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Medicine during the Nazi period and the Holocaust: what are the implications? An interview with Volker Roelcke

Medicina durante el período nazi y el Holocausto: ¿cuáles son las implicaciones? Una entrevista con Volker Roelcke

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Abstract

In this interview, Volker Roelcke explains and analyzes historical evidence refuting erroneous assumptions about medical atrocities committed by physicians during the Nazi era, provides insight into the implications of medicine during the Nazi period and the Holocaust for medicine and bioethics today, analyzes the history of the term "genocide," and suggests formats for future teaching, among other topics.

Keywords: Holocaust; Germany; history; medicine; genocide.

Resumen

En esta entrevista, Volker Roelcke explica y analiza evidencia histórica que refuta las suposiciones erróneas acerca de las atrocidades cometidas por los médicos durante la era nazi, brinda información sobre las implicaciones de la medicina durante el período nazi y el Holocausto para la medicina y la bioética en la actualidad, analiza la historia del término "genocidio", y sugiere formatos para la enseñanza futura, entre otros temas.

Palabras clave: Holocausto; Alemania; historia; medicina; genocidio.

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Volker Roelcke, professor of the History of Medicine at Giessen University, has conducted remarkable studies on medicine during the Nazi period. This era is still surrounded by myths: for example, only a few fanatical physicians committed medical atrocities, and all other physicians and medical scientists were coerced by the Nazi regime.

In this interview[1] with the journal *História, Ciências, Saúde – Manguinhos* (an expanded version of the interview that appeared on its blog), Roelcke explains and analyzes historical evidence that refutes these assumptions, provides insight into the implications for medicine and bioethics today, analyzes the history of the term "genocide," and suggests formats for future teaching, among other issues. He acted as founding co-chair of the *Lancet* Commission on Medicine and the Holocaust, which was established in January 2021 (Roelcke, Hildebrandt, Reis, 2021).

Why is it important for physicians and healthcare professionals to reflect on the Holocaust today?

The Holocaust was a "rupture of civilization" (*Zivilisationsbruch*), a rupture that contradicted anthropologically anticipated certainties, as the historian Dan Diner (2008) diagnosed. It was a fundamental challenge and indeed subversion of the self-images, modes of thought, and value hierarchies of Western societies which are conventionally understood as enlightened and rational, as culturally, scientifically, and technically "developed," and which – in this perspective – are usually perceived as a model for the future development of non-Western societies. The massive cooperation of physicians in the planning, implementation, and justification of breeding utopias, racism and anti-Semitism, selection procedures, warfare, and the systematic mass annihilation of human beings defined as "biologically inferior" or "unworthy of living" has been broadly documented by now (for an overview, see Roelcke, 2010). Significantly, in the self-definition and governmental practices of the Nazi regime, medicine and the biomedical sciences had a prominent place, and even more than other academic professions, physicians were prepared to participate in the selectionist health and population policies of the regime. Many physicians were also complicit with, or actively contributing to, the systematic extermination of the Jews.

In which ways did physicians harm patients or use their authority to devalue social groups like Jews and other populations deemed to be "inferior"?

Physicians were on many levels involved in massive atrocities, such as the scientific authorization of racism and anti-Semitism, the forced sterilization of those defined as suffering from hereditary diseases, the systematic killing of those diagnosed as "unworthy of living," and programs of forced human subject research in "deregulated" spaces[2] such as psychiatric asylums, concentration camps, and hospitals in the German occupied territories (Schmuhl, 2008; Ley, 2004; Friedlander, 1995; Hohendorf, 2013; Weindling et al., 2016).

It has been amply documented that the massive atrocities in the field of medicine were not the activities of individual, isolated, fanaticized doctors, but that they took place with substantial participation by leading representatives of the medical community and medical institutions, and in the context of one of the most advanced systems of medicine. In fact, the initiative for almost all of these atrocities did not originate from political authorities, but from doctors themselves, and in contrast to long-held stereotypes and apologetic myths, these activities may not simply be dismissed as devoid of medical or scientific rationality, that is, as "pseudoscience."[3] However, these activities of physicians to genetically "clean" and enhance the population and to use the opportunities of "deregulated" human subject research were only possible via the conditions created by the racist Nazi state and the war. This situation has been described as a collusion between medicine and the State, in which both spheres represented mutual resources for each other (e.g., Schmuhl, 2011). Remarkably, many of the doctors involved also held prominent positions in postwar medicine and were indeed integrated into the international medical community. Similarly, stigmatizing and debasing terms and conduct towards sick and disabled people which legitimized the atrocious activities during the Nazi period continued to be used by physicians in Germany and beyond to a considerable extent even after 1945.[4]

Could you please discuss the use of the term "genocide" by historians, and its relation to medical crimes during the Nazi period?

The term "genocide" was coined by the Polish-Jewish lawyer Raphael Lemkin in 1944 to describe the Nazi policies of systematic persecution and destruction of European Jews and other social groups, such as Sinti and Roma (people formerly described as "gypsies"). With this, Lemkin intended to provide a legal category which might be used to prosecute massive group-related atrocities which otherwise were not covered by existing international law. During the next few years, in the context of the establishment of the United Nations (UN) in 1945, the preparations for the International Military Tribunal at Nuremberg of 1945/1946, the plans for further trials, and the work on the Universal Declaration of Human Rights of the UN in December 1948, intensive negotiations developed about the exact definition of the term, with its specific meaning and underlying definition continuously changing according to the interests of the actors involved (Weiss-Wendt, 2017; Stiller, 2019; Moses, 2021). The term was used, for example, in the indictment of the International Military Tribunal of 1945/1946, which tried 24 leading Nazi functionaries on charges of crimes against peace, war crimes, and crimes against humanity. Today, genocide is a legal term defined as the deliberate and systematic destruction of a group of people because of their ethnicity, nationality, religion, or race. The definition follows the UN Convention on the Prevention and Punishment of the Crime of Genocide of December 1948. This convention established genocide as an international crime, which signatory nations undertake to prevent and punish.

It is, however, of particular interest to see that the exact legal definition of the UN Convention was highly contested among the Allies, and finally the result of a compromise: the long way to this compromise explains why the definition of 1948 is

rather narrow and entails a few lacunae. Already in 1946, at an interim stage of the intense negotiations, the General Assembly of the UN had passed a resolution which defined genocide much more broadly than the later Convention: "genocide is a denial of the right of existence of entire human groups, as homicide is the denial of the right to live of individual human beings," without further qualifying these groups.[5] In the heated debates between 1946 and 1948, the Soviet Union in particular insisted that only national, ethnic, racial, or religious groups should be included in the definition, but not more generally social or political groups. In this way, the category could not be applied to the victims of Stalinist terror, such as the systematic persecution of *kulaks*, or the victims of the Great Party Purge, both in the 1930s. Similarly, the United Kingdom resisted regarding the inclusion of cultural groups in the definition, since this category might have been applied to the victims of colonial rule; the United States had an interest that racial oppression in its southern states, including lynching, would not be covered by a potential new legal definition. Thus, each of the allied powers (but in different ways) opposed innovations in international law that criminalized the prewar and the domestic policies of the respective States. The common agenda of the Allies in this process might be summarized as follows: "What states did to their own citizens was their own business" (Moses, 2021, p.201).

In view of the clearly context-dependent and politically motivated content of the 1948 legal definition, and the fact that even the categories used there (race, nation, ethnicity, religion) are social constructs which change over time, it appears legitimate to re-evaluate and potentially modify the definition to make it more suitable as an analytical tool for research in history and the social sciences. A first step in this perspective would be to return to the broader understanding of the concept of genocide in the 1946 UN resolution. Using this definition, the systematic killings of psychiatric and mentally handicapped patients ("euthanasia") during the Nazi period fulfill the criteria of a genocide: they were the result of a consciously, intentionally, and rationally planned program of the regime in close cooperation with physicians to annihilate a clearly defined population.[6]

Although the term itself is of recent origin and refers to a specific historical situation, genocide has arguably been practiced in many other historical contexts, as in the case of the Armenian massacre committed by the Turkish-led Ottoman Empire, or the systematic killing of the Tutsi in Rwanda in the 1990s. The systematic killing of psychiatric patients and mentally handicapped individuals ("euthanasia") diagnosed by physicians as "life unworthy of living" may be understood as the first genocide in the context of the Nazi regime: this physician-initiated genocide started in late 1939 (Rotzoll et al., 2006), and preceded the deportation and systematic destruction of the Jews usually noted as starting in 1941/1942. One of the essential preconditions for this killing program, the idea of terminating "life unworthy of living," had already been discussed internationally by physicians well before the onset of the Nazi regime (for example, see Dowbiggin, 2003; Roelcke, 2020), but this idea was only executed by the close cooperation of physicians and Nazi state agencies in the context of the Second World War.

The Commission also studies the resistance of medical professionals to power. Why is this study important?

In addition to willing cooperation and opportunism, the historical context of the Nazi period and the Holocaust shows a broad spectrum of non-compliant and resisting behavior of medical professionals towards the expectations, temptations, and pressures created by those in power: on the side of German and Austrian physicians, this spectrum ranges from the tacit refusal to follow the requirements formulated by the eugenically motivated "Law for the Prevention of Offspring with Hereditary Diseases" (partly out of fear of losing their patients' trust: that is, out of self-interest) (Ley, 2004) to explicit refusal to comply with the expectations and incentives of the medical and administrative functionaries regarding the program of systematic patient killings ("euthanasia") (Schmuhl, 2016, p.305-334). Such cases, however few, are important since they clearly document that room for maneuvering existed. Besides, the post-Second World War retrospective justification of physicians' involvement in atrocities as due to pure force is not covered by the available historical evidence. This insight calls attention to the individual scope of action and responsibility of each individual medical professional, even within the situation of a totalitarian regime.

Even more remarkable is the array of resisting and sometimes subversive behavior among Jewish and otherwise persecuted physicians: again, ranging from the actions of such stigmatized medical professionals in the prewar period who (despite discrimination) were still acting within the context of the German health care system, through the struggles of physicians and nurses to provide medical care in the ghettos of Eastern Europe, to the actions of prisoner-physicians in the camps (Offer, 2020; Siegel, 2021). For these contexts, the historian Sari Siegel has coined the concept of a "coercion-resistance spectrum" of behavior. The use of the term coercion in this context moves the focus away from the frequently problematic concept of choice, or even individual "character," and instead encourages analysis of the physicians' room for maneuvering in the face of dreadful, often lethal, consequences. This implies that the onus for a specific act may not simply be ascribed to the individual physician acting in a framework of massive coercion. Instead, this analytical tool and the resulting historical insights help to shift responsibility to the repressive functionaries and circumstances that applied the force, or the threat thereof, to promote obedience. Resistance, in this view, is defined as conscious engagement in acts that subvert specific orders, thwart general Nazi goals, aid comrades, or accomplish a combination thereof. The insights gained from this perspective also enable an appreciation of the fluctuations in individuals' behavior in response to shifting circumstances. They also help avoid the pitfall of denouncing the behavior of physicians in the ghettos or the camps as "collaboration" (Siegel, 2021).

More broadly, the historical case illustrates the factors and dynamics contributing to resilience and resistance of physicians in view of unacceptable expectations and structural ramifications, temptations, and open pressure. Such historical knowledge may thus encourage medical professionals and students to systematically reflect on the structural conditions and impositions in which they act, to continuously test their scope of action in problematic contexts, and to use the room for maneuvering in order to act according to the

guidance provided by the Declaration of Geneva, namely that the health and wellbeing of the suffering individual will be the foremost priority of the physician's activity.

In your work, what have been the challenges of a dialog between historians and physicians?

For many decades, and even sometimes today, individual physicians as well as representatives of medical organizations have been concerned that confronting the historical evidence, including the intellectual and institutional conditions which enabled the medical atrocities during the Nazi regime, might "contaminate" the reputation of the profession and of specific medical institutions. There was, therefore, a widespread refusal to systematically look into this past, and to reflect on the implications for medicine today. The spectrum of behavior by medical institutions in particular, but also by individual physicians, in the post-Second World War period ranged from explicit denial through silence to scapegoating supposedly isolated "fanatic Nazi physicians" (Roelcke, Topp, Lepicard, 2014). In addition, the massive collusion of medical professionals with political authorities and the resulting atrocities were inadequately denounced as the expression of external political pressure on the medical profession, with the implication that medicine, and physicians, were more or less innocent victims of a vicious political regime and its leaders. Until very recently, physicians, medical students, and (medical) historians who confronted the Nazi past of medicine and addressed such apologetic behavior in the post-Second World War period frequently experienced strong aggression, and had to face allegations of undue whistleblowing. This kind of behavior by medical institutions or their representatives is indicative of an implicit value hierarchy which prioritizes the supposed good reputation and thus the wellbeing of the medical profession or specific medical institutions, compared to an attitude of systematic self-reflection in the service of the wellbeing of the suffering individual (Roelcke, 2014b, p.276-278). More recently, however, this situation is changing, starting with bottom-up historical inquiries from medical students and junior physicians, and those in peripheral medical institutions in the 1980s, and culminating in the first in-depth analysis of a medical association in the history of its predecessor organization during the Nazi period, the 2010 public apology by the German Psychiatric Association (DGPPN) to representatives of different victim groups (Roelcke, 2014b, p.275), and the first public statement and apology in tune with the available historical evidence by the German Medical Assembly in 2012 (Reis, 2012). For the medical community, the great public appreciation of these events illustrated that confronting the Nazi past does not (as previously imagined) result in negative consequences for medical organizations' reputations, but instead is perceived as the expression of a necessary professional agenda of self-reflection. This positive public resonance thus resulted in similar activities of historical self-scrutiny by an increasing number of additional medical associations and institutions.

The Lancet *Commission on Medicine and the Holocaust plans to change medical curricula and promote ethics and empathy. Today, this might be an important goal in science education, in the curricula of many university-trained professionals and even for politicians. Is it possible for the Commission to go beyond medical circles?*

The implications raised by the historical evidence, such as the preparedness of academic professionals to co-operate with those in power or their use of deregulated spaces for their individual or institution's advantage, extend far beyond medicine. In tune with the scope of *Lancet* Commissions, a format initiated by the *Lancet*'s editor Richard Horton, the *Lancet* Commission on Medicine and the Holocaust intends to address not only the medical community, but, beyond that, decision makers in the realm of health and social policies, in universities and research institutions, as well as opinion leaders and media in the broader public sphere.

NOTES

[1] [Mannheimer's note] I am grateful to Marcos Cueto for establishing contact with Volker Roelcke and his participation in this interview.

[2] [Roelcke's note] The term "deregulated" (in inverted commas) is used to indicate that in these spaces, the regulations for human subject research which existed in Germany at the time could be ignored by the medical scientists interested in carrying out their research projects; otherwise, obviously, these spaces were highly regulated by the rules created by various instances of the Nazi regime.

[3] [Roelcke's note] For an exemplary case, see Roelcke (2014a).

[4] [Roelcke's note] For example, the debasing language towards schizophrenic patients used by the prominent German-American psychiatric geneticist Franz Kallmann in the post-Second World War period described in Roelcke (2019).

[5] [Roelcke's note] United Nations General Assembly. Available at: https://undocs.org/en/A/RES/96(I). Access on: 22 June 2021.

[6] [Roelcke's note] Systematic patient killings ("euthanasia") were also categorized as genocide in Schmuhl (2018), but without explicit reference to the 1946 UN resolution. The first attribution of the term to patient killings was most likely made by Hartley Shawcross, the chief British prosecutor, during the 1946/1947 International Military Tribunal (see Stiller, 2019, p.157).

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