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MEDICINE AND PUBLIC ISSUES

Care of the Medical Ethos: Reflections on Social Darwinism, Racial Hygiene, and the Holocaust

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The core values of medicine-healing, relief of suffering, and compassion-have ancient roots and have been reiterated on countless occasions over the millennia. Most physicians have adopted these values and use them to guide clinical practice. However, these principles, which reflect the ethical priorities of medicine in most western societies, are vulnerable to distortion and subversion by various forces. The eugenics movement of the early 20th century, based on flawed and simplistic science, was one such force; it led medicine to adversely affect the lives of tens of thousands of persons in the United States, Great Britain, and elsewhere. The most egregious distortions of the medical ethos took place in Nazi Germany in the 1930s and 1940s, when state policies led German biomedicine to depart radically from the traditional values. Recent decades have seen heightened sensitivity to the idea that the medical ethos is not immutable; rather, upholding it requires concerned attention and ongoing care. Such views have been sharpened not only by reports of ethically flawed research but by striking inequalities in access to and quality of health care among socioeconomic and ethnic groups in the U.S. population. Specific efforts are needed to raise awareness of the central importance of the medical ethos as an active guide across the range of activities of biomedicine.

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The core values of medicine, centered on compassionate and apolitical care of the sick, were profoundly and violently disrupted during the 1930s and 1940s, when the medical profession in Germany adopted the values and priorities of the Nazi state. The impact of those events continues to generate critical questions about the validity of our view of medicine as a social and humanitarian undertaking.

The medical ethos has been composed of an interlocking set of views about the physician, the patient, and the medical enterprise itself. The physician's role has centered on helping-on the primacy of beneficence, as medical ethicists have come to call it. Taken from the Hippocratic writings, primum non nocere has been a central tenet, or, as stated in a powerful 15th century epitome, "to cure sometimes; to relieve often; to comfort always" [1]. We have seen the physician as engaged in a highly moral enterprise that contains echoes of its ancient origins. At the temple to Asklepios on the Acropolis, for example, an inscription reads, "These are the duties of a physician ... he would be like god savior equally of slaves, of paupers, of rich men, of princes, and to all a brother, such help would he give" [2]. We have sought to preserve and transmit these views in our faculties, training programs, and

professional societies.

With regard to the patient, western societies have long endowed sick persons with special worth. This concept was powerfully articulated in the Middle Ages by the Knights Hospitallers of Saint John of Jerusalem, founded at the end of the 11th century. Every Brother, at his induction into the Knights, recited the vow found in the earliest rule of the order: "The brethren of the Hospital should serve our Lords, the sick, with zeal and devotion, as if they were serfs to their Lords" [3]. The special worth of the sick has continued to be a powerful underlying theme in medicine.

The third element of the ethos has had to do with the nature of medicine itself. Over the centuries, physicians have believed that medicine should be at once dispassionate and compassionate-scientific (that is, evidence-based) to the extent that the knowledge of the time allowed and, since the mid-19th century, when physiologic and clinical research emerged, characterized by a sense that the field is permanently unfinished, constantly in search of deeper scientific understanding and greater usefulness to the sick. Although medicine has continued to expand and to add to its capacities in a technical sense, its core values-healing, relief of suffering, and compassion-have been viewed as central, however irregularly they have been expressed.

The tacit view has been that the ethos was immutable, that the core and best values were stable despite individual and cultural variation. In fact, confidence in the stability of the ethos has allowed the view that it needed no special tending, that its persistence could be assumed because it reflected crucially important and widely shared values expressed in an enterprise of fundamentally beneficent intent. Thus, one might note the absence of a formal medical ethics movement or related courses, curricula, seminars and institutional review boards, until the Nuremberg Code focused attention on the rights of human subjects of experimentation. The ethos has traditionally been transmitted informally rather than through structured efforts, largely in medical faculties. It has been expressed and handed on primarily by precepts enunciated by articulate persons and by example, through implicit educational processes-demonstrations, in effect, of how the professional ethos is played out in the physician's activities [4].

In Germany, National Socialism and the events of the Holocaust caused the values of the medical profession to collapse under the weight of politically determined priorities that made medicine an arm of state policy. Physicians adjusted to and accepted a new hierarchy of human worth that demonized the infirm, the disabled, and the genetically blighted and withdrew their care and compassion from these persons and from immense numbers of perceived enemies of the state and polluters of the purity of German blood. At the same time, individual values among the academic and practicing establishments adjusted quickly and effectively to the disenfranchising of villainized Jewish colleagues. The engagement of the academic medical community has recently come under scholarly scrutiny in the documented demolition of the important medical faculty at the University of Vienna, accomplished with the active engagement of its senior academic officers [5]. The medical ethos, in that time and under those circumstances, proved to be frail and porous and was defended by few in the profession.

More broadly, as Langer [6] has pointed out, history itself has been rewritten by Nazi priorities and systems, especially the Holocaust, in the sense that it can no longer be viewed as an uninterrupted chronology of automatic progress. Langer says that the repeated abuses of our era, including genocide as a new norm of violence, call on us to develop "an alarmed vision" that interdicts the normalization of violence, disease, and human abuses; we must deal with "a spectacle of diminished promise" as one legacy of the Holocaust [6]. Biomedicine, too, must deal with these issues through the prism of its assumptions about its own deep nature and the individual responsibilities of physicians. It requires "an alarmed vision," a reflective vigilance, of its own. The history of medicine can no longer be viewed as a chronology of automatic progress.

Science Gone Wrong

The complicity of the German biomedical enterprise with the Third Reich must be seen in historical perspective, including the proud and extraordinarily productive scientific background that arose in Germany in the latter half of

the 19th century and the preeminence of German medicine that quickly followed. Modern biochemistry and experimental physiology had their roots in late 19th-century Germany, and ambitious young physicians from North America flocked to German laboratories and superb clinical facilities where medicine was practiced and taught in a manner based on the new science. So powerful and compelling was the German experience for these future leaders that it was essentially the German university and laboratory model that emerged in North America.

The model did not exist or flourish in isolation. In parallel with the development of biomedical science, a powerful international response began to gather after the appearance of Darwin's *Origin of Species* in 1859. Efforts were soon made to apply the principles of natural selection to human populations. Social Darwinism, particularly as it emerged in Germany, early stressed the need for state intervention [7] on the basis of the idea that racial integrity was threatened because medical care had begun to destroy the natural struggle for existence and the numbers of poor persons and misfits were threatening to overwhelm the talented and able. An international eugenics movement aimed at enhancing the quality of populations emerged in the late 19th and early 20th centuries in response to these concerns and became especially vigorous in the United States, Great Britain, and Germany. *Origin of Species* had acquired a social flavor in the hands of reformers; concern shifted from the development of the individual to the welfare of society as a whole [7]. The rediscovery of Mendel's experiments in 1900 energized efforts to correlate intelligence and various behaviors with biological factors, lending a strong flavor of scientific support to eugenic theorizing. Racist undertones soon appeared, although these had been present and had been supported by the science of the time even before eugenics emerged [8, 9].

The early leaders of the Social Darwinist movement in Germany included Alfred Ploetz, who, in 1895, wrote the founding document of what came to be known as racial hygiene [10], in effect an activist eugenics. Ploetz argued that if the fit were to be the primary survivors, counterelective forces should be avoided, including (perhaps especially) medical care for the weak, because this promoted reproduction among them [11]. In the same year, John Haycraft, a British Social Darwinist, wrote that tuberculosis, scrofula, and leprosy should be considered "racial friends" because they attacked only persons of weak constitution [12]. In the next few years, Ploetz, psychiatrist Ernst Rudin, and others formed the Society for Racial Hygiene, which quickly came to include physicians as well as industrialists, academics, and others from influential sectors of society. The racial hygiene movement expanded rapidly, especially after World War I, when it became established as a respectable part of German biomedical science. The conversion of this early, relatively apolitical series of efforts into an element of state policy with powerful racist overtones was catalyzed with the help of Ploetz, Rudin, and Fritz Lenz, a leading geneticist and an early editor of the *Archives of Racial and Social Biology* (founded by Ploetz in 1904).

While these forces were gathering strength in Germany, eugenics was emerging vigorously in the United States. One of the primary figures behind the rise of the U.S. movement was Charles B. Davenport, founding director of the Station for Experimental Evolution at Cold Spring Harbor. Davenport collected nearly three quarters of a million family pedigrees, assembled retrospectively without rigorous rules of evidence, and concluded from them that patterns of heritability were evident in insanity, epilepsy, alcoholism, "pauperism," criminality, and "feeble-mindedness" and that physiologic and anatomic mechanisms lay behind these traits and behaviors. His writings were overtly racist. For example, he equated national and racial identity and assumed that race determined behavior. He held that the Poles, the Irish, the Italians, and other national groups were biologically different races, as were the Hebrews. He found the Poles [13]

"independent and self-reliant though clannish; the Italians tending to crimes of personal violence; and the Hebrews intermediate between the slovenly Serbians and Greeks and the tidy Swedes, Germans and Bohemians, and given to thieving, though rarely to personal violence."

He identified good human stock with the middle class and especially the native white Protestant majority. In the name of eugenics and with the help of the American Eugenics Society, formed in 1923, Davenport was instrumental in launching a widespread campaign to encourage the better stock to enhance the rate at which they were reproducing and to eliminate defective protoplasm by the sexual segregation of "defective" persons while they were capable of reproducing. This trend later resulted in a program of involuntary sterilization carried out in some 60 000 persons in the United States, primarily criminals and the "feeble-minded," mostly in state institutions. State sterilization statutes were upheld by the Supreme Court in 1924 in *Buck v. Bell* [14], which affirmed the right

of states to interrupt the presumed transmission of "feeble-mindedness" across generations. The emergence of eugenic sterilization programs in the United States during the 1920s and 1930s influenced other nations. Canada enacted sterilization laws [15], as did Sweden, Norway, Finland, France, and Japan.

The most important events took place in Germany, where the Nazis sterilized thousands within 1 year of enacting a eugenics law. The German sterilization law was largely modeled on a draft written by Harry Laughlin, Davenport's associate at the Eugenics Record Office in Cold Spring Harbor. Laughlin accepted an honorary degree in recognition of his contribution from the University of Heidelberg in 1936. The Nazi sterilization program included a system of "hereditary health courts," which acted on petitions brought by public health officials requesting that persons identified by physicians as having any of a long list of disorders, including "feeble-mindedness," schizophrenia, manic-depressive illness, epilepsy, Huntington disease, hereditary blindness or deafness, severe physical deformity, or habitual drunkenness, should be subjected to compulsory sterilization. In 1934 alone, the courts heard almost 65 000 petitions and ordered more than 56 000 sterilizations, for what has been called a "eugenic conviction rate" of 87% [16]. The actual number of sterilizations performed under the Nazi regime is unclear because many of the relevant records disappeared during World War II, but the total was probably considerably larger.

After Hitler's appointment as Chancellor in 1933, a broader radicalized eugenics rapidly emerged with the support and engagement of the medical profession. In addition to the sterilization program, these efforts included an active "euthanasia" program in which some 70 000 inmates of German institutions for the "feeble-minded," many of them children, were gassed and cremated; cost as well as eugenic considerations played a substantial role in these decisions. The "euthanasia" program was organized and carried out by German psychiatrists, who reviewed questionnaires submitted by superintendents of state institutions that categorized inmates by degree of retardation, length of institutionalization, diagnosis, and other characteristics. On the basis of these questionnaires and without contact with any of the patients, the psychiatrists decided who should be killed.

This expansion of the concept of racial hygiene was justified in a vigorous public propaganda effort designed to establish the idea that seriously mentally ill and "feeble-minded" persons in state-run hospitals had "lives not worth living." The German government of the 1930s conducted an elaborate campaign aimed at the dehumanization of such persons, with emphasis on the eugenic idea that they were draining the state and the Volk of health and vigor. These views were soon extended to other groups, such as gypsies, homosexuals, and, especially, Jews. The "euthanasia" program was the forerunner of the techniques used in the Final Solution in the death camps; after the effort in the mental hospitals was effectively closed down, the gas chambers and crematories were dismantled and moved east, in some instances with the personnel who had managed them in the psychiatric hospitals. The eugenics movement, in short, had become linked to a violent social policy, enfranchised through the imprimatur of the state. Physicians were deeply involved in this movement, lending their assistance to the concepts in the new science of eugenics and to the day-to-day needs of making government policies effective.

The Special Role of German Medicine

The complicity of the German medical profession not only was rooted in Social Darwinism and the radicalized eugenics of the Nazi state but was also powerfully shaped by forces that arose during and after World War I. The economic prostration and social devastation that followed Germany's defeat, widespread unemployment (from which physicians were not exempt), and dissolution of confidence in the stability of the social environment pervaded German society. Much of the medical establishment that was in place when the Nazis came to power had been educated in the period immediately after World War I and had been part of the vast social suffering around them. They were ready for Hitler's call to a special role. Noting that he could, if necessary, do without lawyers, engineers, and builders, Hitler told physicians [17]: "You, you National Socialist doctors, I cannot do without you for a single day, not a single hour. If not for you, if you fail me, then all is lost. For what good are our struggles if the health of our people is in danger?" He meant radicalized racial hygiene. In April 1933, Hitler asked that the German medical profession move into the forefront of the race question; racial hygiene was to be the task of the German physician, and German medicine responded. Physicians were among the first to support National

Socialism. They had already formed the National Socialist Physicians League in 1929, with the promotion of racial science and eugenics as expressed in the Nazi agenda as primary goals. By early 1933, even before Hitler's accession to power, almost 3000 physicians (6% of the entire medical profession) had joined the League. By late 1933, 11 000 physicians had joined. Kater [18] has estimated that almost half of all physicians in Germany ultimately joined the Nazi Party, 26% were in the SA, and more than 7% were members of the SS (Schutzstaffel)-seven times more than the average for the employed male population. Physicians had accepted a special role in the reconstruction of the state. Formal centers for training in racial principles were set up, and the medical profession was coordinated in a single structure responsible to the National Socialist Physicians League, which became, in turn, an arm of national policy. Gerhard Wagner, a physician elected to the Reichstag as a Nazi party representative in 1933, was appointed Fuhrer of the German medical profession. Physicians were encouraged to move from doctoring individuals to doctoring the nation.

Around the time of World War I, a powerful holistic trend emerged in Germany, a reaction to the strongly scientific character of German medicine and to mechanistic views of life. Aspects of wholeness and mechanism "came to be identified with the Nazi fight against everything racially foreign" [19]. Disabled persons were an offense to the values of wholeness, just as the Jews were, and were themselves transformed into metaphors of mechanism. Accordingly, Nazi medicine turned away from the sick and useless and toward the healthy, who had the most to contribute to the Volk. It focused on disease prevention and education and generated powerful and effective public health programs. A vigorous antitobacco campaign was waged [20], and campaigns against alcohol and environmental toxins were promulgated. The model of the obese German burgher with a large stein of beer and a long curved pipe gave way to the young, lithe, muscular, nonsmoking, physically fit new ideal. The public health programs excluded those outside the pale, notably Jews, Communists, gypsies, and other "undesirables."

These trends were assembled by the Nazis, welded to rabid anti-Semitic state policies, and used successfully to embrace the medical profession in a kind of national therapeutic movement designed to heal the German state and promote a radical Nordic supremacism. A credo repeatedly articulated by the National Socialists held that what was wrong in Germany could be powerfully and usefully expressed through medical analogy. The "body" of the German people was threatened, and its healer was Hitler. As anti-Semitism was added to social Darwinism and racial hygiene, the so-called Jewish question was rendered a medical problem, "the therapy of which was to be realized in places like Auschwitz and Dachau" [21]. Gradually, the medical profession embraced the belief that to cure individual persons was one thing, but to heal the nation was incomparably more important; thus, most in the profession adopted the ideas of racial hygiene as a massive public health measure. "The aim of generating pure Aryans had taken precedence over the most fundamental ethical issues in medicine" [22], and healing acquired a new, sociopolitical definition that swept aside the vulnerability and suffering of large numbers of individual persons, who, in a sense, lost their humanity and were transmuted into pollutants of the state.

Physicians in Germany did not simply acquiesce; rather, they accepted, supported, and were instrumental in the application of the racist policies of the Third Reich. They made selections in the concentration camps; they dispatched prisoners who became ill to the gas chambers; they engaged in medicalized killings for political purposes, injecting cultures of live tubercle bacilli or other organisms into party officials and others whose deaths, it was thought, should appear to be from natural causes; they carried out premarital examinations, looking for evidence of the taint of Jewish blood; and they reported to the authorities persons with disorders thought to hold eugenic dangers for the Volk. By participating in the processes that doomed some children in state hospitals to death, in so-called racial courts that considered the presence or absence of non-Aryan blood, and in publications in medical journals dealing with the principles of racial hygiene, German medicine was not merely deflected from its traditional ethos but was invested in a perverse ideology of death and suffering [19].

Experimentation in the concentration camps, carried out on unwilling and nonconsenting human subjects, has emerged as an especially graphic instance of perversion of the medical ethos. Most of the experiments were done at the behest of the German armed forces. In high-altitude experiments, prisoners were placed in pressure chambers and taken to simulated altitudes at which pilots might have to eject. They were then subjected to rapid decompression to simulate ejection, and various factors were measured, including survival time. In the infamous freezing experiments, conducted for the benefit of the Luftwaffe and nominally intended to determine the conditions of survival for airmen downed at sea, prisoners were placed in ice baths or were forced to stand naked

in freezing outdoor temperatures and were periodically drenched with water to determine the limits of human endurance and the efficacy of various rewarming techniques. These experiments were performed without regard for the suffering inflicted and with the expectation that the subjects would die. Other efforts included studies on techniques for sterilization, especially of women, by using radiation or other methods. Perhaps the most widely known and, in some ways, the most abhorrent experiments were those done on twins by Josef Mengele and his colleagues. In these experiments, for example, a twin might be injected with typhoid bacilli and the other twin killed when the first one died so that the organs could be compared. Mengele, who held a PhD in anthropology as well as an MD, provided his mentor, Otmar von Verschuer, a leading researcher in racial hygiene at the Kaiser Wilhelm Institute, with "materials" that he acquired at Auschwitz, including blood samples, eyes, bodies of murdered gypsies, internal organs of dead children, and skeletons of murdered Jews.

An earlier and more pragmatic theme emerged from personal agendas. As Jewish physicians were disenfranchised, thousands of positions were filled by non-Jews and the salaries of non-Jewish physicians began to increase. The average taxable income for a physician grew from 9280 reichsmarks in 1933 to 14 940 reichsmarks in 1938. As Proctor has noted, "in purely financial terms the majority of German physicians prospered under National Socialism. Nazi policies provided a bonanza for those willing and able to move with the regime" [23]. As Jewish members of medical faculties were disenfranchised and ejected, non-Jews on the faculty seized opportunities for academic advancement and all that it carried [21]. Even Mengele hoped to use the results of his twin experiments as material for his "habilitation," an academic submission required for faculty appointment. Other physicians, such as Gerhard Wagner and his successor, Leonardo Conti, sought and achieved important political appointments.

At the end of World War II, the Berlin Chamber of Physicians, effectively the national medical organization of Germany, asked two of its members, Alexander Mitscherlich and Fred Mielke, to attend the Doctors' Trial in Nuremberg and report the proceedings. The Berlin Chamber was shocked by the report and did not release it for several years. The report consisted largely of excerpts from the almost 1500 documents introduced as evidence at the trial. Mitscherlich and Mielke wrote, in part, that

"the atmosphere ... remained oppressive. Never once was suffering vouchsafed the boon of pity in that great dungeon from which the ensuing leaks brought news, bit by bit, ominously belated. Amid the growing desolation, each act of cruelty had merely served to wear away one more fragment of what had once been whole."

They added [24]

"There is not much difference whether a human being is looked on as a "case" or as a number to be tattooed on the arm. These are but two aspects of the faceless approach of an age without mercy This is the alchemy of the modern age, the transmogrification of subject into object, of man into thing against which the destructive urge may wreak its fury without restraint."

The lesson was brought home again in the politically based perversion of psychiatry in the former Soviet Union [25].

Current Challenges to the Medical Ethos

Powerful challenges arise for physicians as this history is contemplated. Four issues are especially trenchant. The first has to do with sensitivity and response to human suffering and vulnerability as primary responsibilities of medicine. Responsiveness to suffering and demonization of humans cannot coexist: in fact, any scale of worth that might be applied to patients or their suffering damages not only the care of the individual patient but also the physician, diluting and vitiating the quality of care that can be brought to any other. From the new bioethics to a significant degree and, paradoxically, a product of the participation of medicine in the inhumanities of the Nazi era has flowed new emphasis on the primacy of the individual patient and justice and equity in medical care, as well as profound concern for the welfare of human research subjects [26]. In another paradox, an increasing focus on

the centrality of suffering has taken us increasingly into questions of end-of-life care, efforts "to recover humbleness before an awesome event" [27], a sharp and compassionate departure from the trivialization of death that characterized the Holocaust, one of its greatest horrors.

A second set of issues has to do with what might be called science regnant: that is, science insufficiently encumbered by concern for its human implications. As Harrington has asked [19], are there faint echoes for us, in our intensely scientific era, in the expediency that can emerge from scientific "interest" and efficiency? Muller-Hill, in an impassioned comment on science under the Nazis, has noted [28], "Scientists espouse objectivity and spurn value judgments. But pure objectivity leads to regarding everything as being feasible. For these scientists objectivity opened the door to every conceivable form of barbarism." Harrington adds

"Is it an accident that such stories get written in red with such passion in today's era of high tech medical treatment, relentless research, and fears that the voice of patients and the ethic of personal clinical care are being lost in a system that values "cure" as a dissociated end in itself?"

Concerns about the central importance of the individual underlie such commentaries.

The importance of hubris-the power of excessive certainty, especially at the intersection of biomedicine and public policy-is a third lesson to be drawn. The rise and spread of the eugenics movement-based on a primitive genetics and flawed reasoning from weak data and linked to a thinly veiled (and, later, overt) murderous, state-controlled racism-worked to the disadvantage of tens of thousands of persons in the United States and the deaths of millions in Europe. Biomedical science must recognize its own tentativeness and priorities, especially as scientific advance abuts social policies. The costs of research and clinical care, the evolution of health care systems, and the power of new technologies have, in effect, brought public policymakers into the laboratory and the sick room, in fact to the bedside. From this springs a clear responsibility for those in biomedicine to be not only literate but engaged with regard to the policy process and for professional societies and associations to be active in advocacy. We have learned the powerful lesson that with regard to health, the priorities of the state and of society must flow from priorities of concern for the individual rather than the reverse. Medicine has a clear responsibility to see that those priorities are articulated and represented in public policy.

Finally, profound questions of equity and fairness spring from variations in health status and access to care. In the United States, poor persons seek care at later stages of disease, have worse background levels of health, and frequently have inadequate health care arrangements. Furthermore, questions of poverty are compounded by issues of race and ethnicity, with serious impact on the quality of care and with racist implications, veiled though they may be. Hispanic persons with isolated long-bone fractures, for example, have been found to be twice as likely as white persons to receive no pain medication in an emergency medical center [29], and ethnic minority patients have been shown to receive less adequate analgesia than other groups [30]. In the United States, poor persons and members of ethnic minority groups, particularly African Americans, have worse processes of hospital care and greater instability at discharge than other groups [31], and women, black persons, and patients with dementia or incontinence are more likely than others to have do-not-resuscitate orders written [32]. These observations imply a disturbing echo of a central tenet of the Nazi era, namely, the existence of hierarchies of human worth.

In addition to facing hierarchies based on race, ethnicity, sex, age, and socioeconomic status, we are now confronted, as a result of scientific success, with potential discrimination on the basis of genotype. We face the possibility of a new eugenics that is immensely more powerful because it is based on valid science [33]. Of profound importance is the question of whether we can mobilize the social wisdom to handle the applications of the new molecular genetics-especially a new, more powerful, biological determinism that could sweep aside attention to environmental influences-at the individual and the policy level. A gene closely associated with violent behavior in men has been identified in a Dutch family [34]. What will happen, as Muller-Hill has asked, if additional crime genes related to mutational events are identified and are found to vary in frequency among ethnic groups (Muller-Hill B. The specter of kakogenics. Presented at "Eugenic Thought and Practice, a Reappraisal Towards the End of the Twentieth Century," Jerusalem and Tel Aviv, Israel, 26-29 May 1997)? The issue for all of us will be

whether we are willing to recognize the eugenic impulses that are likely to flow from such discoveries and, perhaps especially for physicians, whether we are willing to enter (or lead) the societal debate that will follow.

Lessons from History

With regard to the ethos of medicine, what have we learned? What are the lessons for us as we contemplate this history?

We have learned that the ethos is not altogether an abstraction but is a set of principles that, to have meaning, must be translated into behaviors that determine, in an immediate sense, how we respond to the sick. These principles also have translational meaning for the responsibilities of medicine to society and for the views medicine holds of its responsibilities for the poor, the marginalized, and the vulnerable.

We have learned that the ethos is not immutable but, in fact, is malleable. It can be shaped by the priorities of the state, personal agendas, careerism, the profit motive, and deep biases in society and in ourselves.

We have learned that the ethos is inconsistent with hierarchies of human worth. When we participate in such prioritization, whether it is generated by other social structures or within medicine itself, the ethos is deeply corroded and inhumanity follows with frightening ease.

We have learned that the ethos requires tending based on reflection that is rooted in awareness of its vulnerability as made plain in its history, especially the history of the past 75 years and the history of the Holocaust in particular.

Apart from the occasional lecture or seminar, medical faculties have done little to formally teach the ethos of medicine in the context of this history. More organized efforts would be useful. Young persons entering medical school are to a significant degree moved by altruism and a sense of medicine as a calling. However, the medical school years are crowded; they focus intensely on the necessity of transmitting an enormous bulk of information on the biology of disease, the clinical concerns of various specialties, and even the organization and economics of medical practice. In the intense pragmatism of modern medical education, in the endless pressures for technology and efficiency, students must often infer the altruism and caring intentions behind the activities of busy faculty members and complex institutions. Something more explicit is needed, an educational ambiance that reflects less indirectly, less stochastically, the stewardship responsibilities of the faculty with regard to the ethos and offers an enhanced focus on the nature of doctoring; suffering; the primacy of the patient; and, ultimately, the goals of medicine.

Pressure on the medical ethos has achieved new force in recent years as the U.S. health care system has undergone radical revision, largely on the basis of cost considerations. Abbreviated hospitalizations have become a summum bonum, mostly for reasons related to the fiscal welfare of insurers and institutions, and gag rules, withholds, bonuses, and requirements for increased patient throughput exert severe pressure on the responsibilities of the physician, which were traditionally focused in a clearer and less trammled manner on the patient. Patient trust in physicians is widely viewed as eroding as the patient–physician relationship is increasingly shaped by economic forces. For the individual physician, important issues in professionalism arise in the ability to seek the best personal expression of acting in behalf of patients in a competent, trustworthy, reliable manner. More broadly, the current pressures in the health care system push each of us to consider and protect the traditional values of the ethos. History beckons us to scrutinize not only the past but ourselves, to search for the buried links, the hidden echoes, the silent burden that we all bear in our efforts to find expressions of our responsibility for the welfare of medicine itself. Examination of the events of the Holocaust and the complicity of German medicine provides a lens that can help in that difficult but compelling set of tasks.

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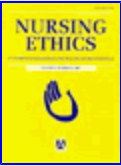
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