Casebook on Bioethics and the Holocaust
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Foreword

The initiation of Dr. Tessa Chelouche, a well-known Israeli physician and scholar of medical history, to edit a book on the phenomenon of medical treatment and physicians’ behavior during the holocaust should be highly appreciated. The collection of the relevant data and its drawing out from the hidden archives should have been not only a complicated scientific mission, but also an incredibly difficult emotional experience.

It is told about Shimon Dubnov, the great Jewish historian, that when he was led, together with other Jews in Riga, to the execution, he turned to them, saying: “Remember, remember (in Yiddish: schreibt un verschreibt), write down everything”.

Remembering – what good will come of it?

Why should we conjure up ghosts? Why should we open the gas chambers, the Pandora box of torture and despair that the holocaust evokes? Why should we gather every string of our strength in order to remember, when it hurts so much?

“If we look too intently in the direction of the dead”, Elie Wiesel said, “we run the risk of being tempted to join them”.

Remembering is not an end in itself, it is only a tool. The use of this tool might be justified for one purpose only: NEVER AGAIN!

Not for the purpose of scientific recording, not for the purpose of glorifying the martyrs’ deaths. What’s done cannot be undone, and remembering dead will not bring them back. “Never again” calls for the survival of mankind, of humanity.

While reading the cases that have been collected by Tessa Chelouche, Geoffrey Brahmer and Susan Benedict, it is difficult to understand how a people could become a people of killers or accomplices of killers, and how the medical doctors could afflicted such pain on human beings.
In the words of Elie Wiesel: “I don’t understand how it happened. And the more I live, the less I will understand. But I will go on learning, and that is another lesson- although we don’t understand, we must continue to learn”.

The Bioethics Chair (Haifa) was authorized by UNESCO to promote and advance the teaching of ethics in medical schools worldwide.

The Chair satisfies the need of teachers and students by producing and providing them with a series of guiding books of which this publication is one of them.

The formation of ethical codes and books is not enough until their implementation. Implementation means education.

*Bioethics and the Holocaust* offers the understanding of the Holocaust phenomenon. The struggle with the insoluble question – how could it happen – may enable our students to realize the wish and the need of Never Again, and to fulfill the testament of: schreibt un verschreibt.

Prof. Amnon Carmi, Head
UNESCO Chair in Bioethics (Haifa)
Introduction

The greatest stain on the record of medicine in the 20th century is the role played by German physicians in the Nazi period. When the Nazis came to power, German medicine was among the most sophisticated in the world. German medicine had contributed to, and shaped, academic and clinical medical practice worldwide. Despite its preeminence, however, German medicine became enmeshed in the Nazi ideology and then broadly complicit in the conceptualization and promulgation of the Nazi racial and social programs. The engagement of the medical profession was extensive and was led by the active involvement and support of the academic establishment. Medicine was not alone in its support of National Socialist policies, but the medical profession differed from the other professions in its explicit commitment to an ethical basis, to a humanitarian stance and to a 2000 year old Hippocratic Oath that placed the sufferer first.

At the post war trial at Nuremberg, only twenty German physicians were tried for crimes against humanity. After this trial, the world medical establishment cultivated the theory that the violations that had occurred within the profession were the acts of a handful of physicians working in a few notorious places like the concentration camps. The trial and the Nuremberg Code which emulated from the trial did not receive sustained attention until the mid 1960s. What the medical profession had done in Nazi Germany seemed altogether irrelevant to physicians in the rest of the world.

Today, we know better. The whole profession and not just a handful of doctors, was implicated in the gross offenses that occurred under Nazi rule. In the 1980s, historians began to publish studies that showed the full extent to which Nazism had permeated German medicine. More than half of the German physicians were members of the Nazi Party, the highest percentage by far of all other free professions.

German physicians began to elevate service to the state above medical ethics well before the Holocaust, the term used for the genocide of the
Jews, occurred. In the early years of the 20th century, German physicians promoted policies of racial hygiene and eugenics in their eagerness to limit the reproduction of people believed to have hereditary disorders. Between 1939 and 1945, they sterilized an estimated 400,000 Germans with mental and physical disorders. German physicians designed and implemented the notorious T-4 program, where they performed medical murder on their mentally and physically handicapped patients in the name of “Euthanasia.” The goal of producing a pure Aryan race took precedence over fundamental medical ethical principles. German medicine became an arm of state policy. Nazi physicians failed to see themselves as physicians first, with a calling and an ethic dedicated to healing and caring for the well-being of human beings. Instead, they were seduced into believing that the welfare of the state was to take precedence over their patients, and that the extermination of millions of people was considered as “treatment” for the state.

During the war years, Nazi policy, with the active support and cooperation of the physicians, depicted Jews, Gypsies and other minority groups, as metaphors for disease, thereby legitimizing and rationalizing the horrors of the Holocaust. Physicians were crucial to the operation of the concentration camps, decided who would work and who would die in the gas chambers, and performed excruciating experiments on prisoners.

One of the first post-war trials to be held was the “Doctors’ Trial.” For the first time in history, physicians were tried for crimes against humanity for their participation in murderous and tortuous experiments conducted in the Nazi concentration camps. In the final judgment, the court articulated what is known as the “Nuremberg Code” which declared the rights of research subjects, and condemned the Nazi’s inhumane experiments and most of the defendants. Even before the war, other ethical codes for human experimentation were already in existence, including an extremely detailed German one formulated in 1931, but the Nuremberg Code was the first international code. A series of international documents on human rights and human experimentation were subsequently created including the World Medical Association’s Declaration of Geneva, the Helsinki Declaration and the UNESCO Declaration on Bioethics and Human Rights. Although these documents, and others, on bioethical and human research ethical tenets have their origins in Nuremberg, they do not refer to it. It has indeed been argued that the field of bioethics originated in Nuremberg, and not in the 1960s, as is generally perceived.

What is certain is that the medical world was silent for many decades.
after World War Two. Nuremberg, while seen as an important historic event, had no formal impact on medical ethics. Modern bioethics had little to say on the subject of the Holocaust. The only referral to the Nazi medical past was, for many decades, the invocation of analogies to Nazi medicine, mostly inappropriately so and without any informed basis.

One of the reasons for the silence was probably the discomfort that the confrontation with the past caused. It was easier to continue the myth that Nazi medicine was inept, mad or coerced, and to distance ourselves from the Nazi physicians. It was also easy to hold the view that it could never happen to professionals like us. It was not comfortable, for us as medical professionals, to recognize that physicians like ourselves were involved in creating the scientific rationales and foundations for the Nazi racial programs that were eventually to culminate in genocide. The world medical community was not ready to admit that many of our peers had supported and flourished in the Nazi regime, where medicine was not only deflected from its traditional ethos, but invested in a perverse ideology of death and suffering.

But the discourse on medicine’s involvement in the Holocaust would be a failure if it did not cause discomfort; the discomfort that arises from this discourse can in fact be considered to be one of the basic premises of bioethics. Bioethics is, after all, the reflective examination of ethical issues in health care and health policy with the aim of providing us, medical and healthcare professionals, with moral standards that address our sense of discomfort in medical practice. Discomfort that arises during the discourse on medical ethics could be perceived, in a way, as moral integrity. It was this “discomfort” that led to the articulation of the 1947 ten point Nuremberg Code governing human experimentation. The first and main precept of the Code is the doctrine of informed consent; the subsequent doctrines of modern bioethics consider the principle of autonomy to be one of the basic tenets of ethical clinical care. Autonomy can be viewed as the empowerment of patients with the right of informed consent. Both of these issues, as well as others in today’s bioethics, have their roots in medicine’s past “discomforts,” including in what occurred during the Third Reich.

Any suggestion that there may be analogies between the way the Nazis were and the way we are, between what they did and what we are doing would be held by some to be absurd. In their view what transpired during the Holocaust was unique and therefore unusable in the present discourse on bioethics. Others would state that inquiry into the value judgments and moral actions of the Nazi doctors can inform current debate and practices.
and furthermore prevent the use of inaccurate analogies in current bioethical debates.

The editors of this casebook concur with this last point of view. We are of the opinion that health care professionals must study and understand these perversions of medical care in order to hold a viable and instructive dialogue on bioethical issues. However, we want to emphasize that by analyzing the moral arguments that can be learned by studying the lessons of the Nazi medicine, we are not suggesting that any moral or ethical present day bioethics discourse, or opinion, is in any way morally equivalent to the Nazi doctors.

Why should we revisit these events years later? Not because we anticipate another Holocaust, but because the medical profession must be ever alert to the challenges to the integrity of its ethics. Traditional views of the core values of medicine were profoundly and violently disrupted during the 1930s and 1940s, as the medical profession in Germany lent itself to the perceptions and priorities of the Third Reich. The history of German biomedicine in the Nazi years presses us to examine our own central assumptions, the perceived verities on which modern medicine proceed.

We should not forget that what the Nazi doctors did reveals the capacity for violence and aggression inherent in all human beings. Numerous experiments, experiences, and studies point to the fact that, given the right circumstances, we are all prone to cruelty, capable of blindly following a powerful evil. Doctors, as human beings too, should do well to be reminded of this as we hold the power of life and death decisions in our hands.

The Holocaust was not an abstraction, but rather a succession of daily actions taken by human beings like ourselves. The icon of evil did not present itself whole, but happened an hour at a time, a decision at a time, a decision evaded at a time.

The same can be said for virtuous acts. The list of physicians who committed atrocities is complemented by that of the prisoner physicians who attempted to stay true, under the most horrendous conditions and circumstances, to the Hippocratic Oath, the best in their humanity and to their medical vocations. Prisoner physicians in the ghettos and camps were confronted with incredible personal and professional dilemmas while at the same time facing the fate of ultimate destruction. These difficult circumstances resulted in varied and often anguishing responses. In 2005 Elie Wiesel, holocaust survivor and Nobel laureate wrote an article in the New England Journal of Medicine about the camp prisoner doctors that he knew:
“Yet inside the concentration camps, among the prisoners, medicine remained a noble profession. More or less everywhere, doctors without instruments or medications tried desperately to relieve the suffering and misfortune of their fellow prisoners, sometimes at the price of their own health or their own lives. I knew several such doctors. For them, each human being represented not an abstract idea but a universe with its secrets, its treasures, its sources of anguish, and its poor possibilities for victory, however fleeting, over Death and its disciples. In an inhumane universe, they had remained humane.

When I think about the Nazi doctors, the medical executioners, I lose hope. To find it again, I think about the others, the victim-doctors; I see again their burning gazes, their ashen faces.

Why did some know how to bring honor to humankind, while others renounced humankind with hatred?”

The Holocaust began in depersonalizing the victims and ended in depersonalizing the perpetrators. The Nazi medical establishment began by depersonalizing their patients and ended in the perpetration of genocide. One of the aims of this handbook is to personalize both the perpetrators and the victims. Giving a name to a perpetrator doctor, a victim of the cruel procedures or to a physician who was a prisoner in a Nazi ghetto or concentration camp makes us all realize that we are first and foremost vulnerable human beings, and only secondly medical professionals. By personalizing these historical events, we are beckoned to look at ourselves anew, and to search within ourselves and our societies for the burden and responsibility that we all bear for humanity and for the welfare of medicine itself. The examination of the bioethics of the Holocaust and the complicity of German medicine provides a vital lens that can help in that difficult but compelling task.

Dr Tessa Chelouche M.D
Part One: The Nazi Doctors

Historical Background of Nazi Medicine

Complicity or indifference to the crimes of the Nazi state by some of the most educated people in German society is one of the most disturbing issues that society at large must confront. The most disconcerting example of highly educated professionals acting as perpetrators in this context is the medical establishment. Trained to care for the sick, relieve suffering and save lives, some physicians withheld care, inflicted pain by experimenting on human subjects and committed murder. Of those who did not participate in such crimes, most were indiﬀerent or acquiescent to the behavior of their colleagues and the suﬀering of the victims. Physicians and other medical professionals became some of the most lethal perpetrators of crimes against humanity.

The German physicians during the 1930’s and 1940’s did not respond to the Nazi racial ideology and the career opportunities it offered as if they existed in a scientiﬁc and philosophical vacuum. The ﬁrst three decades of the twentieth century witnessed the growth of the eugenics movement in Europe, North America and elsewhere. This movement provides the necessary context for understanding the role of German science and medicine in Nazi crimes against humanity. The term “eugenics” was coined in the 1880’s by Francis Galton, a nephew of Charles Darwin. Eugenicists argued that many social problems could be eliminated by discouraging or preventing the reproduction of individuals deemed genetically unﬁt (negative eugenics) while desirable social traits could be increased by encouraging reproduction among those deemed most genetically ﬁt (positive eugenics). The period in which eugenics
thrived was one of great social upheaval worldwide, of industrialization, urbanization and increasingly unstable economic processes of recurrent recessions and unemployment. The eugenicists argued that their approach was the most rational and efficient way to solve the recurring problems in society. The eugenic view held that science, not religion or social philosophy, would direct humanity toward a biological, social and moral utopia.

The first organized eugenics group in the United States was founded in 1906, and the major research center was organized by the Eugenics Record Office at Cold Spring Harbor, Long Island. Many distinguished professionals served on the advisory committees and boards, and the programs were funded by wealthy, philanthropic institutions. Research was performed to try and prove that socially undesirable traits such as pauperism, feeblemindedness, criminality and others existed in certain ethnic groups. Beyond research, eugenicists were also interested in social action and in working to pass laws that would promote their goals. Eugenicists were especially active in the enactment of the United States’ immigration laws where it was believed that certain immigrants were biologically inferior and as such were prohibited from entering the country.

Eugenicists were also instrumental in compiling compulsory sterilization laws. The first state to enact a sterilization law was Indiana in 1907, and by 1935 thirty states had enacted such laws allowing for inmates of state institutions (prisons, asylums, sanitariums and mental hospitals) to be forcibly sterilized after examination by special “eugenics” committees. The categories included were “hereditary feeblemindedness”, “habitual criminality”, “sexual perversion”, epilepsy and others. By 1935 over twenty-one thousand eugenically motivated sterilizations had been performed, and by the 1960’s an estimated sixty-four thousand people had been sterilized in the United States. A similar amount of sterilizations were performed over the same time period in Sweden.

The eugenics movement had officially existed in Germany since 1905, when the Society for Racial Hygiene was established in Berlin. However during the Weimar years German eugenicists were not successful in passing legislation or putting eugenic principles into effect. It was only with the Nazi’s rise to power that eugenics became so central to state policy.

In 1920 two distinguished German scholars, law professor Karl Binding and medical doctor Alfred Hoche wrote a crucial work “The Permission to
Destroy Life Unworthy of Life.” This study reflected the fear in Germany after WWI that the best young men (and their genes) had perished on the battlefield leaving only the “inferior” to proliferate freely. The study proposed that eliminating these “inferior elements” would restore the balance. This book made a great impression on Hitler who, while imprisoned at the time in 1924 in Landsberg, wrote “’Mein Kampf’ in which he defined the principles of the Nazi ideology. In this Nazi vision of the “New Germany” there was no place for the perceived “alien blood” of the Jews, Gypsies and the “genetically inferior” in society.

The earliest eugenic action taken by the Nazi’s was the enactment of the Sterilization Act in 1933. This law, also known as the “Law for the Prevention of Hereditarily Diseased Offspring,” was in fact based on the American Sterilization Law, and there was a great deal of cooperation between the American and the German professionals in favor of these laws. Individuals with any of the nine conditions assumed to be hereditary were destined to be sterilized: genetic feeblemindedness, schizophrenia, manic-depressive disorder, genetic epilepsy, Huntington’s chorea, genetic blindness, genetic deafness, severe physical deformity and chronic alcoholism. The German sterilization program went far beyond any level reached in other countries, sterilizing over four hundred thousand people by the end of the war. Although the Nazis later defended their sterilization program at the Nuremberg Trials by referring to the United States, the American program never reached the scale of the Nazi program.

In addition to the sterilization law, the Nazis passed the Nuremberg Laws in 1935 which prohibited marriage and sexual intercourse between “Aryans” and people of more than one –quarter Jewish descent. When criticized for this law, the Nazis responded by pointing again to the United States and several other countries where there existed anti-miscegenation laws for decades. The German medical establishment perceived the Nuremberg laws as public health laws that would aid in strengthening the post war (WWI) health of the German nation. Given the economic crisis in the Weimar Republic, the eugenic paradigm gave rise to considerations of “national efficiency” and the elimination of “non productive eaters” or “lives not worthy living.” Eugenics provided the biological justification for reducing aspects of social welfare and health care for those deemed a burden on society as well as those deemed genetically handicapped. Racism and anti-Semitism were only one component of the pre-Nazi eugenic ideology, and eugenicists were divided on
the issue of race as a eugenic idea. But by the time that the Nazis took power, eugenics-based racism and anti-Semitism became the mainstay of the Third Reich policy and were accepted as “scientific facts.”

The forced sterilization of those suffering from “hereditary diseases” turned out to be inefficient and costly, and at the same time WWII broke out providing the opportunity to extend the programs to the “extermination of unworthy life.” The war provided the pretext and cover for measures that would have been more difficult to accomplish in peacetime. The decision to implement the “euthanasia” program was made on the highest political level with Hitler’s authorization for designated doctors to carry out “mercy killings.” The physicians were never forced to comply; rather they were empowered to do so. This program was never made legal.

The “euthanasia” program began with the murder of infants and small children with physical deformities or mental conditions who were selected for murder in specially designated “pediatric wards.” In reality these wards were operated by medical staff, physicians and nurses, whose sole function was to kill the children. The methods of killing used were overdoses of drugs, injections and starvation. More than 5,000 children were killed in this first phase of the “euthanasia” program. The program, later expanded to include the murder of adults, was known as Operation T-4. A system was constructed whereby all institutionalized patients were registered on a basis of whether or not they were capable of working, had received visits, had been hospitalized for five years or more, or had certain psychiatric and neurological diseases. A panel of medical experts was created to examine these registration forms, without examining the patients, and thereafter decide who was to be killed. The designated patients were then transported to six carefully selected institutions that had specially constructed gassing facilities. The gas chosen for these killings was carbon monoxide and was to be delivered through false showerheads. These institutions were staffed by specially chosen doctors and nurses. This whole operation was to be kept secret. Death certificates were sent to the relatives noting causes of death that were in effect fictitious and chosen from a preselected list.

It is estimated that about 70,000 patients were murdered by their physicians in this phase of the “euthanasia” program. All disabled Jews were murdered in the T-4 killing centers.

Inevitably such an elaborate system of deceit resulted in human errors which were discovered by the families and their priests. This led to
the protest by some priests and to unrest in Germany. Subsequently, in 1941 the “euthanasia” program was officially halted by Hitler. But in effect the killing did not stop. The physicians and other staff in the asylums in Germany continued to murder their patients in a decentralized manner, in what is known as “wild euthanasia,” until weeks after the Allies had occupied the area.

Historical research has shown that in its effort to cleanse the national community of the “unfit,” the Nazi medical establishment carefully planned and covertly executed an operation that eventually murdered more than 200,000 people.

Initially when the concentration camps were built they lacked the capacity for mass killing, and methods were required to reduce the growing camp populations. The success of the “euthanasia” program had convinced the Nazi leadership that mass murder was technically feasible, and so the SS turned to the T-4 staff for help in this effort. In spring of 1941 a new killing operation in the gas chambers of the T-4 killing centers began. Camp inmates who were denoted as being ill by the camp physicians, were sent to the T-4 facilities to be murdered by the physicians in these institutions in an operation designated “14f13.”

As many as 20,000 camp inmates perished during the two and a half year course of this program, until 1943, when the growing need for forced laborers ended this phase of the process.

The next extension of the “medicalized” killing began when the T-4 personnel were contracted to run the “Operation Reinhard” death camps in occupied Poland. This operation was the codename for elimination of the populations of the major Jewish ghettos in Poland, and proved an intrinsic link between the T-4 and the “Final Solution.”

Physicians were omnipresent at the death camps and medicalized the procedure by taking charge of the initial selections of people who arrived by train. The killing methods in the death camps too were adopted from the T-4 operation and modified according to the needs of the camps. The staff from the T-4 program advised and assisted in the operation of the extermination camps.

The physicians availed themselves of the human materials to conduct so-called scientific research on the camp inmates. Germany’s most prestigious research institutes and medical scientists collaborated with physicians from both Operation T-4 and, afterwards in the concentration camps, who conducted these experiments.

The entire killing enterprise that commenced in January 1940 with the
medical murder of the most helpless human beings, institutionalized patients, was expanded in 1941 to include Jews, Gypsies and others, and by 1945 it had cost the lives of at least six million men, women and children.

References:
1. The Adoption of the Concept of Eugenics by Nazi Medicine

1.1 Eugenics: Physician Participation in Decisions Concerning the Value of Human Life

Case study:
In 1922, the German psychiatrist, Dr. Hermann Pfannmuller, became a member of the Nazi Party and in 1933 joined the SA (the Nazi paramilitary group, also known as the “brownshirts”). In the mid 1930’s, he headed the Augsburg office for race and heredity. The Nazi Party, recognizing his skills, utilized him as an expert lecturer to educate the German public on the “Hereditary Health Law” from the perspective of “racial-political” and “hereditary- medical” concerns. The Bavarian government appointed Pfannmuller director of the mental institution of Elfing-Haar in 1938, a position he held until the end of the war. In 1939, he submitted a report to the public insurance examining board regarding the maintenance of “life unworthy of life” in state hospitals. He voiced his opinion on the need to “eradicate” such patients with the following words:

“As a confessionally unattached and fervent National Socialist director of a mental hospital, I feel myself obliged to influence favorably the economic standing of the institutions. In this position I believe it appropriate to refer clearly to the need of us doctors to grasp the importance of the eradication of life unworthy of life. Those unfortunate patients who live only a shadow life of a normal human being, who have become perfectly useless for social membership in the human community by virtue of their illness, whose existence is to themselves, their relatives and their surroundings a torment and a burden, must be subjected to rigorous eradication. Precisely these days in which the heaviest sacrifice of blood and life is demanded of our most valuable men, teach us emphatically that it should not be possible on economic grounds to fill institutions with living corpses for the sake of a high principle of medical care that is no longer relevant. For me it is unimaginable that the best, blooming
youth die at the front while the incorrigible a-socials and irresponsible anti-socials have a secure existence in our institutions.”

At his post war trial in 1951, where he was charged with the murder of children as part of the Nazi “euthanasia” program, he told the judges: “For me the term ‘volkische’ means national and the term Aryan means that Germans must be in charge. Only those of German descent can be Aryans.”

References:

Background:
Following the discoveries of Charles Darwin in the late nineteenth century, some scientists began to promulgate theories of human inequality as scientific fact. These scientists concluded that human differences were hereditary and unalterable. The term “Eugenics,” first coined in 1881 by the British scientist Francis Galton, was defined as the “science of improvement of the human race by better breeding.” Eugenicists believed that, just as Mendelian laws govern the hereditary transmission of human traits like color blindness, these laws also determine the inheritance of social traits.

In the early twentieth century, eugenic theories began to be applied by national policy makers, who campaigned to halt “social degeneration” in society. They viewed individuals with mental disabilities as burdens to society. Eugenic societies and research centers were established in many Western nations. One of the early leaders in this movement was the United States.

In 1824 the Americans passed the Immigration Act, a eugenically based law allowing the entrance of certain immigrants (those from northwest Europe and Britain) and opposing the acceptance of immigrants from southeast Europe, the Middle East, and Asia. Another solution to the problems of society proposed by the eugenicists was sterilization. Indiana was the first American state to enact sterilization laws in 1907, and by 1925 over 20,000 eugenically motivated sterilizations had been performed in the United States. Other countries had similar programs. For instance, during the same time period in Sweden a similar number of sterilizations were carried out.

In Germany, eugenics became known as “Racial Hygiene.” After
Germany’s defeat in World War I, German scientists and policy makers increasingly began to link eugenics with nationalism and the social “health of the nation.” Many research centers were founded to study the field of racial hygiene. In 1920, a controversial book was published by a lawyer, Karl Binding, and a psychiatrist, Alfred Hoche, called “Permission for the Destruction of Life Unworthy of Life.” The book raised the question of whether or not a nation faced with a dire emergency could actually afford to sustain what they called “life unworthy of life.” The authors argued that society should kill off “incurable idiots” as well as the terminally ill and the critically injured; that individuals should be given the right to choose to die on their own terms through a painless medically administered procedure; and that doctors who performed this service should not be prosecuted. This book caused a considerable stir in Germany, especially among the psychiatrists. These proposed theories were readily adopted and implemented by the Nazi Party, whose nationalist policy was suited to these claims.

With the Nazis’ assumption of power in 1933, eugenic racial hygiene became incorporated into their political health and social policies. These strategies were originally applied to the handicapped (the physically malformed and mentally disturbed) who were considered a burden to the state and thus “unworthy of living.” The policies were next applied to those people who were racially different (mainly Jews and Gypsies). The medical community had a central and essential role in the murderous programs that were founded on these exclusion and eugenic racial theories including the “euthanasia” programs and, eventually, the Final Solution.

Reference:

Questions:
Does eugenics exist today in medicine?
If so how can we approach it?

Discussion:
Eugenics comes from the Greek word eugenēs (eu[well] and genōs[born]). The term refers to improving the race by the bearing of healthy offspring. Eugenics is the science that deals with all influences that improve the inborn
quality of the human race, particularly through the control of hereditary factors. A eugenic program is a public policy structure designed to effect gene frequencies in whole populations. Negative eugenics is a systematic effort to minimize the transmission of genes that are considered deleterious. Positive eugenics is a systematic effort to maximize the transmission of genes that are considered desirable.

In the past, as we have shown in Nazi Germany, the US and other countries, various racial characteristics have been used in formulating eugenic policies, both negative and positive. Utilitarian reasoning was the basis of the Nazi eugenic policies. The Nazi physicians in particular, and the Nazi community in general, did not hold to the view that human life should be respected in all cases. Rather the conviction was that only if human life was one of value to society then it should be respected. Such utilitarian arguments are sometimes evident today. In the present, with the increased cost of medical care, and increased financial pressure on third-party carriers, there are already suggestions to minimize health care at both ends of the spectrum, namely newborns with congenital malformations or genetic diseases, and the elderly or chronically ill. Health care resources are being drained because of new technologies, and the elderly are particularly vulnerable to discrimination on an economic basis. In the middle of the spectrum is the frequent issue of assessing the life (and death) of a terminally ill patient, and making decisions on whether or not to resuscitate.

The Human Genome Project has opened new spheres of research. Its applications have also proved useful to clinical care, by allowing physicians to utilize knowledge of the human genome in order to diagnose future disease as well as to individualize drug therapy. Today, genetic counseling has become an integral part of modern day medicine. Often, medical decisions, based on genetics, have cost-effective or utilitarian grounds.

It can be difficult for today’s medical practitioners to reflect objectively concerning our actions and practices, particularly with regard to how new advances in science and technology, and their applications to genetic counseling and clinical care, can possibly be deleterious to our patients.

In the past, as in the case above, we have seen how innocuous medical practices or public policies have been distorted to be applied as negative eugenics abrogating the rights and privacy of millions of individuals. Today some of our accepted practices (e.g., prenatal diagnosis and screening) are considered by some as negative eugenics, and the intense debate on these issues is ongoing.
Physicians possess the knowledge and skill to provide a realistic assessment of the quality of a patient’s life. However, the ultimate evaluation of one’s quality of life, whether it be a prenatal diagnosis or at the other end of the spectrum with the elderly or terminally ill, should only be made by the individual patient. In cases in which the person is unable to make the decision, or has not made prior statements concerning such eventualities, the evaluation should be made by the family or surrogate with input, if requested, from the physician.

1.2 Eugenic Sterilization

Case study:
Dorothea Buck was born in Germany in 1917. In 1936, at the age of 19, she was hospitalized at the Von Bodelschwingsche Asylum in Bethel and diagnosed with schizophrenia. At this asylum, she was sterilized without consent. In addition, she was not told the true nature of her surgery, but instead, informed by a ward nurse that she had undergone an appendectomy. She later learned about her sterilization from a fellow female patient.

Up to 1959, Dorothea would subsequently suffer four psychotic episodes and hospitalizations. She eventually rehabilitated herself, becoming a sculptor. In 1961, after learning from the Adolf Eichmann Trial about the sterilization and euthanasia programs, Dorothea started researching the history of sterilization and euthanasia in Nazi Germany. Dorothea spent the rest of her life teaching, lecturing and writing about the crimes that were performed in the psychiatric institutions. She also became a severe critic of forced sterilizations and euthanasia, as well as various treatments for psychosis.

Reference:
http://www.bpe-online.de/english/dorotheabuck.htm
Background:
Prior to the National Socialist’s rise to power, surgical sterilization was illegal in Germany. In the final years of the Weimar Republic, which were marked by a severe economic depression and political unrest, eugenic sterilization emerged as a popular stream of thought among geneticists, economists, political policy makers, as well as the medical professionals.

A few months after Hitler’s rise to power in 1933, the Nazis passed the “Law for the Prevention of Hereditarily Diseased Descendants” (Sterilization Law) allowing for compulsory sterilization on “eugenic indications.” The medical profession not only supported the Nazi policy but was a leader in the campaign for its practical implementation. Many doctors envisioned this as an opportunity to influence the “regeneration” of the German nation by eradicating those with “biologically inferior hereditary traits,” in order to “cleanse the genetic pool of the German race.” According to this law, an individual could be involuntarily sterilized if, in the opinion of a Eugenic Health Court, he or she suffered from any of several “genetic” illnesses. These included “congenital feeblemindedness,” schizophrenia, manic depressive insanity, genetic epilepsy, Huntington’s chorea, “genetic” blindness or deafness or “severe alcoholism.” Physicians were required to undergo training in “genetic pathology,” and a special medical journal was founded to help them determine who should be sterilized and by which methods. The Nazi medical journal, Der Erbarzt, was founded as a supplement to the prestigious German journal Deutsches Arzteblatt in 1934. This supplement provided the forum for discussion of methods, as well as the criteria and rationale for the Nazi sterilization program.

Coming into effect on January 1, 1934, the sterilization law laid out a very specific legal and medical process: doctors were required to register every case of genetic illness known to them, without obtaining the permission of the patient, to special genetic courts. The genetic court consisted of three members: a magistrate, an official doctor, and a second doctor qualified in eugenics. Between 1934 and 1939, the courts ordered about 375,000 operations, thirty-seven percent of which were voluntary, thirty-nine percent involuntary (against the patient’s will), and twenty four percent non-voluntary (consent granted by a guardian). The commencement of the Second World War in September, 1939, slowed down the progress of the courts. Nonetheless, by the end of 1944, almost 400,000 people in the German Reich had been sterilized. Similar sterilization programs were in existence in many other countries at the
time including the United States, Sweden, Switzerland, Norway and others. These programs provided the models for the German sterilization laws. In the United States the first compulsory sterilization law was enacted in Indiana in 1907, and eventually 28 states had laws allowing forced sterilization. By 1930, 15,000 American men and women had been sterilized. The Nazis cited this American example as a justification for their program.

In many countries these laws persisted into the 1970’s. To the present day there are still countries where forced sterilization persists. In the U.S recent legal rulings in the State of North Carolina have ruled on behalf of a class of plaintiffs who were, in the past, sterilized against their wills and without informed consent. The State is expected to pay monetary damages on behalf of the patients.

Reference:

Question:
Is it ethical to force a patient to undergo sterilization procedure?

Discussion:
Involuntary sterilization is a clear infringement of a person’s reproductive autonomy and basic human rights. This is especially relevant in cases of people with mental illness or other intellectual disabilities. Questions may be raised on this issue as to how far the rights of parents and guardians extend concerning their mentally disabled dependents. Who is responsible for the medical rights of the mentally disabled when their reproductive health is considered? Is it the physician’s duty to decide who would benefit from a procedure that is essentially irreversible in future decisions on family planning?

The Nazi program of forced sterilization violated the patient’s right to self determination, human dignity, privacy and autonomy. It was also in violation of the principle of obtaining informed consent for any medical procedure, and in addition violated the patient’s right, or the surrogates right, of decision making in family planning and reproductive health.

A sterilization procedure is a permanent, life-altering, invasive procedure. There may be some situations in which sterilization is merited when the patients, and/or guardians, are fully aware of the nature and consequences
of the procedure. In September 2011, The World Medical Association and the International Federation of Health and Human Rights Organizations (IFHHRO) condemned the practice of coerced sterilization as a form of violence that severely harms the physical and mental health of patients and infringes on their human rights. They stated that voluntary sterilization is a form of birth control that should be available, accessible and affordable for every individual, within the full range of all alternative contraceptive methods. Barriers to sterilization, once an informed choice has been made, should be minimized.

While there may be instances where sterilizations may be ethically and medically appropriate, the decision-making should be based on the best interests of the patient and not on the interests of society or other involved parties.
2. Racism and Nazi Medicine

2.1 The Use of Race as a Medical Diagnosis

Case study:
In Saul Friedlander’s book, he discusses the 1939 case of a German woman called Fraulein M. She wished to marry a civil servant and wanted to be reassured about her Aryan ancestry, as her grandmother’s name, Goldman (a common Jewish surname) might have raised some doubts. The pre-marital “genetic” examination was performed in the Genetics Department of the Kaiser Wilhelm Institute for Anthropology, Human Genetics and Eugenics in Berlin. Professor Otmar von Verschuer, a prominent physician and geneticist, was the head of this department.

One of the questions that Dr von Verschuer’s specialists attempted to solve was, “Can Fraulein M. be described as non-Aryan in the sense that she can be recognized as such by laymen on the basis of her mental attitude, her environment or her outward appearance?” The “genetic” examination, which was based on photographs of Fraulein M.’s relatives as well as on her physical characteristics, led to favorable results: the medical report excluded any signs of Jewish origin. Although Fraulein M. had a “narrow, high and convexly projecting nose,” the report concluded that she had inherited her nose from her father and not from the grandmother (with the name Goldman). Fraulein M. was declared an Aryan.

Reference:

Background:
After the defeat in the First World War, many German racial hygienists and scientists blamed Jews and Communists for the nation’s defeat, as well as for many of the social ills in the country. Adolf Hitler was deeply influenced by German racial hygienists and incorporated their ideas of race into his book, Mein Kampf. Hitler’s ascension to power enabled German politicians,
scientists and policy makers to implement their racial views on society. While Hitler was a great catalyst in these efforts, physicians and scientists played a primary and essential role.

Biological imagery played a major role in Nazi social policy: Jews and Gypsies were perceived as diseased, as “bacilli,” “abscesses” or “parasites” that threatened the “health” of the nation. Nazi medical annals, using racist metaphors in articles, equated both Jews and Gypsies with disease. These racist metaphors were also promulgated by the state at every level of society and were utilized in the education of both adults and children, from primary school through to the universities.

With Hitler’s rise to power, the German Medical Association incorporated anti-Semitism into its doctrine, perpetuating the belief that Jews suffered from specific diseases, and warned against the mixing of Jewish and non-Jewish blood. German anthropologists and geneticists attempted to develop racial techniques that identified racial characteristics in an individual. Germany’s foremost public health journal published detailed reports on how to determine racial affiliation. Physicians identified Jews as suffering from lack of hygiene, and as having an exceptionally high incidence of mental illness and homosexuality. In addition, Gypsies were identified as racial “asocials,” who also weakened the purity of the Aryan race and led to a degenerative society.

In the fall of 1935 Hitler signed a series of three laws known as the Nuremberg Laws to further “cleanse” the German population from unwanted elements. These laws included:

1. The “Reich Citizenship Law” that distinguished between residents and citizens. Citizens were those of pure Aryan blood;
2. The “Blood Protection Law” that forbade marriage and sexual relations between non-Jews and Aryans;
3. The “Law for the Protection of the Genetic Health of the German People.” This law required couples to submit to medical (“genetic”) examination prior to marriage in order to determine the genetic health of the future couple and of their offspring. It also forbade marriage between individuals suffering from venereal disease, feeble mindedness, epilepsy or any other “genetic infirmities” specified in the 1933 Sterilization Law. Those considered to be genetically ill were permitted to marry other genetically ill, but only after being sterilized to ensure that they would not produce any offspring.
The Nuremberg Laws, as well as the Sterilization Laws, were responsible for the expansion of the power and responsibilities of the German medical services. Thousands of physicians, including racial hygienists, were employed to provide marriage counseling, which became an integral part of German public health. New jobs were created, so that despite the exclusion of the German Jewish physicians, the total number of medical personnel actually rose during these years. In addition, the dangers of miscegenation were widely published both in the popular press as well as in medical literature.

The Nuremberg Laws, administered primarily by physicians, were perceived by the German medical community as public health measures. They were viewed as health laws and not simply as anti-Semitic measures. German medical journals applauded these laws and published articles to aid German physicians in implementing the racial laws and policies. Germany’s leading health officials saw the prevention of human genetic disease, along with the prevention and elimination of racial miscegenation, as part of a program of responsible public health policy. There is no record of opposition to the Nuremberg Laws in the German medical literature of the time.

With Hitler’s expansion of power, overt anti-Semitism and racism emerged within the medical profession as it interfaced with the Nazi party. Physicians became leaders in the formulation and implementation of the Nazi world view. The interface led to a bio-medical vision which consisted of three complimentary images: 1) the Jews and Gypsies as diseases, that needed to be cleansed from the body politic; 2) the German people as the patient; and, 3) National Socialism as physician, with Adolf Hitler designated as the “Great Physician of the emerging Aryan Nation.”

During World War II, Nazi medicine was later used as a tool to justify anti-Semitism and racism. The official journal of the German Medical Association published a regular column during the war years called “Solving the Jewish Problem.” With the German occupation of Poland in September, 1939, Jews as “carriers of disease” became a justification for Jewish ghettoization across Eastern Europe. Jews were systematically transferred to the ghettos under the pretense of quarantine. Because the conditions in the ghettos were so horrific, infectious epidemics did indeed occur. German medical journals then invoked ghetto statistics on infectious epidemics, such as typhus, to further denounce the Jewish “race” as diseased. Likewise, Gypsies were also rounded up and incarcerated in ghettos or in concentration camps, which also led to high incidences of infectious disease. Such epidemics were then utilized
as a rationalization and justification to systematically eliminate (murder) both Jews and Gypsies across Germany and occupied Europe.

References:

Question:
How do we prevent racial issues from affecting medical decisions?

Discussion:
‘Race’ is a complicated term with a wide variety of definitions. Some medical researchers think that race is critical for the knowledge of ancestry and essential for clinical and biomedical research. While there is concern with the potential misuse of racial and genetic information, these researchers maintain that an individual’s racial or ethnic affiliations will continue to provide valuable information for epidemiological studies, as well as for clinical and pharmaceutical research. By contrast, other researchers insist that definitions of race and ethnicity are unsound, making them flawed surrogates for the multiple environmental and genetic factors in disease causation, including ancestral geographic origins, socioeconomic status, education, as well as access to health care.

While medical oaths and ethical codes vary from one nation to another (and sometimes can even vary within the same country), they have many common features, including the ethical mandate that physicians, nurses, and other health care providers should not discriminate against patients or medical personnel on the basis of race, ethnicity, religion, class, sex, or sexual orientation. Nonetheless, despite the existence of these ethical codes, race and racism in medicine continue to plague most societies and have also been implicated as causes for discrimination, prejudice, marginalization, and even subjugation. For example in the United States, it has been documented that Blacks, Hispanics, and Native Americans often receive lower-quality health care than whites. This disparity generally is attributed to lower incomes, inadequate insurance coverage and lack of doctors in minority areas. All of these factors can contribute to higher death rates and lower survival
rates among minorities compared with whites, suffering from illnesses of comparable severity. Moreover, minorities are more often denied advanced treatment, and are more likely to receive less desirable treatments that impair their quality of life.

Despite the opposing views of race and human genetics in the present, most researchers and clinicians have a shared commitment to seek out greater knowledge and a better understanding concerning the human genome for the improved health care of both individuals and populations. At the same time, there is also a shared concern by many, about the potential dangers, misapprehensions and misuse of such genetic research.

Historically, as in the case above, there have been many instances of abuse in the utilization of so-called “racial” science. Moreover, humanity also has a long history of racism, as well as the abuse, subjugation, and enslavement of minorities. In Nazi Germany, misuse of knowledge on genetic medicine provided the justification for the German medical profession to sponsor and participate in murderous programs “in the name of health and science.” This pseudo-science, based upon racial ignorance, misperceptions and prejudice, was to a large extent responsible for the destruction of certain parts of the population, especially the Jews.

More education in racial awareness and cultural understanding is one way that the medical profession can better guard against the dangers of racism.

Courses should be included on the relationship between racism, genetics, and the scientific study of “race.” Finally, in the long and still unfolding story of humanity, the history of the misuse of genetics and race in medicine should not be forgotten; it should be taught to all medical students. Such lessons should be instilled into our hearts, minds, and consciences so that they will be less likely to happen again. Informative courses and critical reflective discourse will also help clarify both the problem of the misuse of genetic/racial information and also the best ways to address it.
2.2 Racism within the Nazi Medical Community

**Case study 1: Medical students.**
In 1935 Moshe Prywes was a Jewish student at Warsaw University Medical School. The Academic Senate of the Warsaw University adopted special anti-Jewish legislation to segregate Jewish students from the non-Jewish students. Separate benches were reserved exclusively for non-Jewish students in lecture halls. Auditoriums were also divided into two sections – Gentiles on the right and Jews on the left. This was known as the “bench ghetto.” In addition, examination papers, which previously had been anonymous to the professor, were now compulsorily stamped according the religious belief of the student. This policy was common at other university campuses throughout the Reich. To counter the anti-Semitism, Prywes, who was head of the Jewish Medical Students’ Association, convened a series of emergency meetings to discuss the policies and to organize an action in response. Jewish students agreed, after a long debate, to refuse to occupy the seats that were set apart for them. Instead, they decided that they would stand in single file on the steps between the rows and would take notes while leaning on the shoulders of the student in front. Moshe Prywes, in his book, Prisoner of Hope, notes:

“From 1935 until the outbreak of the war, in class after class, day after day, year after year, such was the way Jewish students pursued their studies. In short order, the practice spread and became universal among all Jewish students at universities throughout Poland. Almost surely, never before or since, has there been such a sight as the vertical students of Poland.”

**Reference:**

**Case study 2: Physicians.**
Dr. Lucie Adelsberger was a German Jewish pediatrician who worked in the field of immunology at the Robert Koch Institute in Berlin. She published at least 15 papers between 1924 and 1933 and was a founding member of the German Women’s Medical Society. In March 1933, two months after the Nazi takeover, Dr Adelsberger and eighteen other Jewish scientists from
the institute were dismissed. She was restricted to her private practice only, and was no longer allowed to call herself a “doctor.” Instead, she became an “attendant.” Dr. Adelsberger was denied participation in the National Health Insurance Plan as well, and in 1938 she could no longer treat non-Jewish patients. She was deported to Auschwitz in 1943.

Reference:

Background:
In March 1933, when the National Socialists took control of the German government, anti-Semitic decrees were immediately undertaken by the new regime. The German medical community, in compliance with the Nazis, took major organizational steps in support of the political anti-Semitic policies. At the time, 13-17% of the physicians in Germany were Jewish, and in Berlin this number reached 50-60%. Within weeks of the formation of the new Nazi government, Jewish physicians were dismissed from their hospital posts in the major German cities.

In April 1933, the Civil Service Law was passed. This law forbade Jews and communists from holding positions in government service, including medical service jobs. Professional medical organizations and health care insurance companies also dismissed Jewish doctors. At all levels of government, society, and the work place, it was urged that Jewish doctors be replaced by non-Jewish physicians. By the end of 1933, there followed a series of both legal and administrative decrees that prohibited Jewish physicians from treating non-Jewish patients, from having professional interactions with non-Jewish colleagues, and from receiving medical degrees. By 1934, 31% of Jewish physicians had been removed from practice.

The Nuremberg Laws, enacted in 1935, legally defined a Jew and in effect stripped German Jews of their citizenship. The laws barred Jewish participation in most sectors of German society and entailed serious consequences for the Jews in the medical profession. The Reich Physicians’ Ordinance of December 1935 stated that no new licenses would be granted to Jewish doctors.

In 1936, most medical faculties prohibited their Jewish students from performing gynecological examinations on Aryan women. The decisions
regarding the application of these restrictions were left to the hospital directors responsible for the Jewish gynecology interns. No longer able to practice, many Jewish physicians fled the country. The expulsion of Jews from the universities and other posts vacated a large number of positions in Germany’s medical schools, institutes and clinics. These vacant positions were rapidly filled by young unemployed local non-Jewish German doctors.

In 1938, a final piece of legislation was passed. This law was the final blow to the German Jewish medical profession. The Reich Physicians’ Chamber decertified Jewish physicians. Jewish doctors were no longer regarded as members of the medical community and they were only allowed to treat fellow Jews with special permission. The title “doctor” was removed. Jewish physicians, now decertified, were to be known, henceforth, only as “attendants.”

It has been estimated that at least 25% of the German Jewish physicians were murdered during the Holocaust, and that 5% died from suicide.

References:

Question:
How do we prevent racial prejudice among medical professionals?

Discussion:
Increasingly, most of us live and work in multicultural societies, both in terms of the patients we treat, as well as the colleagues with whom we study and practice. While doctors should be confident that their career progressions will be based solely on their abilities, there is evidence in many places that race can be a barrier to advancement. Inequality of opportunity is a concern that the every health care system and every medical professional should take seriously.

Discrimination on the grounds of race, gender and disability is unacceptable. Discrimination can result in a lack of motivation, frustration and reduced confidence. In many countries racism does exist in the medical systems and is often experienced by doctors from ethnic minorities. For example, it has been shown that doctors from ethnic minorities, as a group,
experience worse terms and conditions of service and opportunities for career progression than other doctors. Research has also demonstrated that acceptance into medical schools is also an area where minority groups are discriminated against. Certain medical associations worldwide have prevented doctors from differing cultural groups from becoming members of the associations.

The American Medical Association Code of Medical Ethics states that no professional endeavor should be denied to a physician based on race, color, ethnic affiliation or national origin. The AMA encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected.

The medical profession should demonstrate leadership in excision of racism and demand selection procedures to become transparent and be based on competency alone. A culture of respect and fairness must be developed so that all individuals can feel valued and confident that they will be judged on their capabilities alone.

One of the ways that racism can be dealt with is to introduce discussion of cultural diversity and racial prejudice (as in the above mentioned case) into the curriculum at medical schools.
3. Medical Education under Nazi Rule

Case study:
In 2010, Dr. Theresa M. Duello, while researching in the library of the University of Wisconsin-Madison, discovered six theses of German medical students that were written between 1937 and 1940. These doctoral theses, written as a requirement for a medical degree, detailed the first five years of medical experience with the sterilization of hundreds of women by physicians at German hospitals. The students’ research was supervised and approved by the physicians and hospital directors of the institutions where the sterilizations were performed.

One thesis, written by Erich Bacher, from Würzburg, in 1940, analyzed 210 sterilized women at the gynecological clinic of the city hospital of Pforzheim. In his introduction, Bacher wrote:

"It is of fundamental importance to swiftly counter any public unrest concerning the measures taken due to the law, and to firmly establish the idea of hereditary health among our population."

Bacher also discussed patients’ objections to be operated on against their will, as well as the problem of hospitalizing sterilized patients together with other patients in the wards. The student describes two of the cases where women were sterilized:

"In a family where the father was an alcoholic and the mother feebleminded, five of the seven children had to be cared for in an institution because three had a high degree of feeblemindedness and two were idiots. One daughter is married. One child is of below average intelligence. The youngest girl is above average and has received prizes several times in school. The whole family has already cost the government care system over 50,000 Marks...In another case, public welfare has to care for four children, born out of wedlock, who have four different fathers. The children are feebleminded, too. This family has several branches where many cases of mental weakness, feeblemindedness and mental illness have been observed. Due to impossible conditions in the household, six children had to be removed from their
A feebleminded mother and taken to care by the local authorities. Out of these, four have also been proven to be feebleminded; two girls have already been sterilized. The seventh child, that the mother expected, was never born thanks to the Court of Hereditary Health.”

Another student, Storch, examined 190 cases of sterilization performed at the City Hospital in Speyer, and wrote:

“We are bound by duty as physicians to bestow the persons who are affected according to the Law with the best possible care. The most important thing today is to safeguard life... Only future generations will be able to judge the real outcome of the law; however, our task, now as ever, continues to be reducing the risks of the operation to a minimum and using methods which are as reliable as possible.”

All six theses included extremely detailed documentation on the details of the various surgical procedures performed and the surgical complications encountered. There is no discussion about the validation of the definitions of the conditions that determined the justification for the procedures. The theses proclaimed the virtue of the Sterilization Law for the improvement of the German people and credited the Third Reich’s eugenic policies as positive for the nation.

Reference:
Theresa M. Duello, Misconceptions of “Race” as a Biological Category: Then and Now, in Sheldon Rubenfeld ed, Medicine After the Holocaust. From the Master Race to the Human Genome and Beyond (Palgrave MacMillan, 2010).

Background:
Educational reform was an important part of Nazi medical policy. As early as 1922, the Society for Racial Hygiene demanded that racial hygiene be considered an obligatory field of study in the German medical curriculum. Racial hygiene was also incorporated into the state medical exams which were an essential requirement for graduation. Racial hygiene courses included subjects such as blood group research, anthropological measurements, twin research, genetics, criminal biology, racial law and war medicine. Medical faculties placed less emphasis on basic research, modified the classical curriculum and shortened the time of medical study to produce more doctors for the Nazi state.

Medical students were taught that these courses were essential to
their professional education of preparing them for their duties as “marital counselors and guardians of the genetic constitution.” Medical students were also told that they were to be trained as “biological soldiers”; training that involved military and paramilitary education in order to prepare them to serve the militarized ideological authority of the state. Students wrote dissertations on the various racial medical programs. Racial training was also incorporated into post-graduate courses for physicians with emphasis on sports medicine, organic medicine and war medicine.

References:

Question:
Should medical education be affected by political or other social policies?

Discussion:
At the turn of the 20th century, German medical education was considered to be one of the most developed in the world. In 1910, after learning about the German medical education method, Abraham Flexner produced what is known as the “Flexner Report,” which transformed the nature and process of medical education in America. The report embraced scientific knowledge and its advancement as the defining ethos of a modern physician. This report was to become the basis for medical school education worldwide. So, in fact, medical education in most countries today is based on the German system.

But that changed drastically during the Nazi period. The medical educational instruction, and thereby the medical students, in Nazi Germany were greatly influenced by the political climate of the country at the time. While this could probably be said for any student at any time, what was different in Nazi Germany was that the medical students were taught that ideological racial Nazi policies were acceptable medicine and science. Students were expected to become advocates for the Nazi political and racial agendas, which were promulgated as good “science.”

In this highly structured and pressurized political context, much emphasis was also placed upon obedience, and upon the adherence and allegiance to the
political agendas of Nazi leaders. These beliefs were expected of the medical students as well.

In this political climate, the Sterilization Law was justified as both good science and good politics. It was a method to rid Germany of any future “undesirables” or individuals who were considered burdensome to the State. There was a firm conviction that the “health” of the nation took precedence over the care and treatment of individuals.

Ethical questions concerning these racial laws were not considered. Instead, they were presented in such a way that simply proved and supported the Nazi world view. This can be seen as a form of political brainwashing. But should such brainwashing be part of medical education? Is not critical and reflective thinking one of the basic premises for the development of a sound, creative and ethical medical education?

What are the goals of medical education? Is scientific knowledge enough to produce good doctors? Should we teach students to become physicians who will become technicians in the service of science, or physicians who can utilize their scientific knowledge in the service of patients? Should medical students (and physicians) become social or political advocates?

The aims of medical education are many and the education process should be life-long, a continuum of learning beginning with medical school and ending with retirement from practice. As well as preparing students to apply scientific knowledge for the prevention, alleviation and cure of diseases, medical education should also inculcate personal ethical standards of thought and behavior as well as critical thinking.

Medical education should embrace the full value and power of the tools at physicians’ disposal to ensure improved health and social welfare. Students should have an understanding of health in which environmental, social, behavioral, physical, economic and political factors contribute significantly to the health and well-being of patients. Students should also be taught that physicians have the power and authority in society to become influential advocates for the advancement of their patients. This can be seen as political advocacy in certain circumstances, but should always have the goal of the patient’s or the general public’s well-being or health in mind.
4. Medical Press under the Nazis

Case study:
One of the largest and most prolific of the popular medical magazines in Nazi Germany, with editions running over 100,000 copies, was Die Volksgesundheitswach (The People’s Health Watch). This magazine was placed in patient waiting rooms in clinics and hospitals throughout the Reich. Dr. Eugen Stähle, a neurologist, and leader in the National Socialist German Medical Association, as well as head of the Ministry of Health in the German state of Württemberg, wrote an article in 1934 titled: “Blood and race: New Research Results,” which focused upon the use and importance of human blood as a means and tool for identifying race:

“In describing the various races, we must not stop with the external shape of the body, . . . We must go beyond this, to explore equally important differences in the inner organs of the body, differences that may reflect deeper, physiological differences among the races . . .”

Dr. Stähle also asked his readers:

“. . . think what it might mean, if we could identify non-Aryans in the test tube! Then neither deception, nor baptism, nor name change, nor citizenship, and not even nasal surgery could help (the Jew escape detection). One cannot change one’s blood.”

A few years later, in 1939, Dr. Stähle, a decorated WW I veteran and a member of the Nazi party, helped establish the secret “euthanasia” center at Grafeneck Castle, located in an isolated area in the Münsingen district. The castle became a killing center for the murder of the mentally disabled in the Nazi “T-4” program. More than 10,000 children would be murdered in Grafeneck in less than 2 years. In 1943, Dr. Stähle was appointed to a medical professorship by Adolf Hitler. After the defeat of Germany in World War II, he was arrested for his role in the euthanasia program and died in prison in 1948.
Reference:

Background:
Prior to the National Socialist rise to power, German medical science was one of the most vibrant and creative of all medical traditions in the world. The German medical press played a vital part in this tradition. In 1933, shortly after Adolf Hitler became Chancellor, German medical leaders merged the two former main medical journals into a new single publication, the Deutsches Arzteblatt. This publication became the official journal of the Reich Physicians’ Chamber and the Association of the German Health Insurance Physicians. This consolidation marked a turning point in the Nazi’s control over the German medical press. From this point on, medical journals were explicitly ordered to receive approval of Nazi medical authorities, which consisted predominantly of loyal Nazi ideologues. Political censorship prevailed at every level of publication.

This also marked the beginning of a campaign to eliminate Jews, as well as Communists and Socialists, from German medical science. Editors and consultants to the medical press would now only be of German-Aryan origin and loyal supporters of the Nazi views. The Deutsches Arzteblatt announced that the German medical press would “purge itself of non-German influences” in order to return the profession to “German-feeling” and “German-thinking.” Socialist medical journals, with a long tradition of medical prominence, were also banned, as were any publications that allowed views opposing the Nazi medical-political vision.

From 1933 through to the end of the war, innumerable articles were published in the medical press on racial purity, hygiene and health policy. They were part of a government sponsored campaign intended to promulgate and saturate the medical community with the Nazi’s racial hygienic and political views. Thus, the goal of publishing changed from one of providing scientifically valid information to one that supported and promulgated the policies of the State.

Manuscripts were accepted for publication based upon their commitment to further the policies of National Socialism, rather than the quality of the research. Special journals, based upon pseudo-scientific, pro-Aryan, and anti-Semitic conceptions, were established for academics and the
general population. One primary theme of the German medical press was to inculcate the readers to the importance of “blood purity” for the Aryan race and the German Reich. These articles warned about the dangers of “polluted blood” that was “carried” by the disabled, the congenitally ill, Jews, Blacks, and Gypsies. The danger of this “bad blood” to the body politic was later used as a political and medical rationale for hygienic and ethnic cleansing.

References:

Question:
What are the ethical codes that apply to the medical press?

Discussion:
Prior to the Nazi period, the German medical journals were considered to be some of the most prestigious medical publications in the world and the research published in these journals considered to be reputable. This situation changed considerably after the Nazis took control not only of the political stage, but also the medical press. The ethics of medical publishing was clearly violated as conflicts of interests arose between the medical community and the political agenda of the Nazi state. Once medical leaders, academics and editors were co-opted by the Nazi political agenda, no counter or opposing notions were published in the journals that expressed concerns about the scientific validity or content of some of the articles. Such a policy clearly violated the ethics, not only of medical journalism, but journalism in general. This was again another example of the unhealthy relationship between Nazi medicine and Nazi politics.

Ethics in publication is an important foundation of scientifically valid research. It is important to ask not only if results have been published, and what these results are, but also why and how the results were gathered, interpreted and published. Today there is great concern about conflicts of interest in academic research. Conflicts of interest are those which, when revealed later,
would make a reasonable reader feel misled or deceived. These conflicts may be personal, commercial, ideological, political or academic. Conflicts of interest arise when authors, reviewers, or editors have interests that are not fully apparent and that may influence who is published, what is published, as well as the timing, scope, and method of the publication process.

Today it is widely accepted that medical research should be peer reviewed before publication. Moreover, publication should also take into account any biases (whether potential or actual) due to any conflicting interests. It is generally expected that editors should disclose to readers their own conflicts of interest and those of their teams, family members, editorial boards, managers, and owners.

Just as interest in research ethics led to the creation of Institutional Review Boards and the requirement that research proposals receive ethics approval, specific awareness of publication ethics has led to the creation of several institutions that seek to foster adherence to ethical publication practice. Prominent among these groups are The World Medical Association of Medical Editors (WAME), Committee on Publication Ethics (COPE) and the International Committee of Medical Journal Editors (ICMJE), whose criteria for authorship have been widely adopted.

Violations of ethics in publication are not separate or distinct from violations of the ethical norms that govern the treatment of patients in research. Medical journals should be concerned with advancing medical knowledge in the service of human health, rather than acting as part of the marketing arms of commercial industries. In addition they should not be used as tools for promoting political ideologies and policies unless these are consistent with the best interests of the patients.
5. Dual Loyalty of Physicians: State vs. Individuals

Case study:
Dr. Hans Deuschl was born in 1891, in Grafing near Munich. He studied medicine in Munich where he joined the student fraternity. Like his later friend and benefactor, Heinrich Himmler (who was to become the leader of the SS), Deuschl was influenced by the spirit of this student fraternity, the impact of the German defeat after the First World War, and his experience as a volunteer-corps fighter in Bavaria. He identified with German nationalism at an early age.

As a medical practitioner, Dr. Deuschl advanced in his political career as the local Branch Leader of the “Völkischer Block” (Nationalist Bloc) and was a candidate for the post of Mayor of Grafing in December, 1924. He joined the National Socialist Physician’s League (NSDAP) in September 1929 and the SS in June 1931. As an SS member, he was given the assignment to develop and command the medical services of the SS by Heinrich Himmler. Dr. Deuschl became the director of the NSDAP journal and made public political statements, encouraging his fellow physicians to join and to serve their country. As chairman of the NSDAP, he wrote:

“This organization is not only a professional organization of physicians, but a military one too. Our members are first and foremost Nazis and then only are they doctors. They represent the nation as a whole and should put aside their own personal interests and become leaders who strive for the interests of the whole German nation.”

Dr. Deuschl was also a close friend of the head of the NSDAP, Dr Gerhard Wagner. In 1935, Dueschl was appointed the head of the “Fuhrer” School of the German medical profession at Alt-Rehse.

References:


**Background:**

Shortly after the rise to power of the National Socialist Party in Germany in 1933, the various German medical associations were coordinated and unified into a hierarchical organization called the National Socialist Physicians’ League (NSDAP). This body was subordinated to the Nazi party. In one of Hitler’s earliest speeches before the Physicians’ League, he announced:

“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.”

The Nazi party ideology was often portrayed in a way that attracted doctors. In *Mein Kampf*, Hitler stated:

“Anyone who wants to cure this era, which is inwardly sick and rotten, must first of all summon up the courage to make clear the cause of this disease.”

Utilizing biological and scientific metaphors, the Nazi government viewed certain sectors of the population as posing a threat of contagion that could “infect” and weaken the German people. Physicians were to be the “guardians” of health of the German state, and to be active in the prevention and treatment of the “infectious contagion” wherever and whenever it occurred.

The leading figure in the medical organization was Dr Gerhard Wagner, who was recognized as the “Fuhrer of the Physicians League.” Wagner declared that:

“Health care was to be replaced by health leadership; curative medicine was to be replaced by preventative medicine and individual hygiene was to be replaced by racial hygiene.”

In Wagner’s view, physicians were to become physicians of the nation; they were no longer required to be the doctors of their individual patients. Through Wagner and other Nazi medical and political leaders, the medical profession totally allied itself with the National Socialist political philosophy. This philosophy was based on Racial Hygiene eugenic principles in which the nation’s health was to surmount the health of the individual patient.
One of the political objectives of the Physicians’ League was to train German doctors in the beliefs of the Nazi Party. A Leadership (Führer) School of German Physicians was built at Alt-Rhese in Mecklenberg. This school was known as the “character school of the German doctors.” Dr Hans Deutschl was the first director of this school.

The Führer School’s mission was to supplement traditional medical training with new emphasis on training physicians to become Nazi “Health Leaders.” All lectures were taught by high-ranking Nazis. The School, organized like a military training camp, featured classes on Nazi medical and political policies, public health administration, and holistic medicine. Genetic and racial science became the central focus of lectures. Residents followed a strict regimen of militaristic exercises and manual labor. At the time, official medical journals noted that:

“The new physician in Germany had become more than a curator of the ill; he was now a curator of genetic health and a health leader of the German people.”

By early 1936, nearly a thousand physicians had been taught in the Führer School. The School’s message focused particularly upon junior doctors who showed potential for future political leadership. Many of these young German physicians were attracted to the Nazi Party by its promise that the National Socialists would restore Germany’s power. Others thought that the Nazis would increase the honor and dignity of the medical profession. Finally, many young physicians and researchers thought that the Nazi Party was a means to obtain superior jobs, better academic positions, as well as greater and more lucrative political affiliations and economic rewards.

Physicians responded by joining the Nazi Party earlier and in greater numbers than any other professional group. By 1942, nearly half of Germany’s doctors were members of the Nazi party. This number was far in excess of the other professions like teachers or lawyers.

References:
Questions:
Where does a physician’s duty lie?
Is he responsible to the organization/political affiliation or to his patients first?
What tools are available to solve issues of dual loyalty?

Discussion:
Current international codes of medical ethics generally mandate complete loyalty to patients. In practice, however, health professionals often have obligations to other parties besides their patients. It is in the context of competing personal and professional obligations that dual loyalty may emerge between the clinical professional duties to a patient and obligations, expressed or implied, real or perceived, to the interests of a third party.

Dual loyalty may be unavoidable and can be commonplace in the work of medical professionals. Some examples of this might include a patient’s family, police or prison authorities, a medical institution such as a hospital or organization, an employer, an insurer, the general public, the state or the military. The problem of dual loyalty may therefore be evident in many settings. Conflicts resulting from dual loyalty can potentially give rise to human rights violations in all societies, even those thought to be the most open and free. However, these violations are likely to be greatest and most prevalent in societies that lack freedom of expression and association; for example, where state officials demand that health professionals contribute to the suppression of dissent, as was the case in Nazi Germany.

Perhaps one of the most polarizing examples of dual loyalties arises among military physicians and nurses. Sworn to defend their nation, they sometimes may find themselves acting in ways that violate health ethics.

Many health professional organizations and individual scholars have identified ethical principles and guidelines for dealing with dual loyalty conflicts. The World Medical Association has made several policy statements on the ethical conflicts of dual loyalty whereby physicians are required to consider first their loyalty to their patients. But it is recognized that, in certain situations, the needs of others will prevail over those of the patients in their care. When this happens, physicians must take all appropriate measures to mitigate any harm to their patients. Physicians should learn to recognize the situations where dual loyalty exists, and be aware of the ethical and professional guidelines provided to assist them in dealing with the resulting dilemmas.
6. The Pressure of Economics on Medicine

Case study: The Economical Grounds for the Nazi “Euthanasia” Program

The Nazi argument for the destruction of “life not worthy of living” was not simply a eugenic rationale for euthanasia; it was also grounded on an economic justification that certain categories of ill people posed too great a financial burden on the State to care for them. In 1934 a representative of the Nazi Physicians’ League, Dr Heilig, published an article in one of the medical journals, Deutsche Freiheit. Heilig argued:

“It must be made clear to anyone suffering from an incurable disease that the useless dissipation of costly medications drawn from the public store cannot be justified. Parents who have seen the difficult life of a crippled or feebleminded child must be convinced that, though they may have a moral obligation to care for the unfortunate creature, the broader public should not be obligated...to assume the enormous costs that long-term institutionalization might entail.”

Dr. Heilig also stated that it made no sense for persons “on the threshold of old age” to receive services such as orthopedic therapy or dental bridgework; such services, he argued, should be reserved for healthier people of the population. Heilig’s comments were typical within the Nazi medical profession, where popular medical and racial hygiene journals depicted the costs of maintaining the sick at the expense of the healthy.

Yet, such an economic argument of caring for the disabled, congenitally and chronically ill, was not exclusively posed in Nazi Germany. It was argued in other countries as well. In 1927, Supreme Justice Oliver Wendell Holmes, speaking for the eight-man majority in the US Supreme Court Case, Buck v Bell, upheld a Virginia law on sterilization that foreshadowed some of the later Nazi arguments concerning the societal burdens that were placed upon the State for caring for the disabled. Justice Holmes wrote:

“We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who
already sap the strength of the State for these lesser sacrifices . . . in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.”

References:
2. Edwin Black, War Against the Weak. Eugenics and America’s Campaign to Create a Master Race (Four Walls Eight Windows, 2003).

Background:
The idea of systematically sterilizing and then “eliminating” (killing) mentally disabled patients gained broader acceptance after the defeat of Germany in World War I. Racial hygienists claimed that the cost of maintaining “defectives” was a major problem during the war when hunger was omnipresent. At the time, almost half of the patients in German mental hospitals perished from disease or starvation.

In 1920, Dr Alfred Hoche, a professor of medicine, and Rudolf Binding, a law professor, published their book “Authorization for the Destruction of Lives Not Worthy of Living.” The authors argued that the principle of “allowable killing” should be extended to the incurably sick. Claiming that psychiatric institutionalized patients have “lives not worthy of living,” they concluded that their “elimination” was not only tolerable, but humane, and should be legalized. They favored ending the lives of terminally ill patients who, they claimed, had a right to a painless death. They also asserted that the right to live must be earned and justified, and not dogmatically assumed, and moreover that human life was determined, not simply by its worth to the individual, but also by its worth (and/or burden) to society.

Binding argued that these ill patients imposed a “terribly difficult burden” on both their relatives and on society, “occupied an entire profession of healthy individuals and caused a total misappropriation of valuable human resources.” Hoche claimed that “it was distressing that entire generations of nurses shall vegetate next to such empty shells, many of whom will live to be seventy years or older.” Hoche did not accept the traditional obligation of
the Hippocratic Oath to do no harm and dismissed it as “a physician’s oath of ancient times.” The authors also encouraged legislation that would protect physicians who performed euthanasia on such patients.

Hoche and Binding’s book prompted a nationwide debate on when-if-ever a physician was justified in taking life. During the 1930’s, psychiatrists and other racial hygiene pioneers argued that the costs of maintaining the disabled must be reduced. This economical rationale was also used by policy makers and politicians to justify budget cuts for this population, and resulted in deteriorating conditions in staffing, housing, food and medical treatment for the disabled in mental hospitals. These budget cuts took place at the same time that Germany was restructuring its economy and investing in its military. The cuts, considered “savings” by those in charge of the policies, were passed down to the regional and local levels across Germany, creating economic short-falls, imposing a re-shaping of local priorities, and negatively affecting hospitals and public welfare for the disabled across Germany.

Some individual German doctors spoke out against this economically-prioritized elimination policy and warned against its implementation. At a meeting in Munich in 1931, Professor Oswald Bumke, a psychiatrist, said:

“If sterilization can prevent the occurrence of mental disease then we should certainly do it, not in order to save money for the government, but because every case of mental disease means infinite suffering to the patient and to his relatives. But to introduce economic points of view is not only inappropriate but outright dangerous because the logical consequence of the thought that for financial reasons all these human beings, who could be dispensed with for the moment, should be exterminated, is a quite monstrous logical conclusion; we would then have to put to death not only the mentally sick and the psychopathic personalities but all the crippled, including the disabled veterans, all old maids who do not work, all widows whose children have completed their education and all those who live on their income and draw pensions. That would certainly save a lot of money but the probability is that we will not do it.”

It was not until 1935, however, at the Nazi Party Congress in Nuremberg, that concrete plans for the destruction of all Germany’s “lives not worthy of living” were discussed. A primary advocate for the plan was Dr. Gerhard Wagner, one of Germany’s most prominent physicians and the Führer (Leader) of the National Socialist Physicians’ League. Wagner argued that the money spent on the “genetically inferior” was at the expense of the normal, healthy
people in the nation. About this same time, Hitler also informed Wagner that “euthanasia” would be implemented once war began.

With the start of the World War II, Nazi economic arguments for the elimination of the disabled became more forceful and took greater precedence. The economic burden placed upon the State for caring for individuals “not worthy of living” was contrasted to that of its heroic, healthy soldiers, sacrificing themselves, for the good of the homeland. Moreover, during the secret Operation T-4 “Euthanasia” Program whereby the mentally disabled were systematically murdered across Germany and Austria, economic statistics were calculated, identifying the “savings” to the State for the elimination of those considered “burdensome” to the nation.

References:

Question:
How does a doctor balance medical decision making, financial concerns and medical ethics?

Discussion:
The Nazi’s utilization of economic arguments to establish racial hygienist programs is an extreme example of how economic factors can influence medical policy and decision-making. Disabled patients were murdered because they were considered financial burdens to the state. Their deaths were the result of Nazi social doctrines that promoted “racial superiority “and the “survival of the fittest.” The utilitarianism of the Nazi regime in general and of the medical profession in particular, made it possible for these patients to be killed for the so-called “good of the nation.”

Today the principle of utility asserts that we medical professionals ought to, in all circumstances, strive to produce the greatest possible balance of value over disvalue for all persons affected (“cost effectiveness”). In health
care, utilitarian thinking stipulates that whenever there is a choice between different, but equally efficacious methods of treatment, patients’ benefits should be maximized and the costs and risks minimized. Yet, in a modern world of scarce resources, when health care delivery systems are under increasing pressure to contain costs (or to induce savings) is it necessarily unfair to limit resource expenditures on any particular group of patients and/or populations?

In generally accepted medical ethical discourse, justice is one of the main tenets to which medical professionals should abide. One of the basic patient rights is known as distributive justice, which is the right to fair, equitable and appropriate treatment. But in the present milieu, increasing economic pressures are compelling doctors to make decisions which may be based on broader economic constraints rather than on the traditional view of acting in the best interests of the individual patient.

Throughout the world, many societies are struggling with the question of how to provide equitable quality health care within the context of rising costs and limited resources. In such debates, it is important to recognize that some of the most vulnerable populations (the mentally disabled, the chronically ill, the elderly, as well as others) are particularly at risk.

Questions arise: How should we take care of the ill in our society? How should we take care of the chronically ill? Is there a limit to the amount of funds that we can spend on one patient, or one group of patients? Should there be an age limit on the distribution of resources or medical treatments? If so, where should the limit line be drawn?

In present day medical practice, technological and scientific advances, coupled with escalating costs of medical care, as well as sociological changes, have fostered an ongoing debate and re-evaluation of the doctor-patient relationship. As the costs for health care rise and the use of medical rationing evolve, we should be acutely aware of the moral choices involved.

Physicians, more than any other professional group, are at the forefront of this vital economic, societal and ethical debate on behalf of patients. While physicians, by virtue of their profession and role in society, can be placed in a position of conflicting loyalties between the needs of their patients and the economic needs (and social policies) of the State, physicians should choose to strongly and compassionately advocate on behalf of their patients. If physicians, and other caregivers, do not do this, who will? Historically, we already have the immoral and murderous example of the Nazi doctors that demonstrates what can happen to a society when doctors fail in their duty of loyalty to their patients.
7. Euthanasia

Case study:
In June 1942, Dr Adolf Wahlmann was appointed chief doctor at Landesheilanstalt Hadamar, a hospital for psychiatric and disabled patients in Germany. Even before Wahlmann’s arrival at Hadamar, 10,000 mentally disabled patients had already been killed as part of the first phase of the Nazis’ “euthanasia” program known as T-4. A lull in the killing ensued from August 1941, when the T-4 program was halted, until August 1942 when Wahlmann became the chief doctor.

In August 1942, additional transports of mentally ill patients arrived at the hospital. The second phase of the “euthanasia” program, known as “Wild Euthanasia” now began at Hadamar. Dr Wahlmann devised a system of morning conferences with his nurses in order to administer the program. At these conferences, Wahlmann and his nurses examined the patients’ records and histories. Then, based upon their reviews, they made their decisions whether killing was indicated. The final decision resided with Wahlmann. If he gave his approval, two nurses wrote the name of the patient on a sheet of paper, noting the amount of narcotics that Wahlmann had specified to cause the patient’s death (for example, the number of tablets of Luminal [Phenobarbital] or similar sedatives).

The paper was given to the station nurses who used it as an authorization for killing the selected patients. During the night, these patients were given substantial overdoses of these drugs. If the tablets did not result in death, an injection of morphine was administered the following morning, which invariably ended the patient’s life. After the patient had been killed, Wahlmann made a brief inspection of the corpse and fabricated false causes and times of death for the patient’s death certificate.

From mid-1942 until Hadamar was taken over by the American forces in March 1945, an additional 4,400 patients were killed at Hadamar by lethal injection or drug overdose.

At Dr Wahlmann’s trial in Frankfurt in 1947 the state court found him guilty of murder and sentenced him to death.
Reference:

Background:
The wave of legislation between 1933 and 1936 identified categories of “unworthy life” that would become the targets of the National Socialist killing policy between 1939 and 1945. The rationale for eliminating people “unworthy of life” was derived from the Nazi bio-medical vision that the handicapped and other disabled people with congenital diseases had tainted genes and were not worthy to live. The idea was that not only did such people weaken the Aryan gene pool and lead to a further degeneration of society, but that they also constituted a substantial economic burden. The Nazi policy makers thought that this economic burden was too costly and that the nation could not afford it, particularly in the time of war.

In late 1938 or early 1939, a relative, likely the father, of an infant named Gerhard Herbert Kretschmar who had been born blind and lacking one leg and part of an arm, requested the child’s “mercy killing.” Hitler ordered one of his personal physicians, Dr. Karl Brandt, to consult with the child’s physicians and to “empower” them to euthanize the child if they deemed it appropriate. These physicians were promised exemption from any legal actions that might be taken against them. Hitler then commissioned Dr Brandt and Philipp Bouhler, the head of the German Chancellery, to make similar authorizations that they deemed necessary for other cases in the future.

By the late 1930’s, thousands of German families with sick relatives had already sent petitions to Hitler’s Chancellery, requesting “euthanasia” for their loved ones. However, the Kretschmar case inaugurated the “Children’s Euthanasia Program” which was designed to kill mentally and physically handicapped children. In this secret (and legislatively illegal) initiative, children were killed by a combination of starvation or lethal medication.

The process for the killing was as follows. Disabled newborns and infants, who were not institutionalized, were reported by physicians and midwives. Parents and/or guardians were coerced into placing their children in one of the special children’s wards. The records of those, as well as children already institutionalized, were reviewed by a panel of medical experts that had been appointed by high Nazi officials and doctors. The doctors who sat on
these panels and who never saw or examined the children, decided upon the life or death of the child.

The killing methods themselves became a basis of experimentation and scientific inquiry by the killing physicians. Brains and other body parts were often sent to medical academic centers for research. As the selected child neared his or her end, the parents were informed with a standardized letter that their child was seriously ill. These letters were often sent late, near or even after death, so that parents did not have time to visit their loved ones, many of whom were institutionalized in hospitals that were not easily accessible for family visits. Some institutions also prohibited parental (or guardian) visits. After the child was killed, the doctors falsified the death records (both cause and time of death) which were then sent to the family. Parents were also informed that, due to the danger of epidemics, the body had had to be cremated immediately. In some cases, the letters also stated that the medical staff performed “heroic” measures to save the child, but were unsuccessful. Sometimes, death was not reported for several months so the institution could still accumulate payments for the care of the patient.

It has been estimated that around 5,000 children were killed by starvation or overdoses of narcotics. This was to be a secret program so as to limit opposition and protest among the German public. The patients were killed without their or their families’ or guardians’ consent.

Shortly after the children’s “euthanasia” program was initiated, the program was expanded to include disabled and handicapped institutionalized adults. The Nazi definition of “euthanasia”: killing “life unworthy of life” would be applied to large groups of disabled and chronically ill children and adults. The headquarters of the program was situated at Tiergartenstrasse 4 in Berlin and the operation was thence known as T-4.

The T-4 Program evolved from the killing protocols of the children’s “euthanasia” program. Now killings were also performed with gas, initially using carbon monoxide, but also involved experimenting with other gassing methods, including the use of Zyklon B (later used at Auschwitz and other extermination camps). Specifically constructed gas chambers, using carbon monoxide gas, were built in specified institutions, most of which were hospitals, designed as killing centers.

In a similar way to the children’s “euthanasia program”, T-4 physicians forged false death certificates. In addition, physicians performed autopsies and sent pathological specimens to medical institutes in Germany for further research.
Both the children’s “euthanasia” program and T-4 were the testing ground for the “Final Solution.” Murder by gas, later used to murder millions of Jews and hundreds of thousands of Gypsies, was first tested upon the German mentally disabled. The gas killings were planned, tested, supervised and authorized by T-4 physicians. From these “euthanasia” programs emerged the protocols, processes, medical leadership and staff that would later supervise and implement the murder of millions in the death camps. More than 70,000 people were killed in the period between January 1940 and August 1941 in the T-4 program.

On August 24, 1941, Hitler ordered the cessation of the “euthanasia” program because it had become too public. The main source of public protest was from German Protestant ministers and Catholic priests, once they discovered what was happening in these hospitals across Germany.

In reality, the program did not end, but, only morphed into a new and different phase referred to as “wild euthanasia.” In this “wild euthanasia” phase, killings became decentralized. Selections were performed by large numbers of doctors and nurses in many medical institutions in Austria, Poland and Germany where these killings took place as part of the normal hospital routine. Doctors utilized the same “euthanasia” methods used for children, and killed disabled and chronically ill adults by starvation and overdoses of medication. Other mentally disabled patients, particularly in the occupied areas, were simply shot.

During the “wild euthanasia” phase, categories for “euthanasia” were expanded to include “public menaces”, criminals, “anti-socials” and those who were deemed to be “racially inferior.” Even German shell-shock victims, both civilians and soldiers, were killed, as were foreign workers from Eastern Europe who had fallen sick while performing slave labor for the Germans. Approximately 200,000 people were murdered in the “wild euthanasia” program.

By this time, concentration camps were filling with inmates and so a new killing program, called “14f13”, was initiated. The camp doctors, usually members of the SS, selected the prospective victims based on racial and eugenic guidelines. One’s ability to work also became a critical factor in the selection process. Once these victims were selected, T-4 “expert” physicians arrived at the camps to proof the SS doctors’ selections. At this stage the camps did not have the equipment necessary for mass killing and therefore the victims were transported back to Germany’s killing centers and murdered there. Subsequently the gassing facilities, disguised as showers, were built in
the death camps themselves utilizing the advice of the T-4 medical staff. From 10,000 to 20,000 persons were murdered in Operation 14f13.

Holocaust historians regard the children’s euthanasia program, T-4, 14f13 and “wild euthanasia” as the forerunners of the murder of the millions of European Jews, Gypsies, and others deemed undesirable.

References:

Question:
The ethics of euthanasia and physician assisted suicide?

Discussion:
Originating from the Greek terms “eu” (happy or good) and “thanatos” (death), euthanasia means literally “happy death” or “good death.” The American Medical Association’s Council on Ethical and Judicial Affairs defines the term as follows: “Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy.”

The use of the term “euthanasia” in the Nazi context is, in essence, an inaccurate use of the word. Rather the Nazi “euthanasia” program was designed to rid German society of certain individuals who were considered “not worthy of living.” Many of these patients were not suffering and today would probably not even be considered as being incompetent. Moreover, these killings took place, whether the person was incompetent or not, without informed consent, either from the individuals and/or their families or guardians. The Nazi method of “euthanasia” was not in any ways a provision of a “good death,” as the word denotes, but a systematic program of killing without any mercy whatsoever.
Today when the term “euthanasia” is used it can actually mean a variety of different things depending upon the context in which it is used. For this reason, a number of defining terms have been established when discussing euthanasia. These terms help to subdivide and classify different types of euthanasia. Several key terms include: voluntary/involuntary and active/passive.

Voluntary euthanasia is a death performed by another with the consent of the person being killed. This consent may be in writing, as in the case of a living will, or as an advance directive. Involuntary euthanasia is the provision of euthanasia for an incompetent person according to a surrogate’s decision or even the decision of the physician.

Passive euthanasia entails allowing a patient to die by removing artificial life support systems, such as respirators and feeding tubes, or simply discontinuing medical treatments necessary to sustain life. Active euthanasia, by contrast, involves explicit steps to end the life of a patient, typically by lethal injection. The right to passive euthanasia has also been termed “the right to die,” and there are countries with laws protecting this right.

Physician assisted suicide, which occurs when a physician provides aid to a patient so they can commit suicide, differs from euthanasia. Euthanasia and assisted suicide differ in the degree that a physician, or another party, participates in the action that leads to death. Euthanasia entails a physician, or someone else, performing the immediate life ending action. Assisted suicide occurs when a physician, or other person, facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.

The World Medical Association’s Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, October 1987 states:

“Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.”

The WMA Statement on Physician-Assisted Suicide adopted by the 44th World Medical Assembly, Marbella, Spain, on September 1992 likewise states:

“Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. When the assistance of the physician
is intentionally and deliberately directed at enabling an individual to end his or her own life the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.”

The World Medical Association has noted that the practice of active euthanasia with physician assistance has been adopted into law in some countries.

Today, it is most often the Nazi program that is referred to and analogized when discussing euthanasia and physician assisted suicide. However, it should not be forgotten that the Nazi program was never euthanasia at all; it was murder.
8. The Significance of the Hippocratic Oath

Case study 1:
Dr Alina Brewda, a Jewish gynecologist and obstetrician, was born in Warsaw in 1905. In 1940, she was confined in the Warsaw ghetto and worked there as a physician. In the spring of 1943, Dr. Brewda participated in the Warsaw Jewish Ghetto Revolt, caring for wounded and dying Jews in hidden bunkers, secret tunnels, cellars and sewers. She survived the uprising but was captured by the SS and deported to Majdanek. Later she was sent to Auschwitz where she became prisoner #62761.

In Auschwitz, Dr. Brewda learned of the Nazi gynecological experiments that were being performed. As she was an experienced gynecologist she had no doubt that she would be asked to perform these operations. In her memoir she notes:

“*That certain operations were being performed on Jewish girls I already knew and also that the Germans were very angry when she [a prisoner physician colleague] declined to cooperate. That I would be faced with the same dilemma seemed very likely. I am not the heroic type. I only know what is wrong and what it right. Always in the forefront of my mind I have kept the Hippocratic Oath which I took when I qualified as a doctor and I have always tried to live up to that standard in all that I have done as a medical practitioner and as a surgeon. That I would be shot or sent to the gas-chamber if I refused to cooperate was, of course, possible. “*

As she had feared, Dr. Brewda was sent to work in the infamous Block 10 (the block in Auschwitz where notorious medical experiments were performed). She was put in charge of the medical care of the patients, who included young Jewish women who had been subjected to experiments. Although the experiments were secret, her close proximity to the victims enabled her to learn details about the cruel procedures, as well as to witness their disastrous effects on the patients. On numerous occasions, she was ordered by the German doctors, Eduard Wirths and Horst Schumann, to
perform experimental operations. She refused. Instead, although she had no medical supplies and equipment to treat them with, she did everything possible to comfort and aid the helpless victims. In addition, she tried to find menial jobs for her patients to prevent them being selected for the experiments.

As she had done in the Warsaw Ghetto, Dr Brewda joined the underground resistance movement in Auschwitz. One of her activities was stealing drugs from the SS dispensary for her girls in Block 10. Years later, one of her patients described Brewda’s work:

“If it had not been for Dr Brewda, I should not have lived. She was at the most important moment of my life by my side. I shall remember it until I die. During the operation, towards the end, I felt like vomiting and started to say “Oh Mother!” and Dr Brewda said: ‘L’operation est finie, mon petit. C’est finie.’ And still again: I remember Dr Brewda sitting at my head, like a mother.”

After the war Dr Brewda immigrated to England where she continued her gynecology practice.

Reference:

Case study 2:
Dr Ella Lingens–Reiner, a non Jew, was born in Vienna in 1908. She had a doctoral degree in law and studied medicine at the local university. During the war, she and her husband, Dr Kurt Lingens, hid several Jewish friends in their apartment over a period of several months in 1941 and 1942. On October 13, 1942, the couple was arrested for assisting their Jewish friends. Kurt Lingens was assigned to a unit made up of soldiers who were sent to the Russian front as a form of punishment for various crimes. While at the front, he was seriously wounded. Ella was initially jailed for four months in a Gestapo prison in Vienna, interrogated repeatedly, and then deported to Auschwitz, where she was put to work as the doctor of the camp inmates.

In her memoirs, written in 1948, she recalls a conversation that she had with a Nazi physician, Dr. Fritz Klein.

“Originally he had shown some consideration to his non-Jewish patients, which made his unspeakable cruelties towards Jewish prisoners stand out all more glaringly. I told him that I felt ashamed of being counted
among the Germans. He asked naively: “Why?” I pointed to the chimney of the crematorium and answered: “How can you ask – you, a doctor? ...The only question here is: “Have you, as a doctor, no respect for human life? How can you reconcile that with your Hippocratic Oath as a doctor?”

Dr Klein was in no way embarrassed. He only said:

“Of course I am a doctor and I want to preserve life. Out of respect for human life, I would remove a purulent appendix from a diseased body. The Jews are the gangrenous appendix in the body of mankind.”

Dr. Ella Lingens-Reiner was sent on a death march from Auschwitz to Dachau, and managed to survive the war. She died in Vienna in 2002. On January 3, 1980, Yad Vashem (The Holocaust Martyrs’ and Heroes’ Remembrance Authority in Israel) recognized the doctors, Kurt and Ella Lingens, as Righteous Among the Nations.

References:

Questions:
What is the significance of the Hippocratic Oath?
Is the Hippocratic Oath still relevant today?

Discussion:
The Greek physician Hippocrates (460-377 B.C) is traditionally regarded as the founder of scientific medicine and medical ethics. The Hippocratic Oath, first taken by ancient and medieval doctors, requires high ethical standards from medical doctors. Even today, its principles are considered important in professional and ethical education of medical doctors.

The taking of a Hippocratic Oath occurs at a crucial time in the development of physicians. It lays the groundwork for their future careers and their future care of patients. While the Oath is not legally binding, it is recognized as a critical moment in the lives of physicians. It is a symbol of personal importance, communal solemnity, and a life-long commitment to
the ethical and compassionate care of patients. In taking the Oath, physicians follow in the footsteps of Hippocrates and the many generations of physicians who preceded them, as well as future generations of physicians who will follow. The Hippocratic Oath has survived for centuries. It has stood the test of time since it addresses the intrinsic nature of medicine, as well as its ethical mandates. Although its language may appear old fashioned, its precepts are as valid today as they were in the time of Hippocrates.

The impact of Hippocratic Oath on medical practice is universally recognized. However, some physicians continue to raise questions about its validity and some medical schools no longer use it in graduation ceremonies. In addition, new versions have also been written in an attempt to update it and make it more relevant to today’s doctors. Some people claim that today the Hippocratic Oath is inadequate to address the realities of modern medicine and that it should be radically modified or abandoned altogether. However, most doctors, as well as the informed public, probably believe that a physician’s calling should include a commitment to Hippocratic principles (even if outdated or modernized) of healing and not causing harm.

The cases above demonstrate how different physicians can perceive the tenets of the Oath. The influence of a society’s political and cultural values can be recognized by the two very different approaches to the Oath. The prisoner doctors’ view of the Oath, conveyed by their testimonies, was that it stood for ethical practice in general. They viewed the Oath as a symbol of their personal and professional moral codes. Even in the most difficult of circumstances, these prisoner doctors mostly managed to abide by these principles in the camp.

On the other hand, the Nazi doctor’s view of the Oath represented a warped sense of medical ethical values, which placed a greater precedence on the Nazi racial and political goals, over that of individual human beings and patients. This Nazi doctor’s view and values mirrored the Nazi medical profession’s ideology and conduct. Robert Lifton, in his book “The Nazi Doctors,” tells us that the Nazi SS doctors took an oath of allegiance to Hitler as SS military officers. This oath superseded the traditional Hippocratic Oath which was perceived as little more that a distant and muted ritual that had been performed at medical school graduations.

Today it is not certain what influence the Oath has on physicians in their practice of medicine. Some studies have shown that only a small percentage of physicians believe that the Oath that they took in medical school has influenced their practices.
Medical students should be given the opportunity to analyze the content of the Hippocratic Oath and the way its values are related to concrete situations of past and present medical practice. By learning about the identified limitations of the Hippocratic Oath, and other pertinent oaths and codes, the student will be enabled to appreciate the value of the ancient and traditional principles that have supported and inculcated medical ethics and practices for the centuries.

In the words of Dr Andrew Ivy, one of the primary medical expert witnesses at the Doctors’ Trial in Nuremberg 1947:

“The moral responsibility that controls or should control the conduct of a physician should be inculcated into the minds of physicians just as moral responsibility of other sorts, and those principles are clearly depicted or enunciated in the oath of Hippocrates, with which every physician should be acquainted. According to my knowledge, it represents the Golden Rule of the medical profession. It states how one doctor would like to be treated by another doctor in case he is ill. And in that way how a doctor should treat his patients or experimental subjects. He should treat them as though he were serving as a subject.”
9. Medical Research

9.1 Doctor – Patient Confidentiality

Case study:
Helene Lebel, raised as a Catholic in Vienna, Austria, first showed signs of mental illness when she was nineteen. Her condition worsened, and she had to give up her law studies and her job as a legal secretary. In 1936, she was diagnosed with schizophrenia and was placed in Vienna’s Steinhof Psychiatric Hospital.

In March of 1938, Germany annexed Austria. Helene’s condition had improved in the hospital, and her parents were informed that she would soon be moved to a hospital closer to the family. Instead, Helene was transferred to a former prison in Brandenburg, Germany, where she was undressed, subjected to a physical examination, led into a “shower room,” and killed with deadly gas.

Reference:
http://www.holocaust-trc.org/lebel.htm

Background:
In August 1939, the Nazis created an organization called the “Reich Committee for the Scientific Registration of Severe Hereditary Ailments” which circulated a strictly confidential decree entitled “Requirement to Report Deformed Newborn.” The directive stated that “for clarification of scientific questions in the field of congenital malformation and mental retardation, registration was required of all children under three years of age who suffered from any of the following serious hereditary diseases: Idiocy, Down Syndrome, microcephaly, hydrocephaly, physical deformities and forms of spastic paralysis.”

Both midwives and doctors were mandated to report such children. District physicians were responsible for certifying the reports, and the head physicians of all maternity clinics were notified that such reports were required by the Reich. The form required demographic information as well as a detailed
description of the illness, hospital stays, projected life expectancy, as well as chances for improvement. Later, the questionnaires were expanded to include other details on patient and family history, including hereditary conditions, use of alcohol and nicotine, details of physical and mental development, as well as descriptions of convulsions.

The wording of the questionnaires led many physicians to believe that the affected children were only being registered for statistical and research purposes. At no time did the decree reveal the actual reasons for the requirement to report handicapped children. Registration orders were published in many medical journals. Doctors and midwives who complied with the order received payment per case.

The forms were sent to the Reich Committee in Berlin where they were processed by bureaucrats and then sent on to three expert physicians: Professor Werner Catel (a Professor of Psychiatry), Dr. Ernst Wentzler (a Pediatric Psychiatrist) and Dr. Hans Heinze (Head of Gorden State Institution). These three doctors were committed proponents of “euthanasia” and members of the planning committee. They based their medical decisions solely on the basis of these questionnaires without examining the children, consulting with their guardians, or reading their medical records. Children selected to die were marked with a plus sign; those allowed to live with a minus sign. Children marked with a plus sign were then transferred into one of twenty eight institutions that had been rapidly equipped with extermination facilities. These “killing centers” included some of Germany’s oldest and most reputable hospitals. Parents were told that the transport was necessary to improve the treatment for their child.

References:

Question:
What is the significance of doctor-patient confidentiality?
Discussion:
Confidentiality is not only an ethical principle in itself but can be seen as a duty of the physician to his/her patients. In essence, the physician’s duty to maintain confidentiality means that a physician may not disclose any medical information revealed by a patient or discovered by a physician in connection with the treatment of a patient.

In general, medical ethical codes state that the information disclosed to a physician during the course of the patient-physician relationship is confidential to the utmost degree. The purpose of the physician’s ethical duty to maintain patient confidentiality is to allow the patient to feel free to make a full and frank disclosure of information to the physician, with the knowledge that the physician will protect the confidential nature of the information disclosed. In return for the patient’s honesty, the physician generally is required not to reveal confidential communications or information without the patient’s expressed consent, unless required to do so by law.

There are a few exceptions to the rule, such as where a patient threatens bodily harm to himself or herself or to another person. There are some countries with mandatory reporting laws compelling physicians, or other health care providers, to report to health departments or law enforcement agencies patients with certain medical conditions or with injuries known or suspected to have been sustained by nefarious mechanisms. The former group includes patients with seizures, other lapses of consciousness, or infectious diseases, and those suspected of driving while intoxicated. The latter group includes victims of child abuse, sexual assault, or domestic violence, and patients with injuries from violent incidents. Failure to comply with such laws can result in criminal or civil consequences.

Mandatory laws present a conflict when the patient does not want his or her condition reported. In circumstances such as seizures, lapses of consciousness, or HIV in a spouse or other sexual partner, the argument is that the duty to protect other members of society overrides the interest of the individual patient. Thus, the principles of beneficence and distributive justice override the principles of nonmaleficence, autonomy, and confidentiality. While this is often justified, it places the physician in the undesirable position of serving as an agent of the state rather than for the individual patient. This could deter some patients from seeking care.

In the present, with the technological advances of computerized medical records, access to confidential information has become more prevalent. One
current challenge for physicians is to utilize this new and evolving technology, while simultaneously honoring and respecting patient confidentiality.

The Nazi doctors violated the duty of doctor-patient confidentiality when they reported on their patients to third parties without obtaining the consent of the patients or their legal guardians. The medical information, that was supposed to be confidential, was used against the patients, without their knowledge, and led to their state-sponsored murders for the “utilitarian needs” of the state.

Initially, some of the doctors may not have been aware or informed of the real or final purpose of these reports. Nevertheless, in compliance with what is the acceptable, long-standing medical tradition of doctor-patient confidentiality, the physicians should have questioned the reasoning behind the request for reporting prior to disclosing the patients’ medical information.

9.2 Informed Consent in Human Experimentation

Case study:
Sterilization experiments were conducted primarily at Auschwitz and Ravensbrück, concentration camps from March, 1941, to January, 1945. These experiments, conducted by the gynecologists Dr. Carl Clauberg and Dr. Horst Schumann, were attempts to develop a method of sterilization that would be capable of efficiently sterilizing millions of people within a minimum time span. The purpose of the sterilizations was to prevent reproduction of the races that the Nazis considered “inferior, unclean or genetically contaminated.”

Rosalinde de Leon, a Jewish woman survivor from the Netherlands, who was imprisoned in Auschwitz, testified against Clauberg on 26 July 1956:

“The elder [Blockälteste] told us in general that Dr Clauberg intended to perform scientific experiments on us and if we did not obey, we would be sent to Birkenau [location of the gas chambers]. We said that we would then prefer to go to Birkenau and that we already knew that we would be killed.
I cannot recall one woman who had agreed to any such experiments – to the contrary, Dr Clauberg performed sterilization experiments on my person without my consent. I did not protest because it would have been senseless. It happened anyway.

Two nurses assisted him — the latter one was a prisoner herself. The sterilization was done by injection and it was a very large size syringe that was injected into my body’s vagina and a white substance was then injected into me. Most likely this substance was injected into my uterus. The syringe was about 30 cm long. Such injections were done to me three times with breaks of 3-4 months. After each injection, I had a terrible burning sensation in my abdomen. X-rays were taken following every injection and another one was done on the following day. After the injection, I had to remain in bed for one week. As far as I can recall, the pain was the same after each injection and the injections were so painful that the nurses would sit on the victim’s arms.”

In Lore Shelley’s book, “Criminal Experiments on Human Beings in Auschwitz and War Research Laboratories”, former Block 10 prisoner Renée Duering of Amsterdam, described how the new arrivals were told by a man that they had to “sign up for certain physical examinations” or be killed. Duering includes a drawing of the “consent form” that she signed. She stated:

“Almost all of us signed the piece of paper. Some women who lived through it say today that they never signed anything for the Nazis, but they did; everybody who remained in Block 10 and was used as a guinea pig did if they wanted to stay alive.”

Duering recollects one woman who refused to sign and was subsequently transferred to Birkenau. This woman survived the war.

References:

Background:
Nazi doctors are infamous for their cruel medical experiments. The Nazi medical experiments can be separated into three main categories: 1) Experiments that sought to facilitate the survival of German military personnel. 2) Human
experiments that tested pharmaceuticals and treatment methods for injuries and illnesses contracted by German military personnel in the field. 3) Medical experiments that sought to advance the racial and ideological tenets of the Nazi worldview.

There were at least 70 various experimental programs at Nazi concentration camps, involving thousands of prisoners and hundreds of physicians who worked in the Nazi health system as well as those who worked directly in the concentration camps. These Nazi researchers maintained close professional and research contacts with leading medical and scientific institutions, drug companies, and universities in Germany. Some of the data derived from the human experiments was utilized for academic presentations, publications, and promotions.

The victims of these medical experiments were forced to undergo cruel, extremely painful procedures without any form of informed consent. Moreover, the prisoners were continually terrorized and feared for their lives, either from the experiments themselves or because they knew too much. The vast majority of the subjects died from complications from the experiments, were murdered by lethal injections, or sent to the gas chambers.

There were some victims of the Block 10 (the notorious experimental block at Auschwitz) experiments who also recalled that they had to sign “consent forms.” Given the nature of the experiments, the risks, as well as the threat of death for not signing, these pieces of paper certainly did not qualify as consent forms.

The medical experiments constitute but a small part of the extensive Nazi medical programs. Nevertheless, it was these medical experiments, performed without informed consent, which led to the establishment of the Nuremberg Code. In 1946, during the “Doctors’ Trial,” twenty-three defendants (20 German medical doctors and 3 public servants) were tried for war crimes and crimes against humanity. This trial provided the occasion for a substantive analysis of medical ethical standards. The judgment of this trial contains documented proof of medical crimes and then proceeds to the permissibility of medical experimentation. It concludes with the enumeration of a 10-point code of human experimentation ethics that is now known as the Nuremberg Code. The principles of the code form the basis of the modern ethical criteria for human experimentation, of which informed consent is the most important. (See Appendix 1)

Even before the declaration of the Nuremberg Code, explicit directives
on the welfare of people subject to human experimentation were in existence in Germany. In 1900, the Prussian Minister for Religious, Educational and Medical Affairs issued the first regulation that related to human experimentation. (See Appendix 2) This directive, in response to a public debate that was taking place on human experiments, advised medical directors that all medical interventions, other than for diagnosis, healing and immunization, were excluded under all circumstances if “the human subject was a minor or not competent for other reasons,” or, if the subject had not given his or her “unequivocal consent,” and after a “proper explanation of the possible adverse consequences” of the intervention. Moreover, all research interventions could be performed only by the medical director or with his or her authorization.

While this directive was not legally binding, and little is known of its actual impact on human experimentation, it is critical in the history of the development of non-therapeutic human experimentation guidelines. The directive not only sets substantive standards for the ethical conduct of research, but it also contains specific details to ensure responsibility for the research.

In 1931, several decades later, due to criticism of unethical human experimentation in the press, in the German parliament, as well as in the context of a political reform of criminal law in Germany, the Reich government issued detailed “Guidelines for New Therapy and Human Experimentation.” (See Appendix 3)

These guidelines clearly distinguished between therapeutic (“new therapy”) and non-therapeutic research (“human experimentation”) and set out strict precautions and protections for the human subjects. In addition to the principles of beneficence and non-maleficence, the regulations were based on patient autonomy and a legal doctrine of informed consent. In some instances, the regulations were even stricter and more detailed than those contained in the Nuremberg code and the much later Declaration of Helsinki. (See Appendix 4)

References:
Questions:
What are the ethical mandates for obtaining informed consent?
Is there a place for coercion in obtaining informed consent?

Discussion:
The Nazi medical experiments were designed to facilitate both the German war effort as well as to advance the racial ideology of the Nazi regime. Addressing the issue of how German doctors justified these heinous human experiments with the medical premise of the Hippocratic principle to “Do No Harm” is complex.

The Nazis justified their actions through both utilitarian and economic rationales. They designated the mentally disabled, habitual criminals, the physically handicapped, and patients with chronic diseases as persons who were living lives “unworthy of life.” In the Nazi view, these individuals, due the nature of their conditions and the burdensome economical costs of caring for them, could be legitimately sacrificed to improve the quality of health and life for the majority of the population.

This utilitarian justification also took place in the concentration camps, where prisoners were not viewed as individuals, but rather, simply as bodily materials that could be utilized for “medical research” projects for the “good of the State” and for the “benefit of the Aryan race.” Since the doctors in Nazi Germany were guided by utilitarian moral principles, they did not need to consider informed consent. If a greater social good was to be achieved without securing an individual’s agreement, it was viewed as morally legitimate.

After the war, when these atrocious experiments were exposed at the Nuremberg “Doctors’ Trial,” there arose an international need for protecting people involved in human research programs. As a part of its written decision, the war crimes tribunal developed the “Nuremberg Code” which is regarded
as the first international code of human experimentation ethics. The Code begins simply, with one statement set apart from all the rest:

“The voluntary consent of the human subject is absolutely essential.”

The Nuremberg Code goes on to detail other critical elements inherent in the principle of voluntary consent. Since Nuremberg, however, additional codes have been developed by the Helsinki Declaration and others, which have attempted to more clearly define “informed consent.” These new codes were deemed necessary because human experimentation continued to take place without the informed consent of human subjects and patients.

Informed consent, in a health care setting, is the procedure whereby competent patients voluntarily consent to, or refuse, an intervention based on a thorough disclosure of information provided by a health care professional regarding the nature and potential risks of the proposed intervention. Autonomy is the primary ethical principle that serves as the basis for informed consent. Informed consent supports and respects a patient right to make a decision, and to choose a treatment option. It also facilitates and encourages the input of patients into the medical decision-making process. The principle of autonomy highlights that competent adults always have the right to decide what ought or ought not to be done to them, providing that the exercising of that right does not infringe on the comparable rights of others.

By all ethical standards, voluntary consent was absent in the signing of the so-called consent forms in Block 10. Neither the autonomy of the women prisoners, nor their medical conditions or needs, were respected or considered. Instead, coercion, in its most severe form, was clearly apparent.

Today coercion is still present in some situations, albeit, not always in an overt manner. For example, a potential research subject may be convinced, or at least highly optimistic, that a clinical trial will be of personal benefit when the probability of benefit might be low. Yet participation may be the only source of hope to the individual and family.

Another example is when people are paid to be participants as research subjects. Even small payments or gifts may be sufficient to entice people to be subjects. If one’s resources are very limited, any financial reward can be seen as a form of coercion. In these cases, certainly one has the freedom to not participate. However, if one is unemployed or in difficult financial straits, willingness to participate may be unduly enhanced.

While the Nazi experiments present some of the most extreme examples of violations of informed consent for research, all cases of using persons, as
simply subjects, have an offensive character. Yet, even after the Nazi crimes were revealed to the world, scientists continued to perform research without the use of informed consent. In 1966, Henry Beecher, professor of anesthesiology at Harvard, published an article in the New England Journal of Medicine, entitled “Ethics and Clinical Research.” The article drew attention to twenty-two examples of unethical clinical research where the lives of research subjects had been put at risk. These trials included the Tuskegee Syphilis Experiments, as well as other studies in which prisoners, and those who were not free to choose or give consent, were experimented upon to their detriment.

Despite all the ethical guidelines, codes and directives that have been developed in the past, science and medicine have a long history of ignoring or misusing the ethical principle that individuals should be included in research only if they freely and knowingly choose to participate.

9.3 Parental Consent to Medical Treatment

Case study 1:
Friedrich S. was born in Germany in 1937. When he was four years old, he suffered from meningitis and subsequently developed epilepsy [cerebral cramps]. His parents were persuaded to hospitalize their son in the Eichberg Mental Hospital. The director of the institution wrote to the mother saying:

"Your little son is well. It is a case of brain damage, the cause of which we are not yet able to establish with any certainty, since we have had too short a time to observe him. If we are able to establish anything else, or should your child become ill, we will notify you immediately. You do not need to worry. We have recently commenced a course of medication."

The parents visited the child at the hospital on his fourth birthday on October 21, 1941. They noticed that he was covered in bruises and was malnourished. The doctor forbade them from removing the boy on the grounds that they were still treating him. They were told to return in a month. After
two weeks, the father wrote to the asylum. He received an answer, sent on November 14, 1941, that their little son Friedrich was already dead.

Case study 2:
Margot E. was born on January 28, 1941. She was mentally retarded. On the advice of the district doctor, Margot was sent to the Kaufbeuren Mental Institution. The mother was told not to visit the child for the first five weeks to help the child adjust to her new surroundings. After receiving many letters of inquiry as to the child’s wellbeing, the director of the mental institution eventually replied and informed the mother that Margot was “disturbed and that she cried constantly.” In a second correspondence, he informed her that Margot had “started playing with things and speaking a few words.” In the same letter, the director also wrote:

“Unfortunately I am not in a position to give you a report every fourteen days. If you consider that we have 1,300 patients, then if we had to make a report every fourteen days for each one, we would have no time left over for medical activities.”

Five days later the child was dead. Arriving at the asylum, the mother was given no cause of death, and found that the undernourished body of her daughter had been subjected to an autopsy.

Reference:
Michel Burleigh, Death and Deliverance. ‘Euthanasia’ in Germany 1900-1945 (Cambridge University Press, 1994).

Background:
As part of the Child “Euthanasia” program, thousands of mentally and physically sick children were sent from the various clinics in Germany to “killing institutions” where they were starved to death or given overdoses of narcotic drugs. In some instances the initiative to consign a child to one of the pediatric clinics in Germany came from the parents. In other cases the National Socialist public health nurses and doctors recommended hospitalization, persuading families that their children would receive better and more specialized treatment in these institutions.

When the children were transferred to the “killing centers,” parents were typically not notified. In cases where notification occurred, family members were often told that they could not visit. After a certain period of time the institution’s
personnel then notified families that their children were seriously ill. In reality, the child was already dead and parents or guardians were not given an opportunity to visit their loved ones. Families also had to bear the costs of the funerals.

Consent was never requested or obtained from the children’s parents or guardians. 

(For further historical details and references on the Nazi “Euthanasia” program see the background on the “Euthanasia” case).

**Question:**
Is it ethical for a doctor to treat a minor or other legally incompetent patient without guardian/parental consent?

**Discussion:**
The WMA (World Medical Association) Declaration of Helsinki states that people who are legally incompetent, whether minors or adults, or physically or mentally incapable of giving consent, should not be used in diagnostic, therapeutic, rehabilitative, or research procedures unless the following conditions are met: 1) The procedure is necessary to promote the health of the population represented. 2) This procedure cannot instead be performed on legally competent persons. If these conditions are met then the physician/researchers must obtain consent from the legally authorized representative in accordance with law. This consent must meet all the normal conditions for informed consent. (See Appendix 4)

As with other ethical issues, the already complex and unresolved problems of consent are compounded when children are involved. The assumption that parents can provide informed consent for their children rests on the presumption that they can provide it for themselves. However, there is evidence that educated, competent adults are frequently not adequately informed to give meaningful consent. Thus, a guardian’s right to speak for others, at times, may also be questioned. This is often due, not to the lack of intelligence or motivation on the part of the parent, family member or guardian, but rather to the more complex factors involved in the case including legalities, conflicting interests, the nature of the disease, the stress and anxiety caused by the illness, the need for a quick decision, the lack of sufficient information, the intimidating milieu of the hospital, as well as the sense of awe, trust, and dependence on the physician. All of these factors may conspire to make solicitation of consent a ritual where few people are actually
meaningfully informed. These issues can be even more compounded if the patients are mentally disabled or incompetent.

In addition, it is sometimes accepted that children themselves should be actively engaged in the consent process. Depending upon the ages, it is arguable that children are capable of being partners in their treatment decisions and that they have rights to receive information, to be listened to, as well as to give or withhold consent if judged competent to do so.

In the cases depicted above, the patients were both minors and diagnosed as mentally ill (epilepsy was considered then to be a mental disease). These patients were hospitalized and “mistreated” with total disregard for any consent from the parents, legal guardians or the patients themselves. Records were also falsified to hide the crimes. While these are extreme cases of the abuse of parental or guardian consent, they are valuable lessons of medical history, reminding us of what can happen when rights of patients, parents and legal guardians are disregarded.

9.4 Utilitarianism in Clinical Research

Case study:
At the Doctors’ Trial at Nuremberg in 1946, some of the defendant physicians made ethical arguments in support of their experiments in the concentration camps. Some used the rationale that it was reasonable to sacrifice the interests of the few in order to benefit the majority.

One doctor to use this argument was Dr Gerhard Rose, an academic physician and a world authority on tropical medicine, who was the head of the “Koch Institute of Tropical Medicine” in Berlin. Serving as the consulting hygienist to the Medical Inspector of the German Air Force (Luftwaffe), Dr. Rose was promoted to the rank of Brigadier General in the reserve. He was also the medical adviser of Dr. Leonardo Conti, the Reich Health Leader and State Secretary for Health.
Rose performed experiments on prisoner patients in Dachau and Buchenwald Concentration Camps. While initially opposing potentially lethal human experiments to create typhus vaccines, Rose came to the conclusion that:

“It made no sense not to risk the lives of a couple of hundred men when a thousand German soldiers were dying of typhus each day on the Eastern front”.

In addition, due to Rose’s discovery that the mortality rate among his research subjects was lower than the general prisoner population, he argued that the odds for survival among his subjects was actually greater than for other prisoners. Thus, Rose also justified his human experiments using the rationale that they might increase the odds for survival of his subjects.

During his trial, Rose testified:

“What were the deaths of a hundred men compared with the possible benefit of getting a prophylactic vaccine capable of saving tens of thousands?”

Reference:

Background:
During the war, typhus was rampant among the troops. German military and civilian researchers attempted to develop vaccines and drugs to prevent and treat the disease. At a conference in 1941, high level German medical officials concluded that “as animal tests cannot provide adequate evaluation of typhus vaccines, experiments on human beings must be conducted.”

Initially Professor Gerhard Rose objected to the idea of using prisoners for experimentation, but Dr. Leonardo Conti, Reich Health Leader and the most powerful Nazi physician in Germany, argued that the German public health was at stake. Rose acquiesced and initiated a study of a mouse liver vaccine, later testing it on prisoners in Buchenwald.

At the Nuremberg Doctors’ Trial, the prosecution encountered some difficulty with Rose’s argument. Rose’s defense team argued that the Allies themselves justified the compulsory drafting of men for military service throughout the war, knowing that many would certainly die, on the grounds that the sacrifice of the few to save the majority was morally just. Moreover, his
defense lawyers also pointed out that throughout history medical researchers in Western countries have used versions of utilitarianism to justify dangerous experiments on prisoners and institutionalized persons.

Rose, as part of his defense argument, also accused the Americans of carrying out coercive experiments on malaria in state penitentiaries. While such human research had been performed, Dr. Andrew Ivy, the American Medical Association’s ethics consultant at the trial, insisted that these experiments were voluntary experiments and not coercive.

For War Crimes and Crimes against Humanity, Dr. Gerhard Rose was sentenced to life imprisonment. Upon appeal, his sentence was reduced to 15 years. Rose was released from prison in 1955. He died in 1992.

References:

Question:
Is utilitarianism an ethical ground for human experimentation?

Discussion:
The World Medical Association has defined consequentialism as ethical decision-making that analyzes the likely consequences or outcomes of different choices and actions. In consequentialism, the right action is the one that produces the best outcomes. Of course there can be disagreement about what counts as a good outcome.

Utilitarianism is one of the best known forms of consequentialism. In this philosophical framework, utility is defined as “the greatest good for the greatest number.” According to utilitarian principles, potential benefits and harms should be measured, and a balanced judgment made on the proportionate good achieved by a given choice or action. A specific conflict or problem
occurs when a group for whom there is a risk of harm is not the group likely to receive any benefit, as is sometimes the case in clinical research trials.

The potential risk of harm to participants has led to widespread agreement that sound ethical standards must be observed in clinical research regardless of the perceived benefits. The ends alone, no matter how good, are insufficient justification for the means employed where they might unduly harm those involved.

During the Nazi era, the experimental subjects were mostly camp prisoners who were considered to be sub-human, racially inferior, or “living lives not worthy of living.” From the Nazi perspective, these people were not worthy or entitled to human rights. Some people, such as the Jewish inmates in concentration camps, were in double jeopardy; they fell into more than one “subhuman” category. Already having been deemed undesirable as humans and also being destined for death in the “Final Solution,” they were perceived as a captive group of research subjects totally devoid of rights. Having a captive group of potential subjects, coupled with Germany’s emphasis on the health of the population as being more important than the health of the individual, the perfect combination was created for the ultimate testing of utilitarian values, with disastrous results.

Guided by utilitarian moral principles, Nazi doctors did not need to consider informed consent. According to the Nazi medical ethics, the benefit gained superseded the ethical norm of obtaining agreement to the experiments. This was viewed as morally legitimate.

The Nazi doctors’ use of the utilitarian principle to rationalize their cruel and inhuman experiments is an example of how this principle can be cynically abused. The experiments were conducted on vulnerable camp inmates with total disregard for any ethical principles that are expected of clinical researchers. The use of their utilitarian rationale was just one of the excuses that they used in the post war trials.

There have been many other examples of abuse of the utilitarian principle on other vulnerable populations in other parts of the world. These populations have been experimented on with the justification that the experiments were performed “for the greater good of society.” Prison internees, soldiers, ethnic minorities, third world citizens and institutionalized patients have often been victims of such experiments. In the last decade, there has been much debate in the medical literature about the clinical research trials in developing countries, particularly by pharmaceutical companies who wish to use drug-naive subjects
with prevalent illnesses. A utilitarian perspective of these clinical research projects in these populations would be that the survival interests of the subjects must have priority over the profit-related interests of the shareholders of the pharmaceutical companies involved in the trials.

Utilitarian rationale for human experimentation should not be used as justification, or be accepted, unless the consequences of the utilitarian decisions are taken into account.

9.5 Use of Unethically Acquired Body Parts

Case study:
Dr. August Hirt, a Professor of Anatomy, was the Dean of the medical school at the University of Strasbourg. He formulated an anthropological skull project, with the hope of proving that Aryan skulls could reliably be differentiated from Jewish skulls. To obtain approval, funding and support for his research, Dr. Hirt contacted the Ahnenerbe Society, an organization whose mission was to assist research to support Nazi ideology. The head of the Ahnenerbe Society was Wolfram Sievers, who along with Heinrich Himmler, Chief of the SS, approved the secret project.

The plan consisted of the following: The Nazi researchers, led by Dr. Hirt, determined that a collection of skeletons was needed in order to prove their hypothesis. They decided that the skeletons would be taken from prisoners in Auschwitz. In June, 1943, eighty six living subjects, whose skeletons were to be used, were selected by Dr. Bruno Beger, a philosopher-physician and a SS captain. At Auschwitz, the prisoners were quarantined from the rest of the prison population and also separated by sex. They were subsequently examined and approved as suitable subjects by Dr. Beger. Adolf Eichmann was responsible for transporting the living humans from Auschwitz to Natzweiler-Struthof Concentration Camp.

Upon arrival at Natzweiler, the subjects were undressed and pushed naked into a gas chamber, where they were gassed. In July, 1943, the corpses
were swiftly transported to Hirt’s Anatomical Institute in Strasbourg. They were placed in specially designed containers where they remained for over a year without being touched. Skull measurements were in fact never taken.

With the allied advance into Germany, the defleshed corpses were discovered by the French. Photographs were taken and were later used at a war crimes trial. Dr. Hirt, after being arrested and incarcerated by French forces, committed suicide on June 2, 1945. Sievers was found guilty of medical crimes at the Nuremberg Doctors’ Trial and was hanged.

On December 11, 2005, a memorial carrying the names of the eighty-six victims was unveiled at the anatomy institute of Strasbourg hospital, and at the Cronenbourg Jewish Cemetery in France. The unveiling was attended by relatives of Hirt’s victims from Thessalonica, London, Germany, Israel and France. The plaque reads:

“Souvenez-vous d’elles pour que jamais la medecine ne soit devoyée.”
(Remember them so that medicine never be corrupted again)

Background:
The use of dead prisoners and/or the executed for dissection, illustration, and anatomical research is a long chapter in human history that goes back to Herophilus in Egypt in 300 BC. In the Middle Ages, due to religious laws that prohibited desecration of the body, cadavers were often obtained illegally for both medical knowledge and artistic depiction. In the 17th and 18th centuries the only legal source for cadavers were the corpses of the executed.

With the expansion of the medical professions and the establishment of medical schools, there became an even greater need for cadavers and new legislation was required for cadaver collection. In the United States, Massachusetts was the first state to enact laws in the 1830’s to allow unclaimed bodies for dissection and anatomical purposes. This was followed by other states that legislated that unclaimed bodies from hospitals, mental institutions and prisons could be used by medical research.

In 1908, Eugen Fischer, an ardent German eugenicist, arrived in German occupied South West Africa (now Namibia). There the German army had incarcerated many of the locals in concentration camps. The bodies of executed prisoners from these camps were shipped to Germany for dissection. Fischer’s efforts to prove the racial inferiority of the local inhabitants were published as a paper called “Die Rehoboth Bastards” in 1913 and had a tremendous impact in Germany. In 1921 Fischer co-authored “The Principles
of Human Heredity and Race Hygiene” with Erwin Baur and Fritz Lenz, one of the works that was used as a reference in Hitler’s “Mein Kampf” and therefore was to have a crucial impact on the racist Nazi doctrine. In 1927, he became the director of the Kaiser Wilhelm Institute for Anthropology, Human Heredity, and Eugenics in Berlin where his primary focus was in developing a biological basis for anti-Semitism.

In Nazi Germany the universities were under direct governance of the Reich Ministry for Science, Education and Culture (REM). This ministry was responsible for removing the “non-Aryan” faculty and aligning science with National Socialist doctrine. The REM was responsible for the anatomical institutions at the medical schools, including the cadaver supply. A Prussian law from 1877 and other laws granted the anatomical institutes the right to use the bodies of the executed for dissection if the relatives did not claim the body. These laws were reinforced repeatedly in 1933 and in 1939. The anatomists complained about the need to inform the families, and thus, in 1943, it was decreed that the families of the executed did not have to be asked for consent for dissection. In addition, it was forbidden to release the bodies of Jews, Poles and those executed for high treason to their relatives.

Each place of execution had certain anatomical institutes allocated to it, which were notified about eminent executions so that the bodies could be transferred efficiently to the anatomists. The anatomical departments of Germany, Austria, Czechoslovakia and Poland numbered thirty-one. A very high percentage of the anatomists were members of the Nazi Party (as were the physicians in general). Many of them taught courses at the medical schools on racial hygiene as part of the regular curriculum. August Hirt, the Dean of the Strasbourg Medical School, was a SS officer and supported many medical research projects for the Nazi regime. These projects supported eugenic thinking and were developed as part of the “war effort.” Hirt carried out lethal medical experiments with mustard gas on prisoners at the Natzweiler camp in addition to the “skeleton” collection project.

Johann Paul Kremer was a professor of Anatomy who worked at Auschwitz. He was involved in selections at the ramp and pursued research on the effects of starvation on the human body. For these studies he selected prisoners prior to their execution by intra-cardiac phenol injections, and harvested their post mortem tissues. Kremer was tried at the Auschwitz Trial in November-December, 1947, found guilty of war crimes and sentenced to death. The sentence was later commuted to life imprisonment.
References:

Question:
Can we use unethically acquired body parts for medical research or other studies or endeavors?

Discussion:
This case brings into question the use of the body, and body parts for therapeutic, research or other medical purposes.

Past legislation (for example the 1968 Uniform Anatomical Gift Act in the United States) has declared that body donation is a right that is based upon the free choice of the donor. According to this law, the donor’s wishes should be respected even though family members and next of kin may object to the donation. The Uniform Anatomical Gift Act, amended in 1987, prohibits the sale of organs and tissues for transplant, but not for use in teaching and research.

Yet there was, and still is, a large shadowy area where medical practitioners and scientists take, keep, and use parts of human bodies without questioning the ethics.

In recent years the constant expansion of clinical research requiring blood and tissue samples, as well as the exponential growth in the amount of personal information that can be recovered from body parts, raise the issues of lawful possession, respectful disposal, informed consent, and biological privacy to new heights, scrutiny and greater critical awareness. For example, the therapeutic use of human substances, from blood transfusions to the implantation of fetal brain cells is, and will continue to be, controversial.
Financial incentives for providing or obtaining organs and tissues compromise the ethics of voluntariness and are inconsistent with the principles of justice. The World Health Organization (WHO) and the World Medical Association (WMA) have declared the commercialization of human organs to be “a violation of human rights” and “human dignity” and as such should be prohibited. The appeal to therapeutic benefit, nevertheless, is currently the most convincing way to make the use of human substances acceptable. However, the appeal to “science” is fraught with ambiguities. What can be considered “good for science” by some, could mean the dehumanization of the human person by others. The argument for educational necessity, as with the need for human cadavers for medical students, falls somewhere in the middle, as certain practices, such as dissection, have been justified by the presumed therapeutic benefit of well-trained practitioners.

We may ask why these anatomists in Nazi Germany behaved the way they did. Why did they teach racial hygiene, practice racial hygiene and use the bodies of the Nazi victims for dissection? At the time, corpses of prisoners were a valuable asset in their research and thus in their careers. The Nazi laws, as well as the even greater de-humanization caused by war, provided the Nazi anatomists with a rare opportunity to “test” their racist theories, with no qualms and few regulations or restrictions. Human subjects simply became data with total disregard for basic human decency or ethics.

Human bodies provided by the Nazi government initially followed established anatomical traditions in Germany and many other countries. These practices were reaffirmed by the Nazi regime but also radically expanded, due to the almost unlimited numbers of human subjects (and corpses) available, both in the concentration camp system, as well as from their medical institutions. At the time, racial hygiene was accepted science in Germany. If physicians and researchers had doubts about the Nazi policies, they remained mostly silent. The choices and actions of these Nazi doctors and anatomists were justified as promoting the health of the German people, and within the framework of the culture of Nazi Germany, were considered to be ethically moral.

Today, collecting, storing, and using human tissues for a variety of purposes has become a common practice in Western biomedicine. However, a historical perspective can sharply remind us that practices usually express cultural values (whether overt or hidden) and that cultural values vary considerably among different populations and within different time settings. To create useful, fair, humane and sensitive ethical guidelines for the scientific
utilization of human materials requires that we take into account the diversity of beliefs and practices of a pluralistic society. Moreover, it is vital that all societies advocate for the respect of the human person, whether alive or dead, and carefully monitor the medical and research practices that dehumanize or harm the human person, no matter the race, sex, ideology or class. It is clear that such ethical considerations were not taken into account in the Nazi experiment described above and part of the rationalization of this unethical conduct can be explained in cultural terms.

9.6 Falsification of Medical Records

Case study:
An excerpt from the testimony of Adam Zacharski, former prisoner number 18,293, employed in the prisoner “hospital” in the Main Camp at Auschwitz reads:

“I worked in this hospital, in the chancellery – that is, I worked in a factory for all those false documents that, on the orders of the SS authorities and the office of the camp commandant...were filled out for causes of death. The causes ... were the following: natural death, death by gassing, injection, execution in Block 11. With all due emphasis I wish to state that the falsification consisted in the fact that all of these people were enrolled as hospital patients...There were especially four prisoners who achieved perfection in the technique of writing false certificates. Each of them had at hand a little book containing up to twenty types of the most assorted illnesses. They then made use of a German textbook, ‘Innere Medizin,’ copying out various types of illnesses, their course and symptoms...

In the case history it was necessary to start from the moment when the patient entered the hospital, with the temperature, the symptoms of illness, fever, the medicine administered and the injections that the patient received... Some of the cases were comical and tragic for us. I remember an incident where 120 young boys arrived in the camp, children aged 8, 12, and 14 from the Zamosc region. The children were separated from their parents who
remained in Birkenhau, and they themselves were sent to the Main Camp. Then I remember the tragic moment that almost ended in the death of the prisoner who made a mistake when choosing the diagnosis and wrote down as the diagnosis for an 8-year old child: senile decrepitude- Alterschwache…”

Reference:

Background:
Falsification of medical records did not begin with Auschwitz. It was the established practice in both the Child and Adult (T-4) “Euthanasia” Programs. These unethical and illegal practices, which were intended to hide the true medical status of the patients as well as the causes of death, were transferred from the hospital settings to the concentration camps. Many of the physicians and administrators who were in charge of the “euthanasia” programs also took charge of the planning, implementation, and practices in the concentration camps.

The selected prisoners assigned to the hospital offices in Auschwitz-Birkenau were ordered to maintain extensive records. These records helped SS doctors in their supervision and selections. It also provided the documentation basis for falsification of the records, camouflaging the extermination function in Auschwitz, as well as other prisons and concentration camps.

The prisoner “record-keepers” kept records on sick prisoners and those who were discharged from the hospital. However, their most important task was creating posthumous documentation for prisoners who died either in the hospitals or elsewhere. This documentation also covered prisoners who were shot, died by torture or through human experimentation, as well as those who were killed in the gas chambers, or by lethal injection.

The documentation usually listed either a fictitious cause of death or no cause at all. The causes of death were taken from a list of diseases especially prepared for the use of the clerical staff by the SS doctors. These included heart attack, pneumonia, sepsis, coronary insufficiency and others. In almost all cases, the so-called physician’s report contained an extensive, fictitious description of the course of the illness, and usually also stated that the prisoner had arrived in the camp in a poor state of health which made survival impossible,
despite assiduous medical treatment. When prisoners were killed in a larger group, their dates of death were falsified in the posthumous documentation so as to extend over a period of several weeks, with various numbers of prisoners listed as dying each day.

Witnesses from the Nuremberg Doctors’ Trial in 1946 stated that, if it had not been for the defeat of the Nazis, a detached observer, studying the history of the prisoners’ sicknesses and treatment protocols, might conclude that Auschwitz was a model of good sanitary, hygienic and medical practice, and that prisoners received care that embodied the latest achievements of science and medicine.

Reference:

Question:
Is it ever ethical to falsify medical records?

Discussion:
The case above is an extreme case of how the Nazi doctors in the camps abused their medical ethics and morals when they ordered the records to be falsified. This was just one aspect of the abuse of medical ethics by the Nazi doctors and of the “medical aura” in the hospitals in the concentration camps, but serves as an example of how medical ethics can be abused.

The intentional alteration, falsification or destruction of medical records are against all standards of medical ethics and are considered malpractice with serious legal consequences, even if no harm is done to the patient at hand. Medical records are regarded as being very personal documents, and they are meant to be kept accurate from an ethical and legal standpoint. Even if mistakes occur in the process of medical treatment it is imperative that they be disclosed to the patient or their family, and that the records not tampered with. There are good reasons for disclosing mistakes including maintaining the relationship of trust between the patient and doctor and the possibility that disclosure may actually reduce the number of medical errors in the future.

Medical records should not be falsified to conceal mistakes or any other rationalizations of the treatment process.
9.7 Whether to Use the Data Obtained from the Nazi Doctors?

Case study:
Eduard Perknopf obtained his medical degree from the Vienna Medical School in 1912, and served as a physician in the army for one year in World War I. In 1933, already a Professor of Medicine and the Director of the Anatomy Institute in Vienna, he joined the Nazi Party. A year later he joined the Storm Troopers and throughout the Nazi Era, he was a fervent Nazi supporter. Dr. Perknopf, who was appointed Rector of the University of Vienna in 1943, was the editor of one of the most pre-eminent anatomy books ever produced, *Topographische Anatomie des Menschen* (Atlas of Topographic and Applied Anatomy). The Perknopf Atlas, consisting of seven volumes illustrates more than 800 paintings of the human body. By all medical and artistic accounts, the work is a supreme achievement in anatomical illustration and artistry.

Perknopf began to compile his Anatomy Atlas in 1933 and the work was completed after his death in 1955. He hired artists to illustrate the book, many whom were also ardent Nazi supporters. These artists included Erich Lepier, Franze Batke and Karl Endtresser who frequently demonstrated their allegiance to the Nazi cause by signing their anatomic illustrations with Nazi icons. Erich Lepier often signed his name with a swastika. Karl Endtresser signed his name with an “SS” symbol in his painting of an anatomic dissection of the thigh of an apparently circumcised male. Franz Batke’s signature is followed with an “SS” symbol in his work on an anatomic dissection of the neck. These are just a few of the examples in which Nazi icons appear in the German language editions of the book.

In 1938, just after the German annexation of Austria, Dr. Perknopf was appointed Dean of the Faculty of Medicine at the University of Vienna and also the Chief Editor of the official journal of the Viennese Society of Doctors. After the war, although not convicted of any crime, he was imprisoned for three years. On release from prison, Perknopf was stripped of all titles but continued to work on his atlas. He died in 1955, and the final anatomical volumes were published after his death.
More recent editions of the book contain the same illustrations, but with most of the Nazi icons eliminated or with the signatures altered. The student or surgeon using the more current versions of Pernkopf’s Atlas would have no knowledge of the Nazi sympathies of Eduard Pernkopf and his artists.

Background:
For many decades after the war little was said or written about Pernkopf’s personal history or about the origins of the atlas. In the early 1960s the swastikas were removed from the printing plates of the illustrations and the atlas was translated into other languages.

In 1990, a review of the atlas in the New England Journal of Medicine stated that “this outstanding book should be of great value to anatomists and surgeons” and “is in a class of its own and will continue to be valued as a reference work even if its prohibitive cost and great detail make it unsuitable for purchase by medical students.” Another review from the Journal of the American Medical Association,” also in 1990, indicated that this atlas is a “classic among atlases of anatomy” and that it “will be most useful to otolaryngologists, plastic surgeons, head and neck surgeons, ophthalmologists, oral surgeons, and orthopedists.”

Volumes of Pernkopf’s Atlas can be found in leading medical centers throughout the world. Undoubtedly, this classic anatomy atlas has helped train and assists numerous anatomists, surgeons and other physicians for many decades.

In 1985 Gerald Weissman published an article on Pernkopf’s speech on “National Socialism and Science” which focused on his virulent nationalistic, racial hygienic rhetoric, as well as the deeds of other Nazi physicians at the time. In 1988 David Williams wrote an article on the history of the atlas revealing detailed biographical details on Pernkopf’s political activities. In 1995, an article in the Annals of Internal Medicine, recounted the history of the University of Vienna in 1938. It detailed Pernkopf’s administrative and political activities and described his professional work on the publication of an anatomic atlas. The atlas was said to contain material from children killed in a Viennese hospital and that Pernkopf’s Institute of Anatomy used the corpses of executed persons for teaching purposes.

These articles, as well as additional research on the subject, led to a 1995 formal request by the Israel Holocaust and Martyrs Remembrance Authority,
Yad Vashem, that the University of Vienna conduct an official inquiry into the background of the Pernkopf Atlas.

The article that sparked the current controversy about the Pernkopf atlas, was a letter to the editor of JAMA in November 1996 signed by a professor of dental surgery from Columbia University, Dr Howard Israel, and a professor of family and community medicine from the University of Toronto, Dr William Seidelman. They specifically noted that some of the pictures contained expressions of Nazi sympathies (the swastikas and “SS” letters in the artists’ signatures). Their letter called the Pernkopf Atlas a legacy of the tragic era when abuses of medicine pervaded the entire medical profession.

The final report of the commission at the University of Vienna was issued October 1, 1998. The investigation reported the following:

“That the Institute of Anatomy received at least 1,377 bodies of executed persons, including 8 victims of Jewish origin. ... On the basis of a general decree of February 18th, 1939, the bodies of persons executed were assigned to the Department of Anatomy of the nearest university for the purposes of research and teaching. ... No proof could be found that bodies had been brought to the Vienna Department of Anatomy from the Mauthausen camp complex. ... The presumptions and suspicions that some of the illustrations might be of prisoners of war, or Jewish victims, are based predominantly on impressions which strike the critical observer. In these cases, however, the investigation was able neither to prove nor to disprove the suspicions. Because of the systematic practice of making specimens anonymous, it seems likely that a final clarification of such suspicions will not now be possible.”

The tremendous abuse of power by Nazi doctors is well documented. During World War II, unspeakable crimes were committed against innocent people by the Nazis. Some of these crimes were merely execution, while others were slow, torturous, agonies brought on by daily living or Nazi medical experimentation. The Nazi medical experimentation has been a major controversy in today’s advancing medical field. Many questions are raised on whether or not the Nazi data, obtained from unconsenting prisoners and others, should be used to better the medical field’s knowledge in certain areas. For example, Dr. Sigmund Rascher’s notorious Dachau hypothermic experiments were not the work of a deranged madman working in the isolation of the concentration camp. Rascher’s experiments, which involved the immersion of concentration camp prisoners into freezing water, were performed for
the Luftwaffe, the German Air Force. The results of Rascher’s hypothermia experiments continue to be cited in the medical literature.

German medical science also seized on the murders of the Hitler era as an opportunity to exploit the remains of the dead. There were regular transports from the execution chambers of Gestapo prisons to university institutes of anatomy. As far as is known today, all the anatomical departments in German medical schools, without exception, took up the offer of bodies willingly and without hesitation.

Currently there is a great deal of research being performed on the ethical role of the German anatomists during the Third Reich, and their use of the bodies of executed victims.

References:

Question:
Is it ethical to use the Nazi medical data?

Discussion:
The Pernkopf case study involves the use of an anatomy atlas that contained drawings of victims of the Nazi crimes. It was developed decades before the widespread availability of anatomical images from other sources and was
used in many, if not most, medical education faculties. Thus, the significant
collection of this classic anatomy atlas to the health professions over the years
remains unquestioned. However, an exploration of the background of Eduard
Pernkopf and his artists and, in particular, how this work was produced, raises
significant questions of biomedical ethics which are extremely relevant today.
Some of the questions that arise with this case are: Whether it is important to
determine the origin of the subjects used in Pernkopf’s atlas? Whether it is
appropriate to use this information? How do we approach any research data
that has been obtained unethically?

There are many positions on this ethical debate:

1) The Atlas and other data should be used, when appropriate, for medical
research and education, with no restrictions or censorship. There is nothing
that can now be done about how the cadavers were obtained. Scientific
knowledge can often occur under conditions (for example, wars) that are
not always ideal or ethical. In using the data now, some good or benefit
could be derived from the use of the atlas today, to save a life or to enable
a surgeon to perform more skillfully.

2) The data should be used for research and education with some restrictions
and censorship. Some of the restrictions could include: a) Investigation
of the issue; b) Commemoration of Victims; c) Acknowledgment in new
editions concerning history of Pernkopf and the Atlas; d) Some restricted
censorship (not available on public shelves).

3) Others argue that by not using the data we are allowing Holocaust deniers to
strengthen their claims, and at the same time we are forgetting the innocent
victims who endured the experiments. People believe that by publishing the
data, we not only can prove that these atrocities did in fact happen, but also by
remembering them, we are helping to prevent them from ever occurring again.
By using the data, some feel that we are honoring the sacrifice of the victims.

4) Some of the survivors of the experiments believe that the data should be
used, and since the destruction happened to them first hand they can speak
for those who were not as lucky as they were.

5) Some others may argue that the real purpose of science is to serve
humankind by relieving suffering and improving the quality of life. The
Nazi experiments and the example of the anatomy atlas were performed
without any form of consent and involved cruel unethical methods and
torture. The proponents of this opinion indicate that science and ethics are
inseparable and that it is impossible to justify the use of scientific data that
has emanated from doctors abusing their ethical code in performing the research in which they caused incomprehensible human suffering.

6) Some would consider the moral and ethical backgrounds of the researchers (in this case the artists) to be an essential factor in medical experiments. They would argue that we should “separate the work from the man.” Others would argue that we should never separate the work from the person.

7) Others will further argue that using scientific data that emanated from Nazi crimes creates the environment for a repeat of such breaches of biomedical ethics, in which there is further potential justification and rationalization for unethical medical experimentation in the name of furthering scientific research.

8) Another concern that has been voiced is that of the scientific validity of the Nazi experiments.

9) An additional rationale for not using the data is the claim that in order for an experiment to be done correctly, it has to be able to be repeated. The cruel experiments by the Nazi’s would be near impossible to replicate, especially considering the state the patients were in.
10. Doctors and Torture

Case study:
Georges-André Kohn was born in Paris on April 23, 1932. In August, 1944, he was sent to Auschwitz and imprisoned in Barrack No. 11, which housed nineteen other Jewish children from all over Europe, aged between five and twelve years. Nazi physicians planned to use these children for medical experiments.

In late November, 1944, as the Red Army advanced on Auschwitz, Georges, together with the nineteen other children, was transported to the Neuengamme concentration camp near Hamburg. In Neuengamme, SS doctor Kurt Heissmeyer performed cruel and horrible medical experiments on the children; initially he infected them with tuberculosis, a lethal lung disease. Before Christmas, all the children were seriously ill. Georges was especially weak and was unable to stand up by himself, as was later reported by French inmate doctors and Dutch nurses, who were prisoners themselves. These inmate doctors and nurses took care of and treated the children, becoming their surrogate parents.

Dr. Heissmeyer then removed the lymph nodes of the children because he believed they contained specific substances generated by the body to protect against tuberculosis. After he had removed all the lymph nodes from the children, they were photographed. The children then lifted up their arms to display their operation scars to the camera.

In April 1945, as the end of the war rapidly approached, the SS doctors and the Neuengamme camp leaders feared that they would be punished by the Allies if their atrocities were discovered. In order to cover up their medical experiments, the SS leadership took the children, together with their nurses to the school on Bullenhuser Damm, which was located in a bombed-out and abandoned section of the city of Hamburg. On April 20, 1945, the SS hung all the children in the school’s basement. Their corpses were loaded into the truck and returned to Neuengamme, where they were cremated. The war in Europe ended seventeen days later.
**Background:**

Kurt Heissmeyer studied medicine in Marburg where he joined an Anti-Semitic fraternity called *Arminia*. Licensed to practice medicine in 1933, he became a resident in Auguste-Victoria Hospital in Berlin. In 1937, Dr. Heissmeyer joined the Nazi Party, and a year later, was appointed senior physician at Hohenlychen, a health spa run by the Red Cross at Uckermark, north of Berlin, where he eventually became assistant director.

To realize his aim of becoming a professor of medicine, Heissmeyer proposed to undertake experiments on tuberculosis. Although his knowledge of the disease was very limited, he was well connected in Nazi circles and received permission to proceed with his experiments on concentration camp prisoners. In June, 1944, he began his experiments at Neuengamme where he initially experimented on adults with a strain of live tubercle bacilli, and then proceeded to utilize children as test subjects. Every Wednesday, he traveled the 165 miles from Hohenlychen to supervise his experiments on the prisoners of Neuengamme.

Although the medical records from only 32 adult experiments have been preserved, it is believed that Heissmeyer experimented on over 100 individuals. The children were selected from the Auschwitz concentration camp. They were ten girls and ten boys, ranging in age from five to twelve. Their two-day journey to Neuengamme was made by rail. Heissmeyer assigned one guinea pig to each of the children and then both were injected with the same bacilli. After one month, despite subcutaneous injections of tubercle bacteria, all of the children were ill.

As their conditions worsened, Heissmeyer thought it would be useful to see how the axillary glands of the children had reacted to the bacteria. Since he was not a surgeon, he ordered a Czech inmate surgeon, Bogumil Doclik, to perform the lymph node dissections. These cruel procedures were performed under local anesthesia, and the wounds were packed open, rather than sutured closed. One week after surgery, the packing was removed. Within two weeks, each child had undergone bilateral axillary node sampling. The glands were preserved in formalin, and when all the procedures were completed, the specimens were sent to a pathologist.

After the procedures had been performed, the children grew weaker and were confined to their barracks. Subsequently Heissmeyer was confronted with a dilemma: What to do with twenty sick and dying Jewish children? To hide the evidence, it was decided that the children were to be murdered. On the evening of Adolf Hitler’s birthday (April 20), the children were hung.
Dr. Heissmeyer fled Hohenlychen on April 21, 1945. He eventually settled in Magdeburg, as a lung specialist. For 18 years, he enjoyed a successful practice as the director of the only private tuberculosis clinic in Germany. In 1966, he was sentenced to life imprisonment at Bautzen. Fourteen months later, he died of a heart attack.

After much initial resistance, the school at Bullenhusen Damm was eventually turned into a memorial for the murdered children. Today, it is the “Janusz Korczak School,” named for a Jewish physician who directed a Warsaw orphanage and who was murdered together with his orphans in Treblinka in August, 1942.

Reference:

Question:
Is it ethical for a doctor to participate in torture?

Discussion:
During the Nazi era, medical ethics were often superseded by racist ideology, as well as by political, economic and military expediencies. The Nazi world view legitimized torture and the annihilation of the infirm, the mentally retarded, and the healthy alike. Both the rationales for torture, as well as its methods, were often developed by medical doctors. Some physicians also actively participated in torture. This is particularly seen in the Nazi’s inhumane medical experiments in which thousands of victims were maimed and killed.

While the atrocities perpetrated by the Nazis, more than half a century, ago may be the most prominent human rights abuses in the global consciousness, torture and other inhumane acts are still carried out today. Torture is still justified and practiced in many countries, and it has even been perceived as a necessary evil in the global “war on terror.” While it is difficult to imagine how doctors can be linked with torture, there is documented evidence that, in some places in the world, physician involvement in torture is still taking place today. Doctors are trained to reduce suffering and to save lives; torture, however, involves the deliberate infliction of suffering, sometimes to the point of death. How can we reconcile doctor participation in torture?

Doctors come into contact with torture in many ways. Torture victims
often need medical attention, whether in the prison, detention center or hospital. So doctors are frequently the first line of detection for cases of torture, as they are the first to examine the victim. Those who commit torture sometimes seek the help and consultation of doctors. Reports from various countries indicate that doctors have been present when torture takes place and at times, doctors have acted as medical advisers or supervisors of torture. Doctors have also used their expertise to provide medical treatment during torture to sustain the victims or to resuscitate them. In other instances, doctors have been called upon to provide medical reports after the torture and in some cases provide false or inaccurate medical records.

Torture usually takes place in prisons, police detention centers and military institutions. Prison, police and military doctors are, therefore, the doctors who are most likely to encounter cases of torture. They are also the most likely to be exposed to it.

There can be many reasons why doctors become involved in torture, ranging from workplace loyalty, threats of violence, religious, ideological or national beliefs, and in a few cases, perhaps even sadism. Ethical issues in medicine seldom have clear black-or-white, right-or-wrong solutions, however, in the case of torture, we get as close as possible to certainty. Doctors’ involvement in torture, in whatever form and degree, is always contrary to medical ethics. This is established by all international and regional human rights standards.

Evidence reveals that most doctors consistently attempt to act in the best interests of their patients. They find torture abhorrent and do not want to assist or take part in it in any way. Nevertheless, despite these motivations and concerns, as shown above, some doctors may find themselves in circumstances where they may be coerced into acting in ways that are contrary to the principles of medical ethics.

All doctors should refuse to collaborate in torture. Yet, it has to be recognized that placing the sole burden of refusal on the individual doctor can impose a difficult decision, in the most stressful of environments and circumstances. The refusal of the doctor to participate in torture will be made immeasurably easier if the collective weight of the medical and legal professions stands behind such refusals.
11. Physician Participation in Genocide

Case study:
Imfried Georg Rolf Eberl was born in Bregenz, Austria in 1910. He began his medical studies in Innsbruck and joined the Nazi Party in 1931. After graduating from medical school, he moved to Dessau, Germany, where he served as the head of public health. In 1939, despite his limited training in psychiatry, Dr. Eberl was appointed head of the Brandenburg Facility, a prison that was transformed into the first T-4 “Euthanasia” site.

While at Brandenburg, Dr. Eberl was responsible for the organization and implementation of “euthanasia” for the mentally ill patients. Subsequently, he was appointed head of the Bernberg Psychiatric Hospital, where he was again assigned to establish a “euthanasia” program, including killing by gas. Dr. Eberl also played a prominent role in maintaining the secrecy of the program, including the falsification of death records. During the course of the “T-4 Euthanasia” program, 9772 patients at Brandenburg and 8601 patients at Bernberg were killed under the precept of “euthanasia.” A total of 70,273 people were killed in the 18 month long T-program (1939-1941).

In April 1942, Dr. Eberl was assigned to manage the construction of Treblinka, a death camp built exclusively for the implementation of the mass murder of Jews. On July 23, 1942, the first transport of Jews from the Warsaw ghetto arrived, shortly followed by daily trainloads of hundreds of thousands of unsuspecting victims. In late August 1942, Dr. Eberl was relieved of his duties at Treblinka because although he established a killing record for the number of people murdered, he was accused of being administratively inefficient in the disposal of bodies.

It is estimated that 280,000 people were murdered at Treblinka in the six weeks of Dr. Eberl’s command. From July 1942 through November 1943, between 870,000 and 925,000 people were killed at the Treblinka killing center.

In 1944, Dr Eberl joined the Wehrmacht where he remained for the duration of the war. He was arrested in January, 1948 and hanged himself in his cell on February 15, 1948.
References:

Background:
Operation T-4, the first National Socialist mass murder program, targeted German citizens including the mentally disabled and the congenitally ill, all of whom were considered “unworthy of life” and economic burdens to the State. This “euthanasia” program first established the organizational personnel and protocols, as well as the bureaucratic and scientific mechanisms for efficient mass murder.

Some of the physicians and technical professionals who had gained experience in killing the psychiatric patients in Germany were later transferred to supervise and implement the genocide of Jews and Gypsies in the extermination camps, primarily located in Poland. These camps included Chelmno, Belzec, Treblinka, Madjanek, and Auschwitz.

Physician participation in genocide took many forms. Some doctors, such as Dr. Imfried Eberl, were in charge of building, organizing and managing the extermination facilities. In other cases, physicians served as consultants with chemists and other scientists and engineers, to oversee and perfect the specialized techniques of killing, whether through injection, starvation, or gassing.

Medical doctors determined the “life and death selections” of prisoners, both upon their arrival into the camps, as well as later, after the prisoners had been in the camp for a few days, weeks, months, or in some cases, even years. Doctors decided which prisoners were fit to work and which should be sent to gas chambers. Physicians provided advice as to how to keep the selections running smoothly. They were consulted about the efficient operation of the crematoria, determined the fictitious causes of death of the victims, and were responsible for the falsification of death records. In many instances, Nazi doctors administered lethal injections or instructed nurses to do the killings. Physicians were responsible for the initiation and implementation of the barbaric, cruel and unethical human experimentation.

Physicians took part in the actual murder process from its calculated origin to the post-mortem examination of some of the victims.
References:

Question:
Is there ever a role for physicians in state-sponsored killing?

Discussion:
How do physicians reconcile their Hippocratic Oath with a mandate of genocide? Like many other professional groups, doctors are simultaneously members of a society and are susceptible to a society’s prevailing moral code and social climate. But doctors are also trained to act and perform according to their professional ethical stances. In most societies, physicians are considered public servants; they are also trusted and respected by most people in a community or nation. Sometimes, political authorities attempt to use physicians as agents to provide a legitimizing framework for actions taken by the State. When a nation adopts an exclusionary policy of hyper-nationalism, all of its citizens, doctors included, can find themselves on both sides of the divide. At such times, doctors can find themselves in a situation of professional and ethical ambiguity. To whom does their allegiance lie: to their patients or the nation? Whether as willing participants or as reluctant accomplices, physicians have become involved in the planning and implementation of mass murder in numerous countries.

In 1915, some Ottoman Turk physicians conducted medical experiments, participated in mass deportations, and promoted a genocidal ideology that led to the widespread death of the Armenian population. Less than two decades later, physicians in Nazi Germany also perpetrated atrocities in a system that culminated in the Holocaust. Carnage also occurred when Hutu doctors turned against Tutsi patients during the Rwandan genocide. Similarly, an international tribunal charged Serbian doctors with war crimes for their role in ethnic cleansing in Bosnia and Kosovo. These are but a few examples of physician involvement in instances of genocide.

Even in situations not necessarily intended as full-scale genocides, doctors have lent their medical expertise in an effort to remove or restrict “undesirable” elements of the population. For instance, medical personnel in
Argentina, Bolivia, Chile, Iraq, and elsewhere participated in the torture and death of dissidents and enemies of the state. Another example of physician-involvement in government sponsored killings is in the case of executions, including those in the US.

There are many theories that offer differing perspectives to explain how physicians come to justify and endorse programs so seemingly at odds with their role as healers. One theory argues that doctors do not abandon medical ethics to follow eugenic or genocidal policies; rather, they reinterpret ethics to coincide with the dominant and prevailing political agenda of the time.

A second theory promotes the idea of participation via the “slippery slope,” whereby transgressions of the medical, ethical, and societal moral codes begin on a small scale, but gradually build on themselves, eventually spiraling out of control.

A third theory argues that physicians participate because they cannot find a way to excuse themselves from such activities without suffering grievous personal, professional, or bodily harm.

A final theory argues that some doctors aggressively seek to participate in genocidal or eugenic programs with motivation that ranges from an opportunistic desire for personal or professional gain to an entrenched belief in the exterminationist ideology advocated by the political powers and authorities.

It is pertinent to consider whether or not there is ever a role for physicians and nurses to participate in state-sponsored killing. The World Medical Association mandates a consistent physician ethic, which does not differentiate between war and peace. According to their guidelines, medical ethics in times of armed conflict is identical to medical ethics in times of peace. The primary obligation of physicians is to their patients; in performing their professional duty, the conscience of the practitioner, as well as and the long-standing tradition of ethics in medicine, should be their guide.

There is no doubt that the actions of Irmfried Eberl, and other physicians under National Socialism were unethical when they killed in the name of the State. Some of their defenses included the following: 1) they were just following orders; 2) euthanasia relieved people of their suffering; and, 3) they were healing the nation by eliminating unhealthy segments. A few were convicted of their crimes and were punished. Some like Irmfried Eberl, committed suicide rather than face trial. Most of the Nazi physician perpetrators continued with their lives after the war without having to pay any price for their actions.
12. The Ethics of Pharmaceutical Companies in Medical Research

Case study:
SS Captain Dr. Helmuth Vetter, born in 1910 in Rastenburg, Turingen, was employed for many years with the pharmaceutical company Bayer Group WII of the I.G Farben Industry Inc., Leverkusen, where he worked as a salesman and drug representative. As part of his work, he traveled to Auschwitz, Mauthausen and other camps to administer medical experiments that were being conducted on pharmaceutical drugs on the camp inmates. Between 1942 and 1944, Vetter commuted between Auschwitz and Mauthausen to supervise clinical studies of the effects of Bayer products on medical conditions such as typhus, typhoid, paratyphoid, diarrhea, tuberculosis, erysipelas and scarlet fever.

To obtain human subjects for his research, Vetter selected prisoners who were suffering from specific diseases. Camp inmates were chosen based upon various criteria including control groups which exemplified different stages of the disease processes. The prisoner subjects were administered regulated doses to test the toxicities and the efficacies of the drugs. In Auschwitz alone, Vetter utilized between 150 and 250 prisoner patients for these experiments. In each case, detailed case histories and results were documented. No consent was asked for or received from the persons experimented on.

These pharmacological experiments were not intended to help the patients. Rather, the intent was to simply observe and record the reactions of the drugs on the patients. Even when it was obvious that the drugs were toxic, caused extremely painful conditions, and had no therapeutic effects, the experiments continued in order to collect scientific data for the pharmaceutical company. Such data would then be used to manufacture, produce, and sell new drugs by the corporation. A high percentage of the prisoner patients died from the experiments.
Dr. Helmut Vetter was convicted of war crimes in 1947. He was executed in 1949.

**Background:**

I.G Farben, the largest chemical company in the world at the time, was a powerful German corporate cartel of BASF, Bayer, Hoechst, and other German chemical and pharmaceutical companies. IG Farben, the single largest donor to the election campaign of Adolf Hitler, donated 400,000 marks to Hitler and Nazi party, shortly before he became Chancellor. Its support of the Nazi war machine enabled IG Farben and its various economic subsidiaries to become one of the largest war profiteers.

Some of the pharmaceutical departments of the IG Farben cartel used prisoners in human experiments to test new and developing drugs and vaccines. Zyklon-B gas, first used as a pesticide and later as a method of gassing in order to murder millions, was derived from one of the companies connected to the IG Farben business conglomerate, the *Deutsche Gesellschaft für Schädlingsbekämpfung* (Degesh) subsidiary.

In Auschwitz, Bayer Leverkusen, another subsidiary, paid for 150 female prisoners for experimental purposes. Correspondence between the Auschwitz Camp commander and the Bayer Company has revealed the following:

> “With a view to the planned experiments with a new sleep-inducing drug we would appreciate it if you could place a number of prisoners at our disposal ...We confirm your response, but consider the price of 200 RM per woman to be too high. We propose to pay no more than 170 RM per woman. If this is acceptable to you, the women will be placed in our possession. We need some 150 women ...We confirm your approval of the agreement. Please prepare for us 150 women in the best health possible ...Received the order for 150 women. Despite their macerated condition they were considered satisfactory. We will keep you informed of the developments regarding the experiments ...The experiments were performed. All test persons died. We will contact you shortly about a new shipment “.

A former Auschwitz prisoner also testified about this human experiment sponsored by Bayer:

> “There was a large ward of tuberculars on block 20. The Bayer Company sent medications in unmarked and unnamed ampoules. The tuberculars were injected with this. These unfortunate people were never killed in the gas chambers. One only had to wait for them to die, which did not take long ...
150 Jewish women that had been bought from the camp attendant by Bayer ... served for experiments with unknown hormonal preparations.”

In May, 1943, two influential Nazi doctors, Karl Gebhart and Fritz Fischer, honored the Military Medical Academy in Berlin for its sponsorship of the new drugs produced by the Bayer Pharmaceutical Group of the IG Farben Industry. The doctors reported on Dr Helmuth Vetter’s research that was conducted on 200 female prisoners in Auschwitz. Their report revealed how Vetter had injected the women’s lungs with gas or bacilli, causing them to die from pulmonary edema. Their presentation, hosted at the Ravensbrueck Concentration Camp, was published and the experiment results were distributed to the German medical profession.

The SS physician Dr. Waldemar Hoven, in Buchenwald and one of the defendants at the Nuremberg Doctors’ Trial in 1947, provided testimony on IG Farben role on the human experiments conducted on prisoners in concentration camps:

“It should be generally known, and especially in German scientific circles, that the SS did not have notable scientists at its disposal. It is clear that the experiments in the concentration camps with IG preparations only took place in the interests of the IG, which strived with all means to determine the effectiveness of these preparations. They let the SS deal with the – shall I say – dirty work in the concentration camps. It was not the IG’s intention to make any of this public, but rather to put up a smoke screen around the experiments so that ... they could keep any profits to themselves. Not the SS but the IG took the initiative for the concentration camp experiments.”

In addition to its role in human experiments and the manufacturing of Zyklon B gas, IG Farben used tens of thousands of inmates as slave labor to both build and work in the Buna-Monowitz Camp in Auschwitz. Slave labor was most particularly used to manufacture synthetic rubber and fuels, a major war-time activity of the cartel.

In 1946, an American military tribunal opened criminal proceedings against twenty-three leading German physicians and administrators for their willing participation in war crimes and crimes against humanity. Among the charges were that German physicians conducted medical experiments on thousands of concentration camp prisoners without their consent. Most of the subjects of these experiments died or were permanently crippled as a result. As a direct result of the trial, the Nuremberg Code was established in 1948, stating that:

“The voluntary consent of the human subject is absolutely essential.”
The code made it clear that subjects should give their consent and that the benefits of research must outweigh its risks. Although it did not carry the force of law, the Nuremberg Code was the first international document on human experimentation which advocated voluntary participation and informed consent. (See Appendix 1)

In August 1947, twenty-four executives of IG Farben Incorporated were indicted and tried for war crimes, including charges for war plunder/spoliation, slavery and murder. The IG Farben Trial led to the conviction of thirteen of its top executives. Eleven other defendants were set free. Based upon changing post war politics, many of the convicted executives served little time or had reduced sentences.

In 1951, the IG Farben Cartel was broken up into several major companies, including Bayer, Hoechst, BASF, and others. By the mid-1970’s, these three firms constituted, once more, some of the largest corporations in the world.

In 1964, the World Medical Association established recommendations guiding medical doctors in biomedical research involving human subjects that is known as the Helsinki Declaration. The Declaration governs international research ethics and defines rules for “research combined with clinical care” and “non-therapeutic research.” The Declaration of Helsinki was revised in 1975, 1983, 1989, 1996, 2000, 2002, 2004 and 2008 (and will be revised again in 2014) and is considered the definitive document on how to conduct clinical research today. (See Appendix 4)

References:

Question:
What ethical issues arise when pharmaceutical companies are involved in medical research?

Discussion:
The IG Farben cases demonstrate how, in the past, pharmaceutical companies
abandoned all ethical stances and practiced research without consideration for the patients involved.

Pharmaceutical research still plays a major part in medicine today, and many physicians and healthcare organizations are increasingly asked to become partners in medical research that is sponsored by industry. The cost of medical research is enormous and so medical research is often dependent on the financial support of the pharmaceutical corporations.

One of the inherent conflicts in a physician’s partnership with the drug industry is the potential to become simply the “arm” of industry at the cost of the patients. Given this economic reality physicians, hospitals and prestigious research institutions cooperate with the pharmaceutical industry, and other companies, in order to advance medicine, but, at the same time, to also maximize corporate profit.

Research ethics are applicable to all those involved in medical research, whether it be an individual researcher or a drug company. The goal should be to benefit the patients. However, industry funded research alters, in a fundamental way, both the patient-physician relationship as well as ethical concerns raised by clinical research. Pharmaceutical companies typically focus on generating profit and increasing stock price and market share. Indeed, it is a given that corporations have an obligation to their shareholders to pursue increased market share and share price. This approach may well lead companies to pursue new medical treatments which have little or no potential to improve the overall health and well-being of patients.

To gain access to both patients and physicians for research, industry often pays physicians as consultants or provides them with either monetary or other types of rewards (conferences, free travel, housing, food, business contacts, jobs for family members, etc). Physicians, who obtain pay or favors from an industry, have a greater potential to have conflicts of interest between their relationship with the industry versus their responsibility and care of their patients. This relationship can also negatively affect a physician’s or scientist’s research goals and findings. It also has the higher likelihood to affect or warp judgment in ways that conflict with appropriate treatment for patients, as well as in the protection of the research subjects.

At times, the drug industry also provides financial incentives and payments to patients. Despite the prevalence of the practice, the appropriateness of paying research subjects can be questioned on the grounds that it might undermine the ethical protection of free and informed consent.
Ethical regulations of pharmaceutical involvement in clinical trials exist and vary from country to country. Some medical associations have published strict ethical guidelines on the relationship of physicians to the pharmaceutical companies in order to ensure the balance between the various interests while maintaining maximum transparency and integrity of all the involved parties.

This bond between the physicians, on the one hand, and the pharmaceutical companies, on the other, is complex and strict codes of ethical behavior for both involved parties need to be established and monitored. It is vital that physicians remain independent of any relationships that may harm the patient-physician relationship.
13. Medical Conscience and Whistle-Blowing

Case study:
On August 15, 1940, Gottfried Ewald, Professor of Psychiatry and Director of the Göttingen State Hospital, was invited to Berlin and asked to serve as a leader in the secret Nazi “T-4 Adult Euthanasia” Project. The proposed position would require that he render judgments on whether certain patients would be killed by medical staff. Surrounded by other high-level physicians and leaders in the project, Dr. Ewald refused to participate due to what he said was his “medical conscience” and “inner need” and was subsequently asked to leave the meeting. Ewald stated:

“On principle, I would not lend my hand to exterminate in this way patients entrusted to me.”

He also pointed out that schizophrenics were “not as empty and hopeless” as claimed and that they might be able to benefit from new forms of therapy just then being developed.

Subsequently Dr. Ewald wrote a letter of protest to the dean of his faculty at the University of Göttingen, as well as to other high-level Nazi medical leaders in Berlin, stating his opposition to state-sponsored “euthanasia.” He argued that euthanasia, by definition, was supposed to be a “higher medical and general goal” for patients who were terminally ill and sought a merciful death. He stressed that the family bond between parents and child, and other mentally disabled loved ones, always deserves respect and dignity and therefore the Nazi “Euthanasia” program was unacceptable to him:

“I cannot choose a profession whose daily business it is to eliminate a sick person because of his sickness after he or his relatives have come to me, trusting and looking for help.”

Despite his fear of reprisal nothing happened to him.

Reference:
**Background:**
The professional status of physicians did not place any obstacle to their participation in Nazi crimes, and many doctors demonstrated a profound commitment to the atrocities. Many physicians were instrumental in instituting a system of identifying, notifying, transporting, and killing hundreds of thousands of mentally ill and “racially and cognitively compromised” individuals in settings including centralized psychiatric hospitals, prisons and death camps.

The physician’s role was central and critical to the success of Nazi policies and plans. Psychiatrists, along with many other physicians, helped facilitate the regime’s ideological medical practices. There were very few physicians who resisted or even expressed any disagreement with the Nazi’s goals or methods.

More than half of Germany’s physicians were members of the Nazi Party. Physicians played a prominent and central role in the sterilization and euthanasia programs. Physicians sat on planning committees for both processes, and they provided the theoretical backing for what transpired. The physicians reported their patients to the authorities, coordinated their transfer from all over Germany to gas chambers in the killing institutions and facilitated their killing. Finally, it was physicians who falsified the causes and timing of death on certificates sent to these patients’ next of kin.

Much of this process took place before the plan was developed to annihilate the Jews, Gypsies, homosexuals and other groups in Europe. Hitler never gave the order to kill patients with mental illnesses. He only permitted it in a letter written in October, 1939, and backdated to September 1, 1939. Physicians were, therefore, never ordered to facilitate the process or carry out the murder of mentally ill; instead, they were empowered to do so. This activity, carried out in the psychiatric institutions, constituted the connection between “euthanasia” and the larger scale annihilation of Jews and other “undesirables,” in what came to be known as the Holocaust.

Dr. Leo Alexander, the main medical consultant at the Nuremberg Doctors’ Trial in 1946, contrasted the actions of the German medical profession with those of doctors in the Netherlands under German occupation, who refused to take the first small step to genocide. In December 1944, an order was issued by the Nazi authorities to all Dutch physicians:

“It is the duty of the doctor, through advice and effort, conscientiously and to his best ability, to assist as helper the person entrusted to his care in
the maintenance, improvement and re-establishment of his vitality, physical efficiency and health. The accomplishment of this duty is a public task.”

This statement might appear, on first reading, to be unobjectionable and innocuous. However, the Dutch medical profession, which was aware of the Nazi extermination system, recognized that this order would serve as a basis for the promulgation of a new standard of care. This standard would place first priority upon the return of patients to productivity for the State, rather than upon their compassionate treatment and the relief of their suffering. In this context, both patients and physicians would consequently be subordinated to the State and its own interests to maintain power, to coordinate society, and to maximize economic efficiency and utility.

Dutch physicians unanimously refused to comply with this order. When the Nazis threatened to revoke uncooperative doctors’ licenses to practice, the Dutch doctors returned their licenses and closed their offices, but continued to see patients in private. The Nazis then arrested 100 Dutch doctors and sent them to concentration camps. However, the medical profession still refused to back down. The result was that no Dutch doctor participated in a killing and the Nazi plans for medical exterminations in the Netherlands were not carried out.

Dr. Gottfried Ewald was one of the very few German physicians who openly opposed “euthanasia” of the mentally disabled. He did this, not as an opponent of the Nazis, but as a supporter. He supported the Nazi Party, but he was refused membership, probably because he had only one arm, which had been amputated, after a World War I injury. Thus, he was prevented from serving actively in the SA. Ewald’s primary rationale was that the “euthanasia” program was in direct opposition to his personal conscience and to his professional responsibilities as a caring and compassionate physician. He thought that the Nazi’s “euthanasia” program would also violate the trust among the physician, the patient, and his/her family.

Few other physicians refused to participate in the killings although, like Ewald, Dr. Friedrich Hölzel, a physician at Egflind-Haar, was one. In a letter to the Director of the institution, he stated:

“I am reminded of the difference which exists between a judge and an executioner. Therefore, despite all intellectual insight and goodwill on my part, I cannot escape the realization that according to my personal nature I am not suitable for this task. Lively as my desire is in many cases to improve upon the natural course of things, it is equally repugnant to me to carry this
out as a systematic policy after cold-blooded deliberation and according to objective scientific principles, and without any feeling towards the patient.”

Hölzel subsequently resigned from his position.

The “T4 Adult Euthanasia” Program, which had already put to death about 70,000 people, was formally halted by Adolf Hitler in August, 1941, due to protests from prominent church leaders, both Protestant and Catholic. Hitler feared that further protests might lead to bad public relations and negatively affect war morale in Germany. However, although formally the adult “euthanasia” was stopped, the medical killing simply moved to new locations including hospitals in the occupied territories, prisons, and concentration camps. Some German physicians continued to murder their patients in what is known as “Wild Euthanasia,” whereby more than 200,000 individuals with mental disorders of all subtypes were put to death. In addition, the Children’s “Euthanasia” Program continued to function throughout Germany.

At the post war Nuremberg Doctors’ Trial Dr Andrew Ivy, the medical scientific consultant for the prosecution stated:

“It is too much to say, perhaps, that one single courageous individual, one single worthy representative of German medicine could, with less careful consideration for his physical comfort, have saved the honor of the entire profession. Yet I am convinced that such an individual could have done something to mitigate the horrors which are related in this book [Doctors of Infamy: The Story of the Nazi Medical Crimes]. Had the profession taken a strong stand against the mass killing of sick Germans before the war, it is conceivable that the entire idea and technique of death factories for genocide would not have materialized.”

References:
3. Alexander Mitscherlich, Fred Mielke, Doctors of Infamy. The Story of the Nazi Medical Crimes (Henry Schuman, 1949).
**Question:**
The question of Medical Conscience: Is whistle-blowing a physician’s duty?

**Discussion:**
During the Nazi regime, medicine supported compulsory sterilization and “euthanasia” of the physically and mentally ill, and subsequently, the killing of “inferior” races. They did this by applying scientifically invalid conclusions from evolutionary biology. Although these philosophical constructs and scientific paradigms of evolutionary theory were flawed, they were also immoral and contravened basic tenets of medical ethics and clinical practice. It has been proposed that the primary downfall of Nazi medicine was the failure of [German] physicians to challenge the substantive core of Nazi values. In this context, too many physicians were willing to go along with the political flow; too many doctors were unwilling to resist, and too many were willing to deviate from the commonly accepted practices that had been established by a racist State.

This is not the place to address the question of why there was so little resistance or refusals to comply among the German physicians. What is crucial to note is that where there was substantial objection on the part of the medical community, as in the Dutch doctors’ case, there was significant success in halting the process of murder in the name of science. This example demonstrates to us just how powerful a tool medical conscience can be. The Dutch physicians’ actions were based on their virtuous outlook that dictated that the first consideration had to be their patients’ best interests and not other ideological policies, whether political, social or economic. Due to the physicians’ ethically-based refusal to partake in the murderous schemes the Dutch mentally ill were spared.

One can only ask the rhetorical question: What would have transpired had there been more whistle-blowers like Dr Ewald?

The obligation to report incompetence, impairment or misconduct of one’s colleagues, often coined as whistle-blowing, is emphasized in codes of medical ethics. For example, the WMA International Code of Medical Ethics states:

“A physician shall...report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.”
Healthcare whistle-blowing encompasses a range of activities, from honesty to patients when medical errors occur, to public revelations of large scale institutional incompetence or unethical practices. Whistle-blowing can be viewed as “conscience made active,” and conscience is a cornerstone of medical ethics and virtuous professional practice. In medicine, acting out of conscience and professional integrity should be the rule and not the exception. This means that medical practitioners should not simply deliberate upon what is right, but they should also implement ethical principles and practices on behalf of their patients.

Doctors can refuse to comply with certain requests on grounds of personal conscience, and they can refuse to perform a certain procedure on grounds of professional conscience, most particularly when the procedure is incompatible with medical ethics and the proper goals of medicine. Moreover, doctors should “blow the whistle” on wrongdoing because doing otherwise is a perversion of the fundamental professional virtues that define his or her role as a doctor.

However, the application of such ethical principles is seldom easy. There can be detrimental consequences for the doctor who reports an abuse, or refuses “to go along” with a procedure or policy that is, in his/her view, ethically wrong. Such actions may be perceived as “betrayal” of one’s colleagues, supervisors, or by the society in which one lives and works. Hostility, professional and political pay backs, as well as personal and abusive attacks may result. Nevertheless, despite these potential drawbacks, it is the professional duty of a physician to seek to do the right and ethical thing. Moreover, doctors are also responsible for maintaining the good reputation of the profession. They may often be the only ones who are in the position to recognize the incompetence, impairment or misconduct.

The expectation of the public and the profession, therefore, should be that behavioral change toward accepting and facilitating whistle blowing in medical education and practice is desirable and urgently required. It is both necessary and prudent that medical and nursing schools develop curricula and training programs in which students are taught to understand the complex ethical, legal, and human rights principles that justify the act of whistle blowing. Historical cases should also be taught in order to provide real human models of medical and moral conscience.
Part Two: The Prisoner Doctors

Historical Background on the Prisoner Doctors

In the early years of the Nazi regime, the National Socialist government established concentration camps to detain political and ideological opponents. Increasingly in the years before the outbreak of war, SS and police officials incarcerated Jews, Roma, and other victims of ethnic and racial hatred in these camps.

To concentrate and monitor the Jewish population as well as to facilitate later deportation of the Jews, the Nazis and their collaborators in the occupied countries created ghettos, transit camps, and forced-labor camps for Jews during the war years.

The ghettos were city districts (often enclosed), in effect camps, where the Jews were held under tremendous duress with their internal life and organization imposed on them and enforced through violent means, from the outside by the Nazi regime. Ghettos isolated Jews by separating Jewish communities from the non-Jewish population, as well as from other Jewish communities.

One of the justifications for the creation of the ghettos was to prevent the spread of contagious diseases by the Jews. Some scholars claim that the ghettos were designed to serve as an indirect instrument of destruction, as a means of physically destroying the Jews by denying them the basic necessities of life, rather by the use of lethal weapons. The Nazis established at least 1,000 ghettos in German-occupied countries, annexed Poland and the Soviet Union.
The Germans regarded the establishment of these ghettos as a provisional measure to control and segregate Jews while the Nazi leadership in Berlin deliberated upon options to realize the goal of annihilation of the Jewish population. Some ghettos existed for only a few days, others for months or years.

With the implementation of the “Final Solution” (the plan to murder all European Jews) beginning in late 1941, the Germans systematically destroyed the ghettos. The Germans and their auxiliaries either shot ghetto residents in mass graves located nearby or deported them, usually by train, to killing centers where they were murdered.

The disasters that occurred in many of the ghettos due to the despicable conditions can be seen as predominantly medical. Dense overpopulation characterized all the ghettos and life in the ghetto focused on getting enough food to prevent starvation, and therefore to avoid the debilitation that made one susceptible to disease. The threat of disease and hunger was palpable long before the Nazis ultimate design was discerned, and the Jewish communities had to struggle to maintain the health services and the public health of the immensely overcrowded population. The ghetto inhabitants lived in appalling conditions with limited space, food, water, heat, electricity, sewerage and sanitary conditions. The medical and medically related needs were immense and the attempts to meet these needs complicated and mostly unsuccessful. Despite the hardships there were pre-existing medical institutions that had to be run and new ones that were created according to the position and needs of the ghetto. Medical practice carried all of the worries and uncertainties that it does elsewhere as well as many that were expressly related to life in a Nazi ghetto. In the ghetto effective treatment measures were unavailable for otherwise treatable diseases. The ghettos contained all the conditions that contributed to the breakdown of community health and the spread of communicable diseases. One of the main problems was the control of infectious diseases like typhus. Ironically the German authorities ordered the Jewish communities, under the leadership of the Jewish Councils in each ghetto, to deal with these problems but the Jewish doctors and other medical staff were not provided with the conditions to do so effectively. The German method of controlling the infectious diseases was to use brutal quarantine and disinfection methods or to set fire to the hospitals with the staff and patients trapped inside. Despite these hardships, in many ghettos the Jewish health departments waged an epidemiological war against these infectious diseases and in many cases were even temporarily successful.
Another factor that had to be taken into consideration was the constant danger and fear that became an inherent part in the ghetto inhabitants lives. German arrests constantly harassed Jewish medical activities as they did every other aspect of life.

The German authorities also established numerous forced-labor camps for non-Jews and a small minority of Jews whose labor the Germans sought to exploit.

Unlike concentration camps, which served primarily as detention and labor centers, killing centers (also referred to as “extermination camps” or “death camps”) were almost exclusively “death factories.” Between 1941 and 1944, Nazi German authorities deported millions of Jews from Germany, from occupied territories, and from the countries of many of its Axis allies to ghettos and to the extermination camps. German SS and police murdered nearly 2,700,000 Jews in the killing centers either by asphyxiation with poison gas or by shooting.

The largest extermination camp was Auschwitz.

The SS doctors were formally responsible for the health of the prisoners, but they all but renounced their medical obligation towards the prisoners and maintained an actual façade of medical treatment. During the first years at Auschwitz prisoner doctors, if allowed to work at all in their profession, were employed exclusively as nurses, and the infirmaries were considered only as a shelter from the horrors of camp existence or as a place to die relatively peacefully. There was almost no medical care provided for the sick inmates and even seriously ill prisoners went to great lengths to avoid hospitalization. With the commencement of selections carried out by the SS doctors and the condemning of sick prisoners to death by phenol injections or in the gas chambers, the hospitals became in effect “waiting rooms for the crematoria.” There were almost no medical instruments or drugs and most prisoner patients received what amounted to a mockery of all accepted standards of patient care. The very few prisoner doctors who were allowed to work at this stage could, in effect, do practically nothing to relieve the suffering of their patients.

As the German war economy’s demand for manpower grew, fed by the labor of concentration camp prisoners, the SS attempted to bring down the high mortality rate in the camps. The SS authorities built new wards and other medical services, and allowed the employment of more prisoner doctors in the camp hospital system. This decision however did not mean that conditions improved in the infirmaries, but rather that the prisoner doctors
were permitted to try to administer some form of medical care for their fellow
prisoners. In some cases the level of treatment did improve, but it never
reached the level of accepted standard of medical care. During this phase the
camp hospital system discharged its medical responsibilities only to those
prisoners whose condition promised fast recovery and return to work. For
more seriously ill prisoners, especially Jews, it continued to function as an
instrument of extermination. Efforts made by the prisoner doctors to protect
as many seriously ill and emaciated prisoners as possible were systematically
frustrated by the continuing practice of the SS doctors of selecting patients
for death in the gas chambers. The prisoner doctors often hid or discharged
patients in advance of imminent selections. Taking advantage of oversights
of the SS doctors, who never examined the patients themselves but instead
checked only the medical charts, prisoner doctors would falsify medical
records and present them of having a good chance of survival.

Many of these Jewish doctors survived because as medical professionals
they had qualifications that could be utilized in the ghettos and camps, and
because they were willing or able to put them to use there. They were aware
of the system that had overridden the normal ethical values and had forced its
victims to collaborate. The juxtaposition of the Nazis’ use of medicine to inflict
pain and suffering on innocent victims with the Jewish doctors’ attempts, in
the absence of even the most basic tools, to alleviate suffering and preserve
life demonstrates the diametrically opposed purposes to which medical skills
could be put. Doctors, as doctors, caring for their patients found a reason to
fight the battle for survival. The course of action that they chose was mostly the
one that they deemed best to help their fellow inmates. The prisoner doctors
and nurses, generally did all they could for their patients despite the incredibly
difficult conditions, and their work in the Nazi ghettos and camps led them to
confront ethical dilemmas which they had not encountered previously. Some
of these ethical quandaries are discussed in the cases presented in the text.
1. Medical Futility in Extreme Circumstances

Case Study:
Dr Albert Haas, a Jewish doctor of Hungarian and French descent, was recruited by the French resistance movement. After being informed upon and exposed, he was captured by the Nazis, who tortured him and sent him to the concentration camp Dachau. Later Dr. Haas was sent to the Gusen 11 Concentration Camp, which was part of the Mauthausen Camp complex in Austria. There he was sent to work in the infirmary block that cared for camp prisoners who were too ill to work. Resources were incredibly sparse. Physicians could do very little. They tried to keep patients alive with the little they had at their disposal. Most patients died of starvation or exhaustion or were killed by the cruel guards before they could be treated at all.

When Dr. Haas arrived at the medical infirmary in Gusen II, he asked a colleague, Dr Henri Desoille, who had already been there for some time, to help him understand the role of physician in the camp. Dr Desoille answered:

“How can I explain the futility of our profession in this place? I’m sure that you were also an idealist as a student, with dreams of conquering the fatal illnesses. You worked hard, you struggled to understand the human body and you finally felt ready to accept the perpetual fight against death . . . . When you see the patients inside the HKB [infirmary], you’ll ask yourself if the Germans haven’t made the Hippocratic Oath into the cruelest of mockeries!”

After this physician’s introduction, Dr. Haas soon experienced the reality of being a physician in Gusen. Haas writes in his memoirs:

“As we entered the ward a pungent, sickening odor assailed me. The beds were filled with tangles of semiconscious bodies, fleshless arms and legs moving slowly and aimlessly, bodies defecating and urinating on one
another. Each bed held a pile of six to eight of these living skeletons writhing in slow motion, skin stretched over bone, burning eyes monstrously huge in proportion to the hideously emaciated head and body. It was not possible to believe that these had once been healthy, happy human beings. . . . The inmates with uncontrollable dysentery waited here for death. They received no medical treatment and only half of the paltry rations given to other infirmary patients.”

“We could do nothing effective for the inmates who had dysentery except to give them water mixed with aspirin and some words of encouragement so they would not feel totally abandoned. For typhus victims all we could do was to prevent severe dehydration during the fever stage.”

“Then a beating would occur and would result rapidly in necrosis. I would debride the area but the lack of antiseptic meant that it was only a matter of time before the patients developed general septicemia and died in the HKB, either of his infection or by the Blockaltester’s hand.”

“And so I began my professional career as doctor of the damned in Gusen II.”

Reference:
Albert Haas, The Doctor and the Damned (St. Martin’s Press, New York, 1984)

Background:
The prisoner physicians and nurses were sometimes sent to work in the medical facilities (barracks) in the concentration camps. These medical blocks were set up when the Nazis realized that the prisoners constituted a valuable source of slave labor for their factories, and that it was in the national interest to keep them healthy enough so that they could work for the military and economic needs of the Reich. In reality these medical blocks were huts just like the other ones that were allocated for the prisoners to receive some form of medical treatment. These so-called hospital barracks were poorly equipped and immensely overcrowded so that the actual medical treatment was extremely limited. Most of the patients in the hospital blocks in the camps succumbed to illness before they could be put to death in the gas chambers, or by some other method, such as injections, shootings, or hangings.
**Question:**
The ethical issue of medical futility: What can a physician do in futile situations when all hope is lost?

**Discussion:**
This case deals with medical futility. Within the context of death, confinement, torture, disease, hunger and extremely limited resources, physicians in the concentration camps confronted the reality of what they could do as physicians. In spite of the horrendous conditions, many prisoner doctors attempted to treat patients, keeping them alive, as healthy as possible, and even risking their own lives, at times, to save their patients from extermination.

The case of Dr. Haas reveals that, in many circumstances, all that the physicians could offer was palliative care at the most basic level: encouraging words, a cup of water, an aspirin. Yet, even these most basic and caring acts, can make a difference in the well-being of patients. This has been reported in many survivor memoirs: many recall the humane approach of the doctors and nurses who cared for them as being the main factor that kept them alive.

Physicians and other professional care givers cannot always heal and save the lives of patients. But the ultimate goal should be to improve the patients’ prognosis, well being, comfort or general state of health. Their vocation, based upon their medical expertise and ethics, is to provide their patients with their best efforts. When the cure is lacking or the medical resources are limited or nil, sometimes all that the caregiver can do is to be a kind, compassionate and caring person for his/her patients. Medical circumstances and resources differ with every patient and in every clinical setting, both in history and in our own times. Medical circumstances can also fluctuate between the most optimal conditions for care and the most horrendous. Nonetheless, the role of the medical professional is to provide compassionate care, no matter the situation or setting. The medical care giver should attempt, to the best of his/her ability, to maximize the conditions for health and healing, to alleviate pain and suffering, and to provide the best possible care that circumstances permit.
2. Medical Triage

2.1 Abuse of Medical Triage: The Nazi “Selections”

Case study 1: Dr Lucie Adelsberger
Lucie Adelsberger, a Jewish pediatrician, was born in 1895 in Nuremberg, Germany. She was transported to Auschwitz in 1943, where she worked in the Gypsy camp and later in the women’s camp as a camp prisoner doctor. In her memoirs she describes the process of “selection” performed by the Nazi doctors:

“The distinguishing mark of the concentration camps at Auschwitz was selection. By that I mean the sorting-out of people who were relegated to the gas chambers and subsequent cremation. It applied almost exclusively to Jews and involved three categories of people, three ‘entries’: those newly arrived in Auschwitz, prisoners from the camp and sick people from the compound. The old, weak, and those obviously sick and unable to work were automatically relegated to selection. . .

. . . The mechanism of selection was too firmly established and everyone knew its every detail. The camp physician commandeered one or more blocks and ordered the naked prisoners to pass by in single file. He then chose those who, because of weakness or under-nourishment, the edema of starvation, or because of scabies or sunburn-these were reasons enough-were to go to the gas. The identification numbers of these unfortunates were recorded on the spot and they were immediately transferred to the selection block, where they waited for death, often without food and fully aware of their fate. . .

. . . The problem for us in Auschwitz was not whether selection but when and how.”

Reference:
Lucie Adelsberger, Auschwitz: A Doctor’s Story. (Northeastern University Press, 1995).
Case study 2: Dr Eduard Wirths

Dr Eduard Wirths was born in 1909 in Germany. While in medical school at the University of Würzburg, he joined the Nazi Party and then the Storm Troopers in 1933. In 1939, volunteering for military service, he was admitted to the Waffen SS and served both in Norway and the Eastern Front, where he was declared medically unfit for combat duty. In 1942, Dr. Wirths was assigned to Auschwitz as the chief medical officer.

Initially, Dr. Wirths was opposed to death selections, as well as to doctors performing them. However, subsequently he became convinced that it was an essential responsibility of camp doctors to make these selections, and he personally began to make selections as part of his medical duties. In addition he exerted pressure upon his medical subordinates to also participate in this work. The selections, performed by these physicians, designated people “able to work” or those considered “unfit”; in other words decided who would die and who would remain alive.

As chief doctor, Wirths authorized the numbers of inmates chosen for death. These numbers were based upon the prisoner capacity, as well as the production “quotas” of the camp, which were established by the Nazi Labor Department and the SS. Due to the ever changing circumstances of war, as well as the constant incoming deportations into the camps of Jews, Gypsies, prisoners, and foreign slave laborers, the prisoner population in the camps fluctuated. Selections were often made to make room for new inmates, to address camp overcrowding, work production quotas, as well as to prevent the spread of epidemics. Wirths was also responsible (together with other doctors and camp functionaries) for the decision whether to separate mothers and children in the selections.

After the war, Dr. Eduard Wirths was arrested by the British. He committed suicide in September, 1945.

References:
Background: Selections at Auschwitz

Upon arrival at Auschwitz, Jews, Gypsies and others were subject to an “intake process.” This is infamously known as the “selection.” It was, in effect, an extreme abuse of the medical function of triage (the original French military term meaning the use of limited resources to treat those who might be saved).

Selections were usually conducted by the SS doctors, together with dentists and pharmacists and other SS functionaries. Selections were primarily based upon race, age and “fitness for work.” Some individuals, having special physical, congenital or inherited characteristics, such as twins, were also “triaged” for human experiments.

The SS doctors carried out additional forms of selections. In the camp, Jewish inmates were often lined up on short notice where the sickest and weakest were selected for death in order to make room in the camp for new arrivals of deportees. Selections also were conducted in the medical blocks, where physicians selected severely infirmed and debilitated patients, particularly those who were in need of more than two or three weeks for their recovery. SS doctors were consulted to determine the best way to efficiently organize and manage selections. They made recommendations about the selections of mothers and their children. They served as medical advisors for the best methods to kill large numbers of people efficiently and quickly. They advised on death quota policies for the camps, and weighed the economic costs and benefits to the Nazi regime for keeping prisoner workers alive versus selecting them for extermination.

Selections at Auschwitz were a continuation of the “Euthanasia” program in German mental institutions, where the principle of killing the sick and undesirable had already been established in the Nazi medical circles.

In the words of Robert Jay Lifton:

“The Nazi versions of “euthanasia” and the Final Solution converged on Auschwitz medical blocks, thereby rendering them an important agency of the Auschwitz ecology of medicalized murder.”

Reference:

Questions:
What are the ethical considerations in performing medical triage?
**Discussion:**

Triage is a medical action of prioritizing treatment and management based on a rapid diagnosis and prognosis assessment for each patient. Triage must be carried out systematically, taking into account the medical needs, medical intervention capabilities and the available resources.

Ideally, triage should be entrusted to authorized, experienced physicians or to other medical teams like nurses, assisted by a competent staff. In selecting the patients who may be saved, the physician should consider only their medical status, and should exclude any other consideration based on non-medical criteria. The physician should act according to the needs of patients and the resources available. He/she should attempt to set an order of priorities for treatment that will save the greatest number of lives and restrict morbidity to a minimum.

The Nazi doctors performed an extreme and cynical form of medical triage as part of their professional performance in the camps. The triage performed was not on ill patients who were in need of medical treatment, but rather on helpless, sick prisoners who were differentiated, not according to their medical needs, but rather according to the cruel criteria established by the Nazis deemed necessary for the functioning of the concentration camps.

The decisions made by these Nazi physicians were not based on the ethical premise that triage is performed in order to save the greatest number of lives, but rather, made with the knowledge that their decisions would, in actuality, lead to the deaths of those selected. The medical knowledge of the perpetrating medical personnel was abused in the extreme, as was their medical status, as this selection process was in reality a form of “organized murder masquerading as triage.” These Nazi doctors, trained as professionals, were in many instances experienced physicians who knew very well what triage was supposed to be. In making the choice of agreeing to perform these immoral selections in the camps, they violated all ethical, moral and professional considerations.
2.2 Distributive Justice

Case study:
Dr Abraham Wajnryb was born in Kielce, Poland, in 1912. He graduated from medical school in Warsaw. In 1941 he was working in the Vilna health department when the city was invaded by the German army and the Vilna ghetto was established. In the ghetto, Dr. Wajnryb was given the responsibility for the administration of the Jewish hospital. The hospital functioned under dire circumstances with hundreds of patients in horrid conditions. The Germans officially prohibited the supply of medicines for the Jews in the ghetto leading to serious shortages of medical supplies and thereby endangering the lives of the ghetto inhabitants on a regular basis. As head of the hospital he had to find a method of deciding which patients would receive treatment with the meager supply available and which not.

Dr Wajnryb explains this dilemma that confronted the Jewish doctors. In his words:

“Who was to be given the right of deciding who shall live and who shall die? The medicines were just not enough for all the patients. The numbers are not what make this question so problematic, after all the number of patients was not comparable to the number that the Judenrat [Jewish Council] had to deal with. The question was how to deal with this question in a humane fashion? One man does not have the right to decide on the fate of another, no matter how many people are involved . . .

The medical supply for the Jews in the ghetto was stopped completely. I remember meeting with the pharmacist, Frumkin, and having a discussion about calcium. In those years calcium was thought of as the only drug available to treat tuberculosis patients with . . . Their supply was about to run out and they had only one alternative left which was to reduce the dosage of this drug and also to reduce the number of patients who would receive it. But this drug is effective only in certain doses! Who would receive the calcium and who would not? Whose right was it to decide? Who would live and who would die?”

No one among the medical ghetto authorities could resolve this dilemma. Wajnryb decided to form a committee composed of three internal
specialists, a rabbi and a lawyer. At the meeting he explained the importance of this medicine for the patients and depicted the dreadful consequences if they did not obtain it. The rabbi explained his position by stating that it was God who gives and takes life and that they had no right to decide. The other doctors present left the room. The lawyer tried to explain the dilemma from a legal point of view. The committee could not solve this problem and they all left the room.

Dr Wajnryb was left with the problem. The calcium supply diminished steadily and eventually ran out after two months.

**Reference:**
Abraham Wajnryb, Personal testimony: *Memoirs of a Doctor from the Wilno Ghetto.*

**Questions:**
Is the issue of distributive justice one that a physician alone has to decide? What are the tools available to the physician in this decision process?

**Discussion:**
One of the guiding principles of medical ethics is the need for justice, which is synonymous with fairness, and can be summarized as the moral obligation to act on the basis of fair adjudication between competing claims. Distributive justice in medicine is the fair distribution of scarce resources. It is generally accepted that a physician has a duty to do all that he or she can for the benefit of the individual patient. However, in conditions where resources are limited, the ability of physicians to fulfill this obligation can be limited. In discourses and societal debates on distributive justice in medicine, physicians, based on their professional expertise, have a duty to safeguard the interests of their patients. While physicians should not necessarily make decisions on their own in such instances, it is vital that doctors participate in the ethical debate and decision-making process in order to safeguard and advocate for the interests of patients at the societal level.

The case of the distribution of limited medicine in the Vilna ghetto depicts an extreme example of distributive justice. The physician, Dr Wajnryb, had to decide. He recognized the importance of others in the decision making process and thus formed a committee from key sectors of the ghetto society. He hoped that such an ethical committee might produce a morally acceptable
and just decision. This is comparable to how decisions of distributive justice are often made today in both organizations and the larger societal and political context. Nevertheless, this case also reveals that when no just solution is formulated or achieved, the problem does not go away. Instead, medical practitioners are still confronted with the ethical dilemma and should attempt to do the best that they can do in the circumstances.

There are two ways that the committee could have approached this terrible dilemma: lottery and triage. Triage is often applied in situations in which health care personnel, procedures, or treatments are insufficient for all who need them. In triage, in emergency situations, those people who are most likely to survive are treated first. Those with a low probability of survival are the last to receive treatment, if at all. In the case of limited medication, likely survivors would have been identified by the committee and would have received the treatment. The advantage of this method is that the individuals who had the best chance of survival would receive the medication. The disadvantages are that not all individuals would have an equal chance at receiving the medication and the committee would have to make decisions that would likely hasten the deaths of some people.

The second approach could have been lottery. If one assumes that all lives have equal value, then all should have an equal chance of receiving the treatment. The committee could have established a procedure in which the maximum number of recipients was determined and those people were selected by random selection. The advantage of this method is there is no question of fairness and those selected are selected by chance. No decision is made by the committee or any individual. The disadvantage is that some individuals who had factors contributing to an overall poorer prognosis may receive some valuable medication whereas others who had a more robust chance may be denied and may succumb when they otherwise could have been saved.
3. The Risks of Medical Care:

3.1 Disclosure of Professional Identity when Confronted with Mortal Danger

Case study:
Dr. Gottfried Bloch was born in 1914, in Bohemia. He went to medical school in Prague but was forced to leave in his last semester after Germany invaded Czechoslovakia in 1938, when Jewish medical students were no longer allowed to continue their studies. After the German annexation, he worked in a Jewish community center as a psychological counselor.

In 1943, Dr. Bloch, together with his family, was sent to the Theresienstadt Ghetto. He worked in the ghetto as a doctor where he learned about the “disappearance of people into the mysterious transports going ‘east.’” After a few months in Theresienstadt, Dr. Bloch, himself, was deported to Birkenau-Auschwitz and imprisoned in the Czech family camp. After being tattooed with a number on his arm, he was told by another prisoner that only those needed for work in the camp had a good chance for survival. Shortly afterwards, he heard a whistle being blown and an order for all physicians to report for a roll call.

In his memoirs, Dr. Bloch writes that he knew this would be a “decisive moment in my life.” He would have to make the decision whether to reveal that he was a physician or not. At the time, he had no idea of the significance of this decision.

Bloch ran quickly and lined up with his fellow prisoners. They waited endlessly for the arrival of the SS doctor. The tension was unbearable. When the prison doctors were all lined up, and the SS doctor was inspecting them, Bloch...
stepped out of line and explained that he was not yet a qualified physician. The SS doctor just laughed at him (“It was the first and last laughter I ever heard in Auschwitz.”), and then proceeded to order him to work in the hospital barrack. According to Dr. Bloch, this decision saved his life. He notes:

“I felt enormously relieved about my assignment. I suspected that a decision about my profession was important. I did not know then just how crucial it would be.”

Dr Bloch continued to work in various camps in Auschwitz. He was able to remain alive because he could work as a medical doctor (and doctors were especially needed in some prison camps to treat other prisoners, keeping them alive to work). Bloch was subsequently transported with other prisoner medical personnel to a labor camp, Ohrdruf, where his own physical condition deteriorated from exhaustion and severely infected feet wounds. After deciding to help a fellow prisoner there, despite his own precarious health, he was once again asked to work as a doctor by a fellow prisoner physician:

“I thought of the lesions on my own feet, hurting with every step but carefully covered by my pants. I could have been the one lying on this table. The next minutes, I knew, would be decisive as to whether I would be a patient and removed as worthless human trash or accepted again as a doctor…”

Once again his life was spared due to the fact that he had admitted to being a doctor.

Reference:

Question:
Should a physician always reveal that he is a physician when the need arises?

Discussion:
The case above occurs in an extreme situation where a physician is called upon to practice his profession despite the frightening, uncertain, and dangerous circumstances. In the medical profession, situations may arise in which a physician is called to provide medical aid when his/her own life could be in danger. While doctors are not legally required to act as Good Samaritans, moral duty generally suggests that they will respond to the call,” Is there a doctor in the house?”
One of the virtues of medical professionalism is the duty to care. A person who becomes a physician takes on the promise that he will use his or her abilities to the best advantage. This promise is a duty in itself and a physician is morally bound to fulfill that duty even if it could put his own life in danger. It is very difficult to quantify “danger” and so the question of a particular physician’s duty to care can be debated where there is imminent danger to his/her own personal safety.

Duty of care is not clearly defined and encompasses the basic medical ethical rules of beneficence, non-maleficence, respect for autonomy, as well as other long standing ethical principles.

Duty to care can mean also different things to different people in different circumstances and must also be considered in the context of other rights, limitations, and responsibilities. For instance, one is reminded of the circumstances that occur when physicians are required to treat patients with highly contagious diseases, for example SARS, or, at the beginning of the AIDS epidemic. Should a doctor or nurse be obliged to care for these patients? Doctors or nurses caring for infectious or dangerous patients also have a duty to care for themselves as well as for their own children and loved ones by protecting them from infection or danger. It could be argued that, in exceptional circumstances, doctors or nurses who omit their duty to care do not necessarily entail a moral wrong, however serious the consequences to the abandoned patients.

Dr. Bloch was aware that his decision to step forward and be truthful and to state the status of his medical training may have major consequences on his life. He recognized that this decision could either endanger his own personal safety or save his life. He discerned that his decision was crucial in that this way he could be provided with the status of a worker deemed necessary for a certain function in the camp. At the same time he realized that his medical status could be a way of ensuring not only his own survival, but also that of fellow prisoners in need of medical help.

Did Dr. Bloch make the right ethical decision in both circumstances? What might have happened if he had made the choice not to have revealed his medical identity and status?
3.2 Treating the Enemy

Case study 1:
Dr. Elkhanan Elkes was the elected leader of the Jewish Council in the Kovno Ghetto in Lithuania. He was appointed as the leader of the ghetto Jewish Council, and as such he often had to make life and death decisions that affected not only his patients but the entire Jewish community. In the Kovno ghetto, as in all other ghettos, Jewish doctors were not allowed to treat any non-Jewish patients and Gentile doctors were prohibited from treating Jews.

One day, SS Master Sergeant Schtitz, who was in charge of Jewish Affairs in the ghetto, felt ill. He requested that Dr. Elkes, who was a prominent internist, examine him and prescribe appropriate medication. While the Nazi Race Laws prohibited Jewish physicians from treating Germans, the law was not always obeyed by SS leaders in the field who, at times, sought medical treatment by Jewish physicians. Schtitz was a cruel man and had already ordered and conducted murderous executions in the ghetto and was known to have stolen many possessions of Jews in the ghetto.

Dr. Elkes was torn between his obligations as the leader of the Jewish community in the ghetto, and his sense of duty as a physician. His decision was to examine the Nazi sergeant, and to prescribe the necessary medication for the sick man.

After the incident Dr Elkes told Abraham Tory, a fellow Jew from the ghetto:

"This patient, whom destiny has forced me to check, is shocking in the extreme. Just to touch him-whose hands are covered with the blood of Jews-was horrible. Yet I suppose I did what I was meant to do. It may help save lives."

Reference:
Case study 2:
Dr. Zymunt Klukowski, a 55 year old Polish physician, spent most of the war as the Superintendent of the Zamosc County Hospital in Szczewbreszyn. In November 1942, Zamosc was declared the first formal Nazi resettlement area in Poland where the Jewish population, of about 60,000, had already been murdered as part of the Nazi program of ethnic cleansing. In addition, more than 100,000 Poles were forcibly removed from the region and sent to slave labor camps. Throughout the war, Dr. Klukowski, who was a member of the Polish underground, kept a secret diary. Below are several excerpts from his diary:

“July 23, 1940: The country surgeon from Bilgoraj, Dr. Snacki . . . called all the physicians together and gave us the new German regulation concerning the treatment for Jews. We are not allowed to sign any notes, such as labor releases . . . We are not allowed to attend to any Jews. After I questioned this by saying that in Szczewbreszyn there is not even one Jewish doctor, the Germans agreed that the hospital can give medical attention to Jews only one hour each day and only when no other patients are present. But we still have no right to admit Jews into the hospital except in case of infectious diseases . . . I was forced to release from the hospital a few Jews. . . Many of them I kept in the hospital to protect them from deported to labor camps and not because of any illness.”

May 8, 1942: Around 3 P.M. a real hell started in town. From Zamosc there arrived a group of Gestapo. They ordered the Judenrat to provide 100 Jews for forced labor, giving only one hour . . . After one hour passed, the Gestapo, with help from the gendarmes, started catching the Jews, but they really began a mass shooting. . . . They shot people like ducks, killing them not only on the streets but also in their own houses – men, women and children, indiscriminately . . . Jews came to me asking for help, so I dispatched a few crews with stretchers to pick up the wounded. After a short while I began to think: I have had instructions . . . not to give any medical aid to Jews. So I called the police station and I was told that Jews are not my business. Then I called the county doctor in Bilgoraj. He told me that hospital has no right to give any help to Jews since a Jewish doctor is in the city . . . I posted a few people at the hospital entrance to explain that we are not allowed to admit any Jews.

Around 4 P.M. two Gestapo men, on gendarme, and one member of the “blue police” entered the hospital lobby, all armed with machine guns, and asked if I had admitted or given help to any Jews. I told them no.
Around 5 P.M. Dr. Bolotny, the only Jewish physician in town, came to me begging for help. I am saddened that I had to refuse to give any help at all. I did this only because of strict orders by the Germans. This was against my own feelings and against a physician’s duties. With my eyes I can still see the wagons filled with the dead . . . and many wounded lying on the sidewalks across from my hospital, where I was forbidden to give them any help."

Reference:

Question:
How should doctors perform when treating patients who are defined as the enemy?

Discussion:
In the cases above, the doctors, a prisoner (Elkes) and a “conquered” non-combatant Polish physician (Klukowski), were required to treat (or not treat) patients who were defined as belonging to the enemy. The circumstances of the war dictated the definitions of the “enemy,” even though these professionals were not performing within a military context. But the ethical dilemmas can be similar to what medical professionals could be confronted with especially in the military service.

The potential dilemmas can be: To treat the sick and wounded or not to treat them? To follow one’s conscience or an external authority? To adhere to the medical ethical tradition and codes or to follow the directive of a State authority, military officer or prison guard? To protect one’s personal safety or risk it by attempting to treat or save others?

The cases also reveal that a changing military and political situation may also lead to inconsistency and variability in ethical choices and decision-making.

In times of war, health professionals are frequently placed in settings where they are asked to weigh their responsibility and devotion to patients against their loyalty to a third party. In some military (or other) circumstances the ethical principles of beneficence, non-maleficence, patient autonomy and self-determination may not necessarily coincide with the military or civilian obligation of physicians. Many ethical dilemmas may confront the physician...
on the battlefield, or elsewhere, in a war region, including the treatment of detainees and the priority of treating wounded enemy soldiers or civilians first.

Such situations can lead to the problem of dual loyalty that is manifested in conflicts between professional duties to patients versus obligations to third parties. They can also lead to complicity by health professionals in violations of human rights and non-adherence to medical ethics. Some situations can arise when the personal safety of the physician can be threatened by the military or governmental authority. To whom does his/her duty lie?

As health personnel are torn between duties to heal on the one hand and to support military objectives on the other, these tensions result in inevitable ethical and human rights consequences for both soldiers and civilians. When physicians are faced with the conflict of following state or national policies versus adhering to international principles of humanitarian law and medical ethics, the physician should opt for the latter.

3.3 Medical Care in Dangerous Circumstances — The Doctor’s/ Nurse’s Duty of Obligation

Case study:
In the late autumn of 1944, the Łódź Ghetto had already been liquidated. Out of more than 200,000 Jews who once lived in the ghetto, only about 900 remained. Six hundred Jews were part of a cleanup crew who lived in a well-guarded labor camp, the other three hundred were hiding in cellars, abandoned buildings, and secret bunkers.

One night, a man secretly came into the camp. His wife, hiding in an abandoned house, was bleeding to death after giving birth to a baby boy. After seeking the help of a surgeon who refused to help, the man was told that there was a midwife in the camp and that maybe she would agree to help. The midwife, Rachel Herschenberg, was married and the mother of a teenage girl,
Salomea. The Herschenberg family had survived in the Łódź Ghetto since it was sealed on May 1, 1940.

Rachel chose to go with the man to help his wife and child. In the words of her daughter, Salomea:

“In a filthy, well camouflaged cellar my mother examined the heavily bleeding woman removed the retained placenta by an ungloved and not too clean hand. She waited till the bleeding stopped, checked the baby, and then returned to the camp alone. “Sally,” she reported, and her face radiated with pride, “it’s a healthy and beautiful baby-boy.”

Rachel decided to make another visit to her patient to check that all was well after the treatment. Salomea attempted to talk her out of it:

“Oh no, Ma, it’s not an after-delivery visit; it’s a dangerous journey. You’re tempting death. The surgeon had enough common sense to refuse. Besides, the woman was foolish to go into hiding when she was pregnant. It’s a double ticket to death. I don’t understand how in the midst of hunger, destruction and deportation one gets pregnant?”

Rachel answered:

“The drive of intimacy is very strong even in the lowest human conditions although hunger made a lot of us asexual . . . You don’t see something symbolic in this delivery?”

Salomea replied:

“No, I see a danger to your life and I’m not interested in symbols.”

Don’t let me die without you and don’t let me survive without you. Don’t go.”

Rachel, after briefly addressing her daughter’s fears, answered her:

“. . . The Nazis took away from us the rights to be pregnant and to bear children. I’m fully trained to deliver babies, and babies are the promise of life. They are the rebirth of our new nation.”

Rachel made a second visit, alone. She came back beaming with joy and with a loaf of bread. The mother and the baby were doing well.

Reference:
Solomea Kape, The Midwife of Łódź,
Question:
Is a medical professional obligated to care for a patient when his/her life is endangered?

Discussion:
In this situation the midwife experiences a conflict of interest: the patient’s best interest in receiving appropriate medical care and her personal interest in staying alive. She also has a conflict in her obligations: her duty to treat patients, based on her professional training, and her obligation as a mother.

The medical ethical tradition has long endorsed the principle that medical professionals (physicians, nurses, and others) should treat patients in need regardless of the risk to themselves. This does not mean that they should disregard risks to themselves, but instead, concerns about risks should not take highest priority. When one becomes a medical professional one takes an oath to be a healer and to be of service to the sick. It is generally expected that medical professionals should strive to do whatever they can to help a patient. While it would be considered above and beyond the call of duty to expect a medical professional to give up his life for the life of another, it is expected that he (or she) act with courage and humanity when necessary.

This case concerns the principle of duty. Physicians, nurses, and midwives have a duty to provide care to others. However, in this instance, there is also a duty to protect one’s family. How does one weigh the professional obligation with the obligation to also protect and care for the family? Just as it is not expected that one would not give up his/her life in order to save a patient, it is not expected that one would expose a family member to death in order to save a stranger. In this case the doctor had a teenage daughter. One is left with the question as to what she would have decided if her daughter had been a baby.

The case of the Lodz midwife also exemplifies another aspect of humanity, and in many cases medical professionalism: the freedom that each person has to make decisions and choices in order to gain a meaning in life.

Victor Frankl, the Jewish psychiatrist who survived the Holocaust, emphasized this in his book “Man’s Search for Meaning.” In his theory of logotherapy, Frankl notes that a person may have his property, family, honor and livelihood taken away, but what cannot be taken away from a person is his ability to think, experience and to make personal choices. Rachel Herschenberg, the midwife, reinforces Frankl’s approach. She had no moral
obligation to risk her life, or her family’s, for the life of another and yet she made a conscious, professional choice to put her own life at risk in order to help a patient, and by doing so personally achieve some meaning for her life, despite the oppressive conditions in the Nazi ghetto.

Reference:

### 3.4 Altering Ethical Stances

**Case study:**
When the Nazis occupied Lvov in June of 1941, Professor Ludwik Fleck, a well known bacteriologist, lost his home, and he and his family were forced to live in the ghetto. In the ghetto, Professor Fleck, along with some colleagues, continued their research on a typhus vaccine. Through their efforts, and in spite of extremely harsh conditions, they succeeded in developing a vaccine. The vaccine, based on the urine of Jewish patients, saved the lives of many patients who were inoculated. While being treated for typhus, patients were also protected from death selections.

In January, 1943, Dr. Fleck and his wife were deported to Auschwitz. In Auschwitz, Fleck contracted typhus but because he had inoculated himself, he contracted only a mild version of the disease. Although Fleck initially worked at hard labor in Auschwitz, he was later assigned to do lab work on bacteriological research for prisoners.

In January, 1944, Dr. Fleck was sent to Block 50 at Buchenwald to conduct research on typhus vaccines. Along with two colleagues, he, discovered that the vaccine that was being produced there was in fact ineffective. With this knowledge, Fleck and his colleagues made a conscious decision to continue with the production of the ineffective vaccine as an act of sabotage of the German doctors’ work. This ineffective vaccine was sent to the German Army for the vaccinations of its soldiers. According to Fleck’s testimony after the war, the Nazi doctors who were developing the vaccine had
a very limited knowledge of this research. This limited knowledge enabled Dr. Fleck and his colleagues to continue with their production of the ineffective vaccine. At the same time that this was taking place, Fleck together with his colleagues, managed to produce an effective vaccine which they administered to their fellow prisoners. Some of the effective vaccines were also sent to the Germans as control samples and so the fake ones were never discovered.

After the war, Dr. Fleck testified at Nuremberg as an expert witness against the German Drug Conglomerate, I.G. Farben, which had conducted human experiments, with SS doctors, for the development of vaccines.

**Background:**

Typhus, a disease spread by lice, was a major infectious disease both in WW I and WW II, as well as in other wars in earlier centuries. Unsanitary conditions and overcrowding, as in the ghettos or concentration camps, led to the disease spreading from one person to another thereby causing epidemic proportion of the disease. The German authorities were particularly concerned that typhus would spread to both their soldiers and civilian population. The fear of typhus, and other infectious diseases, was one rationale that the Germans used to establish Jewish ghettos in occupied territories. The ghettos themselves became “quarantine” areas to confine the disease to primarily the Jewish populations.

German military doctors recognized that the overcrowded and unsanitary conditions in the ghetto were likely to lead to more cases of typhus among the ghetto populations. In the establishment of some ghettos, German physicians worked with Jewish physicians to establish medical protocols which would combat typhus.

When the German authorities felt that a typhus epidemic was imminent, however, they acted quickly and brutally. In December of 1941, when the gypsy camp (initially consisting of about 5000 people) in the Lodz ghetto was infected with typhus, the SS and German Police emptied the camp and sent all of the gypsies to Chelmno, where they were murdered. Another example is the Kovno (Kaunas) Ghetto in Lithuania, where on October 4, 1941, the Germans selected and murdered about 2000 people in the small ghetto, including those in the Jewish hospital, which was doused with gasoline and set on fire, with all the patients and staff sealed inside. The fear of typhus was one of the justifications for the murder.

Throughout the ghettos of Eastern Europe, as well as in the concentration
camps, Jewish, as well as non-Jewish, prisoner doctors, usually did everything possible to control typhus in the overcrowded and unsanitary conditions. They did this to save lives of their fellow inmates. In addition, these doctors also attempted to hide or disguise any outbreaks of typhus from German medical or administrative authorities. They knew that if the Germans ever discovered typhus in the camps/ghettos, there was a high likelihood that many people would be killed.

References:

Questions:
Was it ethically right to produce this fake vaccine?
Are there circumstances when it is ethical to change medical values?

Discussion:
Dr. Fleck and his colleagues did not work in a typical research environment. They were prisoners in a concentration camp and their lives, and the lives of their family members, if still alive, were at risk at every moment. Nevertheless, they chose to use their medical knowledge, both to help their fellow prisoners and also to sabotage the German war effort in the only way that they had at their disposal. They recognized that to falsify research data was unethical in normal circumstances and that their actions would not benefit German soldiers and might even lead to harm. But, although incarcerated and living in a high risk situation, they used their medical knowledge as a strategic opportunity to resist the Nazis. From their prisoner perspective, this was justified action. The harsh reality of a Nazi concentration camp made it inevitable for decisions to be made by the prisoner physicians that were not compatible with their past ethical value systems.

Medical professionals are expected to uphold the values of truth and honesty, but different settings may create different realities and different standards for judging what is honest and ethically truthful. But what if these values come into conflict with other essential values such as life itself, or beneficence or
freedom? Can a lie or another unethical form of conduct be justified if it saves a human life or a community, or if another great evil is avoided?

In this case was it ethically permissible to supply a vaccine that was known to be ineffective to the enemy soldiers? This question juxtaposes an act of war (supplying ineffective vaccine to the enemy) with the Hippocratic Oath element admonishing one to “do no harm.” In a circumstance of war to whom does the physicians owe his loyalty? Should he or she be obligated to save the lives of those dedicated to the murder of innocents? In war, is it always possible for a physician involved in the war effort to act with the highest ethical integrity and what is ethical integrity in that extreme situation?

3.5 Complying with the Nazi Doctors

Case study:
Miklos Nyiszli was born in 1901 in Samlyo, Romania. He started medical school at the University of Clug, continued at Kiel in Germany, and completed his studies in 1930 in Breslau. In 1944 Dr. Nyiszli was deported to Auschwitz-Birkenau together with his wife and daughter. On arrival at Birkenau, they were selected to join the group who were fit for work by the SS physician, Dr Josef Mengele. Mengele ordered all physicians from this group to step forward and told them that he was looking for a physician who had expert knowledge of forensic medicine. After being questioned by Mengele, Nyiszli was separated from the group, shaved, disinfected and tattooed. He was then taken to a newly renovated dissection room to perform autopsies.

Dr. Nyiszli was ordered to perform autopsies on dwarfs and twins who were subjects of experiments, as well as other prisoner corpses that were dissected for medical research. Nyiszli was required to send his anatomical research reports to the Kaiser Wilhelm Institute on Anthropology, Hereditary Science and Eugenics in Berlin. As part of his work, he was also required to provide medical care to SS staff and to the Sonderkommando, Jewish camp prisoners who removed corpses from the gas chamber and transferred them to the crematorium.
Through his work, Nyiszli discovered the precise details of the barbaric experiments, as well as the methods used to murder victims. Nyiszli repeatedly writes that he had no expectation of surviving the camp, but he also knew that unless he performed his professional duty as a physician, he would be murdered. Nyiszli notes:

“...It literally made my hair stand on end when I thought of how much I had learned during my short stay at the crematorium and how much more I would have to learn, without a word of objection, before it was my turn. I realized the inevitable, the moment I passed through the crematorium gate, but now I knew so many secrets, I had not the slightest doubt that I was already a dead man. It was impossible to hope that Dr Mengele and the institute at Berlin-Dahlem would ever let me leave that place alive.”

Dr Nyiszli and his fellow Sonderkommando prisoners recorded the details about the perpetrators, victims, the methods and the tools of the mass murder. The Sonderkommando members signed the document and they buried it. While this particular document was never recovered, similar ones were discovered after the war.

In late January, 1945, Dr. Nyiszli was deported to Mauthausen, where he was liberated by American troops on May 6, 1945. His wife and his daughter were liberated in Bergen-Belsen. After the war, Dr. Nyiszli returned to the city of Ordea and worked again as a physician. In May, 1956, Dr. Miklos Nyiszli died of a heart attack.

Dr. Nyiszli’s memoirs, first published in 1946, serve as one of the earliest and most detailed documented testimonies on the Nazi experiments, the gas chambers and the crematoria in Auschwitz.

Reference:

Question:
Is it ethical for a physician to comply with the enemy?

Discussion:
Although both doctors were involved in the principles and ends of research, Dr. Mengele and Dr. Nyiszli were not working for the same end. Dr. Mengele’s research was intended to help substantiate the Nazi bio-racial theories as well
as his own professional, academic and ideological goals. Dr. Nyiszli, while he participated in Mengele’s research as a doctor and medical anatomist, did so as a prisoner and for the survival of both himself and his family. The goals of both doctors were quite different.

No one who has not gone through or lived in such horrendous circumstances knows the limits or temptations of compliance. We should be humble in our ethical judgments from afar. Moreover, even in the best examples of humanity, the times and circumstances also made a difference.

In the case of Dr. Nyiszli, however, several points stand out:

1) He performed his duty as a physician because to not do so would likely result in his death and the death of his family. This was an undeniable fact.

2) He did not participate in the selections but only performed the role of a pathologist. He did not cause their deaths, nor could he save their lives. At this point, he could only save his own and, perhaps by his compliance, those of his wife and daughter.

3) He worked as a physician, helping both some of the perpetrators (SS) and other camp inmates. In this role, he fulfilled his duty as a physician, helped others survive, and also became more knowledgeable about the extermination process.

4) When given the opportunity, he recorded the murderous methods of the Nazi extermination process. This action, which could have resulted in his death, if discovered, was intended for posterity and for justice.

One of the primary lessons of this case is that we must approach the issue of “compliance” with the greatest of humility. What would we have done? What choices would we have made? And today, when we are asked, in our own nations and times, to comply with policies, regulations and laws that are unjust or unfair, what should we do? And, perhaps, there is a parallel question: What would we do to ensure and/or risk the safety of our own families and loved ones?

A confounding variable arises when reading Nyiszli’s book: Pride in work. Dr. Nyiszli did take pride in his work. This is evidenced by his descriptions of his meticulous autopsies, findings, and clinical reports. Although pride in one’s work is understandable and even commendable in ordinary times, the appearance of it in Nyiszli’s narrative is also disconcerting. Yet, perhaps this pride in work is what enabled Nyiszli to survive the hell of working and living in a crematorium in Auschwitz.
4. Abortion: Perspective of the Nazi doctors and the Prisoner doctors

Case Study 1: Abortions Performed on Healthy Jewish Women in the Ghettos

Dr Aharon Peretz, a gynecologist in the Kovno ghetto, describes how Jewish doctors sought to protect pregnant women. In his memoirs, he writes:

“I succeeded in getting permission for those women who were in the eighth or ninth month of their pregnancies to continue with their pregnancies. The pregnant women tried to hide away and would not come out into the streets in daylight. Because I was officially the obstetrician on the hospital I had to see to it that these births were kept secret. I gave the midwives and the patients instructions as how to keep their pregnancy a secret, and ordered them to call me only in a case of emergency. . .

. . . I was forced to conclude that in the ghetto there was no way out except to abort these pregnant women. Before all this an abortion was allowed only when the woman’s health was in danger. Now, not the TB or any other serious disease were the reason for performing these abortions, rather the Gestapo and their annihilations policy! . . .

. . . When a pregnant woman arrived at the hospital I dealt with each case with a cold heart and spirit.”

Reference:
Aharon Peretz, They did not cry in the Camps [Hebrew] (Massada, 1960).

Case study 2: Abortions Performed in the Concentration Camps

Dr Gisella Perl was a Jewish gynecologist from Maramaros Sziget, Transylvania. In 1944, she was deported to Auschwitz together with her parents, her husband and her son. She was the only one to survive. Dr Perl
treated women inmates in Auschwitz. In Auschwitz, seeing with her own eyes pregnant women being thrown alive into the crematorium, Dr. Perl recalls:

“...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, then by destroying the life of their unborn children. I ran back to camp and going from block to block told the women what I had seen. Never again was anyone to betray their condition. It was to be denied to out last breath, hidden from the SS, the guards and even the block leader. . . First I took the ninth-month pregnancies. . . . I delivered women pregnant in the eighth, seventh, sixth, fifth month, always in a hurry, with my five fingers, in the dark, under terrible conditions. . .

No one will ever know what it meant to me to destroy these babies. After years and years of medical practice, childbirth was still to me the most beautiful, the greatest miracle of nature. I loved those newborn babies not as a doctor but as mother and it was again and again and again my own child whom I killed to save the life of a woman. Every time, when kneeling down in the human excrement which covered the floor of the barracks to perform a delivery without instruments, without water, without the most elemental requirements of hygiene, I prayed to God to help me save the mother or I would never touch a pregnant woman again. And if I had not done it, both mother and child would have been cruelly murdered. God was good to me. By a miracle, which to every doctor must sound like a fairy tale, every one of these women recovered and was able to work, which, at least for a while, saved her life.”

Reference:
Gisella Perl, I was a Doctor in Auschwitz (Ayer Company Publishers, Inc., 1997) [original book published in 1948].

Background: The Nazi use of Abortion as a Eugenic Tool
In Germany throughout the Weimar period, the legalization of abortion was debated and there had been movements to legalize abortion. Many physicians, however, opposed the liberalization of abortion. Once the Nazis took power in 1933, a rapid, and even greater political, shift took place in all sectors of society. Medical associations and physician groups, that once had opposed abortion,
now began to support the Nazi view favoring abortion on racial grounds. Nazi abortion policies, based upon racial hygienic principles, consisted of two primary poles: prohibitive abortion laws for healthy German women (positive eugenics), and legalized abortion for unhealthy German women, as well as for non-Aryans (negative eugenics).

Anti-abortion policy for Aryan women was paramount for the Nazis. Healthy German women were prohibited from having abortions and could be legally convicted for doing so. Bavaria’s official medical journal declared abortion a form of treason. The government established and promulgated what it called a “four family ideal” and women were awarded medals, the “Honor Cross of German Motherhood,” according to the number of their children. Access to birth control in all forms was strictly controlled for healthy Aryan women. Abortions were permitted only if the life of the German mother was in danger. Nazi physicians generally advised marriage as the solution to pregnancy out of wedlock.

Although abortions were illegal for healthy German women, abortion on the grounds of racial hygiene was permitted by law. The Sterilization Law of 1935 made abortion legal on eugenic grounds, allowing abortions for women already slated for sterilization. Moreover, the Ministry of the Interior encouraged public health physicians to apply for abortion for their patients (and sterilization) on “anti-social” German women.

The Nazi plan especially targeted Jewish and other women of “inferior stock,” like prostitutes. From the Nazi perspective, these were the very women that “polluted” the Aryan gene pool and ensured the continuity of life of both individuals and races that was considered “unworthy of life.” In 1938, A Luneberg court declared abortion legal for Jewish women.

Once World War II began, the Nazi abortion policies further radicalized. In the spring of 1942, the Nazis issued decrees banning births in some ghettos. The punishment for having a Jewish child was death for the mother, the child, and potentially, the whole family. If a Jewish woman’s pregnancy was discovered at a concentration camp she was also forced to undergo an abortion because, typically, if a pregnancy was discovered, the woman was immediately sent to be killed.

Polish and other Eastern European women who worked as forced laborers in German factories were also compelled to obtain abortions in order to return to their slave labor early. The Nazi population control policy stated:

“When girls and women in the Occupied Territories of the East have

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abortions, we can only be in favor of it; in any case we should not oppose it. The Fuhrer believes that we should authorize the development of a thriving trade in contraceptives. We are not interested in seeing the non-German population multiply."

“It will even be necessary to open special institutions for abortion, and to train midwives and nurses for this purpose. The population will practice abortion all the more willingly if these institutions are competently operated. The doctors must be able to help out, in case there is any question of this being a breach of their professional ethics. The Russian physicians or the Russian Medical Association, which must not be informed of this order, are to be told in individual cases that the pregnancy is being interrupted for reasons of social distress.”

References:

Questions:
What is the role of the physician on the ethical issue of abortion?

Discussion:
The World Medical Association requires physicians to maintain respect for human life, no matter the circumstances. This is a complicated issue when considering pregnancy. Whose life should be respected if the mother and the fetus/unborn child are in danger? Situations that bring the interests of a mother into conflict with the interests of her unborn child create a dilemma and raise questions about whether or not the pregnancy should be deliberately terminated.

Prisoner doctors in the ghettos and the camps primarily considered the life of the mother, in part, because a newborn infant would have such a low probability of survival in these environments. Moreover, dangerous circumstances dictated that these doctors act according to what they judged right in the ever changing, harsh and uncertain environment. Most physicians acted according to their personal and professional consciences when performing abortions. They wanted to save the lives of the pregnant women; although the woman’s health was not endangered by her pregnancy per se, her life was at great risk if the pregnancy was discovered.
One may ask whether it is an obligation or a prerogative to obey one’s conscience in such hazardous circumstances. Consider the situation in which a physician believes that abortion is wrong regardless of the circumstances and the situation in which the woman, and baby, will certainly perish without the abortion, often under extremely brutal conditions. This was the dilemma that confronted physicians who were conscientiously opposed to abortion but saw the imperative. At the time, Dr Perl’s conscience instructed her to kill the babies in order to save their mothers. Yet, years after surviving the Holocaust, her conscience tormented her for the murder of those babies.

Medical doctors should, to the best of their abilities, respect the diversity of views regarding the life of an unborn child and act according to the law, but at the same time according to their individual convictions and consciences. While it is not the role of the medical profession to mandate policies or to legislate the laws of any particular state or community in this matter, it is the duty of physicians to attempt to ensure the protection of patients and at the same time to safeguard their own rights within society. Therefore, where the law allows therapeutic abortion to be performed, the procedure should be performed by a physician competent to do so in premises approved by the appropriate authority.

There is no doubt that the Nazi laws prohibiting and allowing abortion on certain women, according to their racial origins, were completely unethical. The doctors, performing these procedures (not intended as therapeutic), acted against all ethical principles. They were not concerned about the best interests of their patients. They performed operations on women whose health was not endangered. Instead, they performed abortions simply to maintain the Nazi racial policy established at the time.

Today it is widely accepted that if a physician’s convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague. There are no reports of German doctors refusing to perform abortions on eugenic grounds. In this context, the social goals and racial needs of the State took precedence over the individual and medical needs of the patient. Once again we can see how the conscience, personal or professional, can be greatly influenced by the times, cultural and societal norms, and circumstances.
5. Treating Dying Patients

Case study:
Dr Elie Cohen, a Jewish physician from Holland, was a prisoner doctor in Auschwitz. During his incarceration in the concentration camp, he witnessed thousands of prisoners who were selected for death in the gas chambers. In addition, he saw selections taking place in the medical blocks. During these selections, the Nazi doctor had patients march past him and he chose, often on a whim, prisoners who would live and those who would be condemned to die in the gas chambers. The basic rule was that patients who had been hospitalized for longer than two weeks would be gassed. Dr Cohen was well aware of the Nazi logic that condemned the patients to their deaths in the gas chambers.

One day, after learning about an upcoming death selection, Dr. Cohen was approached by one of his dying patients and who had already been in the hospital block for two weeks. The patient knew that he was destined to be sent to his death and asked:

“Cohen, I’ve a very big favor to ask you. Will you see to it that I’m given enough narcotics to make sure I’m no longer conscious when I go into the gas chamber?”

Dr. Cohen refused the patient’s request and did not give him any narcotics. He later recalled:

“Why didn’t I give that professor any drugs? Well, that of course, is a terribly sore point for me. Because I was scared to! Because I didn’t want to put my own life in jeopardy unnecessarily. He was going to die, anyway. And was I then to...yes, you do your own reasoning, believe me. It’s not that I am seeking to set a standard. But as I reasoned at the time: Was I to risk my life for someone who had already been condemned, yes...condemned to death, who was going to die, who was quite simply being taken to the gas chamber? I could have done it. But I didn’t do it. I didn’t do it.”

Reference:
Question:
What is the ethical stance on treating dying patients?

Discussion:
The case of Dr. Cohen is not a normal case. Both he and his patient were prisoners in the Auschwitz extermination camp. Under those extremely harsh conditions, Dr Cohen was the attending physician caring for a dying patient. This dying man asked his attending doctor to alleviate his suffering and to make his death easier. The patient, knowing that he was condemned to die anyway, was probably frightened and in anguish due to the circumstances.

The physician was in a position to help his patient, but by doing so, he would be placing himself in great danger from the Nazi doctors. What action could he take? Was he ethically obligated to alleviate suffering despite the danger? Was he ethically obligated to help a dying patient whose death was inevitable?

What is a physician’s duty when treating dying patients?

The ethical debate today about physicians aiding the dying is often argued on the grounds that physicians’ help may be a rational choice for a dying person who is choosing to escape unbearable suffering at the end of life. The medical aid may not always be curative or one of healing nature, but may be the relief of emotional, spiritual or psychological symptoms as well.

Several values are involved in treating dying patients. The primary aim of the physician should be to enable the patients to die with dignity and in comfort. The ethical issues involved in this discourse include the value of life, the principle of autonomy, beneficence, and non-maleficence. The basic dilemma is how to strike a balance between the sanctity of life and the principle of autonomy. It is also necessary to decide where the line between these values should be drawn.

This distinguishing boundary line, however, is debatable. These values are not absolute. It is reasonable to assume that when the sanctity of life and the wishes of the autonomous patient both require prolonging life, they should be respected, even if the patient’s request seems to be futile by the caregivers, unless it is harmful to the patient or others. However, when the autonomous wishes of the patient demand the shortening of life, and hence, are in opposition to the sanctity of life, the status of the patient becomes an important factor in the decision making. It is often accepted that if the dying patient is competent, then the respect for autonomy and human dignity may take priority over the respect for value of life.
Some would argue that physician aid in dying is not ethically permissible because it runs directly counter to the traditional duty of the physician to preserve life and to do no harm.

When decisions arise concerning the treatment of dying patients, these options present complex ethical dilemmas. The World Medical Association guidelines state that “physicians should not abandon dying patients but should continue to provide compassionate care even when cure is no longer possible.” The physician is, of course, required to consider his personal values and should act according to his own conscience.

In an effort to avoid the ethical conflicts and to encourage appropriate treatment of dying patients, many advocates both for patient rights and “good deaths” suggest the use of advance directives or living wills. In addition, there are countries where the legislature has provided for the rights of dying patients in order to confront the ethical quandaries involved in this complex issue.

In the case above there are no easy answers. The circumstances were extreme and under these conditions Dr Cohen made his decision according to what he felt to be the right one at the time. Not only was his patient’s life soon to end, but Dr. Cohen’s might be risking his own life if he chose to provide the palliative medication. In retrospect, Dr. Cohen anguished over his choice, both in Auschwitz, as well as later in his life.
6. Truth Telling

Case study 1:
Dr. Albert Haas, a Jewish doctor of Hungarian and French descent, was recruited by the French resistance movement. After being informed upon and exposed, he was captured by the Germans, who tortured him and then sent him to Dachau. Later Dr. Haas was sent to the Gusen II Concentration Camp, which was part of the Mauthausen Concentration Camp complex near Linz, Austria. Dr Haas would later write,

“And so I began professional career as doctor of the damned in Gusen II.”

He was appointed the head medical doctor in the camp hospital by the SS doctor Fetter. He had to present Fetter with a list of the inmates and their numbers when a “selection” day was scheduled. The inmates would then stand with their backs to the SS doctor who would check the patients to be selected for the gas chamber. If the prisoner could pass his fist between their legs that meant that the person was emaciated enough and “fit for the death chamber.” The selected inmates were taken away and never returned.

Dr. Haas writes that the Jewish doctors and staff knew these patients were killed but did not know how. In order to save their lives, he made a decision to lie to them and to tell them that it was to their benefit to be discharged from the hospital. He writes:

“I refused to play a role in the selection of convalescence barrack inmates. Soon I realized that I could be somewhat more active in my fight to save lives, or at least delay death. When I learned that a selection was scheduled, I discharged those inmates I felt were strong enough to survive the next few days out in the camp proper. I would readmit them to the barrack as soon as the selection was over.

The problem was that many of these inmates refused to be discharged. They were convinced that I was sending them out to certain death from starvation or physical assault. They would not believe me. Many selections took inmates who had refused my help”.

Reference:
Case study 2:
Dr Gottfried Bloch was a young, almost qualified doctor, when sent to Auschwitz. He worked with prisoners in the Czech family camp. He and the other inmates there heard descriptions of the killing in the gas chambers and they saw the crematoria smoking. He would later write about his experience as a camp doctor:

"Yet even in the hospital, where we had more contact with the other sectors of the camp than most people, we managed to push to the periphery of our reality what might be going on. Every time some terrible confirmation of the process of annihilation had to be faced, I felt overcome by deep despair and grasped for something to deny the truth. Often I gave words of encouragement to my patients, until I caught myself nearly believing them. Of course, I knew what was going on. . . Was it out duty to inform them? How would it help? . . . I kept the truth from my patients and from the personnel in the hospital, but could not hide my deep distress."

Reference:

Question:
Should a doctor always tell his patients the truth?

Discussion:
This may seem simple but really it is a complex question. Not telling the truth may take many forms, has many purposes, and leads to many different consequences. Questions about truth and untruth pervade all human communication. They arise in many different situations and contexts: in families, clubs, work places, in politics, international relationships, religious organizations, and certainly in the doctor/patient relationship. In each context, both the questions and the key factors can be perceived and configured differently. To tell the truth in the clinical context requires compassion, intelligence, sensitivity, and appropriate timing. In some cases, the harm from not telling the truth may be less than being totally truthful.

If there are reasons for not telling the truth, what are they? When could incomplete disclosure be justified and under what circumstances? What exceptions, if any, exist to the rule against lying?
Lying in a clinical context is wrong for many reasons but less than full disclosure may be morally justifiable. If, for example, a patient is depressed and irrational and suicidal, then caution is required lest full disclosure contribute to grave harm. If a patient is overly pessimistic, disclosure of negative possibilities may actually contribute to actualizing these very possibilities. This could also be argued in the above cases, even though, of course, the situation was most extreme. It is likely that some patients in the camps benefitted from not knowing the whole truth. But others may have been unintentionally harmed. Even in places such as Auschwitz, each person, situation and circumstances, could be different depending upon multitude of ever changing factors.

Telling the truth is not only an ethical obligation but also has to be integrated into the physician-patient relationship, as well as what constitutes clinical judgment. Truth telling has to be linked with patient autonomy, beneficence, justice, as well as the protection of others.

Certain traditional cultures see the patient not as an autonomous entity with inviolable rights, but as part of an extended family unit. Family members rather than the patient, are given medical information, especially threatening information like a fatal diagnosis. Medical ethics and practice require respect for cultural practices and personal preferences that differ among different patients and their families.

In the cases above, the judgment decision made by these camp prisoner doctors was in line with what they considered to be morally correct under those extreme circumstances. In those extreme circumstances the patients probably did, to a certain degree, benefit from not knowing the whole truth. It is also highly likely, based on, at least, the everyday context in Auschwitz that many patients knew what the selections really entailed. Nevertheless, in such circumstances, Dr. Bloch’s “encouraging words” were acts of compassion.

It is also likely that each individual going to his death may have reacted differently if he/she knew that death was his destination. That is, if patients had known that “to stay in the hospital” increased their odds for a death selection, would they have stayed? And, if they knew, might they, or could they, have prepared themselves better for their “final death” walk?

Each person, despite different contexts, ultimately deals with disease and death uniquely as an individual. If we remove the truth-telling from the equation, do we not also remove the individual’s ability to deal with his/her own demise?
7. “Choiceless Choices” in Medicine

Case study:
Dr Maximillian Samuel, born in Cologne in 1880, was a practicing gynecologist until World War I. During the war, he served as a medical doctor and was awarded decorations for bravery. With the advent of the Nazi’s policies that discriminated against all Jewish physicians, Dr. Samuel’s medical license was revoked, and he was forced to close his practice. In July, 1938, he was arrested by the Gestapo, but managed to escape and flee to Belgium with his family. However, in August 1943, he was caught and deported to Auschwitz together with his wife and daughter. While his wife was sent to the gas chambers immediately upon arrival, Dr Samuel and his daughter survived the initial selection and were sent to work in one of the factories in Auschwitz.

Dr. Samuel was then transferred to Block 10 in Auschwitz I, where his gynecological experience was needed for the experiments being performed on prisoner women including the removal of reproductive organs. From survivors’ testimonies, Dr. Samuel is known to have sabotaged some of these procedures in which he did not remove the actual organs but made it appear that he had. Some of these victims, who were able to bear children after the war, testified that he was their savior. Other inmates, however, remember that he seemingly willingly collaborated with the Nazis in performing these experiments. He had also been described as a man in despair or in “a bad mental condition” who feared for the life of his daughter had he not cooperated with the Nazi doctors.

In October 1943 Dr Samuel was taken to the gas chamber in Birkenau and put to death. There are differences of opinion why this occurred. One view is that he was sent to death because of his sabotage; another view is that he “knew too much” concerning the experiments; a third view is that he was “deteriorating” and could no longer perform his work.

References:

Question:
Are there situations in which it is impossible to make ethically sound medical decisions?

Discussion:
The case above almost speaks for itself. This particular doctor found himself in a time and a place where he had to make certain crucial decisions that were to influence his own personal and professional life. These decisions would affect his life, the life of his daughter and the lives of the patients that he operated on.

One primary lesson of the Holocaust, as well as in life in general, is that people, no matter their positions, do not always make the same choices in all situations. As human beings, we are not always consistent in our ethical choices and decision-making. During the Holocaust, such human inconsistencies were often exacerbated by a person’s physical condition, the immediate context in prison, in a ghetto, or in hiding, as well as how decision-making affected the survival of one’s own life, as well as one’s loved ones. Literally, and often on a daily basis, a person’s choice could be life and death to him/herself, as well as to others.

Because Dr. Samuel was sent to the gas chamber, we cannot fully understand what motivated him in his decision making, but from the testimonies of fellow inmates, physicians, patients (victims of the experiments) and others we can, with humility and not by passing judgment, ask the required questions:
• Was he a collaborator?
• Did he abuse his status as a doctor?
• Could he have made other decisions?
• Did he comply in order to save his daughter’s life?
• Did he make the decisions he made in order to sabotage the Nazi experiments?
• Is it possible to make ethically valid choices in such circumstances?
In the case of Dr. Samuel, had he initially refused to comply, the end result for him would have been the same – death in the gas chamber. However, by salvaging the fertility of some prisoners, he accomplished some good that likely would not have happened with other prisoner physicians.

It is not by chance that different people remember him differently. The prisoner medical personnel, who witnessed his professional conduct, perceived of him as abusing his professional ethical values by complying with the Nazis when he performed these operations. On the other hand, the women whose lives and future reproductive ability he saved regarded him as a kind human being and an ethical doctor.
Appendixes:

1. The Nuremberg Code, 1947

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified
persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

2. The Prussian Ministry of Religious, Educational and Medical Affairs Directive, 1900

I. I wish to point out to the directors of clinics, polyclinics and similar establishments that medical interventions for purposes other than diagnosis, therapy and immunization are absolutely prohibited, even though all other legal and ethical requirements for performing such interventions are fulfilled if;

1. The person in question is a minor or is not fully competent on other grounds.

2. The person concerned has not declared unequivocally that he consents to the intervention.

3. The declaration has not been made on the basis of a proper explanation of the adverse consequences that may result from the intervention.

II. In addition, I prescribe that:

1. Interventions of this nature may be performed only by the director of the Institution himself or with his special authorization.

2. In every intervention of this nature, an entry must be made in the
medical case-record book, certifying that the requirements laid down in Items 1-3 of Section I and Item 1 of Section II have been fulfilled, specifying details of the case.

III. This directive shall not apply to medical interventions intended of the purposes of diagnosis, therapy or immunization.

3. The Reich Health Circular: Regulations on New Therapy and Human Experimentation, 1931

1. In order that medical science may continue to advance, the initiation in appropriate cases of therapy involving new and as yet insufficiently tested means and procedures cannot be avoided. Similarly, scientific experimentation involving human subjects cannot be completely excluded as such, as this would hinder or even prevent progress in the diagnosis, treatment, and prevention of diseases. The freedom to be granted to the physician accordingly shall be weighed against his special duty to remain aware at all times of his major responsibility for the life and health of any person on whom he undertakes innovative therapy or perform an experiment.

2. “Innovative therapy” means intervention and treatment methods that involve humans and serve a therapeutic purpose.

3. “Scientific experimentation” means interventions and treatment methods that involve humans and are undertaken for research purposes without serving a therapeutic purpose.

4. Any innovative therapy must be justified and performed in accordance with the principles of medical ethics and the rules of medical practice and theory. In all cases, the question of whether any adverse effects that may occur are proportionate to the anticipated benefits shall be examined and assessed. Innovative therapy may be carried out only if it has been tested in advance in animal trials (where these are possible).

5. Innovative therapy may be carried out only after the subject or his
legal representative has unambiguously consented to the procedure in light of relevant information provided in advance.

Where consent is refused, innovative therapy may be initiated only if it constitutes an urgent procedure to preserve life or prevent serious damage to health and prior consent could not be obtained under the circumstances.

6. The question of whether to use innovative therapy must be examined with particular care where the subject is a child or a person under 18 years of age.

7. Exploitation of social hardship in order to undertake innovative therapy is incompatible with the principles of medical ethics.

8. Extreme caution shall be exercised in connection with innovative therapy involving live microorganisms.

9. In clinics, polyclinics, hospitals or other treatment and care establishments, innovative therapy may be carried out only by the physician in charge or by another physician acting in accordance with his express instructions and subject to his complete responsibility.

10. A report shall be made of any innovative therapy, indicating the purpose of the procedure, the justification for it, and the manner in which it is carried out. In particular, the report shall include a statement that the subject or, where appropriate, his legal representative has been provided in advance with relevant information and has given his consent. When therapy has been carried out without consent, under the conditions referred to in the second paragraph of Section 5, the statement shall give full details of these conditions.

11. The results of any innovative study may be published only in a manner whereby the patient’s dignity and the dictates of humanity are fully respected.

12. Section 4-11 of these Guidelines shall be applicable, mutatis mutandis, to scientific experimentation (cf. Section 3).

The following additional requirement shall apply to such experimentation:

(a) Experimentation shall be prohibited in all cases where consent has not been given;

(b) Experimentation involving human subjects shall be avoided if it can be replaced by animal studies.

(c) Experimentation involving children or young persons under 18 years of age shall be prohibited if it in any way endangers the child or young person;
(d) Experimentation involving dying subjects is incompatible with the principles of medical ethics and shall therefore be prohibited.

13. Physicians and those in charge of hospital establishments should not be denied of the responsibility of seeking new ways to protect or treat patients of alleviate their suffering when they are convinced that known methods are likely to fail.

14. Academic training courses should take every suitable opportunity to stress the physician’s special duties when carrying out a new form of therapy or a scientific experiment, as well as when publishing his results.

4. Declaration of Helsinki

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964 and amended by the:
29th WMA General Assembly, Tokyo, Japan, October 1975
35th WMA General Assembly, Venice, Italy, October 1983
41st WMA General Assembly, Hong Kong, September 1989
48th WMA General Assembly, Somerset West, South Africa, October 1996
52nd WMA General Assembly, Edinburgh, Scotland, October 2000
53rd WMA General Assembly, Washington, DC, USA, October 2002
55th WMA General Assembly, Tokyo, Japan, October 2004
59th WMA General Assembly, Seoul, Korea, October 2008
(To be amended in 2014)

A. INTRODUCTION

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.

The Declaration is intended to be read as a whole and each of its constituent paragraphs should not be applied without consideration of all other relevant paragraphs.

2. Although the Declaration is addressed primarily to physicians, the WMA encourages other participants in medical research involving human subjects to adopt these principles.
3. It is the duty of the physician to promote and safeguard the health of patients, including those who are involved in medical research. The physician’s knowledge and conscience are dedicated to the fulfillment of this duty.

4. The Declaration of Geneva of the WMA binds the physician with the words, “The health of my patient will be my first consideration,” and the International Code of Medical Ethics declares that, “A physician shall act in the patient’s best interest when providing medical care.”

5. Medical progress is based on research that ultimately must include studies involving human subjects. Populations that are underrepresented in medical research should be provided appropriate access to participation in research.

6. In medical research involving human subjects, the well-being of the individual research subject must take precedence over all other interests.

7. The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best current interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality.

8. In medical practice and in medical research, most interventions involve risks and burdens.

9. Medical research is subject to ethical standards that promote respect for all human subjects and protect their health and rights. Some research populations are particularly vulnerable and need special protection. These include those who cannot give or refuse consent for themselves and those who may be vulnerable to coercion or undue influence.

10. Physicians should consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration.

B. PRINCIPLES FOR ALL MEDICAL RESEARCH

11. It is the duty of physicians who participate in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects.

12. Medical research involving human subjects must conform to
generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.

13. Appropriate caution must be exercised in the conduct of medical research that may harm the environment.

14. The design and performance of each research study involving human subjects must be clearly described in a research protocol. The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, other potential conflicts of interest, incentives for subjects and provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study. The protocol should describe arrangements for post-study access by study subjects to interventions identified as beneficial in the study or access to other appropriate care or benefits.

15. The research protocol must be submitted for consideration, comment, guidance and approval to a research ethics committee before the study begins. This committee must be independent of the researcher, the sponsor and any other undue influence. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration. The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the committee, especially information about any serious adverse events. No change to the protocol may be made without consideration and approval by the committee.

16. Medical research involving human subjects must be conducted only by individuals with the appropriate scientific training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional. The responsibility for the protection of research subjects must always rest with the physician or other health care professional and never the research subjects, even though they have given consent.

17. Medical research involving a disadvantaged or vulnerable population or community is only justified if the research is responsive to the health needs
...and priorities of this population or community and if there is a reasonable likelihood that this population or community stands to benefit from the results of the research.

18. Every medical research study involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and communities involved in the research in comparison with foreseeable benefits to them and to other individuals or communities affected by the condition under investigation.

19. Every clinical trial must be registered in a publicly accessible database before recruitment of the first subject.

20. Physicians may not participate in a research study involving human subjects unless they are confident that the risks involved have been adequately assessed and can be satisfactorily managed. Physicians must immediately stop a study when the risks are found to outweigh the potential benefits or when there is conclusive proof of positive and beneficial results.

21. Medical research involving human subjects may only be conducted if the importance of the objective outweighs the inherent risks and burdens to the research subjects.

22. Participation by competent individuals as subjects in medical research must be voluntary. Although it may be appropriate to consult family members or community leaders, no competent individual may be enrolled in a research study unless he or she freely agrees.

23. Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information and to minimize the impact of the study on their physical, mental and social integrity.

24. In medical research involving competent human subjects, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information. After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject’s freely-given informed consent, preferably in writing. If
the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed.

25. For medical research using identifiable human material or data, physicians must normally seek consent for the collection, analysis, storage and/or reuse. There may be situations where consent would be impossible or impractical to obtain for such research or would pose a threat to the validity of the research. In such situations the research may be done only after consideration and approval of a research ethics committee.

26. When seeking informed consent for participation in a research study the physician should be particularly cautious if the potential subject is in a dependent relationship with the physician or may consent under duress. In such situations the informed consent should be sought by an appropriately qualified individual who is completely independent of this relationship.

27. For a potential research subject who is incompetent, the physician must seek informed consent from the legally authorized representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the population represented by the potential subject, the research cannot instead be performed with competent persons, and the research entails only minimal risk and minimal burden.

28. When a potential research subject who is deemed incompetent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorized representative. The potential subject’s dissent should be respected.

29. Research involving subjects who are physically or mentally incapable of giving consent, for example, unconscious patients, may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research population. In such circumstances the physician should seek informed consent from the legally authorized representative. If no such representative is available and if the research cannot be delayed, the study may proceed without informed consent provided that the specific reasons for involving subjects with a condition that renders them unable to give informed consent have been stated in the research protocol and the study has been approved by a research ethics committee. Consent to remain in the research should be obtained as soon as possible from the subject or a legally authorized representative.

30. Authors, editors and publishers all have ethical obligations with
regard to the publication of the results of research. Authors have a duty to make publicly available the results of their research on human subjects and are accountable for the completeness and accuracy of their reports. They should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results should be published or otherwise made publicly available. Sources of funding, institutional affiliations and conflicts of interest should be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

C. ADDITIONAL PRINCIPLES FOR MEDICAL RESEARCH
Combines WITH MEDICAL CARE
31. The physician may combine medical research with medical care only to the extent that the research is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

32. The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best current proven intervention, except in the following circumstances:

- The use of placebo, or no treatment, is acceptable in studies where no current proven intervention exists; or
- Where for compelling and scientifically sound methodological reasons the use of placebo is necessary to determine the efficacy or safety of an intervention and the patients who receive placebo or no treatment will not be subject to any risk of serious or irreversible harm. Extreme care must be taken to avoid abuse of this option.

33. At the conclusion of the study, patients entered into the study are entitled to be informed about the outcome of the study and to share any benefits that result from it, for example, access to interventions identified as beneficial in the study or to other appropriate care or benefits.

34. The physician must fully inform the patient which aspects of the care are related to the research. The refusal of a patient to participate in a study or the patient’s decision to withdraw from the study must never interfere with the patient-physician relationship.

35. In the treatment of a patient, where proven interventions do not exist or have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may
use an unproven intervention if in the physician’s judgment it offers hope of saving life, re-establishing health or alleviating suffering. Where possible, this intervention should be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information should be recorded and, where appropriate, made publicly available.
Casebook on Bioethics and the Holocaust