a strange dream. A voice told me that I could wish for something, that I should only say what I wanted to know, and all my questions would be answered. What do you think I asked? That I would like to know when the war would be over for me.[32]

His dream, full of hope, forecasted that the camp would be liberated in forty days (at the end of March). On March 31, still imprisoned in Auschwitz, the composer died.

Shortly after the story above, Frankl describes another moment in Auschwitz when he practiced a kind of "group therapy." A senior block warden asked him to speak to prisoners after someone had broken into a storage area and stolen some potatoes. It was clear that some of the other prisoners could identify the culprit. In turn, the camp commanders issued an ultimatum: turn in the guilty man or the whole camp would go hungry for one day. All 2,500 men chose to go without food. Frankl spoke to the men in his block on the evening of this unexpected "day of fasting." He wrote, "God knows, I was not in the mood to give psychological explanations or to preach any sermons – to offer my comrades a kind of medical care of their souls. I was cold and hungry, irritable and tired, but I had to make the effort and use this unique opportunity. Encouragement was now more necessary than ever."[33] At one point, perhaps as much to himself as to the men, Frankl quoted Nietzsche saying "that which does not kill me makes me stronger."[34] The general themes of his remarks focused on ways to give their lives meaning, suggesting that each person 1) reflect on another person to whom he felt a close relationship,

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[32] Viktor E. Frankl, *Man's Search for Meaning* (New York: Washington Square Press, 1984), 98.

[33] Ibid., 102.

[34] Anna S. Redsand, *Viktor Frankl: A Life Worth Living* (New York: Clarion Books, 2006), 76.

2) reflect on a goal that he could actualize if he survived, and 3) accept that there is meaning to one's suffering.

Throughout accounts of Frankl's experiences in the ghetto and death camps, two consistent messages emerge. The first is that one must believe in others. The second is "there must be a spark, a spark of search for meaning."[35] While this powerful message of the psychology of hope might promote romanticized ideas about Frankl's own psychological achievements, in his book, *Recollections*, written two years prior to his death, he revealed that even at age 90 he still suffered from nightmares.[36] Yet this underscores even further the value of his work: He affirmed life even as he was constantly reminded of the witness that he bore of man's inhumanity to man. The themes of his work certainly inform how a physician might make sense of their own work, even at times when it feels ineffectual in the face of countervailing powers, be they social or institutional constraints or the natural enemies of disease, suffering, and death.

iv. Dr. Gisella Perl: Resistance and Moral Courage

Dr. Gisella Perl (1907-1988) was a gynecologist and director of a small hospital in Sighet, Hungary (now Romania). Perl's sole literary contribution was a 1948 book titled, *I Was a Doctor in Auschwitz*,[37] which was the basis for the 1998 Showtime film, *Out of the Ashes*.

In the opening chapter of her memoir, Perl recounts a story that reflects the unpredictable terms of life. In December 1943, prior to being taken by the Nazis, she was visited by a medical representative of I. G. Farben, Dr. Kapezius. "Believe me," he said, "there are many people in Germany who, like me, live only for the day of liberation."[38] She invited him to her home to meet her husband and son, continuing, "As the evening wore on, our confidence in Dr. Kapezius' sincere love for freedom and his hatred for the Nazis grew until our dreams of post-war Europe became bolder and bolder." Upon leaving the Perl home, Kapezius shook her hand and admired her wristwatch. Five months later, in the second month of her internment in Auschwitz, Perl had just recovered from a suicide attempt, when she saw Kapezius again. She was shocked to learn that the same man who had disavowed Nazism was now serving as camp commander of the most infamous concentration camp. She took note

[35] Viktor Frankl, "Why Believe in Others?" filmed May 1972 at Toronto Youth Corps, York ON, Canada, video, 4:01.

[36] Viktor E. Frankl, *Recollections: An Autobiography* (New York: Basic Books, 1997), 97.

[37] Gisella Perl, *I Was a Doctor in Auschwitz* (New York: International Universities Press, 1948).

[38] Ibid., 14.

of the stark contrast between this conversation and their last; her head was now shaven and dirty rags covered her body. In a harsh tone, he said "You are going to be the camp gynecologist. Don't worry about instruments, you won't have any. Your medical kit belongs to me now along with that unusual wristwatch I admired. You can go."[39]

Working with a medical team of other prisoners, consisting of five fellow physicians and four nurses, Perl supervised a hospital for 32,000 Roma and Jewish women in Auschwitz. It is hard to conceive of the reality of the hospital. There were no beds, no bandages, no medications and no anesthesia. The work was made all the more difficult by the direct supervision and control of a Nazi physician. And perhaps even more unnerving were the moral dilemmas inherent to those conditions.

Perl described how during her early tenure at Auschwitz, pregnancy was punishable by death, and at the same time, so was performing an abortion.[40] So, she utilized the infirmary, called *The Revier*, to hide pregnant women, disguising them as pneumonia cases, while performing abortions covertly in the barracks at night. In doing so, she risked her own life to save the lives of others.

As a woman raised in a traditional Jewish home, Perl knew that Jewish law (Halacha) permitted aborting a fetus in order to save the life of the mother. She wrote, "Every time when kneeling down in the mud to perform a delivery without instruments, without water, without the most elementary requirements of hygiene, I prayed to God to help me save the mother [...] Every one of these women recovered and was able to work."[41] In this work, Perl functioned not only as a technician, but a source of comfort, reassuring her patients that the day would come when this "hell on earth" would be over and they would be able to have a child in the free world.

Many of Perl's other notable acts of resistance centered on the orders of the infamous Josef Mengele. On one occasion, she and her friends were eating illegally acquired food when he unexpectedly entered. For that violation alone, all of the women could have been murdered. Knowing of his interest in obtaining dead fetal tissue for studies, however, she called his attention to an unusual preserved fetus. Mengele's rage diminished and he said, "'Good... Beautiful...' and spoke of sending it to Berlin."[42] In another instance, Mengele ordered blood tests of every feverish patient to identify typhoid, a diagnosis that would have seen them sent directly to the crematorium. Instead, Perl and her team took blood samples from each other. "The tests were negative

[39] Ibid., 16.

[40] Ibid., 72.

[41] Ibid., 81.

[42] Ibid., 122.

and the patients saved," she wrote.[43] Other stories of resistance punctuate her account.

A physician of strong principles and great courage, Perl survived the Holocaust and eventually practiced as an OB/GYN at New York's Mt. Sinai Hospital, where she delivered over 3,000 babies. Prior to each delivery, she would pray, "God, You owe me a life, a living baby."[44] While Dworzecki and Fleischmann largely represent instructive forms of introspection, and Frankl explicates a pedagogy of hope amid horror, Perl illuminates the morality of active resistance to oppression. Here again, while the inhumanity of the contexts cannot be compared, in Perl's biography, there are nonetheless insights for physicians struggling against an array of strictures that pull away from their moral commitments and even at times run counter to the best interests of their patients.

IV. Lessons for Ethics and Humanism in Medicine

The lessons about how *not* to be inhumane in the context of medicine are brought into focus by the inhumanity of the Holocaust. But so too are lessons for the medical profession as it struggles to know what to do, how to engage patients, colleagues, and the public, and how to care for oneself in the overwhelming landscape of health and healthcare. This is not to compare the tribulations of the Holocaust to the challenges faced today, but simply to say that we can learn from that incomparable history. The four figures we have discussed, albeit briefly and selectively, possess such insights, both in what they explicate in their work and narratives and in what they have signaled by example. The moral sensibilities and professional virtues they rescued from an overwhelming inhumanity can serve as a guide to practitioners addressing questions of contemporary medical practice.

Endemic to medicine is disease and death, and, in turn, despair and hopelessness beckon. Successes against disease and dysfunction are rightfully celebrated, and yet the inevitability of loss highlights that victory against death will never fully be possible. *What, then, helps to raise one out of despair?* Perhaps especially from Fleischmann and Frankl, we can see powerful lessons about hope even amidst hopelessness. They show us that there is meaning and purpose to be found even in the most apparently senseless of tragedies and that doing so is necessary for living well, perhaps even for living at all. For physicians struggling to maintain hope, these meaning-making exercises are essential, whether that meaning is cultivated through artistic expression

[43] Ibid., 94.

[44] Quoted in Nadine Brozan, "Out of Death, a Zest for Life," *The New York Times*, November 15, 1982.

or conscious reflection about self and vocation. And these insights are particularly valuable as medical curricula increasingly promote different forms of self-reflection and mindfulness.

Since antiquity, medicine has been understood as a calling. It confers a high degree of professional latitude in conjunction with entailing an intimate connection between one's self and one's work. Yet today, we witness various forces of deprofessionalization, including models of managed care, increasing automation and algorithmic decisional tools, and the strictures of EMRs and billing requirements that can make a game out of matching quality patient care to reimbursable procedure codes. In the contemporary health care landscape, these shifts can be especially troubling to physicians who maintain deep personal connection to their work and responsibility to their patients. *How then can one maintain a sense of self amidst social circumstances that constantly assault it?* Each of the four figures discussed in this essay seem to have connected their sense of professional identity to personal acts of resistance; that is, they have implicitly or explicitly conceived of medicine as an act of resistance against suffering and death, no matter their origins. This boils down to locating the essential in medicine, perhaps best captured in the variously attributed aphorism, "cure sometimes, relieve often, comfort always." In a situation where their technical expertise may have been the least important capacity they could leverage, often completely useless in the face of overwhelming violence and epidemic, they nonetheless sought to comfort and not in a way that mourned what they could not do as physicians, but because of a sense that comforting is the essential act of doctoring.

This intersection of the personal and professional, however, certainly creates ethical dilemmas and gives rise to challenging questions: *What is altruism and what is its role in ethics? How far must a physician be committed to it under personal threat?* These questions remain essential in medicine today in the face of a range of dilemmas from care of contagious patients during epidemics to questions about patient abandonment in natural disasters or active shooter situations in a hospital. Dworzecki himself explicitly wrestled with these questions in introspective analysis of his own ethical choices. And while the specific boundaries between professional commitment and risk are deeply personal, all of the physicians we have profiled have in common that they made significant personal sacrifices as they engaged in their professional work. Adina Szwajger, the Warsaw Ghetto doctor quoted above also wrote, "You are a doctor in order to help people and not in order to be sentimental about yourself. In any case, when there is so much pain around you, enough to fill the world, it is different from being alone with your private disasters."[45]

[45] Szwajger, 136.

In the most unimaginable horrific circumstances, Dworzecki, Fleischmann, Frankl, and Perl repeatedly put their own lives at risk in efforts to save their patients, but also by exercising other forms of resistance such as the simple act of documenting the horrors. Beyond the sacrifice for their patients, there is in these acts a personal sacrifice for the profession of medicine, a commitment to engagement with its values, in spite of the personal costs. Where medicine, as all professions, constitutes a "community of profession," these personal sacrifices are deeply professional acts.[46]

Finally, everywhere we turn in health and medicine we see vulnerability. Human frailty in the face of disease and death is shared by all, while specific inequalities of risk cascade through some groups far more than others. There are inequalities in health based on race, gender, or place; overt or implicit discrimination in the health care setting; and whole populations precariously situated in hierarchies of power that have life or death consequences, such as the cognitively impaired, children, or the elderly. *How then do we protect the unprotected?* In each of the four physicians we have chronicled we find relevant insights. Perl is the most directly interventional on this account, and importantly, her work shows that physicians, even from positions of near total structural powerlessness, nonetheless have powerful choices to make in the clinical care of their patients. Hers was not a large-scale undermining of an inhuman system, but hundreds of micro acts of resistance carried out in the intimate moments between a doctor and her patients. Frankl shows us that even the most vulnerable can resist victimization by recovering purpose, while Dworzecki and Fleischmann show that the profession itself must collectively resist the inculcations of its science for inhumane purposes, that it is in large part, the responsibility of doctors to ensure that medicine serves the vulnerable rather than generating vulnerability.

The nature of virtue is that it has something to say about ethics for all situations. Virtue transcends a particular ethically charged moment. It is the embodiment of ethics, not fundamentally about this or that action or choice. And so Dworzecki, Fleischmann, Frankl, and Perl, in their writings, and all the more so in the lives they led, have something to say about any question we could raise concerning ethics in medicine. This paper has sampled only a small selection of their stories and cast them towards a small selection of possible issues. To be sure, there is more to

[46] Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Harper & Row Publishers, 1970); William J. Goode, "Community within a Community," *American Sociological Review* 22, no. 2 (1957): 195.

do. In the end, each wrought deeply human experiences from the deeply inhumane Nazi atrocities of the Holocaust. As the profession of medicine seeks to remain humane in the face of new forms of technocratization and bureaucratization, not to mention the age-old challenges of curing disease, the insights of these and other Jewish physicians during the Holocaust are infinite.

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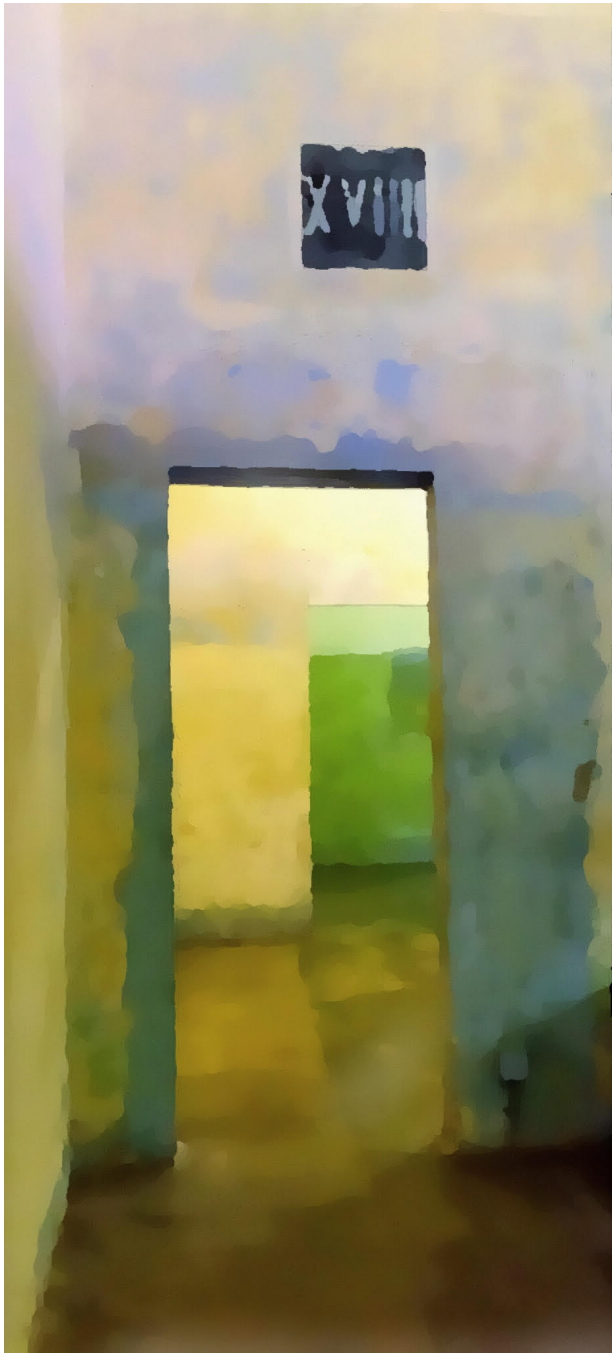

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