Biomedical Ethics in the Medical School Curriculum: Lessons Learned from the Holocaust

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BIOMEDICAL ETHICS IN THE MEDICAL SCHOOL CURRICULUM: LESSONS LEARNED FROM THE HOLOCAUST

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May 14, 2021

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Acknowledgements

I would first like to thank my advisor, Pr. Daniel Bitran, for the guidance and mentorship he has given me over the last two and a half years. Pr. Bitran also advised my translation project during my sophomore and junior year of the book Les Médecins de l'Impossible, concerning French prisoner doctors in the Holocaust, which ultimately inspired the contents of this thesis. The translation project and this thesis would not have been possible without his expertise and guidance, and I am forever grateful for his mentorship throughout my college career.

I would also like to thank my friends and family for supporting me throughout this process, whether it be listening, editing or watching presentations. Additionally, I would like to thank my readers, Pr. Mary Roche and Pr. Thomas Doughton for reading and evaluating my thesis. Finally, I would like to thank Pr. Ellen Perry, the Director of College Honors, for the time and effort she has put into making this program run smoothly. This thesis would not have been what it is today without them, and I am especially indebted to them for their help.
“Those who cannot remember the past are condemned to repeat it.”

- George Santayana

**Biomedical Ethics in the Medical School Curriculum: Lessons Learned from the Holocaust**

The Holocaust, the murder of 6 million Jews, is the only medically-sanctioned genocide. This thesis explores the roles of Nazi doctors in the planning, organizing, and implementation of the organized mass murder of European Jewry. Given the German medical community’s complicity, it is imperative that physicians today are well informed about their profession’s history of involvement in the Holocaust. In addition, and by way of contrast, a study of the moral challenges faced by doctors imprisoned in concentration camps or in the ghettos of Nazi-occupied Europe might serve to better prepare physicians for future ethical dilemmas. In a survey of alumni of the seminar “Science, Medicine, and the Holocaust,” we found a strong appreciation for how science and medicine were influenced by the sociopolitical climate of the Holocaust. Among alumni in the health-related professions, there was high agreement that the Holocaust should be used to teach biomedical ethics. These results echo recent initiatives aimed at infusing Holocaust education in medical school curricula. This history ideally can provide a moral compass to those maneuvering the future of medical practice and ethical challenges, such as implicit bias, resource allocation, obtaining informed consent, and challenges of genomics and technology expansion (Reis et. al. 2019).
Introduction

It is widely known that the Holocaust was responsible for the death of 11 million people, including six million Jews. The picture below\(^1\) of Auschwitz-Birkenau concentration camp depicts the Holocaust as commonly known by most people, with prisoners lining up to be selected to go into the camp or to the gas chambers to be killed. What people may not realize is that the Nazis performing these selections were doctors. Doctors were not only involved in the horrific human experiments in the concentration camps, but in every aspect of the Holocaust and the programs that preceded it. The Holocaust is in fact the only medically sanctioned genocide, which means that the medical profession was responsible for proposing, planning, organizing and implementing the programs used in the murders of these individuals and communities. In addition to this lesser known fact, there are some common misconceptions about the medical profession's involvement in the Holocaust that have important implications for how medical professionals must act today.

One common misconception is that doctors were forced to comply with Nazi demands (Chelouche 2021). However, most doctors eagerly joined the Nazi party, and at much higher rates than other professions. Forty-five percent of German physicians and thirty percent of nurses joined the Nazi Party, compared to seven percent of teachers (Kater 1987, Levine et. al. 2019). During the severe post-war economic contraction following World War I, many physicians experienced a dramatic decrease in status (Levine et. al. 2019). Attracted by “race hygiene,” eugenics, and Social Darwinism, the National Socialist Physicians League offered them a purpose, as they had the ability to use biological “science” as an instrument to create a master race and improve the nation. Hitler specifically called upon physicians to help enact his ideologies: “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…” (Levine et. al. 2019, 290). This plea was particularly effective, as many German physicians flocked to the Nazi party sooner and in higher numbers than other professions.

Another common misconception about the Holocaust is that the doctors involved committed acts of “mad science” with no ethical boundaries. In reality, Germany was one of the leading medical societies in the world at the time, and was one of the first countries to establish a mandatory ethics code. The German Richtlinien was created in 1931 following various research scandals in the 1920s to establish guidelines such as requiring consent for human experimentation and prohibiting experimentation on children if it posed any risks for the child (Roelcke 2017). These guidelines appeared to be widespread in medical journals and publications throughout the country yet the Nazis clearly did not apply these guidelines to their treatment of “inferiors” during the Holocaust. Germany was also the first country to establish a mandatory ethics course in their medical schools. However, these medical ethics courses, taught
by Nazi party members, included the “unequal worth of human beings, authoritative role of the physician, and priority of public health over individual patient care,” which allowed and motivated the Nazi doctors to commit the monstrous medical crimes towards Jews and other marginalized groups during the Holocaust (Reis, Wald & Weindling 2019, 3). This code of ethics portrayed Germany as a body, and Jews as a disease that must be suppressed and removed (Fernandes & Ecret 2019). As Nazi doctor Fritz Klein once said, “My Hippocratic oath tells me to cut a gangrenous appendix out of the human body. The Jews are the gangrenous appendix of mankind. That’s why I cut them out” (Brueggemann 2000, 1).

A third common misconception is that the Nuremberg Code, which was created in response to the atrocities of the Holocaust to establish biomedical ethical guidelines, is not relevant to physicians today, since Nazi atrocities such as these could never happen again. However, the uncomfortable question must always be asked: “How did a professional group that was internationally respected, scientifically innovative, and ethically advanced, evolve an understanding of their ethical, social, and scientific obligations which led them, with only rare exceptions, to use their advanced scientific knowledge and professional ethics to justify committing murder and the most heinous crimes against humanity?” (Horton 2019, 105). It was unfortunately the success and power of the medical profession, combined with a discriminatory political agenda that allowed the Holocaust to grow to the extent that it did. While many think that it is impossible for the Holocaust to repeat itself to the extent that it did, there is still potential for bias and discrimination to influence medical decisions, consciously or not. Medicine today is “even more powerful than it was in the 1930s. The risks of abuse are greater now than then” (Horton 2019, 105).
There appears to be a growing gap in public knowledge and awareness of the Holocaust. A 2018 study revealed that 11% of US adults and 22% of millennials had never heard of the Holocaust, and 66% of millennials were unable to identify what Auschwitz was (Scheon Consulting 2018). Additionally, only 11 US states require Holocaust education in K-12 public schools (Anti-defamation League 2019). Despite these concerning statistics, there are hopeful findings and recent initiatives regarding Holocaust education. Ninety-three percent of US adults believe that all students should learn about the Holocaust in school, and 80% believe that it is important to keep teaching about the Holocaust so that it doesn’t happen again (Scheon Consulting 2018). Additionally, the U.S. Never Again Education Act passed on International Holocaust Remembrance Day in 2020, which created a federal grant program at the US Department of Education to provide teachers across the country with resources and training necessary to teach about the Holocaust in K-12 public schools. Regarding the medical profession specifically, only 22 of 140 (16%) medical schools in the United States and Canada have any required curricular elements on the roles of physicians in the Holocaust, and half of these (11/22) teach this material using a lecture format only” (Wynia, Silvers, Lazarus, 2015). As the Holocaust recedes from public awareness, it is especially important that academic institutions and especially health professions integrate this information into its curriculum.

Given the medical community's complicity in the Holocaust, it is imperative that physicians today are well-informed of their professions’ involvement in the Holocaust, and that we learn about the forces that allowed the Holocaust to occur in order to enrich the field of biomedical ethics today. This thesis will answer the question: How was the medical community involved in the Holocaust, and how can this history be used as a vehicle for biomedical ethical training at the medical school level? This question will be answered in four chapters.
The first chapter, entitled Biomedical Origins of the Holocaust, will describe Nazi programs aimed at purifying the German race. These programs include the eugenics and euthanasia programs. The eugenics program, beginning in 1933 following the Law of Prevention of Genetically Diseased Offspring, called for the obligatory sterilization of those considered “genetically inferior,” which included conditions such as feeblemindedness schizophrenia, manic depressive disorder epilepsy, Huntington's disease blindness or deafness grave bodily malformation in alcoholism (Proctor 1988). Following this, the euthanasia program was then put into place in 1939, and this was aimed at killing those deemed “genetically inferior,” starting with children in the child euthanasia program. Subsequently, the T4 program was implemented, which expanded the killing program to adults. For children and adults, the public was not aware that people were being killed, and after carbon monoxide asphyxiation, a falsified diagnosis was sent back to the families of the patients. Eventually, public suspicions began to arise as to what was truly happening in these centers, and after mass protests against this program, the T4 program publicly ceased in 1941. However, euthanasia practices still continued with more indirect methods, such as starvation, poisoning injections to kill people in these centers and in hospitals in a less suspicious way. The term ‘wild euthanasia’ is used to describe this phase, where killings increased from 70,000 to 300,000 throughout the course of the Holocaust (Hohendorf 2016). It is also important to note that the same personnel and methodology used in these killing centers were deployed to concentration camps throughout Nazi-occupied Europe. As can be seen, the origins of the Holocaust began with killing German citizens who were viewed by the Nazi regime as “worthless eaters.” These lesser known programs leading up to the Holocaust highlights the importance of studying the Holocaust on a deeper level, and making
sure that medical professionals today are aware that the thought processes that allowed the Holocaust to build to what it became were more ordinary than many would think.

The second chapter details the different types of doctors in the Holocaust: Nazi doctors in the concentration camps, prisoner doctors in the concentration camps, and prisoner doctors in the ghettos. The first group of doctors are the Nazi doctors in the concentration camps. These doctors implemented the methods of systematic killing that murdered Jews and other marginalized communities (Lifton 1986). By contrast, however, there were prisoners in the concentration camps that served as medical personnel to their fellow prisoners. Another similar category is Jewish prisoner doctors imprisoned in the ghettos, specifically the Warsaw Ghetto. A comparison of the motives between Nazi doctors and prisoner doctors tells us a great deal about the meaning of the Hippocratic Oath and what it means to stay true to morals as a physician.

Though many have argued that the Holocaust ought to play a part in the medical school curriculum, data to this effect are difficult to come by. For the third chapter, I conducted a survey to assess the impact of an undergraduate Holocaust course on students who went on to engage in a health-related profession. The seminar entitled “Science, Medicine, and the Holocaust” has been taught for more than a decade at Holy Cross. I contacted all alumni who completed this course. I discovered that of those who responded that are currently in a health profession or studying to become one, there was a very high impact of this seminar on how they conduct in their profession today. There was also a high appreciation for how science and medicine were influenced by the sociopolitical climate of the Holocaust. Along with other data from this survey, these results indicate that health professionals who have already learned about their profession’s history in the Holocaust strongly believe that it is important for all health professions to learn in a number of ways that will be described in the next section.
This final chapter then seeks to answer the question: how then do we best teach medical school students today about the importance of the Holocaust on their medical ethical training? Scholars in this field have recognized four categories that are most well-informed by learning about the Holocaust. These are empathy and detachment training, scientific skepticism, challenges of competing loyalties (Levine et. al. 2019) and the hierarchy of the medical profession (Fernandes & Ecret 2019). First, empathy and detachment training emphasize the importance of treating each patient as you would yourself. Second, scientific skepticism involves always questioning information presented to you and being aware of other points of view. Third, challenges of competing loyalties are about balancing the duties as a physician with other duties such as to the employer or companies funding research. Finally, the hierarchy of the medical profession describes the importance of treating all medical professionals as equals regardless of their degree in order to ensure effective communication and trust. It would be difficult to have a mandatory Holocaust course for medical ethics across all medical schools in the US, so I believe that the focus should be on building Holocaust related themes into existing curricula in order to fully integrate the information into what they are currently learning. Ethics in general should not be just a singular separate topic in medicine, but something that is deeply entwined and important in all aspects of medicine.

These four chapters seek to prove that that every medical student and health professional student should learn about their profession’s history of involvement in the Holocaust and how the Holocaust can inform biomedical ethics in order to fully learn from the mistakes of the Holocaust and to make sure that the medical profession conducts its actions in the best way that it possibly can. In the words of George Santayana, “Those who cannot remember the past are condemned to repeat it.”
Chapter 1

Biomedical Origins of the Holocaust

In order to fully understand the Holocaust as commonly known today, it is important to understand that it did not appear out of thin air. An accumulation of programs in Nazi Germany aimed at goal of racial purification allowed for the ideology and methodology of the Holocaust to occur: the eugenics program, which involved forced sterilization of the so-called genetically inferior, the euthanasia program, which involved the killing of the so-called genetically inferior, and the 14f13 program, which involved the killing of the so-called racially inferior and those unfit to work in the concentration camps. The Nazi ideology of these programs was to eliminate “inferior” genes from the gene pool in Nazi-occupied territories. This in turn would allow for “superior” genes to be passed onto offspring, and would create a stronger, healthier, and more pure German race. People with so-called “inferior genes” were those who were handicapped and mentally ill. It was only later that certain races and cultures were considered “inferior” and were taken into account for the purification of the German race.

The eugenics movement in Germany was inspired by a series of compulsory sterilization laws in the United States around the turn of the 20th century. Twenty five states had passed laws calling for compulsory sterilization of the “criminally insane and other people considered genetically inferior” (Lifton 1986, 22). Other European countries had also passed similar legislation around the same time, and German physicians became resentful that other countries were advancing in this field more than they were (Proctor 1988). Several scientists were instrumental in helping formulate Hitler’s eugenics plan. First, Dr. Ernst Rudin, a Swiss born internationally known psychiatrist and moreso an avid geneticist, provided scientific legitimacy
for the Nazi sterilization program, as his “aim in life was to establish a genetic basis for psychiatric conditions” (Lifton 1986, 28). Second, Rudolf Ramm, a medical faculty at the University of Berlin and a self-proclaimed “caretaker of the race,” created a manual for doctors explaining how they needed to become “cultivator of genes, a physician to the Volk and a biological soldier” (Lifton 1986, 30). Third, Gerhard Wagner, the chief physician of the Reich and the co-founder of the National Socialist German Doctors’ League, was involved in the creation of sterilization and euthanasia laws as a strong proponent of purifying and strengthening the German Aryan race.

Upon Hitler’s appointment as the chancellor of Germany in 1933, the medical profession was swiftly coordinated into a single, hierarchical structure ultimately culminating in the National Socialist Physicians League, which in turn was subordinate to the National Socialist party. Termed Gleichschaltung, this process unified the German medical community into a single political entity under the complete control of the National Socialist Physicians League and in accordance with the Führer of the medical profession, Gerhard Wagner (Proctor 1988). This process not only applied to the medical community, but also with all other aspects of German life. There was a Führer solely responsible for education and the arts, women’s affairs, students, sports, youth, teachers, farmers and more. This gave immense power to the National Socialist party, allowing them to control all information and media available to the public. The structure of the medical profession specifically saw a dramatic increase in power through Gleichschaltung, transforming the “organization of the medical press, the nature of the medical profession ... the structure and priorities of medical research,” and who could and could not participate in German medicine to fulfill Nazi ideology (Proctor 1988, 74). This will prove to be an instrumental reason
why the Holocaust was able to occur - the ability for checks and balances did not exist to counter
decisions of the National Socialist party.

Concurrently with the formation of *Gleichschaltung*, a series of laws were passed with
the goal of creating a pure Nordic race under eugenic pretexts. First, after an early sterilization
law passed on January 30, 1933, Hitler passed the “Law of Prevention of Genetically Diseased
Offspring” on July 14, 1933 (Proctor 1988). This law called for the obligatory sterilization of
those considered “genetically inferior,” which included conditions such as feeblemindedness,
schizophrenia, manic depressive disorder, epilepsy, Huntington’s chorea, blindness or deafness,
grave bodily malformation, and alcoholism. It became compulsory for doctors to report these
genetic “defects” in spite of patient confidentiality. Genetic health courts were established in
1934 to assess whether certain patients should be sterilized. Out of 84,525 applicants, over 90%
of these were decided in favor of sterilization. When this law was passed, it was for eugenic
purposes only; it did not make provisions for sterilization on racial grounds. However, in 1937,
*Rheinlandbastarde*, or the offspring of black French occupation troops and native Germans, were
secretly and illegally sterilized.

Several months after Hitler’s appointment, the Nazi Party devised the beginnings of the
Nazi concentration camp system in order to imprison and suppress Nazi opponents in Germany.
On February 28, 1933, the Nazi Party passed the “Decree of the Reich President for the
Protection of the People and State,” more commonly known as the “Reichstag Fire Decree,”
which declared a civil state of emergency in the German Reich. This allowed the Third Reich to
detain political opponents without trial, mainly targeting communists, social democrats, and
labor union activists (Buggeln 2015). About one hundred concentration camps were established
in abandoned factories, prisons, etc. around this time to detain between 150,000 to 200,000 people without trial in the year 1933.

During this time, a series of Nuremberg laws were also being passed, aimed at preventing the professional advancement of Jews. On April 7, 1933, a law requiring proof of Aryan ancestry for government employment was passed, making it possible to legally discriminate against non-Aryans in the professional world. These laws also worked to genetically separate Jews and other “inferior” groups from the Aryan Germans. On September 15, 1935, a law prohibiting marriage or any sexual contact between Jews and non-Jews was passed, and shortly after, on November 15, 1935, a law was passed distinguishing “citizens” (Aryan Germans) from “inhabitants” (non-married women and non-Aryans) which stripped Jews of many civil rights (Lifton 1986). These laws had eugenics motivations behind them. While they did not go so far as to sterilize these racially and culturally “inferior” races, these laws were aimed at purifying the Aryan German race by separating Jews and other non-Aryan races professionally and reproductively - creating two distinct groups in all aspects of life. This separation alone indicates the Nazi Party’s inclination to favor reproduction of the desirable traits within the Aryan German race, and to put the other groups at a disadvantage by ensuring the reproduction of their “undesirable” traits amongst themselves.

The sterilization program was brought to an end with the onset of World War II around 1939; only 5% of sterilizations were performed after this time (Proctor 1988). Between 1934 and 1945, 350,000 to 400,000 forced sterilizations were performed under the Nazis, whereas in the United States, around 60,000 were performed during this time period (Kaelber 2011). Several factors were involved in this termination. First, conflicts arose within Nazi leadership concerning the administration of the sterilization law. Some complained that sterilizations were occurring
without adequate proof that the defects were genetic at all. Second, and most importantly, the euthanasia program began in Germany in 1939, and attention likely turned toward this program and away from the sterilization program.

Euthanasia practices began in 1934, when mental hospitals were encouraged to neglect their patients. Each year, funds were reduced and state inspections of standards “were either made perfunctory or suspended all together” (Lifton 1986, 48). The Nazi motivation of euthanasia was an economic one, as as the party encouraged the physician to “discover for whom health care at government expense will be worth the cost” (Proctor 1986, 185). More direct euthanasia practices, where the patients were actively killed by physicians, took place with two distinct euthanasia directives: child euthanasia and adult euthanasia.

Euthanasia began with disabled children in Nazi Germany under the term gnadentod, or “merciful death.” This “merciful death,” in the eyes of the Nazis, was seen as a blessing to the child, relieving them from living a life “not worth living” and alleviating the parents of the burden of caring for a disabled child. Furthermore, these mercy killings would reduce the need of the government to feed “useless eaters.” Child euthanasia practices began when the Reich Ministry of the Interior passed a decree on August 18, 1939 that all physicians, nurses and midwives must report newborn infants and children under the age of three who showed signs of severe mental or physical diability (Lifton 1986). In October, families were “encouraged” to admit children with disabilities to one of around 30 specialized pediatric clinics, or Kinderfachabteilungen, throughout Nazi-occupied Germany, as they were told that the government would no longer provide financial support for the care of the child if they did not comply (Kaelber 2012). Parents were informed of their child’s “sudden unexpected” death, after having been told their child was approved to receive advanced “treatment” by three medical
evaluators. “Treatment” was always synonymous with murder, unknowingly to the families, and these centers went to great efforts to keep it this way. All together, around 5,000 children were killed through lethal injection or starvation.

Subsequently, the T4 program aimed at the “mercy killing” of “incurable” adults began in October 1939. This was after Hitler had signed a document dated back to September 1, 1939, the day World War II began, which stated: “Reichsleiter Bouhler and Dr. med. Brandt are charged with the responsibility to extend the powers of specific doctors in such a way that, after the most careful assessment of their condition, those suffering from illnesses deemed to be incurable may be granted a mercy death” (Hohendorf 2016). These “incurable illnesses” fell under one of the following categories: those with specified diseases under the sterilization law such as schizophrenia, people institutionalized in mental facilities for five or more continuous years, the criminally insane, and patients who were not German citizens. Around 200,000 adult patients were sent to one of six killing centers, where around 70,000 were selected to be killed through carbon monoxide asphyxiation. The public was aware that patients were sent to these centers for “treatment,” but were initially unaware of the killing taking place. The infamous shower gas chamber was created in the Brandenburg killing center, and served as a model for other hospitals (Proctor 1988). The original intent of the euthanasia program was to keep to a 1000:10:5:1 model: for every 1000 Germans, 10 needed some form of psychiatric care, 5 required continuous care, and among these one should be destroyed. The program kept close to this schedule, as out of the German population of 65-70 million at the time, 70,000 were killed at the end of the gassing phase. Upon cremation of the bodies, a false death certificate was fabricated with a disease consistent with the symptoms shown by the patient. A letter was then sent to the families of the deceased indicating the cause of death and that the body had been cremated as an epidemic
prevention measure. If the family asked for the ashes, an urn of any random ashes was given, and the deceased patient’s valuables were only returned to the family upon request.

Around 1940, less than a year after the beginning of the program, public suspicions began to arise on what was actually happening at these centers. People working at the centers would frequent nearby bars and drink heavily, sometimes revealing aspects of what they were doing at work (Lifton 1986). There was also direct sensory evidence from the smoke from the crematory buildings, and children at schools in Hadamar, one of the killing centers, were reported to threaten each other with phrases such as “You’ll end up in the Hadamar ovens!” (H.E.A.R.T. 2007). Angry crowd protests ultimately began against the events taking place at these centers, and the Catholic church played an active and public role in these protests (Proctor 1988). Hitler ultimately ceased the T4 program on August 24, 1941 in response to these protests, but he had already achieved his goal based on his 1000:10:5:1 method. Although the program officially ended at this time, killings still occurred, but more subtly and secretly - termed ‘wild euthanasia.’ Instead of killing through carbon monoxide asphyxiation, more indirect killing methods were used to avoid public suspicion, such as poisonings, injections, and starvation. Starting around 1941, euthanasia also took place in general hospitals, as the mentally ill and handicapped were killed to economically aid German war efforts. Their reasoning was that these patients were taking up too many beds that could be used by German soldiers, they were consuming too much food, and were using up too much money that could have been used to manufacture guns. It is estimated that a much larger number of people were killed in this way - 70,000 deaths with the T4 program increased to 300,000 deaths with wild euthanasia (Hohendorf 2016).

In April 1941, operation 14f13 was put into place by the Nazi Party, which called for the extermination of the sick and those no longer able to work in the concentration camps. This
served as a starting point for the transition from the destruction of the mentally ill to those considered racially inferior, as Himmler sent secret orders to the concentration camps to include Jews in this operation. When one was selected as “no longer fit to work,” forms were to be filled out indicating the diagnosis of the patient, including questions on race and whether the individual was suffering from “incurable physical ailments” (Proctor 1988, 208). Many of the same personnel from the T4 program were dispersed to the concentration camps to administer this program, and the carbon monoxide asphyxiation killing methodology perfected in the T4 centers was also transferred to the concentration camps.

The transition from the rationalization of the destruction of the mentally ill to the destruction of those considered racially inferior was not a clear one, but began when medical reports tried to prove that Jews were medically inferior. For example, several medical reports tried to prove that Jews suffered from more illnesses than non-Jews. In 1902, a leading Austrian medical journal reported that Jews suffered disproportionately from insanity and acute psychosis, especially psychoses of a “hereditary-degenerative nature” (Proctor 1988, 196). Otmar Freiherr von Verschuer, the director of the Frankfurt Institute for Racial Hygiene, detailed evidence in his 1937 book on genetic pathology that Jews suffered from more diabetes, hemophilia and nervous disorders than non-Jews (Proctor 1988). The interpretation of the “Jewish problem” as a medical problem helped to legitimize the Final Solution on a medical basis so that the Nazi party could murder Jews with the same rationale that they used to murder the handicapped and mentally ill.

The interpretation of the Jewish problem as a medical problem was also instrumental towards the creation of Jewish ghettos in the Generalgouvernement, the German occupation zone established after the invasion of Poland in 1939. These ghettos, which will be described further in chapter 2.3: Prisoner Doctors in the ghettos, were designed to house the entire Jewish
population of a certain city into an isolated, insufficiently-sized sector of the city. Overcrowding and malnutrition cultivated an environment especially susceptible for disease. The establishment of the Jewish ghetto in Lodz was originally justified as a necessary measure to protect the rest of the city against disease epidemics (Hagen 1978). When disease became rampant in the ghettos, the blame was attributed to their Jewish heritage, and not the fact that they were confined in dense ghettos without proper medical treatments available. This not only provided the Nazi party with justification for Jewish confinement in terms of a medical quarantine, but also justification for their extermination (Proctor 1988).

In January 1942, Reinhard Heydrich, Himmler’s second in command of the SS, convened the Wannsee Conference in Berlin with 15 top Nazi bureaucrats to coordinate the “Final Solution.” This “Final Solution to the Jewish Question” sought to figure out methodologies towards the murder of as many European Jews as possible. The original plan called for the extermination of all 11 million Jews across Europe. The first and most feasible step towards this plan was the evacuation of established ghettos in the Generalgouvernement, since the epidemics in the ghettos posed a danger to the rest of society, and the majority of Jews were seen as “unfit to work” (The History Place 1997, 1). Operation Reinhard was a code name for the plan devised at this conference to deport all Jews in the Generalgouvernement to one of three specifically designed killing camps: Belzec, Sobibor, and Treblinka. It is important to note that the same killing methodology and the majority of personnel from the T4 program were dispersed to the killing camps to carry out this program (Proctor 1988). For example, Irnfried Eberl, who was the medical director at the Bradenburg euthanasia center, was dually responsible for setting up and leading the Treblinka killing camp (Lifton 1986).
The teaching of the Holocaust almost always begins with the displacement, dispossession, and eventual deportation of Jews to slave labor or extermination camps. Nazi eugenics and euthanasia programs are not often invoked in the genesis of the Holocaust. Whereas eugenics involved the forced sterilization of the so-called genetically inferior, euthanasia involved the extermination of the so-called genetically inferior, and the final solution involved the extermination of the so-called racially inferior, one should not conclude that all of these programs are the same under the lens of the Holocaust as a whole. The transition from the extermination of those considered genetically inferior to the extermination of those considered racially inferior was not a clear one, and they cannot be regarded as the same type of program due to the different rationales behind the implementation of these programs. There still remains much to investigate behind the transition of the euthanasia program to the Holocaust in its entirety. However, the victims of each of these programs were all considered “life not worth living” under the eyes of the Nazi Party for one aspect or another (Proctor 1988, 221). These lesser known programs leading up to the Holocaust as commonly known today highlights the importance of studying the Holocaust on a deeper level, and making sure that medical professionals today are aware that the thought processes that allowed the Holocaust to build to what it became were more ordinary than many would think.
Chapter 2

Types of Doctors in the Holocaust

The complicity of doctors in the Holocaust is clear. Yet, not all doctors played the same role. Nazi doctors actively participated in the planning and implementing of the systematic mass murder of Jews and other marginalized groups in the concentration camps. By point of contrast, prisoner doctors were trained physicians before imprisonment in the concentration camps, and were forced to become doctors to their fellow prisoners while under the control of Nazi doctors. These prisoner doctors were presented with unprecedented moral dilemmas, yet many were able to stay true to their morals as a physician. Also under the control of Nazi doctors, Jewish prisoner doctors in the ghettos faced similar predicaments. While they did not face the immediate danger of death that prisoner doctors in the concentration camps experienced, they took courageous actions to treat patients in a completely resource-deprived ghetto. These next three sections will compare and contrast the motives of these different types of doctors, and how each category can provide valuable insight to the field of biomedical ethics today.

2.1: Nazi Doctors in the Concentration Camps

The category “Nazi doctors” involves members of the Nazi party who acted as medical professionals under Nazi party ideals in hospitals, doctor’s offices, concentration camps, and anywhere the Nazi party could exert its power in a medical setting. This chapter will specifically focus on Nazi doctors in the concentration camps. First, I will describe the roles that the Nazi doctors fulfilled in the concentration camps. Second, I will report on the different “types” of Nazi
doctors regarding their personalities in the camps. Third, I will illustrate situational forces acting upon these doctors. Finally, I will discuss the aftermath of the Holocaust regarding these Nazi doctors, and how they have influenced biomedical ethics today.

Nazi doctors were involved in almost every step of the killing program in the concentration camps. Survivor accounts recall that Nazi doctors were present from the very beginning of their arrival, including riding in ambulances to the crematoria, selecting who would be killed in the gas chambers, choosing how many pellets of gas should be thrown into the gas chambers and who should do it, observing through a hole in the gas chamber how many people were dying, and even as far as extracting teeth from the dead bodies (Lifton 1986). Under T4 policy, “the syringe belongs in the hands of the physician,” and the same philosophy held in the concentration camps as well (Lifton 1986, 71). This medicalization of killing was seen as an honor by Nazi doctors to carry out the orders of the Führer. SS doctor Karl Brandt explained how he administered lethal injections “as a symbolic action in which the most responsible physicians in the Reich subjected themselves to the practical carrying through of the Führer’s order.” (Lifton 1986, 71).

Upon arrival, Nazi doctors selected who would be sent into the camp and who would be sent to the gas chambers to be killed. SS doctor Ernst B. thought that having doctors perform the selections made the selection process seem more “medically legitimate,” even though prisoners were only selected on the basis of working capability (Lifton 1986, 173). For the prisoners that were not sent to the the gas chambers upon arrival, Nazi doctors were also involved in the selection process of prisoners who no longer seemed fit to work in the camp; yet, they often recruited prisoner doctors to perform these selections for them, which will be described in more detail in chapter 2.2. Around mid-1942, IG Farben built a subcamp of Auschwitz-Birkenau
named Monowitz to house prisoners needed as a labor force. Nazi doctors were so ruthless in their process of selecting weaker inmates for death that additional directives had to be taken to ensure that IG Farben and other companies had enough prisoners for their labor (Lifton 1986, 180-181). This selection process could be described as a “combination of efficiency, extreme randomness, and brutality and humiliation” (Lifton 1986, 182).

Not only were Nazi doctors involved in physical actions regarding the killing process, but they were also involved in deceptive tactics to prevent chaos from occurring during the selections. Survivors recount measures that Nazi doctors took to create an illusion of normalcy. One such measure was having a Red Cross ambulance present at the site of initial selection to reassure people that medical care was available if need be. The sick, elderly, children and pregnant women were told to get on these Red Cross ambulances to receive care, and were instead taken directly to the gas chambers. The doctors would even have friendly conversations with the prisoners, asking ‘How are you?’ and ‘What occupation do you have” (Lifton 1986, 166)? Even up to the gas chambers, Nazi doctors continued this deception. One survivor recounts that when he almost stepped on broken glass in the gas chamber, a Nazi doctor told him to be careful (Lifton 1986, 166). Up to the very end, Nazi doctors deliberately continued these act deceptive acts to prevent reactions from the prisoners.

Nazi doctors can be characterized by their personalities and motivations for joining the Nazi party. First, there were people who were passionately and deliberately involved in the Nazi party and its ideals - termed “Old Fighters” (Lifton 1986, 116). These “Old Fighters” were some of the earliest supporters of Nazi ideology, and were often passionately nationalistic. Once the Nazi party took power in 1933, they were highly praised and received preference in their employment. They also were often actively involved in the planning and execution of the killing
processes in the concentration camps. One example of an “old fighter” in Auschwitz is Werner Heyde, who is described by Lifton as having psychopathic and sadistic tendencies with a “bad reputation … a real Nazi who had no inhibitions” (Lifton 1986, 117). After enlisting in the army at age 16 during the last months of World War I, and participating in a series of organizations and events connected with National Socialism, he became a seemingly “ordinary” psychiatrist who joined the Nazi Party on May 1, 1933 and the SS organization in 1935 (Lifton 1986, 118). He became a central figure in the medical legitimation of the euthanasia programs, and played a large role in the planning of deception and killing procedures. He also extended his participation in these medicalized killing procedures to the concentration camps during operation 14f13. His passionate involvement with Nazi ideology led to an almost complete willingness to kill in the name of healing for the sake of the Nazi party.

Second, similar to the “old fighters,” there was a generation of younger physicians who also actively joined the Nazi party early on. Irmfried Eberl, an Austrian physician, joined the party at age 21 in 1931. Shortly after the commencement of the T4 program, Eberl became the medical director of the Bradenburg killing center in 1940, and assumed the same role at the Bernburg killing center in 1941 (Jewish Virtual Library 2021). Working as a special deputy to Heyde, he was involved in supervising false causes of death in these killing centers to help maintain the subterfuge of the euthanasia program, and he became an intense advocate of the laws that would legitimize the euthanasia project (Lifton 1986). After public protest against the euthanasia programs, he was transferred to the Chelmno concentration camp to apply the killing methodology from the T4 program to kill Jews in large numbers. He is unique in the sense that he was the only physician to become a commandant of a death camp, Treblinka, upon its opening in July 1942 (Lifton 1986). He was so zealous in the killing operation that he commanded more
arrivals and gassed more people than the facility could adequately “process.” He was dismissed from this position shortly after, as he was unable to conceal the decaying corpses from the new arrivals, causing chaos and ruining their schedule. “Indistinguishable from a non-physician in his attitude toward killing Jews,” he became totally immersed in the ideals of the Nazi party in the vision of purifying the Aryan race (Lifton 1986, 125).

Third, there was a group of Nazi doctors who can be characterized as careerists, who were more interested in the professional opportunities that the concentration camps offered them. The most well-known of these careerists is Josef Mengele, who infamously conducted experiments in Auschwitz-Birkenau. Before the Nazi party came to power, Mengele did his medical dissertation on genealogy, and was immediately drawn to Auschwitz for the research opportunities, explaining that there “would never be another chance like it” (Lifton 1986, 357). Mengele was notoriously known for his experiments on twins, with which he hoped to find the genetic basis of various traits for the purpose of demonstrating the Aryan racial superiority. When he performed selections, he did so rather casually, and was “absolutely convinced he was doing the right thing,” and also directly participated in the killing process (Lifton 1986, 344). His passion for applying his genetic determinism toward racial policy provides valuable insight into the human capacity to convert healing into killing.

The final and perhaps the largest category of Nazi doctors were ordinary people who agreed with Nazi ideology in general, but did not necessarily agree with the killing processes used to carry out these ideologies. Many of these doctors had little to no experience, and were persuaded by older, prestigious Nazi doctors to participate in the euthanasia programs and concentration camps. One example of this is Horst D. - an SS psychiatrist in the euthanasia program who interviewed with Jay Lifton. After being pressed into military service before
completing his medical thesis, he was frustrated by the lack of medical opportunities available to him. He was then persuaded to join the Nazi party and participate in the euthanasia program by two psychiatry professors, one of which being Werner Heyde, who convinced him that the euthanasia would offer him better medical opportunities than he would have access to otherwise (Lifton 1986). Their high standing and stress on organic and hereditary influences to which he had been exposed during his medical training influenced him on an individual level to join the party and the program. He was under the impression that only a few selections were taking place followed by ‘mercy killings,’ but Horst D. began to feel uncomfortable and guilty upon learning that patients were immediately being sent to the gas chambers. He ultimately stayed with the program due to a “matter of loyalty and sacrifice - a responsibility to the Volk” (Lifton 1986, 106). He personally coped by convincing himself that this was in the name of science, and that he wasn’t personally responsible, since it was the idea and order of the party. During his interview, he admitted to the powerful influence of the party on his decision to stay: “The whole system radiated that authority. Like it or not, I was part of it… I had no choice. I was in this web - this network of authority” (Lifton 1986, 106). Relieved by the cessation of the T4 program, he was ultimately reassigned to the military for the remainder of the war. He also became an obstetrician after the war to alleviate his guilt by bringing life to the world. He indirectly admitted his wrongdoings and guilt to Lifton: “It is the responsibility of today’s psychiatric leaders to point out the human being in the patient, so that one feels obligated to help him and does not regard him as something one can shove away” (Lifton 1986, 107). While he could initially be characterized as a careerist, he differs from Mengele in the sense that he did not agree with the methodology and practices of the Nazi party, but ultimately stayed out of loyalty to the party and to the Volk.
While many Nazi doctors fall into the category above, there is a small subset of Nazi doctors who were initially persuaded to join the party and its programs, but ultimately were able to leave. One example of this is Wolfgang R., another SS doctor interviewed by Jay Lifton. He had been involved in Nazi ideology early on, and was one of the first students to join Hitler’s armed forces, the *Wehrmacht*. Similar to Horst D., Dr. R. had been thrust into the military before completing his medical training, and was then assigned to an “indispensable” position at a euthanasia center. He was briefed by a chief doctor at this facility that the program was only for “completely withdrawn mental patients” in order to conserve food during wartime (Lifton 1986, 108). While he admitted to preparing plausible causes of death for patients based on their charts, he was evasive about whether he was implicated in the killing processes. After about a month, he was disappointed by the complete lack of psychiatry and deception about the true nature of the program, and told the chief doctor that he was not qualified for this position. He was then offered a change in assignment “without any difficulty whatsoever” (Lifton 1986, 108). He felt immense guilt upon leaving, and ultimately took on another task within the party to trace genealogies of prospective SS officers to see if they had any Jewish heritage. In his interview with Lifton, he expressed his disdain for the Nazi party and the deceit they exerted over its members: “no one questioned anything at the time” (Lifton 1986, 107). While Wolfgang R. was able to remove himself from the killing process, unlike Horst D., both were heavily influenced by their loyalty to the Nazi party.

External and internal psychological forces kept Nazi doctors almost unquestioningly involved in the program. One external factor, as previously mentioned in the Biomedical Origins of the Holocaust chapter, was exerted by *Gleichschaltung*, variously translated as “coordination,” and “Nazification of state and society.” This created a vortex of power and a sense of totalitarian
control, as *Gleichschaltung* eliminated all possible opposition and appointed Nazi leaders to medical leadership positions. Since one Führer, Gerhard Wagner, was responsible for the entirety of the medical profession, including medical practice, policy, education and press, Nazi doctors felt, and wanted to feel, a sense of helplessness and powerless in the practices they were ordered, and sometimes threatened, to do. This allowed them to transfer responsibility and the guilt of their participation to the Nazi party instead of themselves. Especially for younger, inexperienced doctors, it was more difficult to question these practices since many Nazi doctors encouraging these practices, were well-educated, and respectable professionals.

Another external factor that was present within the concentration camps, particularly Auschwitz-Birkenau, was socialization. The transition from an outsider to an insider at Auschwitz was another kind of vortex in which Nazi party members were only exposed to the actions of the party with which they were socialized to comply. SS doctors were also the only ones to conduct selections on the ramp, where routinely 60-90% of a transport were sent to the gas chambers, but their attitudes ranged from enthusiasm to ambivalence to reluctance to temporary refusal (Lifton 1986). Ultimately, through socialization, Auschwitz became a place that was “morally separate from the rest of the world … extraterritorial,” where participants did not feel as though they could question or defy any orders given (Lifton 1986, 200). After the initial reaction, selections became a “somewhat unpleasant and exhausting” job for most Nazi doctors, with which alcohol was necessary to adapt to this transition (Lifton 1986, 195)

Internally, most Nazi doctors underwent “an extraordinary individual-psychological shift from revulsion to acceptance” (Lifton 1986, 195). One Nazi doctor described this transition: “In the beginning it was almost impossible. Afterward it became almost routine. That’s the only way to put it.” (Lifton 1986, 195). A main internal driving force that helped motivate this transition
was an intense loyalty and obligation to the Reich. Conformity was a key motivation for taking part in the killing process at Auschwitz, as personal isolation from refusing to go along with the program would have been unthinkable in this gruesome environment (Lifton 1986). While the factors above can help to explain how the Holocaust came to happen, we must be careful not to use these factors as justifications.

What, if anything, can be learned of biomedical ethics from a study of Nazi doctors? Demonizing the Nazi doctors of the Holocaust can have the unexpected consequence of minimizing the relevance of their actions for the men and women who practice medicine today. Myths and justifications that hide the Holocaust from serious biomedical ethical examination must be dispelled in order to truly learn from these events and the forces that allowed it to take place. Arthur Caplan has raised several questions regarding this idea: “If moral justifications can be given for why someone deemed mass murder appropriate in the name of public health … then what good is bioethics?” (Caplan 2010, 84) and “What is the point of doing bioethics, of teaching courses on ethics to medical, nursing, and public health students if the vilest and most horrendous deeds and policies can be justified by moral reasons?” (Caplan 2010, 86). Bioethics may have been silent for so long regarding the Holocaust due the absolute disregard for human rights in the lethality of the experiments conducted against the will of the patients involved, but silence for too long leads to omission. It is not enough to assume that the Holocaust could never happen again, as bioethical violations continued to occur after the Holocaust.

The creation of the Nuremberg Code was instrumental in the establishment of a new standard of medical ethics after World War II, yet this did not curb violations of ethical treatment of human participants in research. The Nuremberg Doctors Trial of 1947 led to the creation of the Nuremberg Code, which established guidelines for the ethical treatment of human subjects.
These guidelines included provisions to protect human participants from harm, including voluntary informed consent, clarity on risks involved in their participation, and the ability to terminate participation whenever they chose to do so. This, however, excluded patients who lacked capacity to consent, such as unconscious patients, children and other groups. As the Cold War began, the Nuremberg Code came to be seen as “overly rigid” with “uncompromising language,” since the code’s restrictions on informed consent impeded efforts to understand radiation exposure from weapons of mass destruction (Rubenfeld 2014, 14; Baker 2021). Additionally, the principles of the Nuremberg Code did not have a significant impact on the American research establishment, and was routinely ignored by researchers in Britain who “believed the guidelines did not apply to them,” since they were not Nazis (Baker 2021, 33). The Declaration of Helsinki was then released as a new medical ethical code in 1964 to account for surrogate consent in the case of legal incapacity and this apparent need for applicable research ethics.

While the Declaration of Helsinki has been continuously updated since its passage and remains foundational for international medical ethics today, this still did not prevent violations in human subjects research from taking place. This began to change when various researchers and physicians publicized unethical research taking place. First, Harvard medical researcher Henry Beecher published a paper in 1966 citing over 20 experiments published in leading clinical journals that violated the informed consent standard of the Nuremberg Code and the Declaration of Helsinki (Beecher 1966). This prompted the Surgeon General to call for a review of all grants funded by the US Public Health Service, or USPHS. Additionally, Peter Buxton, a son of Holocaust refugees, discovered an ongoing study in the 1970s in Tuskegee that violated informed consent guidelines. Beginning in 1932, this study deceived African-American men
into thinking they were receiving treatment for “bad blood,” but were actually being studied for untreated syphilis (Baker 2021, 34). After the USPHS rejected Buxton’s report, he informed the Washington Star about the experiment, prompting a US congressional investigation that led to its termination. This led to the creation of the 1979 Belmont Report, which established the process of institutional board review, approval, and ongoing monitoring of protocols involving human subjects research. This report added autonomy and respect for persons to the ethical principles found in the Nuremberg Code and the Declaration of Helsinki, transforming consent from a “legal concept to a moral concept” (Baker 2021, 34).

Ethical violations did not end there. It was found in the summer of 2013 that the California Department of Corrections had sterilized 148 female inmates between 2006 and 2010 without state approval (Kluchin 2021). There is no telling how many other human subjects research violations occur today that we are unaware of. While international ethical guidelines could prevent the scale of the Holocaust from ever happening again, it is clear that the forces that allowed it to take place continued after the Holocaust, and even continue today. This highlights the importance of making sure that medical professionals today are aware that the thought processes that allowed the Holocaust to build to what it became were more banal than many would think.

Condemnation of Nazi doctors as perpetrators of immoral acts rests on arguments made from theological ethics or moral philosophy. At the same time, however, an argument has been made that the Nazi doctors ascribed to an ethical system. Rubenfeld (2014) describes three main ethical systems when discussing biomedical ethics in terms of the Holocaust: Jewish medical ethics, modern secular biomedical ethics, and Nazi medical ethics. Each system is guided by one dominant principle that guides how they act in medicine. In Jewish medical ethics, human life is
prioritized; in modern secular biomedical ethics, autonomy is prioritized; and in Nazi ethics, eugenics is prioritized. The Nazis used the principles of Social Darwinism to justify their actions, where whatever was necessary to benefit the Volk, or the German state, as a society was ethical, and the rights of the individual could be disregarded. In this sense, it can be argued that the systematic killing of Jews and other groups of people considered "genetically inferior" was ethical according to their standards, since it strengthened the Volk in the long run by eliminating "inferior gene pools." Jewish medical ethics are often used to explain why Nazi ethics and the actions that ensued under them are unethical, since Nazi ethics do not value human life over the health of the society.

A question that arises from this is: what is to say that one ethical system is better than another if we are using one ethical system to deem another unethical? This is a question that may not necessarily have a universal answer. However, in the context of medicine, the desires of the collective society can never override the best interest of the patient. This is part and parcel of the profession that they enter, according to the Hippocratic Oath, modernized versions of the Hippocratic Oath, or extensive ethical codes established by national medical associations, such as the AMA Code of Medical Ethics. When creating the Declaration of Geneva, a modernized medical vow of ethics post-World War II, the World Medical Association noted that during the Holocaust, “the custom of medical schools to administer an oath to its doctors upon graduation or receiving a license to practice medicine had fallen into disuse or become a mere formality” (World Medical Association Inc. 2015, 2). Although multiple ethical systems exist, in medicine there is only one, and the Nazi party failed to ascribe to it.
2.2: Prisoner Doctors in the Concentration Camps

While it is widely known that, during the Holocaust, Nazis performed gruesome medical experiments on inmates at concentration camps in occupied Europe, it is less well-known to the general public that prisoners in the camp with medical backgrounds were often forced to become doctors, under the control of the Nazis, to their own fellow-inmates. These so-called “prisoner doctors” were prominent starting in late 1942 when prisoner labor was prioritized and the sick needed to heal in order to work (Lifton 1986). Prisoner doctors were afforded a privileged status in the concentration camps, including more food rations, better clothing and housing arrangements, and their superior medical training often gave them a position of influence with the Nazi doctors and their decisions. Their elevated status often presented them with unprecedented moral dilemmas regarding the treatment of their fellow inmates, since they faced a number of possible actions and moral challenges. In this chapter I will first describe the roles that prisoner doctors fulfilled in the concentration camps. Second, I will report on the different “types” of prisoner doctors regarding their personalities in the camps. Third, I will illustrate the unprecedented moral dilemmas that faced prisoner doctors regarding the treatment of their fellow prisoners. Finally, I will discuss ways in which prisoner doctor actions can inform the field of biomedical ethics today.

In the concentration camps, prisoner doctors were tasked with jobs such as selections, patient surgery, and patient treatment. While Nazi doctors performed an initial selection process upon arrival at the camps, which determined who would be sent inside the camp or to the gas chambers, selections also occurred inside the concentration camps. Since SS doctors often did not have much medical background, they often relied on prisoner doctors to make “good”
selections (Lifton 1986). Since prisoner doctors were directly in touch with the sick patients, they had the power and the knowledge to select those who were more likely to die, and save those who were more likely to survive. In this sense, by selecting those who would likely die anyway, prisoner doctors temporarily saved the lives of those who had a chance of survival. This often presented prisoner doctors with a healing-killing paradox: As prisoner doctors increased the health of the camp population, this would invariably increase the proportion of new arrivals that would be sent to the gas chambers. Thus the better they got at healing, the greater their indirect contribution to the killing function of the camp. Lifton explains the paradox: “One could save lives only by contributing to Auschwitz selection policies; one could avoid that involvement only by refusing to exercise one’s capacity to save lives” (Lifton 1986, 221). A moral dilemma presented itself when prisoner doctors had to decide how much to cooperate in selections, as prisoner doctors would likely be condemned to death if they refused to participate in selections.

Prisoner doctors also performed surgeries, as the SS doctors did not have the medical training to do them safely and accurately. However, even though prisoner doctors had performed surgeries before the Holocaust in their daily lives, they were not given adequate surgical tools to perform these surgeries safely. For example, in the Natzweiler concentration camp near Strasbourg, France, one prisoner required an amputation where otherwise he would die (Bernadac, 1968). Doctor Bent, a prisoner doctor, was tasked with this amputation, but had no surgical tools at his disposal. Instead, he had two vials of Evipan, a pair of pliers, a pair of old scissors, a metal saw and a small scalpel. The camp electrician loaned him electric wire to serve as a tourniquet, the tailor loaned him a sewing needle and thread, and the kitchen loaned him a butcher’s knife. There was not even a surgical table, and one had to be fabricated out of two planks from the carpenters. All the instruments were boiled in a fish poacher stolen from the SS
chef, as proper sanitation was also lacking. Bent successfully performed the amputation, given the circumstances, and three months later when the patient was liberated, the American surgeon who fixed the amputation with proper medical equipment was astonished by the efficacy of the amputation.

In addition to surgeries, prisoner doctors also had to be creative with treatment plans when proper medications were not available. For example, in the Falkensee concentration camp near Berlin, a sub camp of the Oranienburg concentration camp, French prisoner doctor Breitman used several ancient medical procedures in the absence of medications (Bernadac, 1968). For one prisoner suffering from pneumonia, with whom sulfamides were not effective, Breitman employed an ancient technique called “enveloping” where he covered a blanket in snow and rolled the patient in the blanket to bring his fever down. The technique was surprisingly effective, and the patient came out of his coma several hours after the session. With another patient who was suffering from an infected phlegmon, Breitman sliced up a rubber tube, and put the pieces in incisions made on the hand to successfully cure the phlegmon.

In regards to their actions concerning orders from SS doctors, prisoner doctors can be characterized into one or more of the following categories: passive resisters, active resisters, passive collaborators, and active collaborators. Most prisoner doctors fall into the passive resisters category, where they undermined SS orders while appearing to obey in order to save more lives. One way prisoner doctors undermined orders was by falsifying diagnoses in order to prevent patients from being selected for death (Lifton, 1986). This is because those with certain contagious diseases such as typhus were sent to death to avoid epidemics from spreading in the camps. Typhus would often be diagnosed as the flu in order to prevent a patient from being sent to their death. Prisoner doctors would sometimes have to create physical “proof” of the new
diagnosis to prove to SS doctors that the illness was legitimate. One example of this is in the Natzweiler concentration camp, where prisoner doctors Bogaerts and Laffitte were charged with diagnosing a healthy young boy with appendicitis so that he did not get deported to a camp where he would most likely be executed (Bernadac, 1968). The doctors decided to operate on him for appendicitis, but an SS doctor insisted on being present at the operation. The prisoner doctors decided to rub ether on the appendix to inflame it and feign appendicitis so that the boy could stay longer in the infirmary. Given prisoner doctors’ position of influence among the SS doctors, they could also sometimes arrange for certain records to be altered ex post facto (Lifton 1986).

Additionally, prisoner doctors would help prisoners in more ordinary ways, such as collecting a mouthful of bread from each prisoner and giving larger rations to the weakest prisoners (Bernadac 1968). In addition to ameliorating the prisoners’ physical health, prisoner doctors also helped raise the spirits of the prisoners to motivate them to stay alive. In Oranienburg concentration camp, French prisoner doctor Alfred Bertin was known for pulling pranks on the SS guards to give courage and entertainment to the prisoners in conditions where it was near impossible to have hope (Bernadac 1968). He would often make prank calls, and one time, gave a female SS guard a face cream made of fecal matter from the dysentery ward. More seriously, prisoner doctors would sometimes talk prisoners out of giving up hope completely. In the Natzweiler concentration camp, one prisoner came into the infirmary morally defeated, and the French prisoner doctor Bent gave him an extra meal, and sternly told him to shower, “get his act together,” and that if he didn’t that he would die (Bernadac 1968, 44). Followed by a swift kick to the behind, the prisoner back the next day, grateful for Bent’s tough love. The prisoner thanked the doctor for “sav[ing his] life with [his] kick to [his] ass” (Bernadac 1968, 44). This
shows how the moral actions of prisoner doctors were sometimes more important than medical treatments or interventions.

The actions of prisoner doctors could also fall into a more active form of resistance, where they would openly defy SS orders. A common way of actively defying SS orders without dire consequences was to claim inability rather than opposition for surgeries and other medical procedures (Lifton 1986). Since the SS doctors were often inexperienced or not experienced at all, they often did not know what the correct protocol was to guide the prisoner doctors if they claimed that they didn’t know how to perform a certain procedure. This excuse could not be used all the time, as it would raise suspicions from the SS doctors, but could in the more dire situations. Dr. Z, in the Auschwitz concentration camp, claimed that he did not know how to perform lethal phenol injections so that he would be exempt from doing so (Lifton 1986). Some prisoner doctors resisted SS orders in more defiant ways that put them more at risk for punishment. In the Ebensee concentration camp in Austria, French prisoner doctor Rene Quenouille actively resisted an order to kill a patient with a phenol injection by telling the SS corporal to “execute him [himself],” knowing that the corporal did not know how (Bernadac 1968, 88). This was a risky move, as Quenouille could have easily been executed for talking back to the SS doctor so defiantly. Subsequently, the SS corporal forbade the “barbaric” intravenous injections as a form of execution (Bernadac 1968, 88). Another example of active resistance was in the Oranienburg concentration camp on the eve of liberation: April 19, 1945 (Bernadac 1968). The order was that every person was to be evacuated the next morning, but Breitman refused to let his dying patients go on the roads. He explained this to the SS major, and he changed the order so that everyone but the infirmary was to evacuate. This defiance ultimately led to the survival of hundreds of lives.
While many prisoner doctors courageously risked their lives to save other prisoners, there were some prisoner doctors who collaborated with the SS doctors. To some extent, all prisoner doctors passively collaborated with the SS doctors in order to ensure their survival so that they could continue to save lives; however, the motivations behind the collaborationist actions were varied. This differentiates the definitions of passive and active collaboration. In the scope of this paper, passive collaboration is defined as participation in Nazi actions with an imminent threat of death or under the direct pretext that more lives would be saved if they intervened. Active collaboration on the other hand, is defined as participation in Nazi actions without the imminent threat of death that is *not* under the direct pretext that more lives would be saved if they intervened.

One example of passive collaboration occurred in the Modling subcamp of Mauthausen in Austria when the Nazis knew that liberation was imminent (Bernadac 1968, 122). Prisoner doctor H.J. refused an order from the Kapo of the infirmary to reduce the number of patients from 120 to 40 by the execution of 80 patients. Impatient, the Kapo and a German nurse began executing the patients through intracardiac injections of phenol. Since they were killing at random and not those with the least chance of survival, Dr. H.J. resigned himself to participating in the selections so that the strongest had a chance to survive, and the Kapo implied that everyone in the infirmary would be killed if their quotas were not met in time. The participation of prisoner doctors in selections was an action that helped more prisoners survive, since the prisoner doctors knew which prisoners would die in the near future regardless. However, the Kapo and German nurse improperly performed these injections, and the patients were suffering in clear agony. Dr. H.J. decided to participate in the phenol injections because their death was inevitable, the patients’ suffering would be greatly reduced, and the executions had to be
completed by a certain time. At the rate that the Kapo and the nurse were completing them, they would not be completed in time and everyone would be killed. Dr. H.J. also convinced the Kapo and the guards to limit the number of executions to 50 instead of 80. The first 40 were easy to choose, as they were the sickest patients, but for the last 10 who were all equally sick, discussions began among Dr. H.J. and the two doctors assisting him. Each doctor wanted to save the people of their own nationality, and they agreed to ultimately remove a percentage of each nationality proportional to the total number of people. The motivations for participating in the executions were moral in the sense that they helped to save more people than if they did not participate; however, the doctor did have the choice to participate in the executions himself. Although well intended, it is hard to say whether Dr. H.J. went too far. However, given the number of unprecedented moral dilemmas that the prisoner doctors were faced with everyday, who is to say where to draw the line for the extent to which a prisoner doctor participates in Nazi doctor actions. In this situation, the point is moot, as the camp was evacuated the next morning, and the SS ultimately shot the remaining infirmary patients who had just survived a crucial selection. This is just one example of the moral dilemmas with which prisoner doctors were faced, which will be discussed in detail later in the chapter.

Despite the courageous actions that many prisoner doctors took to save prisoner lives in whatever way possible, there was a group of prisoner doctors who can be described as active collaborators who displayed behaviors similar to those of Nazi doctors. The motivations of prisoner doctors who displayed active collaboration were varied. Many active collaborator prisoner doctors were antisemitic themselves. For example, Adam T. was an antisemitic Polish prisoner doctor in the Auschwitz concentration camp who was initially a member of a Polish resistance group (Lifton 1986). Adam T exhibited opportunistic behavior in order to get on the
SS doctors’ ‘good side’ to increase his chances of getting out of the camp. He came to resemble Nazi doctors in in performing surgery on Jewish prisoners “just to learn the operation,” and insisted that the “most important thing was that the system worked smoothly,” while retaining his power and privilege (Lifton 1986, 293-4). He was also increasingly sympathetic towards SS doctors and their behaviors as a way of defending his own behavior. For instance, he claimed that SS doctors were forced to do selections by the Political Department. Another Polish prisoner doctor, Wladislaw Dering, performed cruel experimental operations on Jewish inmates in the Auschwitz concentration camp (Lifton 1986). He was promoted to chief prisoner doctor and a leading Kapo by Dr. Eduard Wirths, the chief SS camp doctor, in 1943. This allowed him to perform sterilization experiments, where he removed the ovaries and testicles of around 200 Jewish inmates. He often used his influence to have Jewish inmates that he did not like sent to the gas chambers. Active collaboration sometimes even went as far as extreme physical violence and sadistic behavior, as displayed by Polish prisoner doctor, Zenon Zenkteller, who physically abused Jewish prisoner doctors working under him (Lifton 1986).

Prisoner doctors were subjected to unprecedented moral dilemmas in the concentration camps. One important moral dilemma facing prisoner doctors and their choices was deciding how much to become a part of the system and cooperate in selections (Lifton 1986). Although prisoner doctors’ participation in selections signifies sending certain inmates to their death, one could “save lives only by contributing to Auschwitz selection policies; one could avoid that involvement only by refusing to exercise one’s capacity to save lives” (Lifton 1986, 221). In this sense, participation in selections helped to save lives since prisoner doctors knew firsthand which inmates were more likely to survive, and which inmates would die in the near future regardless
of being selected. Choosing the weakest prisoners to be sent to their death helped to save lives compared to the amount of lives saved if the SS doctors themselves made the selections.

Another similar moral dilemma pertains to deciding who receives medication and in what dose. As prisoner doctors only had limited amounts and types of medications available to them, they had to decide whether to give all patients in need small, insufficient doses, or whether to choose which patients to treat with higher, sufficient doses at the cost of lives of others. Furthermore, this dilemma also pertained to limited amounts of vaccines, food, etc. Albert Haas, a Hungarian prisoner doctor in the Mauthausen-Gusen II camp in Austria, described such an ethical dilemma while operating on a fellow prisoner:

I had a split-second decision to make [it]. Should I use some priceless Evipan on an apparently unconscious and dying man, or save it to barter for life sustaining favours? I decided to save it, and prayed that the man on the table would die before I began to cut. As a doctor in Gusen II, I had to make such terrible choices almost daily. (Haas 1984, 5)

In addition to selections, prisoner doctors sometimes had to kill certain Kapos who were deemed ‘dangerous’ or mental patients who were difficult to control in order to protect the lives of others. Dr. Elie Cohen, a Dutch prisoner doctor in Auschwitz, was forced to kill the next prisoner that made noise in the “lunatics room” of his block upon orders from the SS Schutzstaffel, and failure to complete this task would mean that he and the rest of his block would be killed instead (Cohen 1973). In this case, the death of one prisoner saved the lives of not only the other prisoners, but also Dr. Cohen, so that he could continue to save lives. He discussed the depth of his guilt and shame that he carried for his actions after liberation, but admitted, “That will to live, that forcing yourself to carry on, that survives. It just happens to be like that” (Cohen 1973, 84).
Performing abortions were also commonplace, since the mothers and infants were often killed upon birth. Dr. Gisella Perl, a Romanian Jewish gynecologist who worked under Dr. Josef Mengele in the Auschwitz concentration camp, risked her own life to secretly perform abortions on pregnant inmates upon learning that all pregnant women were killed after experimentation. She decided that it was her duty to save these pregnant women from death by inevitably killing their unborn babies. In her memoir *I was a doctor in Auschwitz*, Perl describes this dilemma:

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 a 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. (Perl 1948, 58)

Perl went on to become a gynecologist after the war in New York City, praying before each delivery, “God, You owe me a life, a living baby” (Brozan 1982).

The moral dilemmas and actions of prisoner doctors can be highly informative to the field of biomedical ethics. Under normal circumstances, the actions prisoner doctors took to save lives would be considered highly unethical in regards to their Hippocratic mission to heal. However, the circumstances presented in the concentration camps required prisoner doctors to alter their ethical standards in order to save as many people as possible, sometimes at the expense of others’ lives. Such ‘choiceless choices’ raise the question: Is there an absolute medical code of ethics? The Holocaust revealed that anyone can be capable of blindly following a cruel evil, yet many prisoner doctors were able to stay true to their morals as a doctor. Perhaps our
contemporary code of medical ethics can benefit from an analysis of the decisions and actions
taken by prisoner doctors.

Bioethics in medical schools are mostly taught about what not to do. This teaches
students how to avoid transgressions, but it does not necessarily teach them how to move above
and beyond this baseline. The study of bioethics and the Holocaust often focuses on Nazi
atrocities to explain how not to repeat the mistakes of the past, but an analysis of prisoner doctors
can shed light on positive bioethics, and lessons for how one ought to carry out the virtues and
values of medicine today (Wasserman & Yoskowitz 2019). Many physicians in the concentration
camps maintained a deeply human connection to their work and to others in the face of
unimaginably inhuman conditions. While the horrors faced by prisoner doctors in the
concentration camps cannot be compared to the challenges of contemporary medicine today, the
actions of prisoner doctors who went above and beyond their role as a doctor to save lives can
offer insights for medical professionals today facing moral dilemmas including the challenge of
competing loyalties, scarcity of resources, social injustices in medicine, and the grief associated
with illness and death.

Dr. Gisella Perl, as discussed earlier, risked her life to help as many patients as she could.
In addition to performing secret abortions to pregnant women to save their lives, Perl performed
other notable acts of resistance to Dr. Mengele. One such occasion included a time where Dr.
Mengele entered a room where she and her friends were eating illegally acquired food. Knowing
they could be killed if he discovered this, Dr. Perl successfully diverted his attention to an
unusual preserved fetus (Perl 1948). In another instance, Perl took blood samples from her and
her team to forge negative typhus tests for patients who would be sent to the crematorium if the
tests were positive (Perl 1948). Perl’s potentially fatal acts of resistance demonstrate that even
when almost powerless, physicians have powerful choices to make regarding the care of their patients, and even the smallest decisions can make the greatest impact on a patient's physical and mental well-being.

Additionally, Dr. Viktor Frankl, a Jewish Austrian neurologist deported to the Terezin ghetto in Austria and to the Auschwitz concentration camp, helped to inspire prisoners to find something to live for. In Terezin and Auschwitz, he established a sort of “group therapy” to engage despondent and suicidal prisoners. He particularly helped the prisoners find something unique to that individual to live for, such as a child, or unfinished scientific research, when in the face of extremely hopeless conditions. While in Terezin, he wrote a manuscript entitled *Man’s Search for Meaning* on his observations of these group therapy sessions, and although it was taken from him upon his arrival to Auschwitz, he was able to rewrite the book within 9 days of his liberation, and it has sold over ten million copies today. Even when Frankl was feeling despondent, he found the strength and courage to continue helping them, explaining how “Encouragement now was more necessary than ever” (Frankl 1984, 98). His inspiring actions reveal how emotional and spiritual care is equally, if not more, important than physical care, and how even the most vulnerable can resist victimization through a recovered purpose.

These courageous and admirable physicians made significant personal sacrifices for their patients, and given the nature of the medical profession, “these personal sacrifices are deeply professional acts” (Wasserman & Yoskowitz 2019, 375). Medicine can be seen as an act of resistance against suffering and death, and these doctors were able to stay connected to their professional identity through personal acts of resistance as well. As new and old challenges face the medical profession today and in the future, the insights of prisoner doctors can provide limitless insight on how to remain humane even in the face of unimaginable circumstances.
Chapter 2.3: Jewish Prisoner Doctors in the Ghettos

During the Holocaust, Nazi Germany began establishing ghettos in sections of cities where all Jews were forced to live, the most notable of which being the Warsaw ghetto. Jewish Doctors in these ghettos functioned under a pre-existing medical structure, but were now under the control of Nazis. These doctors afford another opportunity to examine how doctors acted in the conduct of their profession under harrowing circumstances. In this chapter, I will first describe the structure of the Warsaw ghetto and its medical system. Second, I will describe the privileges and roles of these doctors. Third, I will describe the moral dilemmas faced by doctors in the ghetto. Finally, I will discuss lessons of the doctors in the ghettos that can inform biomedical ethics today.

The Nazi takeover of Warsaw, a major center of Jewish life and culture in Poland, occurred on September 29 1939, a mere 28 days after the Nazis invaded Poland. Almost immediately, German officials established a Jewish council, the Judenrat, led by Jewish engineer Adam Czerniaków, to begin implementing plans to establish a ghetto in Warsaw where all Jews were forced to live. German propaganda portrayed the Warsaw Jews as “dirty, lice-infested, rejected and starving parasites, still fighting for their miserable lives,” who were especially susceptible to typhus and must be confined to protect the rest of the Warsaw population (Roland 1992, 22). A German decree on October 12, 1940 required all Jewish residents of Warsaw to move to a designated section of the city enclosed by a 10 foot wall from the rest of the city. This 425 acre area held 30% of Warsaw’s population in 2.4% of the city’s living area (Roland 1992). By January 1942, the population reached 400,000, and living conditions were barely livable. The imprisoned inhabitants received scarce amounts of food rations, clean water, electricity, access to
proper medical care, or sanitation. Smuggling and trading were commonplace, as the Nazis prevented the importation of goods beyond their insufficient rations. Jan Karski, a Christian Pole, visited the Warsaw ghetto and described the conditions he saw:

Everything there seemed polluted by death, the stench of rotting corpses, filth and decay. I was careful to avoid touching a wall or a human being. I would have refused a drink of water in that city of death if I had been dying of thirst. I believe I even held my breath as much as I could in order to breathe in less of the contaminated air. (Roland 1992, 28)

Under these horrible conditions, Jewish doctors in the ghetto worked to treat patients with meager to no medications or supplies.

In the Warsaw ghetto, a preexisting functional medical system was adopted by Nazis who used it as an instrument to execute their orders and implement their policies regarding Jews. The Health department within the Judenrat was responsible for all aspects of sanitation and medicine in the ghetto, and was headed by Dr. Izrael Milejkowski, a Jew imprisoned in the ghetto (Roland 1992, Offer 2020). This department oversaw the functioning of six health centers, two hospitals, three outpatient clinics, eight disinfection units, four bathhouses, three places of quarantine, pharmacies, and various institutions of public welfare. One such institution abbreviated TOZ was a social welfare organization for the Jewish population. There was only one ambulance for the almost 500,000 people in the Warsaw ghetto in early 1941, and it was primarily used to smuggle items for the black market. Additionally, the Jewish Health Council, attached to the health department was created in 1941. Led by Ludwig Hirszfeld, a Jewish microbiologist imprisoned in the Warsaw ghetto, it was created to work on scientific theories to combat and study infectious diseases in the ghetto and to formulate sanitation rules (Offer 2020). There were also two medical societies for the 800 physicians established at the beginning of the ghetto: one for hospital physicians, and one for block physicians, or residential physicians.
Doctors in the ghettos performed tasks such as selections and controlling epidemics. Doctors in the ghettos not only worked in the hospitals, but also performed house visits, and many started private practices. After occupation on February 22, 1940, the Judenrat was ordered to recruit doctors to evaluate 35,000 people designated to register for forced labor (Offer 2020). They faced ethical dilemmas regarding selections: if they did not participate in selections, they could risk being killed and if they participated, they could potentially save healthier people who may have more of a chance to survive. Doctors were occasionally forced to send fellow physicians to the concentration camps. When the doctors refused to accept this task, many difficulties ensued. On May 24, 1941, Czerniaków managed to release the ill from transport to the camps if their medical examinations confirmed their conditions. Doctors were also requisitioned for various jobs assigned by the Nazis. For example, in early 1940, physicians were recruited for the physical examination of all males aged 14-60, which was close to 150,000 in number, in order to investigate correlations between certain medical conditions and different races (Roland 1992).

As epidemics, particularly the typhus epidemic, were rampant in the Warsaw ghetto, doctors were also frequently recruited to perform sanitation inspections, at home patient treatment, lice infestation treatments, and housing disinfections (Offer 2020). The German position on epidemic management was to attack the lice. Upon a positive case of typhus, the infected patient was sent to quarantine for a couple weeks, and the other inhabitants were required to go to bathhouses for personal disinfecting and delousing while the apartment was also deloused. During quarantine, however, no food was allowed to be brought in, and most patients starved. Germans also sometimes made everyone stand out in the cold while the apartment was disinfected all day, and this likely produced more disease than present before
(Roland 1992). The bathhouses became breeding grounds for disease, as people were required to wait outside naked in the cold before going in the bath house. These policies instilled as much fear in the patients as the disease did, creating an atmosphere of panic. In 1942, the Judenrat, particularly Czerniaków, Hirschfeld and Milejkowski, were instrumental in reforming epidemic policy. The Judenrat managed to improve conditions in the bathhouses, promote children’s school hygiene, coordinate trash removal, reform disinfection processes, and create advertisements to provide information and raise awareness of the causes of typhus and ways to prevent it (Offer 2020). Jewish doctors also sometimes secretly treated patients in their homes to avoid the brutal disinfection process.

Doctors in the ghetto garnered various privileges. Doctors were at a disadvantage in the beginning of German occupation and the formation of the Warsaw Ghetto, as they had to wear special armbands and many were arrested for the criminal act of intelligentsia. The doctors did not afford a privileged status until the deportation of Jews from the Warsaw Ghetto, or the Grossaktion, began on July 22, 1942, since a need for forced labor was now prioritized and doctors were needed to keep as many people alive and fit to work as possible (Offer 2020). Such privileges included having a telephone, the ability to leave the ghetto, receiving the typhus vaccine, and no curfew. The ability to leave the ghetto also allowed doctors to smuggle medications. The Warsaw ghetto relatively functioned as a normal society, which necessitated money for services such as medicine. Therefore, doctors and nurses were relatively among the most successful groups in the ghetto and got paid for their services, unlike prisoner doctors in the concentration camps. However, many patients did not have money to pay for medical examinations and treatments, leaving many doctors poor (Roland 1992).
Ethical dilemmas that faced doctors in the ghettos fall into one of two categories. The first one pertains to the dilemma of the extent to which doctors should endanger themselves in order to save lives or aid those in need (Offer 2020). The second category involves other decisions pertaining to conflicting moral values or norms. One dilemma in the first category involves the dilemma of abandoning patients to save themselves before and after the creation of the ghetto. In fear of occupation in 1939, doctors had the choice to stay and serve patients or to flee to a safer area to save themselves and their families. This continued throughout occupation after major events, such as Aktion (the deportation and mass murder of Jews from the Warsaw Ghetto to the Treblinka death camp beginning July 22, 1942) in January of 1943. Such a dilemma is described by Nurse Sabina Gurfinkel-Glocer, who made the difficult decision to send her daughter to the Aryan side while she stayed to continue treating patients: “A battle of powerful forces raged in my heart: the duty of a nurse who is commanded to live and die with the patients and the hospital staff, and the sense of motherhood, which ordered me to live at any price in order to save my daughter” (Offer 2020, 581). Another dilemma in this category involves the decision to risk infection from patients or to withhold care to protect themselves. Around ⅓ of all doctors in the ghetto contracted typhus at one point, and many died (Offer 2020). A question that arises asks whether doctors should be loyal to the ill at any cost even if it meant the risk of contracting life threatening illnesses. Many doctors continued to perform despite these risks, and even after contracting typhus, demonstrating many doctors’ loyalty to their profession.

Falling into the second category, doctors sometimes resorted to bribery in order to hold themselves financially afloat since patients often could not afford appointments or treatments (Offer 2020). However, this bribery also caused the deaths of families who could not afford to
engage in such bribes. In the fight against infectious diseases in the ghetto, the Germans required that every case of illness had to be reported, every patient had to be sent to a hospital for treatment, and every patient’s home had to undergo an intense disinfection process (Offer 2020). Since the conditions of the hospital in terms of cleanliness, treatment and supplies could be avoided with at-home treatment, some well-to-do middle class citizens in the ghetto engaged in acts of bribery with the doctors, where doctors would give them a clean bill of health and secretly treat them at home for a stiff fee. Citizens were as scared of the disinfection process as they were of the disease, and when buildings were inspected for cleanliness, the head of the house committee would often give the doctor a bribe of several hundred zlotys collected from apartment owners who wished to participate in the bribe and tell him which apartments to ease up on with the inspection. This bribery earned the Jewish doctors extensive hostility from other ghetto habitants who could not afford to participate in such bribes. Some doctors also engaged in looting of the apartments subjected to the disinfection process (Offer 2020). Despite the fact that doctors did engage in this sort of bribery, it is difficult to say how many of the 800 doctors truly participated in these corrupt acts. Anonymous reports from doctors, disinfection crew members, and citizens differ on their perception of how many doctors stayed true to their morals. With testimonies ranging from almost all, to around half, to almost no doctors engaging in bribery, one must avoid blanket statements concerning bribery actions of doctors in the ghetto.

Another dilemma was whether to report typhus cases to the authorities even when bribery was not involved. Reporting cases often meant being sent to the concentration camps, which was known to have a high risk of death (Offer 2020). Similarly, another dilemma involved the selections themselves, where doctors were tasked with selecting who to send to the concentration camps, outside of those with reported typhus cases. As seen in the prisoner doctors chapter, these
selections were a constant ethical dilemma for the doctors. Doctors could ethically justify their participation in selections, since they had the knowledge of who was most likely to die regardless, and could save those who had a better chance at survival. Their noncompliance in selections risked death, so by participating in selections, they exercised their ability to save lives. Deciding how much to participate in these selections signified finding the middle ground between not participating at all and potentially allowing healthy people to be sent to their death, and having too much of an involvement in selections to the point of collaboration. These selections differed slightly from those of prisoner doctors, as selections had to be made among medical personnel as well (Offer 2020). This changed the selection dynamic, as doctors were now part of both the selection process and the selection pool.

Other ethical dilemmas involved killing people in the ghetto for various reasons. During the larger rounds of deportations, doctors sometimes gave out cyanide to prevent people from dying a more gruesome death in the gas chambers (Offer 2020). Despite the intentions to help those die more peacefully in the face of an “inevitable” death, who is to say that these people would have absolutely died? Testimonies have reported that these injections were sometimes non-consenting. Another dilemma involved killing babies or mentally ill people to prevent people from being discovered in hiding. In this case, if the baby or mentally ill person were to make noise, it risked the death of everyone in hiding, and it sometimes made sense to kill one in order to save everyone else. This killing was either done by parents or doctors.

The medical profession inherently holds much power, as it has the ability to influence whether people live or die. In dilemmas such as these, doctors were faced with a choice to purposefully kill with good intentions, but who is to say that doctors are ethical in these decisions to kill, no matter the reasoning? Some think that the Hippocratic Oath should be
revised for mass-casualty events so that doctors would then be required to save as many people as possible (Offer 2020). Many of these decisions, or sometimes ‘choiceless-choices,’ caused serious torment among the doctors often on a daily basis. Even though doctors were forced to compromise their traditional medical ethics in the face of these unprecedented circumstances, the question still remained of whether these doctors passed the ‘moral tests’ faced in the Warsaw ghetto. While some passed highly, some did not, and many fell in between. This large grey area of doctors’ actions in the Warsaw Ghetto signifies the need for the medical profession to learn from the Holocaust in order to consistently use their power for the betterment of the patient, even in the face of extreme, unprecedented circumstances.

Despite this large grey area, many doctors in the ghettos performed heroic acts to help save the lives of others that can inspire the field of biomedical ethics today. One such physician was Dr. Mark Dworzecki, a Lithuanian physician imprisoned in the Vilna ghetto. During his time as a physician in the Holocaust, he documented the atrocities he experienced in various ghettos in Estonia and Lithuania and encouraged other prisoners to do the same. After he escaped the Death March in 1945, he wrote about the Holocaust for The Survivors Press before going to Isreal to establish a Chair of Holocaust Studies at Bar Ilan University (Wasserman & Yoskowitz 2019). His work illuminates the commitment of Jewish physicians to public health in the face of extremely dire circumstances. Dworzecki illustrates the power of documentary as an active form of resistance and reflection to hold Nazi doctors accountable for their actions and to bring attention to the heroic acts of others. The act of journaling and reflection are now promoted in medical schools and residencies as a means of making sense of one’s experiences, and Dworzecki’s dedication to making sure the realities of his experiences were known to the public
demonstrate his commitment to the medical profession, ensuring that the future can learn from the mistakes of the past.

Dr. Karel Fleischmann, an Austrian physician in the Terezin ghetto in the Czech Republic, documented his experiences through art rather than through historical documentation. After long days of watching human suffering, “Fleischmann often worked at night to capture in his artwork the horrors of what he saw during the day: the constant struggle of Jewish children, adults, the invalid, and the elderly to survive” (Hoenig 2004, 131). He was one of the most renowned artists in the Warsaw ghetto, and as Nora Levin explains, “More than death, they feared that the world would never know what they were enduring, and worse, that they would not be believed” (Hoenig 2004, 131). Although he died in Auschwitz before liberation, his artwork survived to tell his story. We can see how hope prevails through art, since Fleischmann would have been killed if his artwork was discovered. At the bottom of one of his paintings, he wrote a hopeful poem about survival (Costanza 1982, xvi):

One of us
Will teach the children to sing again
To write on paper with a pencil
To do sums and multiply,
    One of us
Is sure to survive.

Fleischmann’s work teaches us how hope can appear amidst hopelessness, and how meaning-making exercises are essential for physicians today struggling to maintain hope. He made significant personal sacrifices for his profession, serving the vulnerable instead of generating vulnerability.

Doctors also managed to create a full underground medical school in the Warsaw Ghetto hidden under the illusion of Nazi-approved Sanitary Courses for Fighting Epidemics (Roland 1992). Adam Czerniaków and Ludwig Hirszfeld taught a full medical school curriculum hidden
by these epidemiology courses to willing students at a school house a few meters outside the ghetto. Although students did have the excuse of the sanitary courses to go to this building, many still had to sneak in at night and often during the day, students would learn by accompanying doctors in hospitals. The students and professors were highly motivated to participate in this medical school to create a sense of normalcy, and the forbidden nature also provided motivation as a form of rebellion. Despite the almost unlivable conditions of the Warsaw ghetto, the courage and passion exemplified by the students and the professors is a heartwarming example of these doctors’ dedication to their profession and their drive to teach the next generation of doctors even in the face of death. These courageous examples of resistance by Jewish doctors in the ghettos reveal that there are ways to remain true to the values of medicine, even in the face of the most inhumane conditions, that inspire physician conduct today.

Given the description of the medical profession’s involvement in the Holocaust in these three sections, no matter the intentions, it is evident that medical professionals today should be well informed about their profession’s history in order to fully learn from the mistakes and triumphs of physicians in the Holocaust. Nazi doctors were involved in almost every step of the killing process in the concentration camps and in conducting immoral human subject experiments. Although the Nuremberg Code was created to prevent these atrocities from ever happening again, physicians must not assume that there is nothing more to learn from the Holocaust, or that these guidelines only apply to people as ‘sadistic’ as Nazis. Medical professionals today must be aware that the thought processes that allowed the Holocaust to build to what it became were more banal than many would think, and that silence concerning the Holocaust could lead to its omission. As a point of contrast, the actions that prisoner doctors took
in the concentration camps to stay as true as possible to their morals as a doctor in the face of unprecedented circumstances can be informative to the field of biomedical ethics. In normal circumstances, the actions prisoner doctors took to save lives, sometimes even involving the killing of others, could not be considered ethical under the Hippocratic Oath. However, given the circumstances, these actions not only demonstrate these prisoner doctors’ courage to save as many lives as possible, but also the fact that there may not be an absolute code of ethics. Similarly, actions of doctors in the Warsaw ghetto can be used to inform the field of biomedical ethics today, as they were also subject to unprecedented moral dilemmas concerning selections, bribery, and epidemics. Their courage in the Warsaw ghetto is equally informative, particularly the risks and passion involved in running a full secret underground medical school to help keep the medical profession alive. While these subjects are complex, it is clear that medical professionals today have much to benefit from learning about these three doctor types in regards to medical ethics. The following chapter will seek to demonstrate the impact that this knowledge has on health professionals who have already learned about the Holocaust in terms of biomedical ethics.
Chapter 3

Assessing the Importance of Holocaust Education on STEM and Health Professions

Introduction

The third part of this thesis assessed the importance of teaching the Holocaust in terms of biomedical ethics by surveying health professional students who have previously learned this history in this context. A Google form survey was sent to alumni from the last 9 years of Pr. Daniel Bitran’s course in the Psychology Department at the College of the Holy Cross entitled “PSYC314: Science, Medicine & the Holocaust.” The excerpt from the course description below explains the main goals of the course:

This course is intended to examine the influence of sociopolitical agendas in the conduct of scientific research and health professions. Included in this broad aim is the study of important biomedical ethics as well as issues surrounding the use of humans in experimentation. Science is often assumed to be an objective discipline in the search of discovery and truths about natural phenomena; that science is unfettered by the interests and constraints of the political, social, and cultural milieu; that scientific discovery is driven solely by hypotheses generated by the scientific method; that medical and psychiatric practice are informed and affected only by the interests of the patients. The study of the role of scientists and physicians in the conduct of the systematic killing of ‘useless eaters’ during the period of the Holocaust is most informative in debunking this naïve perspective.

Alumni of this course were familiar with the material from the chapters above on the biomedical origins of the Holocaust, the actions of the different types of doctors, and the relation of this knowledge to biomedical ethics today. Data collected from this survey were used to demonstrate why health professionals should learn about the Holocaust as a part of their biomedical ethical training.

Methods and Materials
Using Holy Cross Google accounts in the Holy Cross database, I emailed the alumni of the PSYC314 course using the participant lists given to me by Pr. Bitran. This email detailed the subject of my thesis, and also attached a questionnaire in the form of a Google form. Questions included the alumni’s current profession, the extent to which this course has affected their current profession today, and for those who attended health professional training programs, such as medical school etc., the extent to which they learned about the Holocaust, if at all. These data were used to determine the extent to which this course had an impact on individuals in certain professions, and for what reasons. The results were reported in the aggregate and anonymized.

**Results**

The survey was sent out to 111 alumni who took this course between the years of 2011-2019, with the exception of the year 2013, when this course did not run. Out of the 111 alumni, 42 completed the survey, with 26 of these participants being currently employed in a health or STEM-related profession, or studying to become one. For the purposes of this paper, only the responses of these 26 participants currently in or studying to enter a health or STEM-related profession will be described.

Out of all responses, we found higher response rates from more recent alumni of the course compared to those who took the course in earlier years. A plausible reason for this could be that more recent Holy Cross alumni are more likely to check their Holy Cross emails than older graduates. Due to a mistake in the Google form, the emails and names of 12/42 responses were not recorded. Fortunately, the analysis of the response rate by class year is the only section affected by this mistake. The data shown only takes into account 30 responses out of the 42 received, likely slightly skewing the true response rates. Nonetheless, response rates increased as
class year increased. We do not believe that the inaccuracy of these results affects the validity of the results of the other questions.

<table>
<thead>
<tr>
<th>Year</th>
<th>2011-2012</th>
<th>2014-2016</th>
<th>2017-2019</th>
</tr>
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<tbody>
<tr>
<td>Response Rate</td>
<td>16.67%</td>
<td>20.51%</td>
<td>37.50%</td>
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Did the seminar increase your understanding of how science and medicine were influenced by the sociopolitical climate that gave rise to the Holocaust?
Of the 26 participants currently in a health-related profession, we found a strong appreciation for how science and medicine were influenced by the sociopolitical climate of the Holocaust. Twenty-two participants responded to this question with a score of 5, and 4 participants responded to this question with a score of 4, with an average score of 4.85/5.

Thinking back to the seminar on “Science, Medicine and the Holocaust” you took with Pr. Daniel Bitran (PSYC 314), would you say that this course had an impact on your conduct in your current profession or program of study?
Of the 26 participants currently in a health related profession, we found a strong appreciation for the impact of this course on current health-professional conduct today. Two participants responded to this question with a score of 2, seven responded with a score of 3, eleven responded with a score of 4, and six responded with a score of 5, with an average score of 3.81/5.

**If the seminar impacted your current career or study, please specify how.**

Although this question was optional to all participants, an overwhelming majority of responses were recorded from those in a health or STEM+E-related profession (20/24). The responses collected can be organized into one of five categories: Medical Ethics, Patient Treatment, Power Dynamics, Points of View, and Other.
Medical Ethics

Eleven out of 24 responses discussed the impact of the course on their understanding of medical ethics in their current career. Medical ethics involves the right choice of conduct considering the circumstances of a particular problem within a medical case. This takes into account values, facts and logic to decide the best course of action. Medical ethics pertains to the obligations of the physician to the best interest of the patient. Medical ethics is not static, however, and certain ethical decisions may not be considered ethical in another time or culture. Topics that pertain to medical ethics today involve maintenance of medical records, exposure of unethical conduct, evasion of legal restrictions, implied/informed consent, withholding proper treatment due to budget restrictions, and more. Concerning the Holocaust, it is clear from the contents of this thesis that every one of these topics mentioned were violated at some point throughout the eugenics and euthanasia programs, and within the concentration and death camps. Learning about these violations and how they went largely unchallenged throughout the Holocaust is a crucial step toward creating the most ethical medical society possible. Participants
specifically discussed how the course challenged their ideas of medical ethics in terms of “informed consent,” “research ethics,” and the “potential misuse and abuse of science and medicine.”

**Patient Treatment**

Five out of 24 responses discussed the impact of the course on their understanding of patient treatment in their current career. While similar to the topic of medical ethics, the concept of patient treatment specifically pertains to the sanctity of human life and the equal treatment of all patients in their best interest. The concepts of explicit and implicit bias are important within the realm of patient treatment. Implicit bias concerns negative unconscious attitudes or beliefs about others that can differ from their conscious attitudes. When implicit attitudes differ from explicit attitudes, physicians may not realize that they are treating some people differently than others, but those on the receiving end may feel confused and invalidated. A 2003 report titled “Unequal Treatment” conducted by the Institute of Medicine revealed that racial and ethnic minorities received worse treatment than non-minorities even when access-to-care barriers were controlled for (Smedley et.al. 2003). Implicit bias is more difficult than explicit bias to notice and correct, and further research and methodology must continue to be developed in order to ensure the equal treatment of all patients. Additionally, another concept within the larger topic of patient treatment is the sanctity of human life, and how the physician’s primary responsibility is the protection and preservation of human life. Proper patient treatment was clearly not upheld during the Holocaust, as Jews and other minority groups were explicitly discriminated against and not treated as equal human beings. Although it may seem that the horrors of the explicit bias of the Holocaust would never happen again today, implicit and explicit bias still continue. While they do not manifest to the same degree as during the Holocaust, implicit and explicit bias still
remian problems in today’s medical society and must be addressed. Participants specifically
discussed subjects such as “paternalistic physicians,” “intrinsic value of our fellow human
beings,” and “sanctity of life” in their responses pertaining to patient treatment.

Power Dynamics

Five out of 24 responses discussed the impact of the course on their understanding of
power dynamics in their current medical career. Power dynamics manifest not only through the
patient-physician relationship, but also within the hierarchy of the medical profession. Within the
medical profession, power dynamics play a role through not only different types of medical
professionals, such as nurses vs. physicians, but also through role diversity, such as permanent
vs. temporary staff. Without proper communication, cooperation, respect, and trust among
physicians and between physicians and patients, patient care suffers. With these qualities,
however, power dynamics have the potential to benefit all parties involved, creating an equal
professional status among all parties involved, which allows all parties to grow and flourish.

One area within the concept of power dynamics that has potential for misuse in the
medical field is obedience to authority figures. The Milgram Experiment(s) began in 1961 three
months after the start of the trial of Nazi war criminal Adolf Eichmann to answer the question:
"Could it be that Eichmann and his million accomplices in the Holocaust were just following
orders? Could we call them all accomplices?" (Schulweis 2010, 106). Participants of this study
were instructed by an authority-figure “experimenter” to ask an actor, unknowingly to the
participant, a series of questions and to administer a shock to them if they answered incorrectly.
The participants were not aware that the shocks were not real, and the strength of the shocks
“increased” for every wrong answer. The strength of the shocks increased up to 450 volts, which
would be lethal if the shocks were real. The results of this study revealed that the majority of
participants administered up to the highest shock level, albeit with varying levels of discomfort and stress. While these results cannot be used to directly explain the events of the Holocaust, they do provide insight to the power of conformism, and how those without expertise in a field will often leave decision-making to those higher in a hierarchy. The hierarchy of the medical profession has potential to benefit all involved, but it is clear that without proper communication and equal treatment, there is strong potential for misuse. Participants in this survey specifically discussed the Milgram experiment, as well as “the interconnected nature of policy, government, culture, and psychology in any major event,” the “intersection of history and science/medicine,” “how blindly others can follow a leader if they believe in what is right or can pass the responsibility off, even if it’s unethical or wrong,” and “how people could be so easily influenced.”

**Points of View**

Two out of 24 responses discussed the impact of the course on their understanding of different points of view in their current career. Similar to the topic of power dynamics, participants discussed how the course increased their awareness of the importance of seeking out multiple points of view in any given situation, especially in the medical field. Scientific skepticism highly pertains to this category. This concept describes how one should question the validity of scientific claims unless they can be empirically tested and proven. The topic of obedience to authority figures also applies to this category, and it emphasizes the importance of questioning information presented even when it is presented by an authority figure. Especially within the hierarchy of the medical profession, it is not commonplace to question information and decisions given and made by authority figures. It is evident that many Nazi doctors and medical personnel did not question the tasks they were given or the rationale behind it. Even if
some questioned it, far fewer Nazi doctors actively protested against the tasks and information given to them. The Holocaust reveals the importance of always seeking opposing points of view, not only in medical situations but in any field, in order to make the most educated and fair decisions possible. Participants of the survey discussed ideas such as being “more conscious of the ideas and studies presented to me,” and learning about “new points of view and experiences.”

**Other**

Three responses did not fit into any of the above categories. These responses discussed the “importance of addressing intergenerational trauma” working as a mental health counselor, and awareness “of the impact of the Holocaust on the Jewish community” in the United States. The third response explained how the course was instrumental in “creating who [they] are today” but that the information learned in this course is “very rarely relevant in IT sales.”

**As a member of the STEM or health professions, do you believe that the Holocaust should be used as a vehicle to teach about biomedical ethics?**

<table>
<thead>
<tr>
<th>Should the Holocaust be used as a vehicle to teach about biomedical ethics?</th>
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<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td># of Participants</td>
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**Flanagan 64**
Of the 26 participants currently in a health related profession, we found strong agreement that the Holocaust should be used as a vehicle to teach about biomedical ethics. One participant responded to this question with a score of 2, one responded with a score of 3, three responded with a score of 4, and twelve responded with a score of 5, with an average score of 4.50/5.

**Biomedical Ethics, the Holocaust, and Health/STEM-Related Training Programs**

Of the 26 participants in health/STEM-related professions, 15 attended a health/STEM-related training program. 7/15 participants reported that their training program offered an ethics course, including institutions such as Wake Forest University, University of New England, Northwestern University Feinberg School of Medicine, St. George’s University, Boston College, Loyola University Maryland, and University of Maryland Global Campus. None of these institutions offered a course on the Holocaust, and only one institution (Northwestern University Feinberg School of Medicine) offered limited lectures as the furthest extent of Holocaust education, including subjects such as eugenics and euthanasia, Nazi experimentation and the Nuremberg Code, the medical profession’s involvement in the Holocaust, and bioethics and the Holocaust. Three out of 15 also reported learning about Nazi experimentation and the Nuremberg Code, and eugenics and euthanasia, but not to the extent to cover an entire lecture’s worth of material. The 14 participants who reported not learning extensively about the Holocaust in their professional studies strongly agreed that they could have benefitted from learning about it, with an average score of 4.36/5.

The fact that only one participant reported learning about the Holocaust to the extent of a couple of lectures, and almost every participant strongly agreed that the Holocaust should be used as a vehicle to teach about biomedical ethics reveals a telling sign of the reform needed in
the medical school curriculum concerning biomedical ethics and the Holocaust. Compared with data collected from the Liaison Committee on Medical Education (LCME) in 2013, “only 22 of 140 (16%) medical schools in the United States and Canada have any required curricular elements on the roles of physicians in the Holocaust, and half of these (11/22) teach this material using a lecture format only” (Wynia, Silvers, Lazarus, 2015). The results of our survey reveal the strong agreement among those who have previously learned about the Holocaust in the context of biomedical ethics that all health/STEM professionals should learn about the Holocaust in this context. Given this agreement, the next question is: What is the best way to use the Holocaust to teach biomedical ethics in the medical school curriculum?
Chapter 4

Teaching the Holocaust at the Medical School Level

Given the medical community’s complicity in the Holocaust as described in the preceding chapters of this thesis, it is evident that the Holocaust provides modern day relevances that are especially pertinent to medical professionals today. The field of bioethics and the Holocaust have received recent emphasis, garnering attention from major journals such as the American Medical Association (Chelouche & Wynia 2021), UNESCO (Chelouche et. al. 2013), Conatus (Gallin & Bedrow 2019), and the Lancet (Roelcke et. al. 2021). Scholars in this field have recognized four lessons pertinent to contemporary ethical challenges in medicine that are most well-informed by learning about the Holocaust. These are empathy and detachment training, scientific skepticism, the challenge of competing loyalties (Levine et. al. 2019), and the hierarchy of the medical profession (Fernandes & Ecret 2019). Empathy and detachment training emphasize the importance of treating each patient as you would yourself. Scientific skepticism involves always questioning information presented to you and being aware of other points of view. Challenges of competing loyalties are about balancing the duties as a physician with other duties such as to the employer or companies funding research, and the hierarchy of the medical profession describes the importance of treating all medical professionals as equals regardless of their degree in order to ensure effective communication and trust. Aside from the fact it would be difficult to mandate a course on bioethics and the Holocaust in all US medical schools, these lessons would be best taught through integration with existing curriculum to ensure that the lessons learned from the Holocaust are explicitly related to all aspects of medicine.

Empathy and detachment training
When caring for suffering patients who are in pain, distress or advanced disease stages, physicians, nurses and other medical professionals must find a balance regarding their emotional and moral involvement towards the patient. Caring for these suffering patients requires some emotional distancing in order to objectively treat the patient. If the physician becomes too emotionally involved in their patient’s suffering, it can affect proper care by compromising clinical objectivity by introducing a competing, personal interest in the patient (Levine et. al. 2019). Studies have shown that the empathy of medical students declines over the course of their medical training (Neumann et. al. 2011). However, on the other extreme, a complete lack of empathy concerning suffering patients is a concept that the Holocaust has revealed to have dangerous reprecussions. Teaching medical students about the history of the Holocaust can help to equip them with the tools to treat patients both objectively and with care, compassion and empathy.

In Nazi Germany, this erosion of empathy revolved around the dehumanizaion of Jews and other marginalized groups. As the 1933 Law of Prevention of Genetically Diseased Offspring authorized genetic health courts to sterilize those with certain supposed “herediary” conditions, followed by killing through euthanasia in clinics and eventually in gas chambers in concentration camps, it is clear that anyone who did not fit the Aryan-German mold was not seen as an equal human being, and was treated as such. The atrocities of the Holocaust have much to teach medical professionals and students about the dangers of medical dehumanization, but it is important to note that medical dehumanization and empathy erosion did not end with the Holocaust. While the Nuremberg Code created in response to the medical atrocities helped to create the bioethical foundations of our modern bioethical standards, the code heavily focused on experimentation and euthanasia violations. This was an essential development towards bioethics
today, but the Nuremberg Code failed to adequately address the underlying racist and discriminatory motivations and thought processes that allowed these practices to happen. In fact, unethical human subjects research continued after World War II. One such study was the US Public Health Service Syphilis Study at Tuskegee launched in 1932 and continuing for 40 years, which studied Black men with untreated syphilis in rural Alabama while deceptively promising them free treatment (Reverby 2009). The study only ceased after a front-page scandal exposed the study as blatantly racist and unethical in 1972. Eugenic sterilization also continued in the United States after the Nuremberg Trials and creation of the Nuremberg Code. By 1937, 32 states and Puerto Rico had laws authorizing the sterilization of those deemed “unfit” in terms similar to that of Nazi Germany. These only began to be repealed in the 1970s, when more than 60,000 Americans had already been sterilized (Stern 2016). While no US laws were aimed at specific racial groups, certain groups were sterilized disproportionately more than others. For example, in North Carolina, Black women made up around 60% of those sterilized, even though Black people accounted for only 23% of the population (Scott 2015).

Although great strides have been made in the field of bioethics regarding the equal treatment of all patients, dehumanization still continues to play a role in medicine today towards Jews, people with disabilities, members of the LGBTQ+ community, and other minority groups (Stern 2021). From 2006 to 2010, more than 140 women, of whom a majority were women of color, were sterilized without authorization in two California prisons (Stern et. al. 2017). Many were sterilized by one physician, Dr. James Heinrich, who explained that the money spent sterilizing the inmates was negligible “compared to what you save in welfare paying for these unwanted children - as they procreated more” (Stern et. al. 2017, 54). Additionally, from 1989 to 2014, laws restricting marriage and parenting for people with mental illnesses were passed in
many states (Stern 2021). These examples reveal the underlying eugenics motivations of some physicians and lawmakers today, who attempted, or succeeded, at preventing those who they saw “unfit” from reproducing.

Despite these examples of physicians’ and lawmakers’ extreme lack of empathy and respect, dehumanization also plays a role in everyday medicine today. A 2011 study revealed that only 53% of 800 recently hospitalized patients felt that their physicians were empathetic and caring (Lown et. al. 2011). It is clear that dehumanization and empathy erosion did not end with the Holocaust, and special attention must be paid to this history to prevent the thought processes that allowed it to occur from affecting medicine today. Learning about the horrifying consequences of physician empathy erosion during the Holocaust can help to equip future medical professionals with the training necessary to adequately balance clinical objectivity with compassionate and empathetic patient care.

Scientific skepticism

Medicine has an important obligation to bridge science with society. As the Physician Charter for Medical Professionalism in the New Millenium states, “Much of medicine’s contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience” (Project of the ABIM Foundation et. al. 2002, 243). Physicians violate scientific standards by accepting a theory as fact without adequate, objective experimentation and evidence. The Nazi implementation of eugenics-based programs and laws based on the theory of Social Darwinism without sufficient evidence supporting it, and even in the face of evidence disproving it, is an example of such
scientific violation. Medical ethics education in medical schools during the Nazi era was taught solely by party loyalists, who used a textbook authored by Rudolph Ramm advocating for the cleansing of the Aryan race through sterilization and through the killing of the disabled (Fernandes & Ecret 2019). This education went unquestioned and unchallenged by most medical students, illuminating the dangers of accepting unfounded pseudoscience as fact. The history of American anti-immigration policies also reflect these violations. Even after discrediting several notions that certain immigrants were more likely to bring disease or commit crime, these policies remained for many decades (Okrent 2019). Conversely, rejecting well-reasoned science on the grounds of scientific skepticism also violates scientific standards (Levine et. al. 2019). Recent debates over evolution and climate change education under the pretext that these are “just theories” despite well-established evidence is a dangerous misuse of the scientific method and scientific skepticism.

Information from non-scientific journals has also caused problems regarding public scientific knowledge. Unfounded medical journals and biased blogs provide the public with information of questionable validity that is then spread around on social media platforms, leaving room for misinterpretation and skewing of information (Levine et. al. 2019). The anti-vaccine movement is an example of the dangers of the spread of this information, as there is overwhelming scientific evidence disproving its validity. This is especially pertinent during the COVID-19 pandemic, as people use unfounded evidence as reason to not get vaccinated. Physicians today must evolve new strategies prevent social misuse of science; as we have learned from the Holocaust, the intersection of pseudoscientific theories with public policy can have dangerous consequences.

**The challenge of competing loyalties**
Although physicians have a loyalty to the wellbeing of their patients, physicians also have other concurrent loyalties, such as to the safety of other patients, the greater community, the institution in which they work, the state, and others. Despite these other loyalties, physicians are responsible for balancing these loyalties in order to create reciprocal trust between not only the physician and the patient but also the physician and society. Ethical codes in medicine are created to ensure that physicians do not prioritize nonclinical factors, such as national security, immigration enforcement, customs policies, personal opinions and more, above the best interests of the patient. If the physician fails to prioritize the patient’s best interest, this erodes the trust between the patient and the physician. This also endangers the overall health of the patient: if the patient does not disclose all necessary information to their physician due to a lack of trust, this compromises the level of care that the patient can receive. In Nazi Germany, trust between the patient and the physician was only possible between the physician and Aryan patients. All others were abandoned by the medical profession. Even if Nazi physicians were reluctant to prioritize the Volk state over an individual patient’s health, their complicity in Nazi programs deliberately withholding care from certain groups violate the integrity of the patient-physician relationship. It must also be noted that American medicine in the early-to-mid 20th century was similarly exclusionary, as African Americans, Jews, Catholics, and other minorities were discriminated against in the patient and professional realm (Levine et. al. 2019).

While patient-physician trust has improved since, dual loyalties with physicians continue to remain a problem in the United States today. A recent report from the Pew Research Center found that only 74% of Americans have a mostly positive view of medical doctors and that only 57% believe that doctors care about the best interest of their patients all or most of the time (Levine et. al. 2019, 297). One example of issues with dual loyalties concerns physicians in
detention centers reporting to US and state agents at the US-Mexico border today, who face similar conflicts to those of Nazi physicians (Sirkin et. al. 2021). Several violations of US physicians in these detention centers have been reported.

First, physicians have been reported to force feed individuals participating in hunger strikes protesting ICE detention. The World Medical Association has expressed clear opposition to force feeding hunger strikers if they are competent individuals, as this violates their right to autonomy. Second, physicians have been reported to force children in these centers to undergo dental radiographs to determine their age. Adult detainees are exempt from certain legal protections that migrant children have, such as the right to a non-adversarial asylum interview. These radiographs have been found to be scientifically inaccurate, since they do not account for ethnicity, nutritional status, overall health and development history. These categories tend to be especially important concerning migrant children and adults. Third, migrants’ use of primary and emergency medical care has declined out of fear that physicians will comply with immigration enforcement arrests and raids. Patients have also reported receiving compromised access to care and compromised care quality due to racial, ethnic, and immigration status-based discrimination (Sirkin et. al. 2021). Many detainees are also denied attorney and family visitation privileges and physicians have also been reported to profile detainees in waiting rooms and patients have experienced unauthorized disclosure of their immigration status. Fourth, patients are routinely discharged with no continuity of a care plan upon abrupt orders by US agents to clear patients for deportation or release from detention centers. Physicians have reported being intimidated by these officers for early release from treatment even if it means endangering the patients’ health. Finally, children’s confidential therapy notes were used as evidence against them in deportation proceedings. One example of this violation is described below:
One boy confided to his therapist that, under duress, he joined a gang, later refused to comply with gang demands, and then fled his country. Without the child’s or the therapist’s consent, an ICE prosecutor used these notes to emphasize the child’s gang membership and undermine his case for asylum. Although the extent to which this information is protected under the Health Insurance Portability and Accountability Act (HIPAA) is unclear, violating the confidence of a vulnerable child seeking help neglects the child’s dignity and undermines the therapist’s capacity to execute professional caregiving duties. (Sirkin et. al. 2021, 40)

These violations above may cause physicians moral distress. Physicians have also reported threats of demotion and dismissal, and intimidation by armed agents for not complying with requests such as the ones outlined above. There are a set of guidelines to help physicians respond to dual loyalty issues as seen in the table below (Sirkin et. al. 2021).

<table>
<thead>
<tr>
<th>Table. Guidelines to Help Clinicians Respond to Dual Loyalty Conflicts*</th>
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<tr>
<td>1. Enhance your awareness of human rights principles and “the implications of human rights for clinical practice through study and training in human rights.”</td>
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<tr>
<td>2. “Develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised.”</td>
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<tr>
<td>3. Always “place the protection of the patient’s human rights and well-being first,” especially in situations in which “there exists a conflict between the patient’s human rights and the state’s interests; this responsibility includes affirmatively resisting demands or requests by the state or third party interests to subordinate patient human rights to state or third party interests.”</td>
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<td>4. “Exercise judgment independent of the interests of the state or other third party” in all clinical assessments, whether for therapeutic or evaluative purposes.</td>
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<tr>
<td>5. Recognize how your “professional skills can be misused by state agents to violate the human rights of individuals—especially in settings where human rights violations are pervasive—and take appropriate steps to avoid this misuse.”</td>
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<tr>
<td>6. “Recognize that passive participation, or acquiescence, in violations of a patient’s human rights is a breach of loyalty to the patient.”</td>
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<tr>
<td>7. “Only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.”</td>
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<tr>
<td>8. “Maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.”</td>
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<tr>
<td>9. “Take all possible steps to resist state demands to participation in a violation of the human rights of patients.”</td>
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<tr>
<td>10. Always “act with an understanding of health professionals’ collective obligation to uphold and promote the human rights and well-being of the patient.”</td>
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*Adapted from Physicians for Human Rights.†
Among balancing other dual loyalties, physicians today must be well-equipped with the tools and training necessary to help protect patients’ rights and provide them with nondiscriminatory care access, patient confidentiality and protection during interactions with state agents. Advocating for local, state and federal policy changes by physicians and larger medical societies can also help to protect these rights. Nonclinical pressures on patient treatment continue to affect physician conduct, and the Holocaust has revealed how easily physicians can succumb to state pressure to compromise patient care. Keeping the memory of the Holocaust alive in medical training today helps to hold everyone accountable - Physicians will always have competing loyalties, but the future of medicine relies on learning from those who failed to prioritize their patients.

**The hierarchy of the medical profession**

There is a place for hierarchy in medical education and practice. For example, the teacher and the student should not occupy the same role, and not every medical professional should have the same roles and responsibilities in a given situation. However, there are negative aspects to the hierarchy of medicine that helped to contribute to the mass participation of the medical profession in the Holocaust, and continue to negatively impact proper patient care today. It is essential to analyze the hierarchy of the medical profession in order to understand how medical professionals can blindly follow authority figures.

In the medical field, hierarchy can be described as unequal power gradients between medical professionals, such as doctors, nurses and other professionals, and between medical professionals and patients. Since medical training for any professional involves the approval and guidance of a mentor, there is risk for subjective assessment evaluations, perceived adherence to professional standards of clinical practice, poor communication and poor role modeling
Aside from the hierarchy between a professional and their immediate supervisor, there is also a larger organizational hierarchy in the medical profession that requires professionals to “increase patient outcomes, decrease patient length of stay, and decrease cost of care,” which can complicate proper patient care (Fernandes & Ecret 2019, 25). The hierarchy of the medical profession is also evident in the patient-physician relationship, as vulnerable patients with less authority and education are the ones at risk for compromised care. One example of this hierarchy is the power dynamic between physicians and nurses. Many nurses feel pressured to be silent or are silenced regarding medical errors, no matter the severity and no matter the intention. One nurse reports:

This isn’t about hurt feelings or bruised egos. Modern health care is complex, highly technical and dangerous, and the lack of flexible, dynamic protocols to facilitate communication along the medical hierarchy can be deadly. Indeed, preventable medical errors kill 100,000 patients a year, or a million people a decade […] Because successful health care needs to be interdependent, the silencing of nurses inevitably creates more opportunities for error. In a system that is already error-prone and enormously complicated, where health care workers are responsible not just for people’s well-being, but their lives, behavior that in any way increases dangers to patients is intolerable. When I became a nurse, that’s not the kind of harm I signed on for. (Fernandes & Ecret 2019, 26)

Intentional or not, the silencing of nurses or any medical professional can lead to a deference to authority, which is dangerous for patient care.

These hierarchies have been known to have negative effects on interprofessional communication and on one’s moral conscience. The voluntary and involuntary silencing of nurses and other medical professionals regarding unprofessional and unethical behavior can erode one’s conscience. Many studies confirm this idea, and one Irish study revealed how many medical students are introduced to the hierarchy of the medical profession through humiliation and fear (Crowe et. al. 2017). One medical trainee had the following response regarding their
perception of the hierarchy of medicine: “There’s very much the patriarchal thing of the consultant [senior physician], you never question them and you’re there to do exactly what they say’ (Participant 40, female);” another explained: “You’re dealing with people who’ve been there for 10 years, 20 years, 30 years […] You can’t really say anything because it’s so poorly received’ (Participant 10, male)” (Crowe et. al. 2017, 74). There is also little incentive to alter the hierarchy, as medical students and trainees are not often encouraged to question older and more experienced physicians (Vidal et. al. 2005).

Medical and nursing students living under the Third Reich had little reason to disbelieve their professors or mentors. By 1945, half of physicians and 30% of nurses in Germany had joined the Nazi party, which are much higher rates than other professions (Crowe et. al. 2017). Scholars in the field have also shown that many nurses actively participated in forced sterilization and euthanasia programs, and medical research abuse without much resistance (Crowe et. al. 2017). The amount of members along with the prestige of the medical profession in Germany at the time helped to garner support for the eugenic and euthanasia programs from not only the public, but other members of the medical profession. This shatters the myth that medical professionals were forced to participate in these programs, but rather played an active role in their implementation. The medical profession playing an active role in implementing discriminatory public health practices is not exclusive to the Holocaust, and we must be wary blindly following even the most prestigious physicians.

The Holocaust reveals the importance of interprofessional education and collaboration to ensure that all medical professionals have the tools and courage to speak up to issues they see. We must have rigorous conscience protection for these medical professionals so that they are not fearful of repercussions for speaking up against wrongdoings. Ethical education can help
alleviate these negative aspects of the hierarchy of medicine through small group interactive cases where professionals can practice speaking up in unethical situations. This will provide medical professionals with the tools to prevent silencing from happening in the first place, and will help to foster an environment of trust, communication and transparency. Incentives like these are already in place in certain medical contexts (Ginsburg & Bain 2017), but expansions of programs like these are crucial to empower all medical professionals to hold each other accountable.

**Integration into the medical school curriculum**

Although the importance of Holocaust education in medical schools is clear, there is debate about the most efficient and realistic way to incorporate this education into US medical school curricula. Medical school curricula today are already packed with a plethora of required elements, and the addition of a required Holocaust course across all medical schools seems unlikely. Adding to this difficulty, the Holocaust is a complex and emotionally charged subject that cannot be presented quickly, and requires adequate time for discussion and debrief. Instead, the best way to teach Holocaust education, in general and especially in medical schools, can be compared to the study of acid-base chemistry. Acid-base chemistry constitutes one of the most fundamental aspects of chemistry and also has implications for biology, physics, neuroscience and other STEM disciplines. The study of acid-base chemistry, like the Holocaust, necessitates a focused attention, but it may also be necessary to locate where it is involved throughout the entire curriculum and learn about its implications in a larger context (as referenced by Dr. Matthew Wynia in his presentation, “How Healers Became Killers,” on January 27, 2021). Topics of the Holocaust can be integrated into, but are not limited to, the following examples (Levine et. al. 2019): (1) Teaching that the scientific method and research ethics should include
examples of the misuse of the scientific method to promote Nazi social policy; (2) Consciously referencing the rationale for avoiding eponymous labels on medical conditions associated with Nazi physicians, such as Reiter, Asperger, and Wegener; (3) Discussing the murder and inhumane treatment that Nazi physicians perpetrated on patients with disabilities when teaching about developmental disabilities and mental health issues; (4) Referencing the eugenics program and the rationale behind it when teaching genetics; (5) Examining the treatment of certain groups as “subhuman” when presenting content on clinician bias, racism and health equity.

These topics, also incorporating the lessons of empathy and detachment training, scientific skepticism, the challenge of competing loyalties and the hierarchy of the medical profession, and others, can help model the fundamental roles of ethics in promoting good patient outcomes and professional well-being. As each next generation has less of a personal connection to the Holocaust, it is more important than ever to make sure that the history and lessons of the Holocaust are ingrained in medical education to protect human rights and the integrity of the future of medicine.
Conclusion

One of the most important aspects of medical ethics to recognize is that ethics is not just an accumulation of knowledge of what to do and what not to do, but a skill to develop. The skills that people develop during normal times prepare us to successfully handle the difficult times. The Holocaust can inform us that if we do not make sure that ethics is seen as a skill to develop rather than content to know, then we will not have those skills when we need them. One timely, contemporary connection of the Holocaust in this sense is the COVID-19 pandemic, as there are many aspects of the global response to the pandemic that have roots in the Holocaust, including triage protocols and epidemic response measures, such as quarantine and isolation. The Holocaust began when some lives were deemed unequal to others, and the COVID-19 pandemic has unfortunately shown that systemic inequalities continue to affect health care today. Despite these inequalities, many physicians today have gone above and beyond their role to help provide compassionate care amidst the unprecedented circumstances of the pandemic, revealing that lessons have been learned from the Holocaust, inspiring hope for the future of medicine.

The COVID-19 pandemic has unfortunately shown that the groups most affected by COVID are those who have historically been deemed as less valuable than others. African Americans, Latin Americans and Native Americans have been infected and died from COVID-19 at disproportionately higher rates than whites. In Michigan, African Americans make up 14% of the population, yet they constituted 40% of the fatalities as of May 2020 (Stern 2021). Additionally, the protocol for treating elderly COVID-19 patients has demonstrated an implicit ageist bias, as special clinical protocols, health-screening procedures for visitors and other policies were implemented for children and adult patients before they were for elderly, and in
more detail (Aronson 2020). The priority of younger, and presumably healthier, people during the beginnings of the coronavirus pandemic reveal the entrenched ageism in American health care. Implicit racism, ageism, ableism and other forms of discrimination in health care have been made especially noticable by the global response to COVID-19, and will require a universal commitment to the systemic transformation of the American health care system. We are not playing a “numbers game” during this pandemic, and need to make sure every individual life counts, not for what they can contribute to society, but for their inherent value as a human being. The Holocaust has warned us of the dire consequences of prioritizing certain lives over others, and the global response to the pandemic has made clear that there are still lessons to be learned on a systemic level that everyone must be vigilant to help enforce.

Despite this systemic discrimination in health care, many physicians have demonstrated an unwavering commitment to their profession that provides hope for the future of medicine. In particular, Dr. Anthony Fauci M.D., Holy Cross ‘62, the director of the US National Institute of Allergy and Infectious Diseases and the chief medical advisor to the president, has been a crucial voice of reason as the unknowns of the COVID-19 pandemic cultivated a chaotic and scared ethos throughout America. He has demonstrated an unwavering commitment to the scientific method despite public and governmental pressures to prematurely reopen the country. Most importantly, he recognizes through his words and his actions the importance of objectivity in the realm of medicine: “You stay completely apolitical and non-ideological, and you stick to what it is that you do. I’m a scientist and I’m a physician. And that’s it” (Specter 2020, 1). Fauci’s authoritative and calming presence has been instrumental in the effective handling of the COVID-19 pandemic in America, and his enduring commitment to the virtues of medicine help
to ensure that the sacrifices that so many physicians in the Holocaust made to serve their patients are not forgotten.

The lessons learned from the Holocaust play an important role in the development of ethically responsible and humanistic health profession policy and personnel. Some of the core challenges that faced physicians during the Holocaust are still with us today, and academic leaders must make conscious efforts to develop a consistent and effective curriculum with faculty training to enact it. This will require institutional and leadership commitment to Holocaust education in biomedical ethics in order to ensure that this history resonates with and informs our deliberations on ethical challenges in medicine today. Once again, as George Santayana said, “Those who cannot remember the past are condemned to repeat it.”
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