HISTORY

Why Did So Many Doctors Become Nazis?

In the answer, and its consequences, a bioethicist finds moral lessons for today's professional healer

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THIS ESSAY IS WRITTEN FROM THE POINT OF VIEW OF A PHYSICIAN, medical educator, and bioethicist who sees the deplorable fact of physician involvement in the Shoah as an opportunity to highlight enduring moral lessons for the medical professions. Medicine and law are intimately connected to one another, and, since the professionalization of medicine in the United States and Europe in the latter half of the 19th century, even more so. One discipline that connects both is moral philosophy; for both law and medicine involve reason and the will, directed toward the good of the person. Thus, the story of the Holocaust is a tragedy that unfolded because of the corruption of *moral philosophy first*, and medicine and law second.

Why is this important? The reason is that there are those who argue *against* the contemporary application of lessons learned from the horrors of Nazi medicine. Some say that "Nazi medicine" was not real medicine or science: We cannot even call what the Nazis did "medicine," since medicine contains *within it* an assumption of rigor and beneficence. This is an objection I hear from medical scientists, who point to safeguards such as the Nuremberg Code (1947), the

Declaration of Helsinki (1964), and the Belmont Report (1978) as proof of the radically different nature of science today. But this argument is circular. It defines science as "good science," (relegating anything unethical to "bad science" or "pseudoscience") when in fact these very safeguards were born out of abuses from what was then the most scientifically advanced country in the world. Medicine then, as now, is not somehow immune from this abuse, as the horrific postwar abuses at Tuskegee and elsewhere make clear.

Other scholars have suggested that the real cause of the Holocaust was an economic, political, or racial one—not a moral one—and that, since the United States has a radically different political, economic, and cultural system, the use of the "Nazi analogy" should be restricted. Medical abuses today are somehow less likely because economic, political, and cultural considerations are highly specific. One prominent bioethicist, for example, noted:

> A key component of Nazi thought was to rid Germany … of those deemed economic drains on the state … a fear rooted in the bitter economic experience after the First World War. … [These themes] have little to do with contemporary debates about science, medicine, or technology.

While I agree that the so-called "Nazi analogy" has been misused and even abused, and therefore should be used with restraint and precision, denying the risk of backsliding steps too far. It may be falsely reassuring to suggest that the Holocaust was "merely" politically motivated. Even granting the (disputable) claim that the primary motivation for the Holocaust was economic or political, the Nazis somehow made the leap from identifying persons as "economic drains" to becoming completely and utterly *disposable*.

Finally, it should be noted that just as philosophy has a decisive impact on both medicine and law, medicine and law exert important effects on one another. The Nazi sterilization laws, Nuremberg marriage laws, and euthanasia directives all changed irrevocably the nature of the physician-patient or physician-subject

relationship and gave license and purpose to craven ideas that hitherto were discussed but not technically allowed.

It is worthy of emphasis that although many professions (including law) were "taken in" by Nazi philosophy, doctors and nurses had a peculiarly strong attraction to it. Robert N. Proctor (1988) notes that physicians joined the Nazi party in droves (nearly 50% by 1945), much higher than any other profession. Physicians were seven times more likely to join the SS than other employed German males. Nurses were also major collaborators.The Holocaust should be studied by every health care professional as a reminder of how sacred the substance of our craft is, and what the consequences may be if we forget the dignity of persons again.

Between 1933 and 1945, the Nazis established a "biocracy," which ultimately murdered millions of innocent persons. The notion that doctors were somehow "forced" to participate has been shattered as myth; Proctor's (1988) unparalleled volume makes this vividly clear; Robert J. Lifton's *The Nazi Doctors* (2000) meticulously traces both the medicalization of death, from eugenics to euthanasia to Auschwitz, and the stories of physicians who perpetrated genocide, were subjected to it, and resisted it. Thus, with a wealth of historical research on the subject, a full accounting of this progression from trusted healers to state-sanctioned killers is beyond the scope of this essay.

In 1859, Charles Darwin published *The Origin of Species*. This scientific theory elucidated the theory of evolution in a pre-genetic era but made no broad claims about philosophical anthropology. Darwin's work was decidedly descriptive, not prescriptive. Later, Francis Galton coined the term "eugenics" in his work *Inquiries into Human Faculty and Its Development* (1883),and the application of "evolution" on a societal level was born. Social Darwinists such as Charles B. Davenport in the USA and Karl Pearson in England, for example, made the case, in different ways

and utilizing the "language of science," that the genes of the "fit" should be promoted, and the genes of the "unfit" discouraged. Daniel J. Kevles (1995) traces the origins of the eugenics movement through Europe and the United States, and the powerful influence on social policy in the prewar era, including resistance to it, notably from the Catholic Church and its intellectuals (such as G.K. Chesterton), as well as a minority of brilliant secular scientists.

Still, German eugenicists took "discouragement of the unfit" further, cooperating eagerly with the Nazi party—as they were willing to support *forced* sterilization of the "unfit." More than a decade before the Nazis, Alfred Hoche and Karl Binding (1920) published their influential book, *Die Freigabe der Vernichtung lebensunwerten Lebens* (*The Authorization of the Destruction of Life Unworthy of Life*). The book had spoken of the "incurable feebleminded" who should be killed—but for now, sterilization was a good start.

Most know how the tragic story unfolded from here: The Nazis came to power in Germany in 1933, through a democratic process, and that same year, laws for compulsory sterilization of the mentally ill were passed. The Law for the Prevention of Genetically Diseased Offspring was based on American laws passed in the 1920s, and required 50,000 sterilizations annually. By 1939, 350,000 persons had been sterilized against their will. In 1935, the Nuremberg Laws were passed, forbidding sexual relations and intermarriage between Germans and Jews and establishing "genetic health courts." The sterilization laws led to rapid advancement in the science and technology of sterilization, as well as a major financial gain for many German physicians—racial hygiene had become a veritable cottage industry.

For Hitler and the Nazi physicians, the state was analogous to a living organism– a supreme political vitalism. In fact, it was much more than an analogy. Nazi doctors and scientists, in conceiving the biological *metaphor*, created a powerful, easily understood concept for the general populace: The German Reich *is* a body; whatever contributed to the health and well-being of the racial state was to be preserved, that which did not could be labelled a "disease." The Jews *are* a disease;

disease must be *completely* cut out (not merely suppressed), for it will otherwise poison and kill the body.

Thus, sterilization would never be enough. Suppression of a disease is inferior to ridding the body of it. In October 1939, Hitler authorized euthanasia of the "incurably sick." The right to life now had to be "justified" under a Nazi program to euthanize "lives not worth living." The program began secretly with disabled children, and between 1937 and 1945, the Nazi physicians organized and implemented more than 30 euthanasia centers for children. The history of the move to euthanasia from sterilization, its cruelty and efficiency, and its impact on the progression to the Holocaust is well documented in Michael Burleigh's dense and disturbing book, *Death and Deliverance* (1994).

The Nazi euthanasia campaign was publicly justified with four main arguments. First, ridding Germany of the unfit was simply "good science." Who better to determine what constituted good science than German physicians, who were already the best in the world? The experts knew what was best for the German body.

Second, euthanasia was deemed humane. Since it was supported and implemented by a profession with a long tradition of healing and caring, the argument was even more persuasive. Pediatric euthanasia was often supported by many parents of disabled children for this reason; yet, with mixed motivation, for many wanted to avoid the strong stigma of having a disabled child. This conflict of interest shows how medical culture can influence the ethics of both individuals and society at large.

Karl Brandt, the infamous Nazi doctor, gave this worryingly persuasive defense at Nuremberg—a defense I still challenge my students and faculty with:

> The human beings who cannot help themselves and whose tests show a life of suffering are to be given aid. This consideration is not inhuman. I never felt that it was not ethical or was not moral. But one thing seems necessary to me—that

> if anybody wants to judge the question of euthanasia he must go into an insane asylum and he should stay there with the sick people for a few days. Then we can ask him two questions: the first would be whether he himself would like to live like that, and the second, whether he would ask one of his relatives to live that way—perhaps his child or his parents.

This was no "monster's defense." But if Brandt's words are persuasive, we must have a remedy—both intellectual and experiential—to rebut it.

Still, Dr. Brandt's challenge combines the "humaneness" justification with a third. Especially in the case of children and the mentally disabled, euthanasia was deemed "rational," that is, if they could only choose it themselves under "a veil of ignorance," to reference the terminology of one postwar moral philosopher, they would. It should be noted that physicians at the time were more concerned about the "legality," not the morality of euthanasia, and many insisted that euthanasia was a "private matter" between patients and doctors.

Finally, killing through euthanasia was justified independently on the premise that it was good for the racial state. That "good" eclipsed the good of this individual being. It should be fairly obvious that there are strong parallels between these reasons and contemporary arguments in favor of euthanasia today. While a full accounting of these parallels is beyond the scope of this essay, readers should note professor Peter Singer's justifications for euthanasia, and Michael Burleigh's sharply critical response in *Death and Deliverance*.

By the end of the "T4" program to euthanize disabled adults and children, between 70,000 and 100,000 persons had lost their lives; stigma against the vulnerable in attitude and language had become codified in law. According to Proctor, these three programs—forced sterilization of the "unfit," the Nuremberg Laws, and the euthanasia laws—were the primary means the Nazi physicians and scientists used to accomplish "racial hygiene," and led directly to the technological and medical surge responsible for genocide at the death camps.

But degradation and death was not limited to the clinical aspect of medicine. Research abuses by physicians and scientists, conducted in hospitals as well as in the camps, ranged from the scientifically frivolous (injecting prisoners with typhus) to the malevolent (amputation of limbs and "transplantation" onto other bodies), and are well documented elsewhere. Physicians were held in such high esteem, and thought to be of such high moral character, that experimentation was justified in that it benefited society, added to a burgeoning body of knowledge (a good in itself), and often (but not always) benefited the patient. It should come as no surprise that other populations (such as African-Americans in the USA, and prisoners of war in Japan) were also subjected to grotesque and unethical human experimentation during this period, and beyond.

In 1942, and as a direct result of a deep-seated tradition of anti-Semitism within the German medical community, the Christian churches, and Europe in general, the "Final Solution" was proposed—the murder of the entire European Jewish population. Nazi medicine, through what can only be called, in modern terms, "advocacy," had a profoundly negative effect on culture. Physicians, dressed in white coats, gave the imprimatur that indeed, those that were to be gassed were not human persons at all:

> At every turn, the annihilation procedures were supervised—and, in a perverse sense, dignified—through the presence of medical staff. … We may say the doctor standing at the ramp represented a kind of omega point, a mythical gatekeeper between the worlds of the dead and the living, a final common pathway of the Nazi vision of therapy via mass murder.

The killing of 6 million Jewish persons and 9 million "others"—could only have been accomplished through a buy-in into a twisted philosophical anthropology. Science alone could not accomplish this destruction, because science never stands alone. So, although we may not kill *persons*, we may kill animals, vegetables, and

subhumans. What the Nazis needed was a philosophy to define out of lives inconvenient to the goals of the Race, and then science to do the killing. This is why the Holocaust can be deemed a "bioethical assault" on human personhood.

Nearly two decades ago, the late Edmund Pellegrino, M.D., one of the fathers of modern bioethics and my own mentor, gave us a starting point for procuring valuable, enduring lessons after Nuremberg:

> We see here the initial premises that law takes precedence over ethics, that the good of the many is more important than the good of the few ... The lesson [from the Holocaust] is that moral premises must be valid if morally valid conclusions are to be drawn. A morally repulsive conclusion stems from a morally inadmissible premise. Perhaps, above all, we must learn that some things should *never* be done.

Pellegrino was correct. The Holocaust is not merely a lesson in history, it is an enduring lesson in philosophical ethics. These lessons are perhaps more important to remember today, as personal memories of the Shoah fade, survivors and liberators themselves become a part of history, and young physicians graduate medical school with less empathy and moral resilience than when they began.

The physicians who actively aided the Holocaust believed that they were practicing "good science." But scientific truth alone does not "grasp" the reality of life, and if we believe it so, we are further on the road to what the late Jean Bethke-Elshtain called "scientific fundamentalism." Physicians and health care professionals must, therefore, remember the Holocaust, but remember, as Pope John Paul II said on his visit to Yad Vashem, to "remember with a purpose." I will briefly articulate five lessons of the tragedy of Nazi medicine that we must remember and integrate into our medical practice, if medicine is to survive as a profession of healing.

"As a physician, you must serve the patient exclusively—not some abstracted idea of

‘society.’”

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First, and perhaps most fundamentally, we must affirm a strong personalism. This anthropology has been described briefly above, and extensively elsewhere, by Maritain, but it also has adherents as diverse and important as Mohandas Gandhi, Martin Luther King Jr.,and the late philosopher Karol Wojtyla (Pope John Paul II). Personalism posits the ultimate unit of value of human life is the individual person herself. Society is and ought to be built around this value. In short, society is created for the person, not the person for society, and hence the dignity and integrity of the person and her freedom cannot be sacrificed for the sake of society. No contingent factor—race, religion, economic status, disability, or actions of the past, present or future—can rob a person the dignity she is owed. Integrating this kind of rigorous, universal philosophical anthropology is an antidote to the corruption of medicine, and vital for the prevention of future genocides.

However, disturbing parallels in our contemporary medical, academic, and social culture now argue, for example, for abortion as a form of eugenics and crime reduction; the coerced sterilization of prisoners; pre-implantation genetic diagnosis as a way of promulgating “good genes”; and tours of Auschwitz as a “learning experience” for supporters of euthanasia. Targeted abortion for unborn children with genetic conditions such as trisomy 21 and cystic fibrosis have reduced populations by more than 90%, and are justified on utilitarian grounds. But if a person is the fundamental unit of value of our society, then no “other good” can eclipse her. Politically, legally, and medically, this would mean an expansive and firm definition of person, for it is a far smaller risk to give

protection to an entity where personhood is possible, than to destroy the life a person who in the end deserved our protection. Practically, this must mean the end of physician involvement in state-sponsored torture, capital punishment, euthanasia, and eugenically motivated sterilization and artificial reproductive technologies.

Second, we must have rigorous conscience protection for physicians and health care providers. Contemporary literature in bioethics favors the removal of conscience protection laws particularly on "hot button issues" such as abortion, contraception, sterilization, and now euthanasia. Yet, a physician's oath to her patient is only as strong as her conscience; allow (or even force) her to break it, and we have forgotten: One day, it may be our turn to stand against the tide. On this issue of conscience protection in medicine, of which volumes have been written, eloquent defenses (while still in the minority) made by Dan Sulmasy and others make clear the point that conscience is an active, driving force that is part of who we are as persons, and warn of the danger of a positivistic bioethics.

A medical student once asked me what was the most important lesson I wanted them to know. My answer was this: Between good and evil, there is no "safe space" to stand. There is no neutral void from which a physician can escape his ethical duties, referring it to another. In the time of the Nazis, courageous leaders from opposite ends of the spectrum—Cardinal von Galen, Dietrich Bonheoffer (tortured and murdered), and the Association of Socialist Physicians (whose leaders were arrested or exiled in 1933, and many murdered in Austria and Czechoslovakia in 1938)—would not stay silent. Bonheoffer's words still challenge us today:

> We have been silent witnesses of evil deeds: we have been drenched by many storms; we have learnt the arts of equivocation and pretence; experience has made us suspicious of others and kept us from being truthful and open; intolerable conflicts have worn us down and even made us cynical. Are we still of any use? What we shall need is not geniuses, or cynics, or misanthropes, or clever tacticians, but plain, honest, straightforward men. Will our inward power of resistance be strong enough, and our honesty with ourselves

> remorseless enough, for us to find our way back to simplicity and straightforwardness?

If morality does not assert its dominion over the law, the reverse shall happen, and radical positivism, with its morally inadmissible premises, will reach its equally inadmissible conclusions.

The third lesson to be learned from the study of medicine and the Holocaust is this: Science is not a "god." Science relies on hypothesis, experiment, and validation or falsification of the hypothesis to progress. But it is science's own methodology that also highlights its limitations. Science cannot answer of itself—using its own empirical methodology—whether a particular medical practice is *morally* good. It must rely on philosophy to do so. Moral philosophy extracts truths from reality based on reason and "lived experience." The ethical enterprise is therefore both objective (rational) and subjective (experiential). Albert Einstein once said that:

> And certainly we should take care not to make the intellect our god; it has, of course, powerful muscles, but no personality. It cannot lead, it can only serve; and it is not fastidious in its choices of a leader. This characteristic is reflected in the qualities of its priests, the intellectuals. The intellect has a sharp eye for methods and tools, but is blind to ends and values. So it is no wonder that this fatal blindness is handed from old to young and today involves a whole generation.

Fourth, as physicians and health professionals we must resist the desensitization to *dehumanization* that is so prevalent in medicine's culture. Every clinician can tell you about the terms used to describe patients behind closed doors: "vegetable" (comatose); "P.O.S." (piece of sh*t); "squirrel farm" (neonatal intensive care unit); "breeder" (a woman with more than 2-3 children); "useless"; "parasite"—the list could go on. For it is far easier to kill a "vegetable" than a human person; to not resuscitate a "squirrel" than a little baby; to feel no pang of conscience for disrespecting a "P.O.S." or a "parasite" than a poor drug addicted person.

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The medical literature supports these widespread anecdotal references. Omar Haque and Adam Waytz (2012) discuss causes of dehumanization alluded to previously: empathetic erosion and moral disengagement in training and practice. There is also another that particularly rings true: *dissimilarity* between physician and patient. Dissimilarity "manifests in three primary ways. First is through dissimilarity in illness—patients, by their very nature of being ill, become less similar to one's prototypical concept of human. Second is the labeling of the patient as an illness, rather than as a person who has a particular illness.

Whatever the reason—dissimilarity or something more sinister—language alters perception, and perception affects our ethical calculus. For example, to build support for euthanasia of the disabled, Nazi filmmakers deliberately altered lighting on the faces of the disabled, to make them more "inhuman" in their appearance. Purposeful and dramatic dehumanization has the same ultimate

outcome on our perception as slow, chronic dehumanization. Simple gestures—such as standing up against such language publicly when people dehumanize or showing *personalistic leadership* through examples of patience and even tenderness at the bedside—will do much to begin reversing this narrative.

Finally, a fifth lesson to be learned is that, as a physician, you must serve the patient exclusively—not some abstracted idea of "society." Physicians and health professionals in the Holocaust decided that the good of the racial state took precedence over the good of individual persons. "Nazi doctors hailed a move 'from the doctor of the individual to the doctor of the nation.'" The justification for the euthanasia program, in large part, was couched in economic terms—a cost-saving measure for society in a time of scarcity.

Today, we seem to be losing more of our commitment to the individual patient—for there are other "gods" in medicine. "Quality of life," "public health," or even "patient satisfaction" have become ends in themselves, not a means to an end. Physicians and mental health professionals in this century have (and continue to be) complicit in torture, in racial discrimination, and in capital punishment. In all of these examples, the physician obscures the value and dignity of the person for some other goal—some even laudable ones, perhaps (security, order, public health, etc.) Yet, the power of the "white coat" demands, if we are to fulfill our obligations of trust, that we do not serve the state (and its economic interests), nor the patient's family (however compassionate our motivations), nor any other "just cause" or goal, including our own.

The white coat derived its significance in the last century from the physician as laboratory scientist, surgeon, and hospital doctor—but ultimately, its power rests in its symbolic value of the physician as healer. As black's opposite, which often signified darkness and death, the white coat conveys the pull towards light, and life. This is not to ignore the controversies surrounding the white coat and its contemporary use, misuse, or disuse; it is only to point to a reality of the physician: that our profession was meant to always uphold the life and dignity of the human person, even if we could not preserve it.

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