Medical
Review
Auschwitz

Medical Review Auschwitz: Medicine Behind the Barbed Wire

Conference Proceedings 2019

7–8 May 2019, Kraków, Poland

POLISH INSTITUTE FOR EVIDENCE BASED MEDICINE
2020

Editors: Maria Ciesielska, Piotr Gajewski

Project coordinator: Mateusz Kicka

English translation: Teresa Bałuk-Ulewiczowa

Proofreading: Teresa Bałuk-Ulewiczowa, Jakub Antosz-Rekucki

Book design: Łukasz Łukasiewicz

Typesetting: Wojciech Borowski

Published by Polish Institute for Evidence Based Medicine
Kraków, Poland
www.mp.pl/auschwitz/

Printed by OZGraf S.A.

ISBN 978-83-7430-617-1

A publication funded in 2020–2021 within the DIALOG Program of the Ministry of Science and Higher Education in Poland.

Contents

Introduction

Knut W. Ruyter

Behind the eyelids await the kapos and a horde of SS-men,
and I fight against all of them, with the anguish of blind outrage,
hour after hour, until I wake up in the morning,
diseased in mind and tired until death.

Herman Sachnowitz

It is with great awe and engagement that I introduce the proceedings of the conference held in Kraków in May 2019, set against a somber and thought-provoking visit to the site of Auschwitz-Birkenau.

My interest or, I should perhaps even say, preoccupation with the horrors of Auschwitz goes all the way to my teenage years spent in tranquil rural surroundings in Norway. I was an avid reader and came across the accounts of lives—and the abuse and destruction of them—in concentration camps, first through Simon Wiesenthal's books which were translated into Norwegian in the late 1960s: *The Murderers Are Among Us*[1] and *The Sunflower*.[2] Then I read the autobiography of

About the author: Knut W. Ruyter, PhD, born 1955 in Norway, is a professor at the University of Oslo. He served as Director for the Regional Committees for Medical and Health Care Research Ethics in 2009–2019 and is the newly appointed Ombud for Research for the University of Oslo. He taught research ethics, developed courses in the field (including e-learning courses in English), and published textbooks and articles, always keeping a keen eye on historical examples for warning and learning.

1 Wiesenthal, 1967.

2 Wiesenthal, 1969.

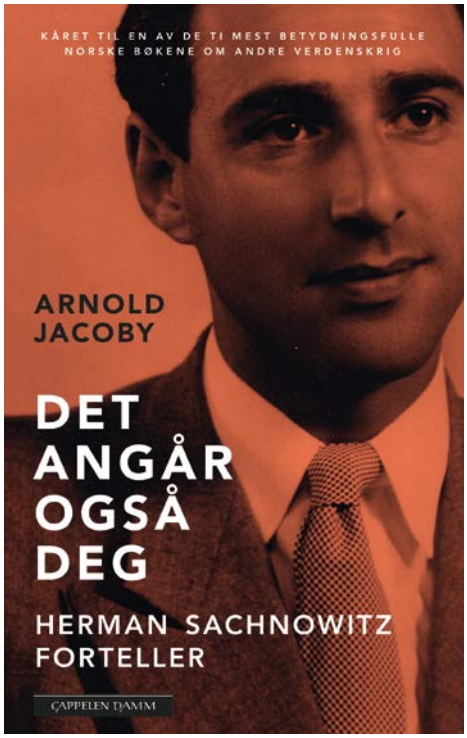


Photo 1. | The cover of Sachnowitz's book *Det angår også deg* (It concerns you, too)

Herman Sachnowitz, one of the very few Jews from Norway who survived Auschwitz.[3] Sachnowitz avoided writing about the inconceivable for thirty years, but then he felt he owed it to the dead and the world to make it known.[4] Many sentences from these accounts have stuck in my mind: "We are strangers to our murderers," "I am a Norwegian Jew," "The commanders cannot have been created of the same stuff as us," "God please return from your vacation," "I envy the dead." The sentences challenged me and made me not only concerned, but also interested in understanding evil and how it might be curbed or eradicated, especially in professional contexts and in research.

As a professor of ethics and a long-standing manager of research ethics committees, I have been mostly concerned with research ethics and professional ethics (especially for doctors, nurses, and priests). Under normal circumstances, it seems, evil can be hindered, through education, regulation, control, and oversight. And though I have often used cases of unethical experiments and unacceptable professional engagements in teaching, I have experienced something that some

3 Sachnowitz, 1976. Translated into German: Sachnowitz, 1981, and into English: Sachnowitz, 2002.

4 His father, Israel, then a widower, and six of his siblings were killed in Auschwitz. His youngest brother, Frank, had been "selected by SS-men" for experiments by Mengele and sent to Struthof-Natzweiler. After intense archival research, H.J. Lang was able to identify the persons that had been sent to Struthof, killed there to test out the effectiveness of new gases, and whose corpses were transferred to the institute of anatomy in Stuttgart for research purposes. Among them was Frank Sachnowitz (Lang, 2004; Lang, 2013). Herman Sachnowitz noted dryly "that human lives didn't count, but numbers and digits did" (Sachnowitz, 1976: 205). This preoccupation with order made it possible for Lang to compare autopsy protocols in Stuttgart which contained the numbers of the prisoners with other records containing their names.

of the contributors to this volume attest to as well, that these subjects are not perceived as relevant or worth discussing. It is thought that those experiments and other criminal practices were performed by lunatics (made of different stuff than we are) and that they are far removed from the present reality. Still, it is well known that even though the world has repeatedly pledged "Never again!" evil erupts time and again when the circumstances are conducive: in Bosnia and Rwanda, in Syria and Myanmar, resulting in genocide and enormous suffering of the perceived others, be they Bosnians or Tutsi, Yazidis or Rohingya.

To avoid another eruption of latent evil, it is of utmost importance to remember the disastrous consequences of disregard for the perceived others and to continuously mull over how to reduce and avert evil, regardless whether we look for answers through the political, the psychological, or the ethical means.

2020 marks the 75th anniversary of the liberation of Auschwitz. "It was hard to believe the evidence of survival, which had been distant and unreal," as Norwegian Jew Kai Feinburg said, referring to when he saw the first Soviet soldier, a cigarette in his mouth, entering the camp on a horse with a carriage.[5] There is a lot to feel grateful to the survivors for, not only for the fact that they bore witness to evil, but also for their contribution to the awakening and standing up against it. Following Sachnowitz, several other Norwegian survivors—Kai Feinberg, Leo Eitinger, Julius Paltiel, Herman Kahan, Samuel Steinmann, Leif (Leiba) Wolfberg, Hans Levold, Pelle (Asrier-Berl) Hirsch, and Assor Hirsch—described their experiences as well, often doing so late in life and sometimes with the help of others.[6] Through the studies of Ellinor Major, we have also gained access to her surviving father, who, as she said, chose silence.[7] And, as it was in Poland, and especially in Kraków, the examination of survivors became an important professional task both for treatment and for research.[8] In Norway this was especially addressed by Leo Eitinger, who had been a prisoner doctor in Auschwitz (a function he called "the darkest work of [his] life") and became a professor of psychiatry at the University of Oslo. Eitinger produced

5 Feinberg and Stefansen, 1995.

6 Skjæraasen, 1988; Feinberg and Stefansen, 1995; Ottosen 1995; Komissar, 2004; Lothe and Storeide, 2006; Bruland 2012; Chelouche, 2014.

7 Major, 1997, about her father Pavel Fraenkl (d. 1995).

8 Ryn, 2019.

Photo 2. | From left to right: Samuel Steinmann, Leo Eitinger, Julius Paltiel, Pelle and Assor Hirsch behind the barbed wire in Buchenwald in 1945

a number of publications on the health of survivors,[9] later expanded to include also the consequences of the Holocaust for survivors' children.[10] There has been also a great interest in understanding the mindset of the "prison guards," especially among criminologists, which emerged long before the Stanford experiments. The most notable example of this trend is probably the work by Professor Nils Christie, who studied the Norwegian prison guards in the so-called Serbian camps in northern Norway during the war.[11] However, it was only in 2017 that we finally got a comprehensive (846-pages-long) critical historical account on the deportation of 767 Jews from Norway (of whom only 26 survived), which also contains an appendix including the names of all the deported and their fate.[12]

The proceedings in this volume address many of the universally important questions and concerns (as my little odyssey to Norway testifies), with the experience of medically sanctioned genocide serving as the starting point for reflecting and inquiring about the relevance and sufficiency of the instruments that have

9 Eitinger 1958, 1964; Eitinger and Strøm, 1973; Eitinger and Krell, 1985.

10 Major, 1996.

11 Christie, 1972. Originally published in 1952 as a doctoral dissertation at the University of Oslo.

12 Bruland, 2017.

been developed to assure good research practices (and to avoid ethical transgressions), regarding guidelines, independent review committees, and education of professionals and researchers.

Stacy Gallin's critical assessment of the development of research ethics is pointed: "The system in use is failing researchers, subjects, and society." The problem is not that the system does not work to a point, but it lacks the most important element of the moral formation of the professional (medical) researchers themselves, which would install a robust inner moral compass giving one the ability to withstand political and ideological pressure and forces—and even the pure self-interest. I agree, but it is hard to determine how it can and should be installed and whether the blatant cases of researchers gone awry are essential tools for educating future generations of physicians and all other helping professionals.

I signaled some of these doubts coming from my own teaching experience to the author of another contribution to this volume. Matthew K. Wynia recognizes the same problems I do, as well as the question of the ordinariness of the perpetrators and evil as such, but his proposals are much more creative and constructive. According to him, the question is not whether the legacy of immoral practices provides essential tools for education; rather, it is *how* to teach about this history. Wynia presents the challenges he and his colleagues faced when creating an education program on the Holocaust, Genocide, and Contemporary Bioethics at the University of Colorado. It is a worthwhile reading for anyone involved in teaching medical research ethics. Its pedagogical inventiveness is impressive, as well as its involvement of external resources, ranging from survivors, through human rights groups, to professional associations. Matthew K. Wynia seems also to presume teacher training courses, though this is not addressed specifically.

In another paper, Tessa Chelouche offers an interesting challenge to the commonly held view that Nazi doctors and researchers abandoned medical ethics and were morally corrupted or even mad. Her claim is that the Nazi Germans developed their own strain of medical ethics, heavily influenced by eugenics, emphasizing the health of the whole body politic (the society or the people) over responsibilities and duties to individuals. This medical ethics system made it possible to legitimize any measure (e.g. sterilization and euthanasia) to improve or protect the people. The basis for that shift, with the medical profession in the lead (both as its architects and henchmen), is well documented and analyzed. Chelouche also demon-

strates that this new, selective medical ethics system was taught at most German medical schools since 1933 to educate "a new type of physician" on the basis of new textbooks. It is noteworthy (or incredible, as Chelouche says) that this thinking influenced the reading of established research ethics norms (from the Prussian directive of 1900 to the German regulations of 1931) to the extent that "subjects" of lesser value were exempted from them for a greater good, even under the pretext of holding on to formalities. One of the survivors of the experiments in Block 10 in Auschwitz remembered that she was presented with a sheet of information for consent! Chelouche reaches the same conclusion as the Norwegian criminologist mentioned above: the Nazi physicians were not mad monsters, but ordinary human beings who could, under specific circumstances and conditions, legitimize evil as the right thing to do.

Susan Miller concurs with Chelouche that Nazi doctors were made of the same stuff as everybody else, to paraphrase Wiesenthal. Are there then certain motivations that can explain deeply unethical behavior? Yes, says Miller, but it is not possible to come up with just one simple answer. Leaning on empirical work in psychiatry and psychology, she discusses interesting topics like rationalization, splitting, compartmentalization, self-deception, group mentality, the significance of secrecy, the pursuit of the common good. These mechanisms are recognizable in research generally, before and after Auschwitz, and Miller therefore asks an uncomfortable question: are medical doctors predisposed to become perpetrators? The short and disturbing answer is "yes." The reasoning is persuasive, but at the same time raises questions such as whether such predispositions can be tempered or directed, and by what means.

A set of articles in this volume presents historical inquiries into specific persons and their involvement in Auschwitz.

Maria Ciesielska delves into the work of the SS physician Johann Paul Kremer, who obtained "fresh specimens" (i.e. people killed a moment earlier) for futile research on the effects of starvation. For non-Polish speaking readers it is especially interesting to get insight into his "operations" as documented by survivors such as Jan Olbrycht and Stanisław Kłodzinski, analyzed against Kremer's well-known diary of matter-of-fact prisoners "reserved" for killing. Ciesielska's rendering is without moral judgment, but she lets the article debouch Olbrycht's contempt and outrage over Kremer's barbarity. By the way, Sachnowitz "met" Kremer in one of

the transit camps after the war and, ironically, had to protect Kremer against a furious mob of liberated prisoners.[13]

Helena Kubica reexamines the life, career, and workings of the SS physician Josef Mengele, suggesting that it would be most beneficial to view him as a part of the system in which he operated, and that perhaps Mengele does not deserve his infamous reputation of the most notorious of all SS physicians. Those others may have been just as evil, he only had many more opportunities to perform criminal experimentation, for which he never stood trial. Mengele managed to escape and lived in hiding in Brazil until his death in 1979.

Marta Grudzińska's paper approaches the subject of the conference from quite a different angle and place, investigating the extraordinary ingenuity and efforts of the Polish prisoner doctor, Stefania Perzanowska, who set up a hospital for women prisoners in the Majdanek concentration camp. Perzanowska argued that the primary goal of the hospital was to protect the Germans from contagious diseases like typhus, knowing full well their fear and the imminent danger coming from each and every prisoner: "*Ein' Laus—dein Tod*."[14] With this cunning approach, she got the permission, and was then also able to offer some treatment, solace, and care to fellow women prisoners. Grudzińska gives us a rare insight into the workings and mindset of Perzanowska, based mainly on the testimonies by witnesses who survived Majdanek, but also on Perzanowska's own letters, reflections, and activities after the war, including the survivors' advisory center.

Bogdan Musiał follows suit and gives us invaluable knowledge about the role and tasks of prisoner doctors in Auschwitz in general, and specifically about Stefan Budziaszek, who was among the first to be recruited by the Chief SS Physician, Eduard Wirths, with the purpose of reducing mortality among prisoners and to keep up and restore the work efficiency of forced laborers. Musiał documents that Budziaszek was well aware of that purpose; still, like Perzanowska, he was able to build up a functional hospital in Monowitz for the sake of the patients through his management skills and recruitment of other prisoner doctors. Budziaszek was without any doubt successful in treating diseases and limiting their spread. But, as Musiał demonstrates, this was not achieved without raising ethical doubts con-

13 Sachnowitz, 1976: 226.

14 German for "one louse—your death" (Editor's note).

nected with e.g. the fate of seriously ill patients who could not be made fit for work and allegations of collaboration.

Rael Strous gives us a moving testimony about the resilience of an unnamed experimental subject who survived Auschwitz and rebuilt his life in Israel. However, the main body of the article deals with the resilience of prisoner doctors and with how they were able to cope with their predicament. Strous bases much of his analysis on the empirical work done by Ross Halpin.

Some of the articles are dedicated to honoring the professional work done by medical staff who treated survivors and their families and the research that ensued.

Zdzisław Jan Ryn recapitulates the key points of Antoni Kępiński's research on the so-called concentration camp syndrome and the devastating effects of the psychopathology of power. Readers of this volume will also benefit from consulting Ryn's own seminal work on the clinical-psychiatric consequences of concentration camp experience for survivors, which deals with the issue in a more complex manner.[15] Aleksander Skotnicki honors Julian Aleksandrowicz for his extraordinary engagement for the survivors' treatment center in Kraków and his extensive research in hematology.

The syndrome of personality disorders found in survivors has also been recognized among their descendants, and so has the "transmission" of trauma to the next generation, which has given rise to therapy for the second (and now third) generation of survivors, as well as launched new research. What is new and very interesting in the TreeGenes Study (currently a work in progress) presented in Maria J. van Beurden and Jacques D. Barth's contribution to this volume, is that they have investigated the *somatic* consequences in the second generation of survivors in the Netherlands. They recruited more than 200 participants who underwent examinations combining interviews, questionnaires, and non-invasive cardiovascular measurements, the latter compared with a control group. Preliminary findings indicate e.g. that cardiovascular diseases are significantly more frequent than in the control group. Van Beurden and Barth acknowledge methodological challenges, stemming not only from the combination of the approaches, but also from the reliability of the type of measurements to assess whether the differences are caused

15 Ryn, 2005.

by transmission from one generation to the next. Such reservations are most welcome and vouch for high expectations for further results from the TreeGenes study.

When the last remnants of humanity was gone, …
I felt an indomitable obstinacy to survive and tell,
but it would not have happened
without the help and encouragement of Polish prisoners,
… of whom I remember Felix Pavlowsky
as a beacon of humanity and goodness …

Herman Sachnowitz

Professor Knut W. Ruyter, PhD
The Science Ombud of the University
University of Oslo

REFERENCES

Bruland, B. 2012. *Øyenvitner* (Eyewitnesses). Lysaker: Dinamo.

Bruland, B. 2017. *Holocaust i Norge. Registrering. Deportasjon. Tilintetgjørelse* (Holocaust in Norway. Registration. Deportation. Annihilation). Oslo: Dreyers forlag.

Christie, N. 1972. *Fangevoktere i konsentrasjonsleire. En sosiologisk undersøkelse av norske fangevoktere i serberleirene i Nord-Norge 1942–43* (Prison guards in concentration camps. A sociological investigation of Norwegian prison guards in the Serbian camps in Northern Norway, 1942–43). Oslo: Pax.

Eitinger, L. 1958. *Psykiatriske undersøkelser blant flyktninger i Norge* (Psychiatric investigations among refugees in Norway). Oslo: Universitetsforlaget.

Eitinger, L. 1964. *Concentration camp survivors in Norway and Israel*. Oslo: Universitetsforlaget.

Eitinger, L. and Strøm, A. 1973. *Mortality and morbidity after excessive stress. A follow-up study investigation of Norwegian concentration camp survivors*. Oslo: Universitetsforlaget and New York: Humanities Press.

Eitinger, L. og Krell, R. 1985. *The psychological and medical effects of concentration camps and related persecutions on survivors of the Holocaust: a research bibliography*. Vancouver: University of British Colombia University Press.

Feinberg, K. and Stefansen, A. 1995. *Kai Feinberg. Fange nr. 79 108 vender tilbake*. (Prisoner no. 79 108 returns home.) Oslo: Cappelen.

Komissar, V. 2004. *På tross av alt. Julius Paltiel norsk jøde i Auschwitz* (Despite everything. Julius Paltiel, a Norwegian Jew in Auschwitz). Trondheim: Communicatio.

Ottosen, K. 1995. *I en slik natt – historien om deportasjonen av jøder fra Norge* (In such a night—the history of the deportation of Jews from Norway). Oslo: Aschehoug.

Lang, H-J. 2004. *Die Namen der Nummern. Wie er gelang die 86 Opfer eines NS-Verbrechens zu identifizieren* (The names of the numbers. How he succeeded to identify the 86 victims of a Nazi crime). Hamburg: Hoffmann and Campe.

Lang, H-J. 2013. "August Hirst and 'extraordinary opportunities for cadaver delivery' to anatomical institutes in National Socialism: A murderous change in paradigm." *Annals of Anatomy*. 195: 373–380.

Lothe, J., and Storeide, A. 2006. *Tidsvitner. Fortellinger fra Auschwitz og Sachenhausen* (Eyewitnesses. Accounts from Auschwitz and Sachsenhausen). Oslo: Gyldendal.

Major, E.F. 1996. *War stress in a transgenerational perspective. Norwegian concentration camp survivors and two other resistance groups and their children. A comparative investigation*. Oslo: University of Oslo.

Major, E.F. 1997. *Reise gjennom krig og fred. En beretning om krigens arv* (Travel through war and peace. A story about the heritage of war). Oslo: Aschehoug.

Ryn, Z.J. 2019. "The KZ-syndrome and its evolution through the generations." In: Ciesielska, M., Gajewski, P., and Chelouche, T. (Eds.) *Medical Review Auschwitz: Medicine Behind Barbed Wire. Conference Proceedings 2018*. Kraków: Medycyna Praktyczna & Polski Instytut Evidence Based Medicine.

Ryn, Z.J. 2005. *Auschwitz Survivors. Clinical-Psychiatric Studies*. Kraków: Przegląd Lekarski.

Sachnowitz, H. 1976. *Det angår deg også* (It concerns you, too). Oslo: Cappelen.

Sachnowitz, H. 1981. *Auschwitz. Ein Norwegischer Jude überlebte*. Frankfurt am Main: Büchergilde Gutenberg.

Sachnowitz, H. 2002. *The story of "Herman der Norweger." Auschwitz prisoner # 79 235*. Lanham: University Press of America.

Skjæraasen, M. 1988. *Lege for livet. En bok om Leo Eitinger – medmennesket* (Doctor for life. A book about Leo Eitinger—a fellow human being). Oslo: Cappelen.

Chelouche, T. 2014. "Leo Eitinger MD: Tribute to a Holocaust survivor, humane physician and friend of mankind." *IMAJ*. 16:208–211.

Wiesenthal, S. 1967. *Morderne iblant oss* (The murderers among us). Oslo: Cappelen.

Wiesenthal, S. 1969. *Solsikken* (The sunflower). Oslo: Cappelen.

The Holocaust as a critical point in the development of medical and research ethics

Stacy Gallin

The Holocaust is a unique event, both in the history of genocide and in the history of professional ethics. As an incidence of mass murder, the Holocaust is the only example of medically sanctioned genocide, with extermination of an entire race of people framed as an issue of public health and implementation of the state's ethnic cleansing program overseen by the medical community through the systematic labeling, persecution, forced sterilization, and eventual killing of those deemed "unfit" or racially inferior. In the history of medical professional ethics, the Holocaust serves as a critical point where ethical standards in medicine and research went from being a priority internal to the medical profession to one that became subject to the oversight of society at large. This is not to say that before the Holocaust the medical profession was completely autonomous

---

About the author: Stacy Gallin, D.M.H., is the Founder and Director of the Maimonides Institute for Medicine, Ethics and the Holocaust (www.mimeh.org), as well as the Director of the Center for Human Dignity in Bioethics, Health, and the Holocaust at Misericordia University. She is the Co-Chair of the Department of Bioethics and the Holocaust and Faculty of the Department of Education of the UNESCO Chair of Bioethics (Haifa).

This presentation is an edited and abbreviated version of "Holocaust as an Inflection Point in the Development of Bioethics and Research Ethics," co-authored by Stacy Gallin and Ira Bedzow, and published in the *Handbook of Research Ethics and Scientific Integrity*, edited by Ron Iphofen (March 2019).

and without any legal or political relationship with the state in which the medical profession was practiced. Rather, after the Holocaust international governmental bodies took a stronger regulatory stance, limiting the autonomy of the medical professionals by holding them accountable to societal oversight and overtly attempting to influence the ethics of the medical profession in a way that did not occur beforehand.

The limiting of professional autonomy through state regulation was not an inevitable progression of medical ethics. In fact, the lack of professional autonomy in Germany was used as a defense for the actions of physicians in the Holocaust during the Nuremberg Trials. However, once the abrogation of medical ethics that took place during the Holocaust came to light, the medical profession as a whole was no longer seen as being capable of self-regulation or of having a strong enough moral core to oppose the type of political pressure that the Nazi regime had imposed on it. The resulting solution was thought to be an international system of legal checks and balances on medical professional autonomy that could be incorporated into the laws of various nations. Hence, the creation of the Nuremberg Code, which has become widely accepted as the "constitution" of bioethics and research ethics.[1] Exploring the genesis of the Nuremberg Code and its impact on subsequent codes of ethics is essential to understanding the development of modern research ethics.

When physicians who took an oath to heal were put on trial at Nuremberg for crimes against humanity, including forcibly performing experiments on prisoners of war that were tantamount to torture, both the prosecution and the defense pointed to the history of international medical and research ethics to bolster their arguments. How is it possible that both the prosecution and the defense were able to use the same argument? The answer can be found in the lack of clarity surrounding the concept of research ethics that continues to persist to this day. The Doctors' Trial forced an examination of the nature and magnitude of research ethics and ultimately led to the recognition of a need for a universal—or, at least, international—set of standards established by a governing body to ensure ethical human subject experimentation rather than continued reliance on internally motivated ethical compliance.[2] This recognition stemmed from the strategies of

1 Caplan, 2010.

2 Grodin, 1992a.

both the prosecution and the defense in the trial, which utilized the (brief) history of the ethics of the medical profession and physicians' participation in research as part of their legal strategies to show how research ethics should be understood as an undertaking internal to the medical profession. The prosecution based their arguments on the work of Hippocrates and other pillars of medical history (i.e. Thomas Percival, William Beaumont, Claude Bernard), while the defense argued that in order to appropriately contextualize the behavior of German physicians operating under National Socialist rule, German professional codes of ethics must be used as the benchmark. Understanding the history of previous medical ethics writings and codes allowed both sides to offer a narrative as to why medical professionals should or should not be held legally accountable for their participation in the genocide of the Holocaust. However, what became obvious from the different arguments was that these moral writings and codes were not objective evidence in and of themselves. They did not exist in a vacuum. Rather, they were malleable, which made medical professionals vulnerable to being manipulated by the social and political environment of the greater society in which the medical profession resided. Therefore, the Nuremberg court sought to mitigate that vulnerability through societally established legal codes to which the medical profession would be held accountable.

On December 9, 1946, Chief Prosecutor Telford Taylor argued in his opening statement, "[T]he defendants in this case are charged with murders, tortures, and other atrocities committed in the name of medical science."[3] His opening statement included descriptions and accusations of the horrific acts of the physicians, however, it also served as a call to action regarding the broader topic of appropriate guidelines for human experimentation. As a result, while the main focus of the tribunal was on the behavior of the physicians on trial, questions about the lack of guidelines regulating human experimentation persisted throughout the tribunal.

The conclusion of the trial followed the same pattern. On August 20, 1947, 16 of the 23 physicians were convicted of war crimes and crimes against humanity, and 7 were sentenced to death.[4] However, just as Telford Taylor advocated for a larger ethical accounting to the medical profession writ large rather than simply charging

3 Taylor, 1992: 67.

4 Grodin, 1992b.

the defendants with murder and torture, the judgment at Nuremberg likewise did not stop with giving its verdict on the individuals at trial, as is typical with legal cases. Fully cognizant of the significance of the testimony and documentation before them, the court took the unique responsibility of establishing universal guiding principles to govern human subject experimentation. The Nuremberg Tribunal set forth ten principles for the ethical conduct of human experimentation, beginning with its most famous statement, "The voluntary consent of the human subject is absolutely essential."[5] Recognizing that the evidence and testimony uncovered at the Doctors' Trial was unprecedented and that the ramifications for the future of medicine, science, ethics, and human rights would be far-reaching, the code was intended to:

> Set the general agenda for all future ethical and legal questions pertaining to the conduct of human experimentation. What are the individual and societal values that justify science and technology? What are the source and the imperative of the quest for knowledge? Who decides on the limits of scientific endeavors? Who determines the benefits and who sets the research agenda? … How willing are we to risk human life to serve individual or societal ends? …"[6]

The publication of the Nuremberg Code was a pivotal moment within the history of research ethics. The creation of a universal standard for the ethical approach to human subject experimentation was revolutionary: however, the difficulty in translating the ideological goals of the Nuremberg Code into practical application soon became apparent.

The Nuremberg Code was created in response to unspeakable abuses of human dignity and ethical misconduct within the medical profession. While the creation of the Nuremberg Code was a necessary step in the codification of research ethics and the development of accountability within the field, its unwavering focus on informed consent ultimately proved to be problematic, particularly for those attempting to conduct research meant to benefit populations incapable of meeting the very strict requirements for informed consent laid out by the Nuremberg Code. Also, despite the Nuremberg Code, scandals of physicians conducting harmful research on subjects without their voluntary informed consent continued. Over the next few

---

5 Nuremberg Military Tribunal, 1947.

6 Annas and Grodin, 1992a: 6.

decades, several other codes of research were created in response to these scandals. Each code attempted to fix perceived inadequacies found in earlier codes and respond to the violations of ethics brought to light by the most recent scandal. Some of these included: the Declaration of Helsinki, published in 1964 by the World Medical Association, the Belmont Code, published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and the International Ethical Guidelines for Biomedical Research Involving Human Subjects, published in 1982 by the Council for International Organizations of Medical Sciences in collaboration with the World Health Organization, and the Universal Declaration on Bioethics and Human Rights, adopted in 2005 by UNESCO. Ultimately, while each subsequent ethical code attempted to improve on its predecessor, certain foundational issues about the primacy of informed consent, the lack of adequate definitions regarding research versus practice and the debate over what constitutes a vulnerable population and what types of special populations should be offered to these groups, made it impossible for any one code to effectively guide international ethical research practices. It has been over 70 years since the publication of the Nuremberg Code, yet society continues to struggle with the same question: "What makes human subject research ethical?" The codification of ethics rests on the four basic principles of bioethics: autonomy, beneficence, non-maleficence, and justice. Yet despite the theoretical similarities within the codes, each of these principles is reflected differently in various documents, and their practical applications remain problematic.

Different codes of ethics were created in response to different scandals within different countries and different historical eras. As a result, the codes lack a universal applicability, making them difficult to employ in a real-world setting. Without a unifying, cohesive ethical framework, everyone involved in the process is left without an answer to what most would argue is the single most important question in the field, "What makes human subject research ethical?"

Ethical guidelines for human subject research continue to be reevaluated in order to better protect the dignity of the individual while still allowing for the advancement of medical science. The history of the codification of research ethics has proven that despite the theoretical and foundational similarities, there is a lack of standardization and cohesiveness among ethical guidelines. Differing opinions regarding the definitions of key terms and an absence of a centralized governing body

to enforce these guidelines further complicate their use. These issues were clear to the judges during the Doctors' Trial at Nuremberg and have been cited as one of the reasons behind the inclusion of the Nuremberg Code as part of the legal judgment that was delivered at the tribunal. Their strategy was to incorporate the Nuremberg Code into international criminal law, thereby ensuring that its repercussions would be felt throughout the world for generations to come. In addition, the judges recognized that while the legal validity of ethical codes was uncertain, violating international law would have definitive harsh penalties.[7] However, because the judges did not offer a concrete method for enforcing the Nuremberg Code, its practical implementation was impossible.[8] The history of research ethics has proven that "although a code is necessary, it is insufficient to safeguard human rights in human experimentation. … The courts of individual countries, including the United States, have consistently proven incapable of either punishing those engaged in unlawful and unethical experimentation or compensating the victims of such experimentation."[9]

As each new code of ethics was introduced in response to a major scandal within the field of research ethics, it became even more apparent that these codes were not preventing legal or ethical abuses within human subject research. Since the publication of the Nuremberg Code, examples of unethical instances of human subject research abound: the Willowbrook Study, the Brooklyn Chronic Disease Hospital, the Tuskegee Syphilis Study, and drug trials in developing countries are just a few of the instances that triggered revisions in preexisting codes of ethics. As medical technology has continued to advance, criticism about the usefulness of ethical regulations within the current research environment is growing. There are increasing new concerns regarding "new medical devices, genomics, the Internet, mobile technologies, and stem cell research—all of which have revolutionized how and by whom research is conducted."[10] The rapid pace of medical and scientific advancement is going to create new challenges for the development of ethical guidelines for human subject research.

---

7 Grodin, 1992a.

8 Emmanuel, 2003.

9 Annas and Grodin, 1992b: 309.

10 Davis and Hurley, 2014: 12.

The Nuremberg Code was written in response to the medical community's blatant and egregious disregard for the dignity of human beings that took place during the Holocaust. This unique example of medically sanctioned genocide led to a codification of ethics that has become increasingly incompatible with the current research environment. Cohen and Lynch argue:

> [T]he fundamental issues at stake are the same as they have always been—balancing protectiveness against autonomy, risks against benefits, efficiency against deontological concerns. But several decades after the current human subjects regulatory framework was first adopted … it is not well suited for the reality of much of the research that will emerge in the twenty-first century and the institutions that will be conducting it.[11]

Modern research ethics must redefine itself in a way that will both protect the rights and dignity of individuals while also meeting the demands of an ever-changing scientific world whose goal is to improve the welfare of society.

The system in use is failing researchers, subjects, and society. Instead of constantly attempting to revise ethical guidelines, as has been the case since the inception of the Nuremberg Code over 70 years ago, a new paradigm must be established that emphasizes the responsibility of the researcher to prioritize the well-being of the subject first and foremost. Even before Henry K. Beecher's landmark 1966 article exposing research violations in major US institutions, he had already expressed doubts about the efficacy of using guidelines to regulate ethical human subject research in his response to the publication of the Nuremberg Code:

> It is not my view that many rules can be laid down to govern experimentation in man. In most cases, these are more likely to do harm than good. Rules are not going to curb the unscrupulous. Such abuses as have occurred are usually due to ignorance and inexperience.[12]

Instilling a moral ethos within the profession will ensure that researchers are treating individuals with dignity and respect not because a code of ethics tells them to, but because it is the right thing to do. This is a synthesis between the priority of maintaining an internal morality of the profession that existed before the Holo-

---

11 Cohen and Lynch, 2014: 6.

12 Advisory Committee on Human Radiation Experiments, 1996: 90.

caust and the priority of external oversight and regulation that was created after the Nuremberg Trials and continues to this day.

It is a fallacy to believe that Nazi doctors acted without any type of moral motivation. The history of medical ethics in Germany up to an including World War II has proven that there was, in fact, a relatively advanced and formalized system of ethics being taught and instilled into physicians.[13] Rather, their ethics were corrupted by a National Socialist biopolitical ideal that stressed the worth of certain individuals over others based on their value to the nation.[14] Thus, it is important to understand that medical and research ethics do not exist independent of society. Yet, this does not mean that physicians and researchers do not and should not have the ability and integrity to go against society's mores when they become corrupted. As Bruns and Chelouche have argued, "[t]he prevailing medical ethos can be strongly determined by politics and the zeitgeist and therefore has to be repeatedly negotiated."[15]

We have seen that ethical guidelines are often created in response to events within a culture or within a historical time period. As a result, these guidelines are likely to be influenced by the prevailing cultural or political zeitgeist. Therefore, they have been—and continue to be—repeatedly negotiated.

Recognizing that the Holocaust has served as a historical turning point in the development of medical and research ethics can allow us, as a society and a community of bioethicists, to develop a personal and professional ethos that values the dignity of the individual in a new paradigm, one that also emphasizes the moral dimension of professionalism, where both the motivation to act morally and what defines moral practice are grounded in professionals reflecting on the ends and values of the profession of medicine itself.[16] While regulatory systems like peer review and informed consent can certainly help prevent ethical abuses from occurring, ultimately focusing on professionalism suggests that a person's own moral compass, as it inheres the values of the medical profession, can serve as an internal guide to ethical behavior and a check to potential external societal pressure. In this way, both external restraints, as derived from regulations and administrative codes, and

13 Bruns and Chelouche, 2017.

14 Proctor, 1992.

15 Bruns and Chelouche, 2017: 591.

16 Pellegrino, 2014.

internal motivation, stemming from the ethos of medical professionalism would combine to form a double layer of protection against unethical behavior.

Teaching about the ways in which the moral compass of the Nazi doctors was corrupted by forces from outside the medical profession is an essential tool for educating future generations of physicians about the true meaning of the Hippocratic Oath and their responsibility as healers. Understanding how these physicians abandoned their professional moral ethos out of deference to social and political pressure and transformed from healers to killers demonstrates the "ease with which a contemporary ideology—one that promises a better future for our country—can undermine ordinary 'good' doctors' core ethical obligations to the primacy of patients' interest."[17] External codes of ethics have proven time and again to be a double-edged sword, regulating professionals while also being subject to the pitfalls of politicization. Shifting away from relying solely on a paradigm of codification towards one that also consists of moral professionalism will allow future generations of researchers to develop an internal motivation to act ethically that will guide them to do the right thing, not because they are required to do so but because they truly believe it is the ethically sound decision.

REFERENCES

Advisory Committee on Human Radiation Experiments. 1996. The Human Radiation Experiments: Final Report of the President's Advisory Committee. New York: Oxford University Press.

Annas, G.J., Grodin, M.A. 1992a. "Introduction." In: Annas GJ, Grodin, MA (Eds.). *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York: Oxford University Press; 3–11.

Annas, G.J., Grodin, M.A. 1992b. "Where do we go from here?" In: Annas GJ, Grodin MA (Eds.). *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York: Oxford University Press; 307–314.

Bruns, F., Chelouche, T. 2017. "Lectures on inhumanity: teaching medical ethics in German medical schools under Nazism." *Annals of Internal Medicine*. 166(8): 591–595.

Caplan, A.L. 2010. "The stain of silence: Nazi ethics and bioethics." In: Rubenfeld, S. (Ed.). *Medicine after the Holocaust: From the Master Race to the Human Genome and Beyond*. New York: Palgrave Macmilan; 83–92.

Cohen, J. J. 2010. "Medical professionalism: lessons from the Holocaust." In: Rubenfeld, S. (Ed.). *Medicine after the Holocaust: From the Master Race to the Human Genome and Beyond*. New York: Palgrave Macmillan; 201–208.

17 Cohen, 2010: 205.

Cohen, I.G., Lynch, H.F. 2014. "Introduction." In: Cohen, I.G., Lynch, H.F. (Eds.). *Human Subjects Research Regulation: Perspectives on the Future*. Cambridge (Massachusetts): MIT Press; 1–8.

Davis, A.L., Hurley, E.A. 2014. "Setting the stage: The past and present of human subjects research regulations." In: Cohen, I.G., Lynch, H.F. (Eds). *Human Subjects Research Regulation: Perspectives on the Future*. Cambridge (Massachusetts): MIT Press; 9–24.

Emanuel, E.J. 2003. "Scandals and tragedies of research with human participants: Nuremberg, the Jewish Chronic Disease Hospital, Beecher, and Tuskegee." In: Emanuel, E.J., Crouch, R.A., Arras, J.S. et al (Eds.). *Ethical and Regulatory Aspects of Clinical Research: Readings and Commentary*. Baltimore: Johns Hopkins University Press; 1–5.

Grodin, M.A. 1992a. "Historical origins of the Nuremberg Code." In: Annas, G.J., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York: Oxford University Press; 121–144.

Grodin, M.A. (1992b). "Judgment and aftermath." In: Annas, G.J., Grodin, M.A. (Eds.). *The Nazi doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York: Oxford University Press; 94–104.

Nuremberg Military Tribunal, from U.S. v. Karl Brandt et al. 1947. *The Nuremberg Code*.

Pellegrino, E. 2014. "Codes, virtue and professionalism." In: Sugarman, J., Sulmasy, P. (Eds.). *Methods in Medical Ethics*. Washington: Georgetown University Press; 91–107.

Proctor, R.N. 1992. "Nazi doctors, racial medicine, and human experimentation." In: Annas, G.J., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code: Human rights in Human Experimentation*. New York: Oxford University Press, New York; 17–31.

Taylor, T. 1992. "Opening statement of the prosecution, December 9, 1946." In: Annas, G.J., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York: Oxford University Press; 67–93.

Medicine and morality in Nazi Germany

Tessa Chelouche

For decades since the Second World War, Auschwitz has become synonymous with the unrestrained tyranny, the power of terror and the systematic murder of millions of human beings during the German Nazi rule. Auschwitz was the largest of the Nazi concentration camps, with the highest death rate among the death camps. Auschwitz was in reality composed of more than 40 camps and subcamps spread across Polish soil. The gruesome history and enduring horror of Auschwitz can be attributed primarily to the machinery for mass extermination of human beings created by the Nazis at the nearby Birkenau camp, a unit of Auschwitz. This was designated as the centrepiece for the "final solution of the Jewish question": the elimination of the Jewish race. According to the best estimates now obtainable, more than one million Jews were murdered in the gas chambers on arrival at Auschwitz and their bodies were incinerated in the camp's crematoria without the victims being ever registered. Of those murdered upon arrival, no trace remained: no name, no record, and no precise information. Around 400 thousand prisoners were actually registered in the camp, while about 200 thousand perished there.[1]

About the author: Tessa Chelouche is Co-Chair of Department of Bioethics and the Holocaust, UNESCO Chair in Bioethics (Haifa), and Co-Director of the Maimonides Institute for Medicine, Ethics and the Holocaust (USA). She is a family physician and renowned scholar of medical history. She has served as co-director and lecturer of a pre-graduate course on "The Study of Medicine and the Holocaust" for medical students as part of the Rappaport Faculty of Medicine at the Technion Institute in Haifa, Israel, for the past 10 years. She has published numerous articles on the subject of medicine and the Holocaust, including *Casebook on Bioethics and the Holocaust*.

1 Gutman, 1998.

Auschwitz has a special significance in the history of medicine and medical ethics. Auschwitz symbolizes everything immoral in humanity, but for the medical profession Auschwitz is especially significant. When one thinks about the Nazi doctors, the first thought usually leads to the unethical experiments performed on innocent victims by those physicians, and many of these experiments were carried out at Auschwitz. In the many lectures and presentations that I have given over the years this is usually the first comment made by the audience after I ask them what they know about the connection between medicine and the Holocaust. But these human experiments were only the tip of the iceberg. They represent the extreme and final part that the Nazi doctors played in what we now know and recognize as the Holocaust: the murder of 6 million Jews. As the well renowned psychiatrist and medical historian Robert Jay Lifton wrote in his groundbreaking study on the Nazi doctors:

> When we think of the crimes of Nazi doctors, what comes to mind are their cruel and sometimes fatal experiments. These experiments, in their precise and absolute violation of the Hippocratic Oath, mock and subvert the very idea of the ethical physician, of the physician dedicated to the well-being of patients. … Yet when we turn to the Nazi doctors' role in Auschwitz, it was not the experiments that were most significant. Rather, it was their participation in the killing process—indeed his supervision of Auschwitz mass murder from beginning to end.[2]

What does Lifton mean by "from beginning to end"? How were these doctors involved? How did it happen that these physicians betrayed not only their professional commitment to caring and healing, but proceeded further down the moral slope by torturing and murdering the very people who were supposed to be under their care?

The usual answer to some of these queries was that the Nazi doctors abandoned medical ethics. This is a myth that was believed to be true for decades. It was not comfortable to consider that they had done what they did with any form of existing moral or ethical stance. It was more comfortable to distance ourselves from the Nazi doctors by believing that we, present-day medical professionals, could never do anything remotely similar. Nazi science and medicine were considered to

2 Lifton, 2000.

be "pseudo-science," unethical and mad. How was it possible to talk about medicine and morality in Nazi Germany?

Following the Second World War, and the discovery of the "medical crimes"[3] perpetrated by the Nazi doctors, the Allies decided to prosecute a number of doctors and scientists who were involved in the Nazi medical atrocities. The Medical Trial (also known as the Doctors' Trial) took place in Nuremberg from December 1946 to August 1947, and was the first of twelve subsequent trials of the American military tribunal. As an immediate reaction to Nazi medical crimes, and in order to distinguish between criminal physical injury on the one hand, and permissible research on humans on the other, the Nuremberg judges established a set of ten principles which would protect the rights of experimental subjects and other vulnerable groups in the future. These principles are today known as the Nuremberg Code.[4] Subsequently, and as a direct response to the revelations in the Medical Trial, the World Medical Association (WMA) was founded. The objective of this organization was to adopt policy directives to maintain the honor and to protect the interests of the medical profession.[5] One of the first acts of the fledgling association was the adoption of a statement about the dedication of the physician to their profession. In 1948 the General Assembly of the WMA formally endorsed the Declaration of Geneva or the Physician's Oath.[6] This was in fact a new version of the ancient Hippocratic Oath. In this new ethical oath, a statement was added that was not previously a part of the Oath, in which a physician who adopted the Oath pledged "not to allow considerations of nationality, race, party politics and social class to interfere with the professional responsibility for the patient's welfare."[7] So for the first time in history, and as a direct consequence to the Nazi doctors' immoral actions, the Hippocratic Oath now had an additional dimension on "race."

In Germany "race" was to become a basic tenet for Nazi medicine. During the first decade of the twentieth century the science of eugenics was mainstream, legitimate and advanced in the United States and Great Britain. The meaning of eu-

3 Weindling, 2013.

4 Schmidt, 2007.

5 Schmidt, 2004.

6 Lederer, 2007.

7 Lederer, 2007.

genics and the uses made of the human genetic knowledge was not the same in every country, but the basic belief was that science (genetics) should be used as a tool to reform and advance society. Germany also became preoccupied with eugenics at the end of the nineteenth century, with medically trained professionals in the vanguard of this movement. Physicians enjoyed extraordinary prestige in Germany because of the medical breakthroughs of the nineteenth century, and they were seen as the one professional group possessing the expertise to safeguard the health and welfare of the nation.[8]

The first eugenics society and journal were established in Germany, and the term "eugenics" was changed to include the term "race": eugenics in Germany became known as Racial Hygiene. At the onset Racial Hygiene was less concerned with the comparison of one race against another than with discovering the principles of improving the human race in general,[9] and it was not anti-Semitic. It contained a diverse blend of all political leanings. But in Nazi Germany the right wing of the Racial Hygiene movement was crucial in its incorporation into the Nazi medical apparatus and would eventually be well accepted by the German eugenicists who accepted ideologies of Aryan or Nordic supremacy.[10] In the course of the 1920s racial hygienists began to link themselves with the growing Nordic movement, and by the 1930s it was difficult to distinguish between the rhetoric of Racial Hygiene from that of official Nazi policy.[11] As Pellegrino writes: "The caduceus joined the swastika in a lethal symbiosis that cost millions of lives and forever branded German medicine as a traitor to every tradition that ever made medicine a beneficent rather than a maleficent enterprise."[12] It was the symbiosis that existed between the German doctors, eugenicists and geneticists, and National Socialism that served to radicalize them all.[13]

National Socialism was claimed to be "applied biology" and supported the idea that nature rather than nurture was the key to the development of the human

8 Weiss, 2013.

9 Proctor, 1988.

10 Weiss, 2013.

11 Proctor, 1988.

12 Pellegrino, 1989.

13 Weiss, 2013.

race.[14] It can be safely said that it was largely the medical scientists who invented Racial Hygiene in the first place. By 1932 Racial Hygiene had become a scientific orthodoxy in the German medical community. The significance of this was that the medical community developed a new ethical stance in line with the politics of the time. Scientists who were driven by a fear of degeneration now propagated nationalist ethics defined on the basis of medical and racial criteria of inclusion and exclusion.[15] Included were those whose genetic makeup was considered as "worthy of living" and excluded were those who were defined as living lives "unworthy of life."

This was in fact a process of weakening humanistic ethics centered on the individual and was now geared for the "good of society." The human losses from the First World War and the perceived biological need of rejuvenating the German nation together with the concept that care for the weak and sick in society was economically unfeasible, provided moral rationale for the German medical profession that it was their duty to take care of the future of the nation. It was in this context that Fritz Lenz, the first holder of the chair of Racial Hygiene in Germany and co-author of a seminal work on heredity would state: "The individual personality cannot be the final goal of ethics. … The people (*Volk*) as an organism is the goal of our ethics. …"[16] With this goal in mind, the German racial hygienists demanded a more practical solution to their beliefs and advocated sterilization as a means of improving the race.[17]

The United States had a pioneering role in eugenic sterilization. Indiana legalized involuntary sterilization on eugenic grounds for institutionalized "confirmed criminals, idiots, rapists and imbeciles" in 1907. By the end of the First World War more than sixteen states had sterilization laws, as did other countries such as Denmark, Sweden, Canada, and others.[18] These developments were closely monitored in Germany and were used to legitimize the German sterilization program, which was legalized only after the National Socialist government takeover in 1933. One of the new government's first official acts was to enact the Law for the Pre-

14 Proctor, 1988.

15 Bruns, 2014.

16 Bruns, 2014.

17 Proctor, 1988.

18 Schmuhl, 2014.

vention of Offspring with Hereditary Diseases, or the Sterilization Law. This law increased compulsory sterilizations to a level never achieved in any other country. Once again, this demonstrated the symbiotic relationship between the German medical establishment that was responsible for the architecture and implementation of the law, and the Nazi politicians. This transformed the German medical profession.[19] This program was considered to be ethically and morally sound and was supported by the National Socialist German Physicians' League (NSDÄB), the organization formed to coordinate the German physicians into one political body subordinated to the National Socialist Party.[20] The head of NSDÄB, Gerhard Wagner, wrote in an editorial:

> If we are serious about our demands that our people and our race be kept healthy, if we really want to put into practice what the teachings of inherited health demand—and we will have to fulfill these demands if we wish our people are to have any kind of future—then we will have to overcome this attitude of charity that not only offers benefit to both valuable and inferior life without distinction but which has also in fact led to the promotion of all inferior life to the detriment of the healthy.[21]

This new morality became an accepted part of everyday medicine, and physicians sterilized some 400 thousand German men and women against their will. German doctors had become "genetic doctors," replacing traditional medical ethics with selective medical ethics. The patient was no longer considered as an individual but only a part of a much larger whole or unity: his family, his race, his *Volk*.[22] German doctors, regarded now as responsible for the genetic future of society, were required to register any case of perceived hereditary conditions in a special set of courts where other doctors, performing the role of judges, would decide whom to sterilize. The traditionally accepted medical norm of doctor-patient confidentiality was forsaken, and its withdrawal was considered justifiable, in line with the new medical ethic so as to abide with this new law. This can be seen from the statement made by Ernst Rudin, one of the psychiatrists involved in the writing of the

19 Proctor, 1988.

20 Proctor, 1988.

21 Bruns, 2014.

22 Proctor, 1995.

Sterilization Law: "It was highly ethical to inhibit the unhealthy in order to open up the field of reproduction to the healthy."[23] This same doctor also claimed that "it would be immoral for a doctor in the interests of his private practice to omit to register for sterilization any individuals suffering from an inherited disease."[24]

These moral and ethical issues were not only addressed by statements made by the main medical functionaries involved, but were also laid out in formal ordinances and directives. The new morality of the Nazi medical profession needed to reach the professionals that it was aiming for, and this goal was attained with the proclamation of the Reich Physicians' Ordinance in 1935. The main purpose of this ordinance was to found a unified organization for all German physicians in the Reich Physicians' Chamber which demanded compulsory membership for every doctor in Germany, and to provide a statute containing ethical and organizational rulings pertinent to the entire medical profession.[25] The doctors were now compelled by law to serve the State and the racial vigor of the German people.[26] The Ordinance set out the classes of persons who were seen as qualified to hold medical diplomas according to the "rights of citizenship" in the Third Reich. This decree was pursuant to the Civil Service Law passed in 1933, whereby the Nazi Party had the right to legally remove anyone either of non-German heritage (Jews) or of questionable political sympathies (communists), those with unacceptable moral attitudes and those deemed physically or mentally unfit for medical practice.[27] Medicine lost its former legal categorization as a "profession" and now had a new definition of a "calling" to the requirements of the Nazi regime. The status of the Nazi physician thereby had risen with this statute in place. In addition the German doctors were now required to undergo continued training in National Socialist concepts of health and medicine.[28] The Physicians' Ordinance expressly safeguarded the traditional Hippocratic privilege of confidentiality between doctors and Aryan patients, and infractions of this statute were to be punishable with fines or even

23 Bruns, 2014.

24 Bruns, 2014.

25 Kater, 1989.

26 Haedenkamp, 1938.

27 Proctor, 1995; Haedenkamp, 1938.

28 Kater, 1989.

prison sentences. But the interests of the State and community were paramount, and if endangered in accordance with Nazi racial eugenic tenets, all cases of serious hereditary or congenital illnesses (such as "imbecilism" or alcoholism) were to be recorded with the authorities.[29]

In 1942, the Reich Health Leader Conti publicly repeated the regime's desire to establish a "health file on every German from the cradle to the grave."[30] Physicians were now compelled to actively support all the State measures for increasing numbers and racial purity of the population.[31] This rationale would form the premise for the doctors' legal obligation to inform on their eugenically diseased patients, and led to eugenic sterilization becoming an accepted medical norm. The same applied to eugenic abortions.[32] This in effect meant that race enhancement (positive eugenics) and eugenic forced sterilization (negative eugenics) were to become accepted medical norms in Nazi Germany. Other traditional medical ethical stances were also laid down in this ordinance such as public health norms, regulation of physicians' fees, medical advertising rules and the sale of drugs by the physicians.[33] This was the Nazi medical ethic of the time. The German doctors responded to these new moral statutes by joining the Nazi Party in greater numbers than any other free profession.[34] The Nazi doctors did not spurn ethics, but instead justified their ethical stance with their support of the Nazi ideology. They did not spurn morality, either. The Nazi medical establishment (as with the general Nazi movement) tried to give the impression that it was guided by moral principles and values, and demanded its adherents to follow these principles. The Nazi medical profession did not just give up on conventional morality, but substituted it with a new racial morality. It replaced universal values and thought patterns of traditional Judeo-Christian morality that it considered incompatible with race ethics, while integrating others into its own value system.[35]

---

29 Haedenkamp, 1938.

30 Kater, 1989.

31 Haedenkamp, 1938.

32 Haedenkamp, 1938.

33 Haedenkamp, 1938.

34 Kater, 1989.

35 Bialis, 2014.

This was the background for the development of the "Euthanasia" program known as "T4 Euthanasia." The distinction between "worthy of living" and "unworthy of living" was inherent in the medical ethics and was a continuum of thought process. In 1920 Karl Binding, a professor of law, and Alfred Hoeche, a professor of psychiatry, published their work *Permission for the Destruction of Life Unworthy of Living*.[36] This launched a public debate in Germany, as well as within medical circles,[37] especially as this coincided with the wake of the medical failures in the treatment of seriously injured soldiers from the First World War and the large numbers of patients who died of hunger in the psychiatric asylums and institutions for the disabled during this period.[38] An example of this can be seen in the attitude of the physician and medical ethicist Georg Benno Gruber, who initially opposed the notion of "mercy killing" but later was to state, "It does not seem to me to be a new question that extinguishing a doubtlessly incurable life that is also devoid of any personal value and completely fruitless while substantially burdening the community is worthy of consideration."[39]

This statement demonstrates how the public in general, and the medical profession in particular, were prepared for the idea of ridding society of its perceived worthless. In their work, Hoeche and Binding posed the question of the dilemma of caring for patients whose existence "has forever lost value to themselves or society." In answer they coined the terms "useless eaters," "empty human shells," and "burdening existences." The National Socialists easily adopted these terms and used them for the creation and implementation of the "euthanasia" program. This would have been impossible under normal circumstances, but the outbreak of the Second World War paved the way for this campaign to begin. Unlike the sterilization program, this was to be a secret one, and public debate, allowed earlier, was to be forbidden.[40] It is estimated that around two hundred thousand people were killed for eugenic or economic reasons.[41]

---

36 Binding and Hoeche, 2012.

37 Bruns, 2014.

38 Wunder, 2014.

39 Bruns, 2014.

40 Bruns, 2014.

41 Burleigh, 1994; Muller-Hill, 1998.

Hermann Pfanmüller, the director of the mental institution at Elfing-Haar, voiced his opinion on the need to "eradicate" such patients.

> As a confessionally unattached and fervent National Socialist director of a mental hospital, I feel myself obligated to demonstrate an actual conservative measure that is suitable to influence favorably the economic standing of the institutions. In this position, I believe it appropriate to refer clearly to the need of us doctors to grasp the importance of eradicating life unworthy of living. These unfortunate patients who live only a shadow life of a normal human being, who have become perfectly useless for social membership in the human community by virtue of their illness, whose existence is to themselves, their relatives and their surroundings a torment and a burden, must be subjected to rigorous eradication.[42]

Those considered to be a burden on society were refused traditional care and medicine, and this was considered to be morally right. This was the new morality of selective ethics from the Nazi medical perspective.

There was an additional perspective to this new medical morality. It was imperative to teach it to future generations of medical practitioners. They were the future, and as such had to become acquainted with the new order. At the beginning of the 20th century, medical ethics did not exist as a formal teaching subject in German medical schools. In the German medical community, as in other Western countries at that time, ethical thinking was expressed primarily in medical literature and codes of conduct rather than didactic teaching.[43] From 1933 onward, Racial Hygiene was taught at most medical schools as part of the medicalization process of Nazism.[44] The revised medical curriculum included newly designed lectures on Racial Hygiene, the science of heredity, population policy, military medicine, and the history of medicine. These subjects seemed particularly suitable for promoting Nazi ideology to medical students, as did another new set of lectures that became obligatory for students: Medical Law and Professional Studies (MLPS). The subject of MLPS, which was included in the new medical curriculum of 1939, focused for the first time on physicians' oral and legal obligations to their patients

42 Bryant, 2005.

43 Bruns and Chelouche, 2017.

44 Kater, 1989.

as well as to their profession and the state. The MLPS lectures were intended to provide medical students with "an understanding of both the written and unwritten laws of the medical profession and of doctors' ethics." The goal of this new course would be to explicitly create a "new type of physician." Such a physician would be trained to internalize and then implement the Nazi biomedical vision of a homogeneous and powerful people (*Volk*) in their daily work. This radical break from the traditional forms of medical morality was a key element of the MLPS lectures. It involved shifting the focus of ethical concern and medical care away from the individual patient and toward the general welfare of society or the people. The lecturers in this new course were all members of the Nazi Party, and half were practicing family practitioners. The textbook used for the course was written by Rudolph Ramm, a family doctor, and was titled *Medical Ethics and Law: The Doctor as Medical Educator*. In his book, which was based on his MLPS lectures, Ramm outlined the Nazi version of medical ethics and the mission of physicians in the Nazi state. He believed in the authoritarian paternalistic role of the physician as a "health leader" and blatantly defined the Nazi physician's ethical obligation as being responsible for ridding society of certain groups: Jews, persons with disabilities, and any others who were deemed unable to contribute to society. Ramm stated that Nazism brought the "reinstatement of a high level of professional ethics." He welcomed the fact that "the profession had been extensively cleansed of politically unreliable elements foreign to our race" (that is, German Jewish physicians). Ramm denounced any form of health care for the "hereditarily inferior" people and asserted that every person in Nazi Germany had a moral duty to stay healthy. He praised the 1933 Eugenic Sterilization Law as a milestone "on the path of restoring racial purity and hereditary health." Ramm justified this law that in effect encouraged the breach of physician-patient confidentiality in certain cases, which he explained as being morally necessary. He also addressed the "problem of euthanasia" and argued explicitly for the "mercy killing" of disabled persons:

> These creatures merely vegetate and constitute a serious burden on the national community. They not only reduce the standard of living of the rest of their family members because of the expenses for their care but also need a healthy person to take care of them throughout their lives.

Some passages approached questions of medical ethics that were less permeated with Nazi ideology but aspired to more traditional medical values. Ramm emphasized, for example, patients' limited right to autonomy in choosing their own physician. He also stated that billing for unnecessary procedures contradicts medical ethics. Ramm further reminded his students and colleagues of the ethical obligation to seek collegial advice and to transfer patients in a timely manner to specialists when confronted with difficult cases. However, he clarified that these customary ethical principles applied to "Aryan" patients only, and thus excluded other patients from the realm of medical morality.[45] The medical students were obligated to participate in these courses and to learn from Ramm's textbook, which made Nazi Germany the first country in the world to have compulsory ethical teaching at medical schools. This fact cannot be overemphasized. The future members of the medical community were taught that they had to perform their vocation in a racially conscious fashion in order to prove that they were worthy of belonging to their profession. They were expected to demonstrate their commitment, struggle, and personal dedication to the cause of Nazism in a fashion that was seen as ethically right. This was the new interpretation to the ancient Hippocratic Oath, and shows us that ethical reasoning can be corrupted and that teaching ethics is, in itself, no guarantee of the moral integrity of physicians.

The Nazis were not only the first in the world to teach medical ethics, but ironically, they were the leaders in another field. As unbelievable as this may be perceived, this was the field of medical experimentation. The 1900 code promulgated by the Prussian Ministry of Religion, Education, and Medical Affairs, for example, was the world's first official regulation of human experimentation, banning non-therapeutic interventions without voluntary consent, along with experiments on minors and others judged vulnerable or incompetent. Experiments had to be authorized by the director of the institution involved, and records had to be kept in writing.[46] Then the subsequent 1931 code issued by the Reich Health Office strengthened sanctions against inappropriate human experiments. These new guidelines were entitled "Regulations on New Therapy and Human Experimentation" and were more inclusive and formalistic than the Nuremberg Code in that they demanded

45 Bruns and Chelouche, 2017.

46 Grodin, 1992.

complete responsibility of the medical profession for carrying out human experimentation. They include clear directives on informed consent and other protocols involving ethical standards of research. They have been called the world's most comprehensive code governing human experimentation.[47] It is unclear whether these guidelines had the force of law, but the point is that they reflect the prewar German principles concerning the acceptable limits of human research.[48] Incredible as it may sound, ethical norms were implicit even in the most horrible experiments in the various hospitals and camps. As the medical historian Robert Proctor asks: how else does one explain the fact that "healthy" German citizens were never experimented on? Those subjected to human experimental violence were invariably people judged less than fully human on the Nazi scale of values: Jews and Gypsies.[49]

Medical ethical discourse continued throughout the Nazi period. On November 24, 1933 for example, a law for the protection of cruelty to animals was passed, banning experimentation causing pain or injury to animals. The law specifically disallowed experiments involving exposure to cold, heat, or infection.[50]

I have shown that the existence of medical ethical regulations and guidelines did not prevent the medical atrocities in Nazi Germany from occurring, but the postwar Nuremberg Medical Trial was an epochal step in the evolution of present medical ethics.[51] Twenty-three defendants (20 doctors and 3 medical administrators) were accused of horrific crimes performed in the name of medicine. After 85 witnesses were heard and 1471 documents were considered, 7 defendants were sentenced to death. The 23 prosecuted at the medical trial can be viewed as physicians, medical researchers, and administrators whose actions were dictated by a commitment to a code of medical ethics primarily based on strict scientific and economic criteria.[52]

---

47 Grodin, 1992.

48 Grodin, 1992.

49 Proctor, 2000.

50 Annas and Grodin, 1995.

51 Ernst and Weindling, 1998.

52 Ernst and Weindling, 1998.

At the trial the main concerns were the "crimes against humanity" committed by the Nazi doctors who had performed the experiments, and the issue of human experimentation. As mentioned above, the response to this was the formation of what we know today as the Nuremberg Code, which merged Hippocratic ethics and patient-centered ethics.[53] The Nuremberg Code was written in response to the medical community's blatant and egregious disregard for the dignity of human beings that took place during the Holocaust and was the first international pronouncement on the rights of research subjects. But for decades the Code was relegated to history and was considered to be a "good code for barbarians but an unnecessary code for ordinary physicians-scientists." The lessons of Nuremberg were isolated from the rest of the world and prevented the judges at Nuremberg from placing the Nazi experiments in their historical context.[54] The Medical Nuremberg Trial heralded a period of great uncertainty for health professionals and national medical organizations with regard to the role that the medical profession was to play in a post-war society,[55] and the Nuremberg Code did not become the guiding code for the conduct of research. Instead it was superseded by the World Medical Association Declaration of Helsinki and other codes.[56] Although these subsequent codes are based on Nuremberg, which grew out of the ashes of the Holocaust, no mention is made of Nuremberg in their protocols. The same can be said for the abovementioned Geneva Declaration.

In addition, the many other areas where medical crimes were committed, such as eugenics, sterilization, euthanasia and the abuse of medical authority, rationalized ethically by the perpetrators themselves, did not fall within the scope of the trial and were not addressed.[57] This was despite that fact that the prosecutors realized that in fact the whole German medical community had been involved and not only those who had performed the barbaric experiments. This is supported by the statement made by the American medical consultant at the trial, Andrew Ivy: "Had the profession taken a strong stand against the mass killing of sick Germans before the war, it is conceivable that the entire idea and technique of death facto-

53 Schmidt and Frewer, 2007.

54 Katz, 1992.

55 Schmidt and Frewer, 2007.

56 Katz, 1992; Annas and Grodin, 1995; Schmidt and Frewer, 2007.

57 Ernst and Weindling, 1998.

ries for genocide would not have materialized."[58] This is the continuum between the Nazi medical professionals' embracement of the concepts of eugenics and race and the "Final Solution to the Jewish question" resulting in the Holocaust. In the words of Robert Proctor, "The ultimate decision to gas the Jews emerged from the fact that the technical apparatus already existed in the hospitals that were used to kill the mentally and physically ill in Germany in the 'euthanasia' program."[59] This continuum was made possible by the symbiosis of a dictatorial regime for which race and heredity served as an ideological cornerstone and a willing and compliant medical profession for which race and heredity functioned as its epistemological categories.[60]

To sum up this paper, I return to the question: how could this happen? How did it happen that these physicians betrayed not only their professional commitment to caring and healing, but proceeded further down the moral slope by torturing and murdering the very people who were supposed to be under their care? Part of the answer lies in the fact that these murderous medical programs could be performed because the victims, the experimental subjects, were considered by their physicians as "lives unworthy of living," as subhuman, and as a threat to the future of the race, and as such did not deserve to be treated according to the regular code of medical ethics. This was one of the moral defenses used at the Doctors' Trial at Nuremberg. Joachim Mrugowsky, one of the defendants, explained how this was possible: "They were not patients of the doctor in terms of medical ethics or in terms of understanding of the relationship between a doctor and a patient. This is the reason why it would be possible to apply what we comprehend as medical ethics to this case only in a very limited sense."[61] Since the concentration camp experiments had been conducted with non-patients as research subjects, the Nuremberg tribunal did not need to address the problem of the impact of the medical profession's ideology on what had transpired at Auschwitz that granted the Nazi physicians the power of such great authority in their *Therapia Magna Auschwitzciense*—the great

58 Mitscherlich and Mielke, 1949.

59 Proctor, 1995.

60 Weiss, 2013.

61 Bruns, 2014.

therapy of and in Auschwitz.[62] The German doctors knew the Hippocratic Oath,[63] had detailed regulations in place on medical professionalism and ethics, and had been taught medical ethics more extensively than in any other country, but the medical ethics were overridden by the prevailing ethics of the zeitgeist. They were not monsters, but rather human beings like us, with moral principles that they upheld. It was precisely the existence of their medical morality blended with social--political-biomedical ideology that provide the basis for the sequence from coercive sterilization to the direct killing in the "Final Solution of the Jewish question"—the Holocaust. This medical morality led down the twisted but final road to Auschwitz.

REFERENCES

"Appendix 3: Declaration of Helsinki: Recommendations Guiding Doctors in Clinical Research." In Annas, G.J., Grodin, M.A. 1995. *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation.* New York, Oxford: Oxford University Press; 331–432.

Annas, G.J., Grodin, M.A. (Eds.) 1995. *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation.* New York, Oxford: Oxford University Press.

Bialis, W. 2014. "Nazi Ethics and Morality: Ideas, Problems, and Unanswered Questions." In Bialas, W., Fritz, L. (Eds.). *Nazi Ideology and Ethics.* Cambridge: Cambridge Scholars Publishing.

Binding, K., Hoeche, A. 2012. *Allowing the Destruction of Life Unworthy of Living: Its Measure and Form.* Modak, C., trans. Suzeteo Enterprises.

Bruns, F. 2014. "Turning Away From the Individual: Medicine and Morality." In Bialas, W., Fritz, L. (Eds.) *Nazi Ideology and Ethics.* Newcastle upon Tyne: Cambridge Scholars Publishing.

Bruns, F., Chelouche, T. 2017. "Lectures on Inhumanity: Teaching Medical Ethics in German Medical Schools Under Nazism." *Annals of Internal Medicine.* 166: 591–595.

Bryant, M.S. 2005. *Confronting the "Good Death." Nazi Euthanasia on Trial, 1945–1953.* Boulder, Colorado: University Press of Colorado.

Burleigh, M. 1994. *Death and Deliverance. "Euthanasia" in Germany, 1900–1945.* Cambridge: Cambridge University Press.

Ernst, E., Weindling, P.J. 1998. "The Nuremberg Medical Trial: Have we learned the lessons?" *J Lab Clin Med.* 131: 130-135.

Grodin, M.A. "Historical Origins of the Nuremberg Code." 1992. In Annas, G.J., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation.* New York, Oxford: Oxford University Press; 121–144.

Gutman, I. "Auschwitz—An Overview." 1998. In Gutman, I., Berenbaum, M. (Eds.) *Anatomy of the Auschwitz Death Camp.* Bloomington: Indiana University Press; 5–33.

Haedenkamp, K. 1938. "Medical Practice in Germany." *British Medical Journal Supplement.* II: 345–347.

62 Katz, 1992.

63 Katz, 1992.

Haedenkamp, K. 1938. "Medical Practice in Germany." *British Medical Journal Supplement.* V: 333–335.

Kater, M.H. 1989. *Doctors Under Hitler.* Chapel Hill and London: The University of North Carolina Press.

Katz, J. 1992. "The Consent Principle of the Nuremberg Code: Its Significance Then and Now." In George, J.A., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation.* New York, Oxford: Oxford University Press; 227–239.

Lederer, S.E. 2007. "Research Without Borders: The Origins of the Declaration of Helsinki." In Schmidt, U., Frewer, A. (Eds.). *History and Theory of Human Experimentation. The Declaration of Helsinki and Modern Medical Ethics.* Stuttgart: Franz Steiner Verlag; 145–186.

Lifton, R.J. 2000. *The Nazi Doctors. Medical Killing and the Psychology of Genocide.* United States of America: Basic Books.

Mitscherlich, A., Mielke, F. 1949. *Doctors of Infamy. The Story of the Nazi Medical Crimes.* New York: Henry Schuman.

Muller-Hill, B. 1998. *Murderous Science. Elimination by Scientific Selection of Jews, Gypsies and Others in Germany, 1933–1945.* Cold Spring Harbor Laboratory Press.

Pellegrino, E. 1989. "The Nazi Doctors and Nuremberg: Some Moral Lessons Revisited." *Annals of Internal Medicine.* 127: 307–308.

Proctor, R.N. 1995. "Nazi Doctors, Racial Medicine, and Human Experimentation." In Annas, G.J., Grodin, M.A. (Eds.). *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation.* New York, Oxford: Oxford University Press; 17–31.

Proctor, R.N. 2000. "Nazi Science and Nazi Medical Ethics: Some Myths and Misconceptions." *Perspectives in Biology and Medicine.* 43(3): 335-346.

Proctor, R.N. 1988. *Racial Hygiene. Medicine Under the Nazis.* Cambridge, Massachusetts: Harvard University Press.

Schmidt, U. 2004. "Post-War Medical Ethics." In *Justice at Nuremberg. Leo Alexander and the Nazi Doctors' Trial.* Hampshire, New York: Palgrave Macmillan; 264-265.

Schmidt, U. 2007. "The Nuremberg Doctors' Trial and the Nuremberg Code." In Schmidt, U., Frewer, A. (Eds.). *History and Theory of Human Experimentation. The Declaration of Helsinki and Modern Medical Ethics.* Stuttgart: Franz Steiner Verlag; 71-116.

Schmidt, U., Frewer, A. 2007. "History and Ethics of Human Experimentation: The Twisted Road to Helsinki. An Introduction." In Schmidt, U., Frewer, A. (Eds.). *History and Theory of Human Experimentation. The Declaration of Helsinki and Modern Medical Ethics.* Stuttgart: Franz Steiner Verlag; 7–23.

Schmuhl, H.W. 2014. "Eugenics and Racial Hygiene: Applied Research Strategies Before, During and After National Socialism." In Rubenfeld, S., Benedict, S. (Eds.). *Human Subjects Research After the Holocaust.* Heidelberg New York Dordrecht London: Springer; 31–38.

Weindling, P.J. Thompson, J.W. 2013. *Psychiatrist in the Shadow of the Holocaust.* Rochester: University of Rochester Press.

Weiss, S.F. 2013. *The Nazi Symbiosis. Human Genetics and Politics in the Third Reich.* Chicago and London: The University of Chicago Press.

Wunder, M. 2014. "Learning with History: Nazi Medical Crimes and Today's Debates on Euthanasia in Germany." In Roelke, V., Topp, S., and Lepicard, E. (Eds.). *Silence, Scapegoats, Self-Reflection. The Shadow of Nazi Medical Crimes on Medicine and Bioethics.* Gottingen: V&R unipress; 301–312.

Behaviors of Nazi doctors and whether their motivations have modern-day relevance

Susan M. Miller

INTRODUCTION

As I prepared for this lecture, my approach was based on placing myself within this historical context: "What if I was a German physician during the Third Reich? Would I, too, have been vulnerable to becoming a perpetrator similar to Nazi physicians?" Why were the physicians enamored by the illusions and fallibility of Racial Hygiene? Tessa Chelouche reminds us that we are all capable of genocide.[1] So, if we merely categorize these physicians as "other than us," or as an aberration, this would be a disservice to medical genocide history and it would diminish our ability to understand and learn from their behaviors.

About the author: Susan M. Miller MD, MPH, FACP, FAAFP, is the John S. Dunn, Sr. Research Chair in General Internal Medicine at the Houston Methodist Hospital and a Professor in the Department of Family Medicine and of Clinical Medicine at the Institute of Academic Medicine, Houston Methodist Research Institute. She is an Associate Professor at Weill Medical College, Cornell University. Dr Miller is Department Chair of Family Medicine at The Methodist Hospital. She is currently the senior Chair of the Institutional Review Board of the Methodist Hospital Research Institute and the Director of the Chao Program for International Research Ethics.
This chapter is an edited transcript based directly on Dr Miller's paper delivered during the 2nd international conference *Medical Review Auschwitz: Medicine Behind the Barbed Wire*.

1 Chelouche, T., 2020, in this volume.

Before World War II, Germany was a pre-eminent destination for medical education and research training. Research experimentation was highly valued, and ambitious physicians from all over the world travelled to German laboratories and medical facilities to learn what was considered the most up-to-date medical techniques in venues which aggregated state-of-the-art techniques. This, for example, was the case for the renowned surgeon Dr Michael DeBakey. Prior to World War II, Germany had more Nobel laureates than any other country.[2] As early as 1900, Germany was an early adopter of research ethics and provided guidance on research practices which explicitly forbade research on children and other vulnerable populations.[3] Furthermore, in 1931, Germany published the "Regulations on New Therapy and Human Experimentation," after an internal case of research misconduct. These guidelines were stricter than the Nuremberg Code which arose from the Nuremberg Medical Trial (i.e., "Doctors' Trial").[4] So, what happened?

Beginning in the Weimar Republic, approximately 50% of German physicians became early members of the Nazi Party.[5] This represented a greater professional percentage of enrollment than for any other profession. Similarly, a significant number of early Nazi members were medical students.[6] In contrast, Jewish physicians were caricaturized by their colleagues as unethical. They were ostracized, demoted, and eventually prohibited from practicing medicine, except on their Jewish patients.[7]

An artist's representation of the changing professionalism of physicians is well illustrated by Arie Galles's drawing, Hippocratic *Oath #1,* which depicts the original Greek script of the Hippocratic Oath trapped behind the image of concentration camp uniform stripes or perhaps of prison bars. The artist used charcoal ash to create this image, which alludes to crematorium ashes.[8] In post-war interviews, Nazi physicians stated that their National Socialist oath of loyalty to Hitler,

---

2 Cf. https://www.nobelprize.org/prizes/lists/all-nobel-prizes.

3 Grodin, 127–128.

4 Grodin, 129–130.

5 Barondess, 1658; Grodin, Miller, Kelly, 53; Haque, 473.

6 Haque, 476; Grodin & Annas, 638–639.

7 Haque, 475.

8 Galles, 2015; Weinstein, private communication.

which they took as SS military officers, was more real to them than a vague ritual they had performed at their graduation from medical school.[9] And even though the Hippocratic Oath is considered fundamental within the patient-physician relationship, and has already been referenced a number of times in today's presentations, the irony is the Oath was originally created in ancient Greece in response to the generalized mistrust and misconduct of physicians by Grecian society.[10] The creation of the subsequent Nuremberg Code represents a modern-day example of a societal response to physician misconduct.

EXTERNAL BEHAVIORS OF NAZI PHYSICIANS

Before discussing the *internal* behaviors and motivations of Nazi German doctors, a review of Lifton's work presents notable examples of their conspicuous, *external* behaviors—those that could be easily observed. These behaviors reflect the transitioning process of how medicine became politicized. In his book, *The Nazi Doctors. Medical Killing and the Psychology of Genocide*, Robert Jay Lifton, an American psychiatrist, interviewed multiple Nazi physicians after the war, providing the first in-depth study and partial historiographical understanding of how medical professionals rationalized their behaviors during the Holocaust.[11] For example, physicians assisted in writing the sterilization legislation, "Law for the Prevention of Genetically Defective Progeny (1933)."[12] This legislation permitted sterilization of those members of society *medically-defined* as unfit. In addition to co-writing the legislation, physicians and other health care professionals were expected to report individuals with disabilities under the guise of "public health," in their roles of "biological soldiers" and "genetic doctors."[13] Moreover, in their professional medical capacity, doctors served as voting members on the hereditary health courts

9 Lifton, 207, 435.

10 López-Muñoz, 792.

11 Lifton, 1986.

12 López-Muñoz et al, 794, 796; Grodin, Miller, Kelly, 55.

13 Lifton, 30.

and used purported "scientific" criteria that would "legally" permit sterilization.[14] Physical examinations to confirm the medical criteria for sterilization were not performed.

In contrast to this prejudicial treatment of its citizens, Nazi physicians discriminated against, stigmatized, and libeled their Jewish colleagues.[15] As early as March 1938, they prevented enrollment of Jewish students into medical schools.[16] Later that year, they revoked the licenses of practicing Jewish physicians.[17] There were very limited, overt protests against these actions. For example, members of the White Rose (1942–1943), a medical, non-violent resistance group, were killed for expressing their criticisms.[18]

Physicians also indoctrinated their students in university courses based on the Nazi biomedical vision of Racial Hygiene. The courses were taught by avowed National Socialist non-academicians and university physician-lecturers.[19] As Chelouche describes, mandatory lectures in ethics were a part of medical curriculum beginning in 1939. The ethical ideas and medical idealism taught included the unequal worth of human beings and the authoritarian role of the physician. These courses also described the moral imperative of physicians to preserve the purity of the Aryan people.[20] The subsequent eugenic sterilizations performed by Nazi doctors eventually affected 0.5% of the state's population.[21]

Those external behaviors became more merciless as the *political* system itself became *medicalized* and physicians were further transformed from healers to killers. For example, physicians were responsible for the non-judicial identification of candidates for euthanasia. This included inscribing a plus (+) or minus (-) sign on the paperwork denoting whether the individual was a candidate for euthanasia.[22]

---

14 Lifton, 25; Grodin, Miller, Kelly, 55.

15 Rees 5–13, 37; Haque, 475.

16 Grodin, Miller, Kelly, 53–57.; Rees, 61.

17 Grodin, Miller, Kelly, 54.

18 Lifton, 39; Sidel, 1679.

19 Bruns and Chelouche, doi: 5–7.

20 Bruns and Chelouche, doi: 7–8.

21 López-Muñoz et al., 795.

22 Lifton, 52–57.

Again, this did not require a direct physical examination. Physicians were also responsible for overseeing the transports of patients to the various "specialized" centers where euthanasia occurred. One physician, Irmfried Eberl, became the commandant of the Treblinka concentration camp based on his *Aktion T4* euthanasia experience.[23] The Nazi doctors themselves performed the lethal injections, oversaw the systemic starvation of patients, and managed the gas chambers. They also coordinated the processes of obtaining autopsy specimens for research and falsifying death certificates.[24] All of these behaviors were separate from the more well-known "medical" selection processes performed by the SS doctors[25] and the criminal research experimentation that occurred in death camps, hospitals, and at universities.

It is worth stressing that Hitler's renowned letter, backdated to September 1, 1939, which authorized medical "euthanasia," was written on his private stationery. This document was not formally part of the German legal code, but Hitler's words effectively became law. The letter provided "legal" protections to doctors against potential lawsuits if they performed "mercy deaths."

But, as historians argue, even though the document had Adolf Hitler's signature, it is thought that the final draft of this correspondence was actually written by a physician, Dr Max de Crinis.[26] This became a mechanism to ensure physicians' support (alongside the politicized war effort) and to minimize any physicians' reticence to participate in the program.[27] Nazi doctors also discussed which mechanism of euthanasia utilized the best technique in this medical deception. Dr Victor Brack, for instance, said, "The syringe belongs in the hand of a physician,"[28] while Dr Karl Brandt would argue that "only doctors should do the gassings."[29] This dispute about technique, gassing versus injection, was adjudicated by Hitler when he asked Brandt, "Which is the most human way?"[30]

---

23 Lifton, 123–124.

24 Lifton, 18, 55, 57, 62, 71, 97, 102; Grodin, Miller, Kelly, 56–57.

25 Rees, 325.

26 Lifton, 63 (footnote).

27 Lifton, 62–63.

28 Lifton, 70.

29 Lifton, 71.

30 Lifton, 72; Rees, 167.

INTERNAL BEHAVIORS OF NAZI PHYSICIANS

Having discussed the behaviors that could be observed, the next question to consider is: "What were the internal and psychological experiences of the Nazi physicians?" Today's medical profession needs to understand how physicians, who were supposed to uphold the Hippocratic Oath, actually justified and rationalized their behaviors. How were they able to cope and integrate these "professional" behaviors associated with history's first medically-sanctioned genocide?

One of the themes which repeatedly occurred in post-war interviews with Nazi doctors is their described sense of duty, not only as members of the military, but also as members of the Nazi Party and of society.[31]

Lifton further illuminates the healing-killing paradox when he compares the Nazi's perceptions of Auschwitz in the context of war. "War is the only accepted institution … in which there is a parallel healing-killing paradox. One has to kill the enemy in order to preserve—to "heal"—one's people, one's military unit, oneself."[32] Although Nazi doctors avoided war on the Russian front, they attempted to claim a moral equivalent of war in their activities at Auschwitz, albeit a race war.

Another internal process explaining the stances of Nazi physicians is known as "splitting." This is considered a subconscious behavior, and is a coping method for avoiding internal conflict, especially if there is a moral conflict about the consequences of one's behavior. For example, "medical practitioners were attracted to Nazism"[33] because it was a way to alleviate a sense of powerlessness that was prevalent between World War I and World War II. Significantly, if one joined the Nazi Party early, this became a mechanism of upward mobility and financial security.[34] As historians note, it is worth mentioning that a subset of Nazi doctors served as physicians during World War I. This traumatic experience had the potential for emotional scarring as they witnessed extensive disease, disability, and death.[35] This is a separate provocation from the humility associated with Germany's

31 Lifton, 207, 435.

32 Lifton, 431.

33 Haque, 476.

34 Barondess, 1657–1659.

35 Haque, 477.

World War I loss and the subsequent consequences of the Treaty of Versailles.[36] Another perspective mentioned by Lifton describes how Auschwitz physicians considered their murderous activities an "ordeal" which could eventually be accepted.[37] To "perform the prescribed ritual slaughter, he offers both himself and his victims to the immortal Germanic people and its hero-deity, Adolf Hitler.[38] Auschwitz was considered to be "exempt from the ordinary rules of behavior."[39]

One of the takeaway points from Lifton is the recognition that we all have the capacity to deceive ourselves. Through this dissembling, we are able to create a foundation for self-deception, not only in our obedience behaviors, but also in how we adaptively cope. For example, an individual who participates in a "mercy death" and is also a "good father," must have the ability to compartmentalize these discordant behaviors. Or, as one physician described his experiences to Lifton, there were "ostensible efforts to heal and help in the midst of … mass killing."[40] These examples further represent the concept of "splitting," an ability to harbor contradictory attitudes, beliefs, and behaviors, which allow an individual to maintain the process of denial. Gabbard, an academic psychologist, describes the utility and benefits of this process and how it enables one to "tap into the evil which is inherent in all of us while maintain the myth that one is *not evil*."[41]

Still, there is a need to better understand how the physicians were able to perform these disparate activities. Nazi physicians were systematized[42] in their activities and attempted to carry out their tasks to perfection, on behavior of a higher goal of "balance."[43] Their organizational structure, socialization, mentoring and peer review processes attenuated any innate reluctance to participate in violence. There was also a subset of Nazi physicians who were actually very ambitious and resolute in their actions and enjoyed their work. But even for the rest, the inherent

36 Rees, 12.

37 Lifton, 437.

38 Lifton, 435.

39 Lifton, 200.

40 Lifton, 202.

41 Gabbard, 39.

42 Lifton, 194.

43 Lifton, 202.

conformity provided by medical training and other activities further maintained a sense of normalcy. Also, multiple individuals subscribed to a shared sense that Auschwitz was morally separate from the rest of the world.[44] The Nazi doctors, instead of acting on the duty to warn when someone would be killed, felt that concentration camp inmates were already condemned to death. Selections were based on concepts of public health and quarantine.[45] If one cleared out a block or barracks because of diarrhea, the physicians could view the behavior as "pseudoethical" or "pseudoidealistic."[46] Because of this "reality," there was minimal remorse or guilt based on their daily research or clinical activities.[47]

In contrast, Nazi physicians' decisions and behaviors were intentionally mislabeled and were deliberately kept secret. For example, there was a special language distancing the labeling from the actions. For instance, the terms "mercy killing" or "selection" were used instead of the more accurate terms of murder or genocide. It is worth noting that if a physician heard a "selection" was going to occur, without actually witnessing or performing the actual cremation, they could have plausible deniability a murder was going to happen. Because one individual did not perform the entire spectrum of activities, the perpetrators could diffuse their perceived accountability and this allowed them to deny their proportionate guilt.[48] Remarkably, these secrets were maintained not only within oneself, but also from one's colleagues and family. In fact, the secrets were even maintained after the war. Through maintaining these secrets, a cogent analysis of causality and responsibility was lost.

An interesting contrast with this analysis is the perception of some Nazi physicians who perceived their role had been to instead provide "islands of humanity" within the camps. In this way, they thought they were actually doing a lot of good. "Building medical facilities … served the psychological purpose of avoiding awareness of one's own killing."[49] However, because the SS doctors' disparate selves could remain unintegrated, their moral conflict was unrecognized and the experi-

---

44 Lifton, 200.

45 Lifton, 202.

46 Lifton, 202.

47 Lifton, 193–202.

48 Grodin and Annas, 642, 645.

49 Lifton, 203.

ence of individual guilt was actually diminished. These rationalization techniques allowed one to maintain the fiction of a good self, and many physicians felt with absolute certainty and conviction that their behaviors were just.[50]

Certainly, anti-Semitism was another factor, as well as the sense that the "Aryan race" (*Ubermensch*) needed to be maintained.[51] But there was also a self-centered interest: if psychiatrists practiced in the "essential" euthanasia centers, they did not have to participate in front-line military duty which would increase their risk of death.[52]

Physicians also used utilitarian rationales to justify their killing. This was best exemplified in the radicalized book, *Allowing the Destruction of Life Unworthy of Living* (1920), written by Karl Binding, a lawyer, and Alfred Hoche, a physician. The authors described an unsentimental justification which stated killing was permissible, especially if it resulted in other lives being saved. These ideas contradicted prior moral, legal, and medical prohibitions against killing. The authors justified their position by claiming these "lives [are] unworthy of living … [f]or their relatives as well as for society, they are a terribly heavy burden."[53] As such, by describing the destruction of life as "purely a healing treatment," there were no discernible ethical repercussions.[54]

ARE PHYSICIANS PREDISPOSED TO BECOMING PERPETRATORS?

It is worthwhile to explore another perspective by considering whether physicians are potentially predisposed to the behaviors perpetrated by Nazi doctors in World War II. Is there a physician-centric explanation? The psychiatrist Dr Haque suggests that physicians, may, in fact, be predisposed to these behaviors.[55] Because physicians

50 Lifton, 205.

51 Grodin and Annas, 638; Lifton, 203–207.

52 Lifton, 59.

53 Binding and Hoche, cited by Schmidt, 35.; Grodin, Miller, Kelly, 55.

54 Lifton, 46.

55 Haque, 474..

are trained in a hierarchical system in which authority and rank result in legitimate respect and their obedience in following the roles assigned by that system is rewarded, they typically adapt with conformity behaviors.[56] This was observed during the Third Reich as well. Medical authority figures with dissenting views were excluded, so one did not hear their repudiations.[57] The "scientific theories" of eugenics and the public health implications of "racial cleansing" had a perceived exactitude and were considered the most up-to-date genetic approach to medicine.[58]

When Nazi doctors framed and demonized others as disgusting, dangerous, unclean, and unethical, they were able to moralize their sense of aversion, making it easier to marginalize and eventually extinguish the targeted populations. As mentioned earlier, social order and social unity were perceived as more important than an individual's rights. Performing research, ethical or not, was seen as helping society and the war effort. The transformational redefinition of killing as a form of healing, and the supposition it was permissible to save lives considered more important, provided further justifications for these behaviors.[59]

Karl Brandt, one of Hitler's physicians, was mentored by Alfred Hoche[60] about how Brandt could serve science by saving those that could be valued from a scientific point of view.[61] During the Doctors' Trial held in Nuremberg, Brandt stated his behaviors were based on ethics. Even after his guilty verdict, he still did not feel that he had done anything wrong, and described his activities as a part of the total character of war. Moreover, once he was sentenced to death, he volunteered to become a research subject, even if it resulted in his premature death prior to his execution; but the military court did not give this serious consideration.[62]

My next perspective on physician motivation is based on the academic work of Michael Grodin, MD, and George J. Annas, JD. Both scholars provide expert perspectives on health law, bioethics, and human rights. They present a contextual

---

56 Grodin and Annas, 635–654.

57 Kolman and Miller, e0007.

58 Lifton, 22–29.

59 Schmidt, 374–375.

60 Schmidt, 33–34.

61 Schmidt, 33–38.

62 Schmidt, 386.

description of the required dissociative skills and social conditioning required in medical training which may facilitate the creation of a perpetrator-torturer. By selectively integrating authoritarian policies into medical training, the individual can embrace these identified rules and values. A special language for inner-group communication is necessary in order to camouflage reality. For instance, expressions such as "purification," "treatment," or "mercy killing" are substituted for the terms murder or genocide. Also, dehumanization and blaming process are required in order to debase the victim. This process, of necessity, also includes routine exposure to violence, social modeling of group violence, and the individual practice of controlled violence. All these provide essential levels of depersonalization and dehumanization. Finally, complicit, obedient behavior must be acknowledged and rewarded.[63]

Still, why are physicians potentially vulnerable to becoming perpetrators? Grodin and Annas describe how medical education training enforces the process of *compartmentalization*.[64] This is an absolutely necessary skill which enables physicians to develop the ability to participate in the inherent violence associated with the performance of surgery. All physicians are taught circumstances in which they have to cause pain as a component of healing. This training is reinforced by scientific justifications for why this violence is done—amputations and, again, surgery, provide perfect examples of this. But a physician needs to develop the skill of medical detachment in order to therapeutically use a scalpel.[65]

Grodin and Annas provide additional clarity as they describe the inherent fragmentation of the genocidal process. The differentiated labor involved from conception to final genocide were divided among many different people. No one individual had full responsibility for the complete spectrum. A bureaucratic decision could identify the victim, others were involved in transport, separate personnel organized the technique, and other individuals performed the final action. If you were able to limit and de-identify your specific activity, this would diminish one's proportionate guilt.[66]

---

63 Grodin and Annas, 630–644, 651.

64 Grodin and Annas, 646.

65 Grodin, 647.

66 Grodin and Annas, 651.

The circumstances of war provided additional justifications for the Nazi physicians' decisions and actions. After all, society and the military required medical information which *could only* be obtained via war-based experimentation. The hypothermia and altitude research studies intentionally incorporated subject death as part of the design.[67] Since Nazis considered the camp inmates as already condemned to death, the inmate's role as a research subject had the potential to serve worthier lives. Also, there was an inexhaustible supply of subjects and subsequent autopsy specimens which further fulfilled academic ambitions toward advanced degree programs.

Physicians became agnostic to the suffering of their institutionalized patients and to those within the concentration camps.[68] However the transactional interactions toward these individuals were not limited to physicians. Concentration camp administrators, academic colleagues, other health care personnel, commercial business and pharmaceutical companies all depended on the supply of inmate--victims for academic and financial outcomes. Finally, during the time of war, there were no external or regulatory constraints on this process. Society did not have a sustained infrastructure for oversight.

CONCLUSIONS

In summary, I wish to share a quotation by Dr Sherwin Nuland after he attended the Deadly Medicine exhibit in Washington, D.C., in 2004:

> To my startled dismay, I found myself understanding why so much of the German establishment acted as it did. I realized that, given the circumstances, I might have done the same. … [W]hat we learn from history comes far less in studying the events than in the recognition of human motivation—and the eternal nature of human frailty.[69]

In closing, I would like each of us to consider whether we have the fortitude, courage, imagination or the insight to be a dissident, to be a witness, to be a con-

67 Weindling, 2004; Weindling, 2015.

68 Weindling, 2015: 190–193, 204–205.

69 Nuland, 2019.

scientious objector instead of a bystander or a perpetrator. We must have an awareness of how we respond when we see amoral behavior or when we witness medical mistakes, or ethical transgressions. Is our dissent visible or invisible? How do we handle the dehumanization that occurs when we have to compartmentalize as part of our medical training? Do we recognize our interdependence with one another? How will we integrate authentically moral behaviors—not the ones we may have received externally as part of our religious upbringing or of our socialization, but those which are genuinely ours?

REFERENCES

Barondess, J.A. 1996. "Medicine against Society: Lessons from the Third Reich." *Journal of the American Medical Association*. 272: 1657.

Bruns, F., and Chelouche, T. 2017 "Lectures on Inhumanity: Teaching Medical Ethics in German Medical Schools Under Nazism." *Ann Intern Med.* 18; 166(8): 591–595. Available online at: https://annals.org/aim/fullarticle/2618421/lectures-inhumanity-teaching-medical-ethics-german-medical-schools-under-nazism.

Gabbard, Glen O. 2002. *The Psychology of "The Sopranos."* New York: Basic Books.

Galles, Arie. 2015. *Hippocratic Oath #1* [charcoal drawing]. High-quality scans available online at: http://ariegalles.com/oath.html; Verbal communication, Andrew Weinstein, From Healing to Killing: Science and Genocide (Exhibition, Budapest, April 25, 2016).

Grodin, M. 1992. "Historical Origins of the Nuremberg Code." In: Annas, G., Grodin, M., *The Nazi Doctors and the Nuremberg Code.* New York: Oxford University Press; 121–144.

Grodin, M., and Annas, G. 2007. "Physicians and torture: lessons from the Nazi doctors." *International Review of the Red Cross.* 89(867): 635–654. https://doi: 10.1017/S1816383107001208.

Grodin, M., Miller, E.L., and Kelly, J. I. 2018. "The Nazi Physicians as Leaders in Eugenics and 'Euthanasia': Lessons for Today." *Am J Public Health.* 108: 53–57. https://doi:10.2105/AJPH.2017.304120.

Haque, O.S., De Freitas, J., Viani I., et al. 2012. "Why Did So Many German Doctors Join the Nazi Party early?" *International Journal of Law and Psychiatry.* 35: 473–479. http://dx.doi.org/10.1016/j.ijlp.2012.09.022.

Kolman, Jacob M., and Miller, S.M. 2018. "Six Values Never to Silence: Jewish Perspectives on Nazi Medical Professionalism." *Rambam Maimonides Medical Journal*. 9(1): e0007.

Lifton, R.J. 1986. *The Nazi Doctors: Medical Killing and the Psychology of Genocide.* New York: Basic Books.

López-Muñoz, F.F., Alamo, C., Dudley, M., et al. 2006. "Psychiatry and political-institutional abuse from the historical perspective: The Ethical lessons of the Nuremberg Trial on their 60th Anniversary." https://doi:10/1016/j.pnpbp.2006.12.007.

Rees, L. 2017. *The Holocaust: A New History.* New York: Perseus Books.

Schmidt, Ulf. 2007. *Karl Brandt: The Nazi Doctor: Medicine and Power in the Third Reich.* New York: Continuum Books.

Sidel, Victor W. 1996. "The Social Responsibilities of Health Professionals: Lessons From Their Role in Nazi Germany." JAMA. 276(20):1679–1681. doi:10.1001/jama.1996.03540200065034.

The Nobel Prize. "All Nobel Prizes." https://www.nobelprize.org/prizes/lists/all-nobel-prizes [Accessed 2 December 2019].

United States Holocaust Memorial Museum. "Deadly Medicine: Physician and Scientist Profiles—Sherwin B. Nuland." https:// www.ushmm.org/exhibition/deadly-medicine/profiles/ [Accessed 20 August 2019].

Weindling, Paul J. 2004. *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent*. New York: Palgrave Macmillan.

Weindling, Paul J. 2015. *Victims and Survivors of Nazi Human Experiments: Science and Suffering in the Holocaust*. New York: Bloomsbury Books. 190–193, 204–205.

Teaching about the legacy of health professionals' involvement in the Holocaust: Five key challenges

Matthew K. Wynia

INTRODUCTION

The Holocaust is the sentinel genocide of our time and medical scientists were not merely complicit in it, they were early, consistent and critical leaders in developing the ideology of eugenics and "racial hygiene" that underlay the most terrifying crimes of the Holocaust. Physicians led programs of forcible sterilization, child "euthanasia," the infamous T4 program, and they helped develop the technologies necessary to carry out mass murder in extermination camps. Many served in the murderous process of "selection" in the camps, and one was a commander of Treblinka. The notion of racial extermination, which we now call genocide, was based on the perverted "scientific" notion that public health required that the nation be "cleansed" of its racial enemies. Other articles in this collection detail aspects of the complex path that led German physicians to become murderers

About the author: Matthew K. Wynia, MD, MPH, is the Director of the Center for Bioethics and Humanities at the University of Colorado, USA. As a university professor and practicing physician, he specializes in internal medicine, health care ethics, and social policies.

together, and to do so not in spite of their medical training, but in the name of medicine, science, and public health.

This article will not explore this history, per se; rather, I will assume the reader knows something about it and is already convinced of its importance. In fact, I premise this article on the assertion that understanding the history of medical involvement in the Holocaust is critical to understanding the ethics and regulation of health professionals today, and that taking lessons from this history is important for medicine and for society. For these reasons, I believe every health professional trainee should be exposed to this history, and I assume readers of this article believe this as well.

Rather than reviewing this history and why it is important, this article will discuss what we have learned about how to teach this history in our health sciences educational programs in Colorado. Our health sciences campus has spent the last several years building a program with the goal of ensuring that not only will every health sciences student in our University have the opportunity to learn about the role of health professionals in the Holocaust, but they will also come to understand how and why this tragic legacy has continuing importance for health care and society today.[1] This paper will summarize the major challenges we have faced while creating our program, because building the program and helping it spread to other universities has been harder than expected; and often it has been harder for reasons that were not apparent when we first started our efforts.

WHY THIS HISTORY IS RARELY TAUGHT IN MEDICAL SCHOOLS

I have been thinking about how to include information about this history in the medical curriculum for over a decade, since the US Holocaust Memorial Museum first developed its special exhibit called "Deadly Medicine: Creating the Master

1 University of Colorado, 2019. Available at: https://www.cuanschutz.edu/centers/bioethicshumanities/education/holocaust-genocide-and-contemporary-bioethics-program.

Race."[2] When I first saw this exhibit—when it was in development at the US Holocaust Memorial Museum in Washington, DC—it hit me hard.

I realized two things: first, there is hardly an issue in medical ethics today where modern thinking is not strongly influenced by this history. Whether it is end of life care, or high priced drugs, or the care of vulnerable refugees, or biomedical research, or genetics, the ways that we think about all of these issues are profoundly affected by the legacy of the Nazi doctors, whether we know it or not.

But second, I realized that most health professionals, in fact, do not know it.

There is often some education about the Holocaust in our high schools and colleges, but relatively few medical schools include any required teaching about this history in the health sciences curriculum. Except for the occasional lecture about research ethics, which might mention Mengele and the Nuremberg trials, in a survey of medical schools in the US and Canada we learned that only 16% include any required teaching about the history of health professionals' involvement in Nazi crimes.[3]

How can we really understand modern medical ethics without understanding this history? I think we cannot—and that is why I committed myself to helping ensure that every health sciences student would be exposed to this history.

My earliest work in this arena was with Dr Allan Wells and Dr Patricia Heberer-Rice, when we developed a traveling lecture about this history, which has now been delivered at dozens of schools around the world.[4] But when I moved to Colorado in 2015, new opportunities arose.

The University of Colorado already had a community of committed physicians and others who thought that educating students about this history was important. The group in Colorado had done several outstanding programs in the prior decade, yet there had not been a consistent annual program. The question naturally arose: why had the program not become sustainable?

---

2 US Holocaust Memorial Museum.

3 Wynia, Silvers, and Lazarus, 2015.

4 Wynia and Wells, 2007.

FUNDING

One reason was that there had not been someone available to run such a program—now that I was in Colorado and committed to this, that issue was solved. But equally important, there was no committed funding for an annual program.

So when I arrived, I got together with people who had been supportive of the program and made the case for consistent annual funding. One of the people I met with—Dr Bill Silvers, whose two parents were both imprisoned in Auschwitz—agreed to provide an initial gift of $100,000 over 5 years to create an endowment for this initiative.

This was an excellent and critical first step—but an endowment of $100,000 gives us about $4,000 per year in annual funding for the program. Dr Silvers and I had much bigger dreams than that—at a minimum, we wanted a program that would reach all of the students on all four of our campuses, spread out across the state of Colorado. We estimated such a program would cost at least $15,000 per year.

Still, finding this core, sustainable funding was a necessary first step, which anyone seeking to develop an annual program should seek to emulate. The Silvers endowment provides a guarantee that we will produce a program every year.

With additional fundraising, we have been able to build on Dr Silvers' gift and to expand the program each year for the last 3 years, so that we now hold events on all four campuses of the University across the Week of Remembrance of the Victims of the Holocaust in the US.

I want to forewarn you however, that core funding is necessary for creating a program but not sufficient. Still, some of our activities have been particularly effective, and I would like to highlight two of these from the 2018 program. First, we hosted the US Holocaust Memorial Museum's "Deadly Medicine" traveling exhibit on our campus in 2018, and we worked with local Holocaust educators to train docents (exhibit guides) who took school groups and others through the exhibit while it was on our campus. Hosting the "Deadly Medicine" exhibit and training exhibit docents was an excellent way to build knowledge on our campus and create a cadre of invested faculty and students. Doing this would be an excellent first step for any program getting started.

Second, we did a series of lectures, concerts, panel discussions and other activities during Holocaust Remembrance Week. One of these panel discussions deserves special mention, in part because we were somewhat anxious about how it might turn out, but it ended up being extraordinarily powerful. In brief, we invited two Holocaust survivors who had been children when their families fled Europe as refugees, eventually coming to the United States. Their stories were incredibly moving, as one would expect. But then we also had two young people who had fled the wars in Iraq and Syria with their families much more recently. Their stories were also powerful. And it was the combination, having them speak with each other about their shared experiences as refugees—what was similar but also what was different—that juxtaposition was what really moved the audience.[5]

Third, partnerships have also been critical to the growth of this program. We have worked not only with local and national coalitions that share our mission of Holocaust education, but also with local museums like the Mizel Museum. Local foundations, especially the MB Glassman Foundation, have been critical supporters, and we have also worked with national organizations like the Maimonides Institute for Medicine, Ethics and the Holocaust. For the 2019 program we are working with Physicians for Human Rights and other advocacy organizations. We also have several university partners, including the University of Colorado School of Law, Program in Jewish Studies, and our undergraduate program in health humanities.

Reading about our growth and partners, one might think we have had nothing but success, but that is not true. While we have a very solid annual program, with elective lectures and other events, we still do not have a required curriculum on this topic in our medical, nursing, pharmacy, public health or dental schools. That is because, separate from funding, there are several additional challenges that a fledgling program like ours must address.

---

5 A video of the event is available at: https://www.youtube.com/watch?v=wxt5MLf4suY&feature=youtu.be.

TIME

Perhaps the most obvious barrier after funding is finding time in an already overcrowded curriculum. Ethics is a required part of the curriculum for many health sciences students, but history is not. And not all people in leadership will recognize that the history of health professionals' involvement in the Holocaust is critical for understanding contemporary professional ethics—after all, few of today's leaders learned about this history and its modern implications when they were in training.

To break into the curriculum, we have started with elective sessions and courses. But we have also formed a student advisory group, because if students ask for something to be taught, it is much more likely to be taken seriously than if a professor asks for it—after all, professors always want to add material to the curriculum, students do not. We are also working on building aspects of this history into existing courses in ethics, professionalism, legal issues, research and more, rather than trying to create a brand new class about just this topic.

TEACHERS

Another scarce resource in education is good teachers. This topic is even harder to teach than most others, because it is very sensitive, the lessons are often nuanced, and the history is extremely detailed and complex. Moreover, because it has not been taught in the past, there are not many health professionals on faculty who feel like they are qualified to teach about this history and why it matters today.

To address this barrier, we have developed a faculty advisory group for the program and, as noted above, when we had the "Deadly Medicine" exhibit on our campus we trained a number of them to serve as docents—walking tour groups through the exhibit, learning more about this history themselves and getting comfortable talking about it with groups.

We have also partnered with local and national groups that focus on Holocaust education—while these groups do not typically focus on the roles of health professionals in the Holocaust, they have a lot of experience in teaching the complex and

painful lessons of the Holocaust, which has been extremely valuable in developing our programs for health sciences students.

TEACHING MATERIALS

There are teaching resources available online, including Powerpoint slides and suggested readings (e.g., http://www.medicineaftertheholocaust.org/), which can be used to create lectures on the history of health professional involvement in the Holocaust. But in medical education the use of lectures for teaching is in decline.[6] More information is being taught using cases and small group formats. But the history of health professional involvement in the Holocaust is not always easy to incorporate into contemporary cases for small group discussion. There is an excellent and readily available casebook on medicine and the Holocaust, with cases based on real events during the Holocaust,[7] but no case books that include contemporary cases that can and should be informed by an understanding of this history. To address this challenge, we have created an annual case competition, where students who have learned about the role of health professionals during the Holocaust develop cases about modern ethical issues based on this history. We give a small prize to the top 3 cases, and we consider using the top case in the next year's curriculum.

The next challenge is less well-recognized, but it might also be the hardest of these challenges to handle, because it is about our culture and the unique place that Nazi doctors hold in contemporary culture.

LEARNING FROM EVIL

In brief, the problem is that the crimes of Nazi doctors were so heinous that they have become the archetype for evil—the epitome of medicine gone mad. Because of this, any time that one tries to learn about an ethical issue today by comparing

6 Krisberg, 2017.

7 Chelouche and Brahmer, 2013.

it to something that a Nazi did, it has two primary effects. First, it makes the person or group whose actions or beliefs are being compared to Nazi actions or beliefs very defensive. So rather than opening their minds to new ideas, they tend to close instead. Second, it tends to shut down conversation altogether. In the US, this has been called "playing the Nazi card" or sometimes, "*Reductio ad Hitlerum*,"[8] and the prevailing assumption is that once you have made an analogy to the Nazis, you have caricaturized the issue. You are no longer interested in even trying to understand the other person's viewpoint, let alone in trying to find common ground. After all, you have called the other side a Nazi, which is unadulterated evil.

I do not believe there is any easy solution to this—but the fact is that the Nazis were human beings, like us. As a result of recognizing this, my suspicion is that, more often than not, they did not think they were evil. Of course today it is obvious that what they did was evil, but a core lesson from this history is that human beings—even including us—are capable of perpetrating evil even while thinking we are doing the right thing.

Rather than trying to get around this issue, our approach has been to openly acknowledge it as a challenge to learning from this history. We do this at the beginning of each discussion about this history, and when I talk about it, I also return to this challenge again at the end. I also personalize how painful it can be to try to learn from this history, and how painful and difficult it can be contemplate how normal human beings like us, even like me, could find ourselves on a path to evil.

A second way to address this is to not start with the Nazis, but start with a contemporary challenge that is somehow related. So, for example, in 2019 our program is focusing on the roles of health professionals in wartime—and we have experts on human rights law and the conflict in Syria, who will speak about how modern human rights laws and the laws of war were influenced by what happened during World War II. Third, we have asked people like Dr Tessa Chelouche to speak directly about stories of medical heroism during the war, to help counterbalance the negative aspects of this history, which tend to be overwhelming.

---

8 Strauss, 1953.

LACK OF STANDARDS

The final major challenge we have had to address in our program is that the history of the Holocaust is extremely complex and detailed. There is so much that could be learned, yet there is no apparent consensus on what are the key aspects of this history that every student ought to know—and what are the key lessons that need to be conveyed from this history that will matter the most to health professionals today?

One way we have addressed this challenge is to have a different program each year—this allows us to explore various aspects of the history and its contemporary implications. But that is also a capitulation to the idea that we do not have a core curriculum that ought to be taught to every student—because different students, in different years, hear about different aspects of this complex history.

Recently, we established a working group of interested faculty and community members who are developing a set of what they consider to be the core aspects of this history that ought to be taught every year. This group is not done with their work, but they are looking at lessons in three main areas that remain relevant today. First, the challenge of dual loyalties—when health professionals have competing obligations to individual patients and to the government, their employer or to the community at large. Second, the role of trusting science, in view of the fact that science is always unfinished and often tentative. In particular, medical science can be very helpful for setting social policies, but there is also a risk in believing scientific theories before they have been fully proven, especially if you plan to use them to set policies that might harm people. Third is the issue of how training to become a health professional creates special risks of losing our humanity, such as by becoming hardened or inured to human suffering, which is something that all of us must be careful to avoid, as we move through our training and our careers.

Of course, these are not the only three lessons to be learned from this history, but each seems important, and there are specific aspects of the history of health professional involvement in the Holocaust that can help illuminate each of these contemporary challenges. Still, in the end, questions about what core aspects of this history and its lessons for today ought to be in the curriculum of modern health sciences programs are questions for broader consideration, deliberation and consensus development.

CONCLUSION

The legacy of health professional involvement in the Holocaust is profound and pervasive across the health professional ethics, yet this history and its implications are rarely taught in medical schools. Our experiences in setting up the Holocaust Genocide and Contemporary Bioethics program, which aims to teach this history and its contemporary implications across the University of Colorado, have been instructive, illustrating a specific set of challenges that many if not all similar efforts are likely to encounter. In laying out these challenges and describing how we have managed or overcome them, we hope that others will be able to foresee and address these issues proactively, saving time and energy in establishing similar programs worldwide. This will be necessary to achieve our vision that no student should graduate from any health professional training program without having learned about and from this tragic and influential history.

REFERENCES

Chelouche, T., Brahmer, G. 2013. *Casebook on Bioethics and the Holocaust*. UNESCO Chair in Bioethics. Available at: http://www.unesco-chair-bioethics.org/wp-content/uploads/2015/09/Casebook-on-Bioethics-and-the-Holocaust.pdf [Accessed 22 August 2019].

Krisberg, K. 2017. "Flipped classrooms. Scrapping lectures in favor of active learning." AAMC News. Available at: https://news.aamc.org/medical-education/article/flipped-classrooms-scrapping-traditional-lectures-/ [Accessed 22 August 2019].

Strauss, L. 1965. *Natural Right and History*. Chicago: University of Chicago Press: 42.

University of Colorado Center for Bioethics and Humanities. Holocaust Genocide and Contemporary Bioethics program. 2019 program. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BioethicsHumanities/education/Pages/Holocaust-Genocide-and-Contemporary-Bioethics-Program-2019.aspx [Accessed 22 August 2019].

United States Holocaust Memorial Museum. "Deadly Medicine: Creating the Master Race" (traveling exhibit). Information at: https://www.ushmm.org/information/exhibitions/traveling-exhibitions/deadly-medicine [Accessed 22 August 2019].

Wynia, M.K., Silvers, W.S., Lazarus, J.A. 2015. "How do US and Canadian medical schools teach about the role of physicians in the Holocaust?" *Acad Med.* 90(6): 699–700.

Wynia, M.K., Wells, A.L. 2007. "Light from the flames of hell: Remembrance and lessons of the Holocaust for today's medical profession." *Israel Med Assoc J.* 9: 186–188.

"The corpse is still taking a stroll..." The case of the German SS Doctor Johann Paul Kremer

Maria Ciesielska

In late August 1942, SS Dr Johann Paul Kremer arrived in Auschwitz. Kremer, a doctor of medicine and philosophy and a member of the Nazi Party, held a chair of anatomy at the University of Münster, and prior to his arrival in Auschwitz, had been employed in the SS Main Sanitary Office in Berlin and the Waffen SS field hospitals in Dachau and Prague. He commenced his duties straightaway on 1 September by taking part in the disinfection of a prisoners' block with the use of Zyklon B gas, and the following night in the selection of prisoners for the gas chamber.[1] Dr Kremer wrote in his diary that from 30 August to 18 November 1942 he participated in 14 *Sonderaktionen* (special operations) and attended the execution of prisoners shot with a small-calibre gun and of women killed with a lethal injection.[2] Yet this is not what he has been remembered for, but instead for

About the Author: Maria Ciesielska is a doctor of the medical sciences specialising in family medicine, as well as a lecturer in the history of medicine and Head of the UNESCO Unit at the Faculty of Medicine at Lazarski University in Warsaw. She is an award-winning author of many publications on the lives of doctors during the Second Word War and the medical aspects of the history of German concentration camps and the Holocaust.

1 Strzelecka, vol. 2: 134.

2 Olbrycht, 1962: 43.

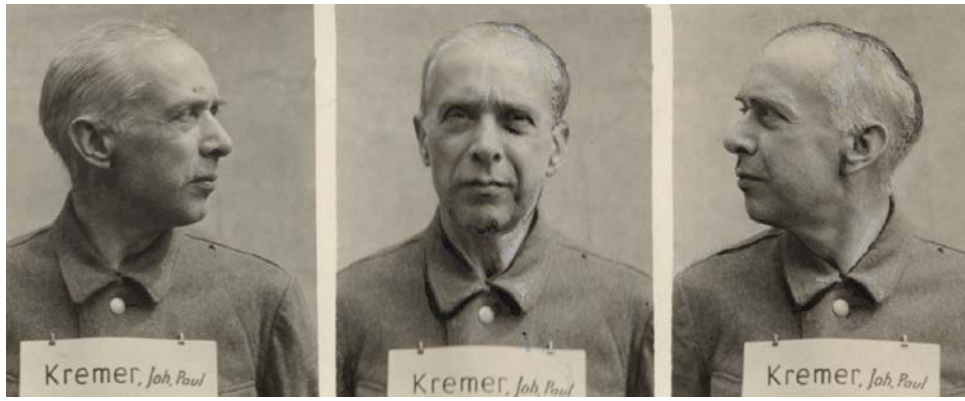


Photo 1. | Johann Paul Kremer, professor of anatomy and human genetics at Münster University. He served in the SS in the Auschwitz concentration camp as a physician, from 30 August 1942 to 18 November 1942. Archives of the Auschwitz-Birkenau State Museum. Source: www.auschwitz.org

his brutal and pointless research on the effects of hunger disease. As he wrote in the statement he made after the War, he had the consent of Dr Eduard Wirths, the chief physician of the SS garrison, to collect "absolutely fresh specimens" for his research from the bodies of prisoners who had just been killed with a phenol injection into the heart. What made these experiments pointless was the fact that the brown atrophy of the liver and the heart muscle he was purportedly observing had already been reported and described in the professional medical literature. Kremer, who presented a paper entitled "*Über die Veränderungen des Muskelgewebes im Hungerzustande"* (On the changes that occur in muscle tissue in hunger disease) for the award of the post-doctoral *Habilitation* degree, wanted to know whether any posthumous changes had an effect on the histopathological image he observed under the microscope.[3] To see if the brown pigment really accumulated due to a long period of starvation, he would choose a live prisoner for his subject, and then have the victim killed with an intracardiac injection of phenol.[4]

Dr Jan Stanisław Olbrycht, an Auschwitz survivor and professor of the Jagiellonian University, where for many years he was head of the Department of Forensic Medicine, was an eye-witness of Kremer's activities. In his post-war recollections Professor Olbrycht wrote the following:

3 Sehn, 49.

4 Olbrycht, 1962: 46.

Photo 2. | Block 28 KL Auschwitz, current state. Photograph by Maria Ciesielska

Although I worked as a pharmacist, I had the opportunity to witness situations involving forensic medicine. A few weeks after I started working in the pharmacy in the loft of Block 28, SDG Klehr came to the pharmacy and told me to prepare to conduct a post-mortem. Unlike other concentration camps such as Mauthausen-Gusen, Auschwitz did not have a special post-mortem facility, and post-mortems were conducted very rarely, contrary to all the principles of medicine and hygiene, in the septic operating theatre on the ground floor of Block 28. In compliance with Klehr's instructions, I went to the *Leichenhalle* (mortuary) in Block 28 and notified my fellow-prisoners who worked as *Leichenträger* (corpse-carriers). But they told me there were no bodies in that room, as they had all been sent to the crematorium. When I informed Klehr that everything was ready for the post-mortem but there was no body, he replied with an ironic grin, "*die Leiche spaziert noch*" (German, "the corpse is still taking a stroll"). And indeed, a while later I saw a young, debilitated prisoner being brought into the Block 28 operating theatre. Klehr told him to lie down on the operating table, and ordered prisoner Pańszczyk to inject a lethal dose of phenol into his heart. When the young man was dead, Professor Kremer, who was a *Lagerarzt* at the time, was called and arrived with jars containing a preserving liquid and

said he wanted to carry out a test to see if *atrophia fusca* (brown atrophy) developed posthumously in the organs. Next he told me to extract samples from the organs in the body, including organs in which brown atrophy never occurs.[5]

INTRACARDIAC INJECTIONS OF PHENOL

Intracardiac injections of phenol were administered to Auschwitz prisoners from September 1941 to April 1943. Survivor Dr Stanisław Kłodziński wrote in a paper published in *Przegląd Lekarski – Oświęcim* (*Medical Review – Auschwitz*):

> From September 1941, for the whole of 1942, right up to April 1943, an SS physician "regulated" the number of patients in the hospital systematically and on a mass scale, sending the "surplus" to the crematorium with the application of phenol. In principle, phenol was administered to sick Jews, but it was also used to kill sick "Aryans," including *Reichsdeutsche* (Germans originating from the territories of the Third Reich proper). There were no medical selection rules for the Jewish victims. Other patients were given a jab if the SS doctor found they were too sick to recover, given the conditions in the camp, and this meant those suffering from tuberculosis, general debilitation, or extensive oedemas. There was no medical examination, and there were no fixed medical criteria for the selection. The second group of prisoners sent to their deaths by means of a phenol jab were those put under "special operations," such as the mass murder of children from the area of Zamość.[6]

The first experiments carried out in Auschwitz with the use of phenol were performed in Block 28. Later phenol killings were done on a massive scale in Block 20. Phenol injections were administered by SS orderlies Josef Klehr and Herbert Scherpe; functionary prisoners Alfred Stössel, Mieczysław Pańszczyk, and Jerzy Szymkowiak; and doctors, Leibus Landau and Władysław Dering.[7] In a statement made in Kraków on 30 September 1946 before the regional prose-

5 Olbrycht, 1968: 86–87.

6 Kłodziński, 62.

7 Klee, 2005: 21–22.

cutor Dr Jan Sehn, survivor Stanisław Głowa said that Dr Dering participated in the phenol killings:

> The first phenol injections were administered by prisoners Feliks Walentynowicz and Dr Doering [Dering]. Mieczysław Pańszczyk administered the largest number of phenol injections. Later they were also administered by Alfred Stessel [Stössel], Jerzy Szymkowiak, and Dr Landau, a French Jew. Pańszczyk himself claimed that he had killed 15,600 persons with a phenol injection. We established that Stössel killed 4,000, Szymkowiak killed about 6,000, Landau killed 5–6 thousand, and Dering killed about a thousand [persons].[8]

In his expertise for the trial of Rudolf Höß, ex-commandant of Auschwitz before the Supreme National Tribunal of Poland, Professor Olbrycht wrote that initially the lethal injections were administered intravenously, and later straight into the heart, using a number of substances, such as hydrogen peroxide, petrol, Evipan (a barbiturate), and eventually phenol, which was cheap and simple to use.[9] The lethal injections used on Auschwitz prisoners were a sort of secret. Neither the functionaries nor the SS orderlies wanted any publicity. There was a prohibition on mentioning the subject, and telling patients about it was a criminal offence, which could cost the informer his life. Victims did not know what was in store for them right to the last minute, to the moment when the needle was jabbed into their heart. They would be made to sit on a stool, with one arm round their neck and the other behind their shoulder. Sometimes they would be blindfolded with a towel. It took only a short time to jab the long needle into the fifth intercostal space centripetally with respect to the midclavicular line, and inject a few centimetres of phenol. The phenol had a corrosive local effect, denaturing the protein tissue, but leaving the glass and metal parts of the syringe intact. Observation of the camp procedure showed that about 10–15 ml applied as a concentrated aqueous solution were enough to kill within about 15 seconds. If the injection was administered in a hurry and missed the ventricle, death ensued a few seconds later. The entire block went dead silent, and all you could hear in the atmosphere of the murders that were being perpetrated were the numbers

8 Statement of Stanisław Głowa, https://zapisyterroru.pl/dlibra/publication/4044.

9 Klee, 2005: 19.

and names being read out of the prisoners who disappeared behind the curtain; rarely was there a groan or a shriek, but later came the loud thud of a body slumping down onto the concrete floor.[10]

KREMER'S DIARY

Kremer kept a diary in which he recorded what he had done and the ideas that came to his mind. When he was arrested in the British occupation zone, his diary was confiscated by the Allied military authorities and provided irrefutable incriminating evidence proving his guilt. His entry for 13 November 1942 reads as follows:

> I took absolutely fresh samples from the liver, spleen, and pancreas of a highly atrophied Jewish prisoner (No. 68030) who had been photographed. As usual, I fixated the liver and spleen in Carnoy's solution, and the pancreas in Zenker's solution.[11]

The prisoner involved was Hans de Yong, who had been sent to Auschwitz in a transport of Dutch Jews on 14 October 1942.[12] At the 1947 trial of the staff of Auschwitz, held in Kraków before the Polish Supreme National Tribunal, Kremer said that during routine inspections of prisoners he used to scrutinise patients selected for death and when he saw one he thought would be interesting for his research, he instructed the SS orderly to "reserve" that patient for him, and notify him when he was due to be killed with a lethal injection. On the day appointed by the SS orderly, the patients Kremer had selected would be taken to Block 28. Each of them in turn would be made to lie down on the post-mortem table while they were still alive. Kremer would then come up and ask his victim a series of questions on details he wanted to know for his research, such as his weight before his arrest and how much weight he had lost, and whether he had been taking any medications recently. When he had all the information he wanted, the SS orderly would come up and kill the patient with an intracardiac injection. Kremer would stand away

10 Kłodziński, 64.

11 Quoted after *Oświęcim w oczach SS*, 158.

12 Quoted after *Oświęcim w oczach SS*, 158.

from the post-mortem table, holding his jars with the fixative solutions. As soon as the patient was dead, prisoner doctors extracted samples from his organs, as instructed by Kremer. In compliance with legislation passed in the 1930s and general forensic practice, post-mortems should not have been performed until six hours had passed since the time of death.[13] In some cases, Kremer had the prisoners due to be killed for his purposes photographed while still alive. The photographs were taken by the Auschwitz management's photographic office. When Kremer left the camp, he took all these photos and the specimens he had collected back to his apartment in Münster.[14] He never got the chance to examine the specimens properly, because he did not have a microtome. After he left Auschwitz, he worked for the Waffen SS units stationed in Prague, while his university career ground to a halt, presumably in connection with a paper he published on traumatic inheritance.[15] Other German scientists were very critical about Kremer's claims, but he was convinced he was right, as he wrote in his diary.[16] In his statement before the Supreme National Tribunal of Poland at the trial of the Auschwitz staff, which was held in Kraków, he claimed that his work on heredity was a blow to Nazi ideology, and he was punished for it by being sent for service in Auschwitz.[17] The Polish Tribunal sentenced him to death, but the sentence was commuted to life imprisonment. He was released in 1958. In 1960 he stood trial in Münster, and said he had taken specimens of tissue for his post-mortem research "out of stupidity."[18]

EPILOGUE

Auschwitz survivor Professor Jan Olbrycht, a forensic expert and an unquestionable moral authority, wrote that it would be hard for him to say which of his personal experiences in the concentration camp he considered the most terrible. In his

13 Olbrycht, 1968: 86–87.

14 Strzelecka, vol. 2, 135–136, after the records of the Höß Trial, Vol. 59, sheets 23–25.

15 Sterkowicz, 222.

16 Quoted after *Oświęcim w oczach SS*, 171.

17 Sehn, 50.

18 Sehn, 60.

opinion concentration camp inmates were all the time exposed to treatment which humiliated them and offended their human dignity. In Auschwitz he witnessed the use of human flesh from the corpses of inmates to cultivate bacteria; in Mauthausen he observed instances of necrophagia—starved and emaciated inmates cutting out pieces of the muscle tissue and internal organs from the bodies of their deceased fellow-prisoners and eating their flesh raw. But what really shocked him were the mass killings perpetrated with the use of hydrogen cyanide and intracardiac injections of phenol. One of his worst experiences was seeing the criminal experiments which were conducted for pseudo-scientific reasons—prisoners being castrated and sterilised with X-rays, prisoners being used for the determination of the lethal dose of a poison, prisoners being bled to death to obtain blood for laboratory use, prisoners being killed with phenol. He made the following record:

> I am still shocked at the mere recollection of these atrocities and cannot find the right words to describe these barbarities. Ever since the times of Hippocrates, physicians all over the civilised world have been expected to observe the principle of *salus aegroti suprema lex* [Latin: the supreme rule is the patient's well-being], yet in Auschwitz thousands of human beings were killed in the most abominable ways. Throughout the civilised world the anti-vivisection league is conducting a campaign to ban or at least curtail animal experiments. … Yet in Auschwitz pseudo-scientific experiments were carried out on human beings and led to their death. These experiments were conducted by individuals who considered themselves members of the *Herrenvolk* [master race] and proponents of an idealistic worldview, yet they regarded others as grossly materialistic. This is how new generations of future physicians were educated—physicians who were to be "mind over matter, salt of the earth, the hand assuaging pain." It was all downright deceit, hypocrisy, and barbarity! There are no words strong enough to express my contempt, outrage, and the punishment which they deserve.[19]

19 Olbrycht, 1965.

REFERENCES

Biography of Johann Paul Kremer (in German) https://www.biologieseite.de/Biologie/Johann_Paul_Kremer [Accessed 14 January 2020].

Ciesielska, Maria. 2015. *Szpital obozowy dla kobiet w KL Auschwitz-Birkenau (1942–1945).* Warszawa: Wydawnictwo Warszawskiego Uniwersytetu Medycznego.

Diary of Johann Paul Kremer. Quoted after *Oświęcim w oczach SS: Höss, Broad, Kremer*. 1972 (First Edition). Jadwiga Bezwińska and Danuta Czech (Eds.); translations from German into Polish by Eugenia Kocwa and Jerzy Rawicz. Oświęcim: Wydawnictwo Państwowego Muzeum.

Gutt, Romuald Wiesław. 1968. "Próba rozważań na temat etyki lekarzy nazistowskich." *Przegląd Lekarski – Oświęcim*: 23–26.

Hildebrandt, Sabine, and Seidelman, William E. 2018. "To use or not to use: the legitimacy of using unethically obtained scientific results or human tissues from the National Socialist era." *Wiener Klinische Wochenschrift. The Central European Journal of Medicine.* 130: 228–231.

ITS (=International Tracing Service); www.us-israel.org/jsource/Holocaust/medtoc.html [Accessed 14 January 2020].

Klee, Ernst. 2005. *Auschwitz. Medycyna III Rzeszy i jej ofiary*. Kraków: TAiWPN Universitas. (2nd Polish edition of *Auschwitz, die NS-Medizin und ihre Opfer*, Frankfurt-am-Main: S. Fischer Verlag, 2001).

Klee. Ernst. 2016. *Das Personenlexikon zum Dritten Reich. Wer war was vor und nach 1945*. Hamburg: Nikol.

Kłodziński, Stanisław. 1963. "Fenol w KL Auschwitz–Birkenau." *Przegląd Lekarski – Oświęcim*. 62–65. English translation online at https://www.mp.pl/auschwitz/journal/english/222711,phenol-in-auschwitz-birkenau.

Kucharski, Janusz. 1998. "Lekarz SS Johann Paul Kremer." *Archiwum historii i filozofii medycyny.* 61(4), 345–355.

Lasik, Aleksander. 1993. "Obsada osobowa służby zdrowia SS w obozie koncentracyjnym Oświęcim-Brzezinka w latach 1940–1945." *Zeszyty Oświęcimskie.* 20: 261–324.

Masłowski, Jan. 1971. "Rocznice oświęcimskie w Krakowskim Towarzystwie Lekarskim." *Przegląd Lekarski – Oświęcim*. 143.

Olbrycht, Jan. 1962. "Sprawy zdrowotne w obozie koncentracyjnym w Oświęcimiu. Orzeczenie wygłoszone na rozprawie sądowej przed Najwyższym Trybunałem Narodowym w dniu 10 grudnia 1947." *Przegląd Lekarski – Oświęcim*. 37–49.

Olbrycht, Jan. 1965. "Z przeżyć obozowych." *Przegląd Lekarski – Oświęcim*. 139.

Olbrycht, Jan. 1968. "Przeżycia medyka sądowego w czasie okupacji hitlerowskiej oraz po wyzwoleniu w sprawach z nią związanych." *Przegląd Lekarski – Oświęcim*. 82–91. English translation online at https://www.mp.pl/auschwitz/journal/english/223383,a-forensic-pathologists-wartime-experience.

Olbrycht, Jan. Opinia [Expertise]. Akta w sprawie karnej przeciwko R. Hössowi przed NTN w Krakowie [Records of the proceedings against Rudolf Höß held in Kraków before the Supreme National Tribunal of Poland], APMAB PH [Archives of Auschwitz-Birkenau State Museum, Records of the Höß Trial], Vol. 7b, p. 8.

Ryn, Zdzisław, and Kłodziński, Stanisław. 1983 "Na granicy życia i śmierci." *Przegląd Lekarski – Oświęcim*. 27–73.

Sehn, Jan. 1962. "Sprawa oświęcimskiego lekarza SS J. P. Kremera." *Przegląd Lekarski – Oświęcim*. 49–61.

Statement made by SS-Untersturmführer Johann Paul Kremer, Doctor of Medicine and Philosophy, Professor of Münster University, delegated for service in Auschwitz on 30 August 1942 and

employed there as an SS physician until 18 November 1942. APMAB Proces Załogi [Archives of Auschwitz-Birkenau State Museum, Records of the Staff Trial], Vol. 59, sheets 13–26.

Statement made by Stanisław Głowa made in Kraków on 30 September 1946 before Dr Jan Sehn, Regional Prosecutor. *Zapisy Terroru. Repozytorium Ośrodka Badań nad Totalitaryzmami*. Online at https://zapisyterroru.pl/dlibra/publication/4044 [Accessed 14 January 2020].

Sterkowicz, Stanisław. 2007. *Nieludzka medycyna. Lekarze w służbie nazizmu*. Warszawa: Wydawnictwo Medyk Sp. z o.o.

Strzelecka, Irena. 2008. "Zbrodnicza medycyna. Eksperymenty medyczne w KL Auschwitz." *Głosy Pamięci*, część 2, Oświęcim: Państwowe Muzeum Auschwitz-Birkenau.

Strzelecka, Irena. 2008. "Zbrodnicza medycyna. Szpitale w KL Auschwitz." *Głosy Pamięci*, część 3, Oświęcim: Państwowe Muzeum Auschwitz-Birkenau, 60–61.

Wiśniewski, Zygmunt. 2010. *Lekarzy losy wojenne, szkice*. Warszawa: Naczelna Izba Lekarska.

Doctor Mephisto of Auschwitz

Helena Kubica

A lot has been written since the War on Dr Mengele, the Angel of Death or Dr Mephisto of Auschwitz, as some prisoners used to call him. In most accounts he usually figures as an exceptionally monstrous murderer who loved sending thousands to their deaths, killing children, twins, dwarfs, etc. Yet this picture gives a false impression of him as particularly notorious, standing out among all the other Nazi German physicians, and that his contribution to the genocide came from his specific personal traits. That opinion fails to take into account the most important point—an examination of the system in which Mengele operated.[1]

How did it happen that this young physician, and an ambitious scientist with excellent prospects in genetics, was capable of sending thousands to their deaths and killing for scientific purposes without so much as blinking, and despite the Hippocratic Oath he had taken, which firmly lays down the fundamental rule for the medical profession—*primum non nocere* (first, do not harm)?

About the author: Helena Kubica is a historian and worked at the research centre of the Auschwitz-Birkenau State Museum from 1977 to 2018. She is the author of numerous publications concerning topics such as the youngest prisoners of Auschwitz-Birkenau concentration camp, Josef Mengele's pseudo-medical experiments, the murder of Poles displaced from the Zamość Region and from the insurrectionary Warsaw in Auschwitz, and the subcamps of Auschwitz-Birkenau.

1 Seidelman, 1169-1172.

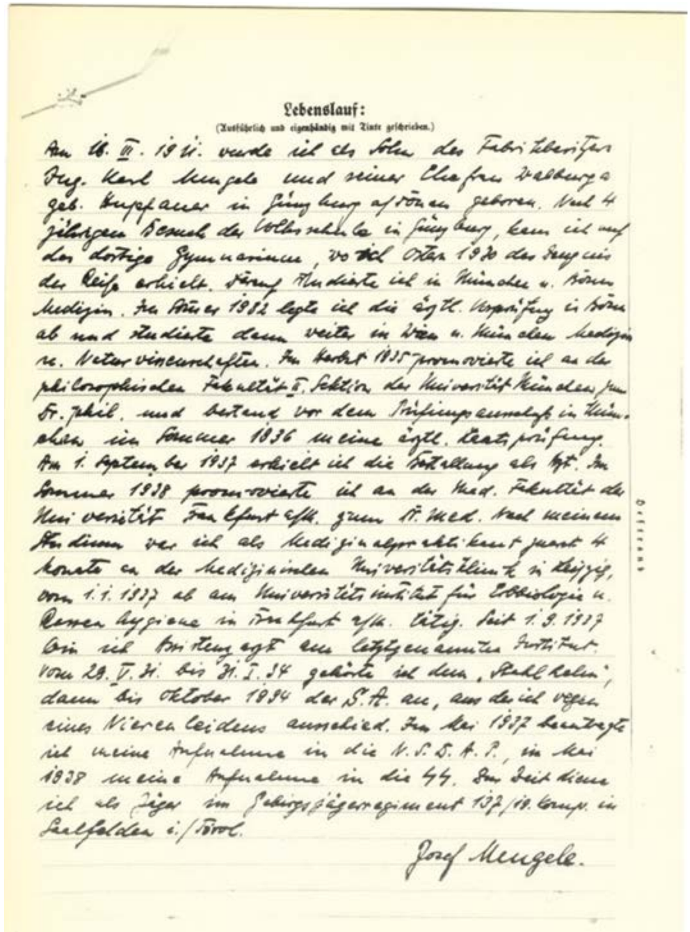
Photo 1. Josef Mengele, 1943. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

Mengele's professional career, and subsequently his atrocities, were strictly connected with his interest in genetics, a discipline which played a special part in the Fascist ideology. The scientists who contributed to the making of the ideology that said the Germanic race was superior to other races, invoked a set of ideas put forward by Sir Francis Galton, who called these ideas eugenics.[2] In Germany interest in eugenics increased particularly after Hitler's rise to power, when an extreme, criminal form of racial genetics was launched.

Racial genetics had its academic focus and headquarters in a scientific institute known as the Universitäts-Institut für Erbbiologie und Rassenhygiene Frankfurt am Main (the Frankfurt University Institute for the Biology of Heredity and Racial Hygiene), whose head was Professor Otmar Freiherr von Verschuer. In 1937, Mengele joined this institute as a young and promising medical intern.

Josef Mengele was born on 16 March 1911 in Günzburg, a small town on the Danube in Bavaria. He was the eldest son of Karl Mengele, then proprietor of a local factory producing agricultural machines. Karl and his wife Walburga née Hupfauer had two more sons, Karl and Alois, born a year and three years respectively after Josef. Josef was a slim-built, likeable lad with a slight squint and an olive

2 In 1869 Galton, a cousin of Charles Darwin, published his book *Hereditary Genius*, launching the concept of eugenics, which promotes the selective breeding of animals and humans to improve the species, especially as regards hereditary features. To improve humankind, he recommended the determination which inherited features were favourable, and which were unfavourable (especially as regards hereditary diseases), and a system of procreation to enhance the good features and curtail the bad ones.



Lebenslauf:

(Ausführlich und eigenhändig mit Tinte geschrieben.)

Am 16. III. 1911 wurde ich als Sohn des Fabrikbesitzers Ing. Karl Mengele und seiner Ehefrau Walburga geb. Hupfauer in Günzburg a/Donau geboren. Nach 4 jährigem Besuch der Volksschule in Günzburg, kam ich auf das dortige Gymnasium, wo ich Ostern 1930 das Zeugnis der Reife erhielt. Darauf studierte ich in München u. Bonn Medizin. Im Sommer 1932 legte ich die ärztl. Vorprüfung in Bonn ab und studierte dann weiter in Wien u. München Medizin u. Naturwissenschaften. Im Herbst 1935 promovierte ich an der philosophischen Fakultät II. Sektion der Universität München zum Dr. phil. und bestand vor dem Prüfungsausschuß in München im Sommer 1936 meine ärztl. Staatsprüfung. Am 1. September 1937 erhielt ich die Bestallung als Arzt. Im Sommer 1938 promovierte ich an der Med. Fakultät der Universität Frankfurt a/M. zum Dr. med. Nach meinem Studium war ich als Medizinalpraktikant zunächst 4 Monate an der Medizinischen Universitätsklinik in Leipzig, vom 1.1.1937 ab am Universitätsinstitut für Erbbiologie u. Rassenhygiene in Frankfurt a/M. tätig. Seit 1.9.1937 bin ich Assistenzarzt am letztgenannten Institut. Vom 20.V.31 bis 31.I.34 gehörte ich dem „Stahlhelm", dann bis Oktober 1934 der S.A. an, aus der ich wegen eines Nierenleidens ausschied. Im Mai 1937 beantragte ich meine Aufnahme in die N.S.D.A.P., im Mai 1938 meine Aufnahme in die SS. Zur Zeit diene ich als Jäger im Gebirgsjägerregiment 137/10. Komp. in Saalfelden i/Tirol.

Josef Mengele.

Photo 2. Mengele's CV, written when he was serving in the mountain riflemen's regiment at Saalfelden, 1938-1939. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

complexion. He was nicknamed Beppo by his family, friends and acquaintances in his hometown.[3]

Mengele Senior wanted his sons to continue the family business. However, Josef was interested in music (he played the violin) and natural science, which made his outlook on life quite different from his father's bourgeois views. He was admired in the town for his polite manners and intelligence, and tried his hand at

3 Gerald L. Posner, John Ware, *Mengele. Polowanie na anioła śmierci*. Kraków 2000: 25. Original edition: *Mengele. The Complete Story*. 1986.

playwriting. Two of his plays, on a trip to Liechtenstein and on William Tell, were performed to raise funds for local charity campaigns.

Young Josef decided to become a doctor,[4] and after passing the *Abitur* school-leaving examination in the spring of 1930, enrolled in the Faculty of Medicine of the University of Munich. At university he became even more interested in heredity and took biology as a second subject. He moved to Bonn to continue his studies and joined the local branch of Jungstahlhelm, a paramilitary youth organisation affiliated to a First World War veterans' association which his father was a member of. Later he spent a semester in Vienna, and finally returned to Munich in 1933. In 1935, he obtained a PhD in anthropology from the Institute of Anthropology of Munich University, on the grounds of a dissertation entitled *Rassenmorphologische Untersuchungen der vorderen Unterkieferabschnittes bei vier rassischen Gruppen* (A racial morphological research project on the lower jawbone in four racial groups), which he wrote under the supervision of Professor Theodor Mollison. In 1936, he passed the state examination for physicians, obtaining the qualification to practise as a physician, and left for Leipzig to complete his internship in the children's clinic of the city's university hospital.[5] In Leipzig he met his future wife, Irene Schönbein, who was six years younger than him. They married in Obersdorf in July 1939.

Mengele was not a brilliant student, but his university colleagues remembered him as very hard-working and pedantic. From the very outset, his special field of interest was anthropology and genetics. He became even more interested in these subjects when he left Leipzig in early 1937 and started working in the Frankfurt Institute for the Biology of Heredity and Racial Hygiene. On 1 September 1937 he was appointed assistant to Professor Otmar Freiherr von Verschuer,[6] and soon

---

4 Ulrich Völklein, Mengele's latest biographer, writes that Julius Diesbach, one of Mengele's schoolfriends, encouraged him to study medicine when they met by chance in Munich University, where Diesbach was reading medicine. Earlier Mengele had been thinking of enrolling for dentistry (Völklein, 56–57, Polish edition).

5 Klee, Polish edition, 437–438.

6 Von Verschuer was one of the leading German eugenics scientists, alongside Eugen Fischer, Fritz Lenz, and Wilhelm Weitz. In 1935, he was appointed head of the newly founded Institute for the Biology of Heredity and Racial Hygiene in the Faculty of Medicine of Goethe University, Frankfurt. Von Verschuer conducted research on human heredity, focusing on twins, which he considered "the most efficient way to identify human hereditary features, especially human hereditary diseases."

became von Verschuer's favourite assistant, fanatically enthusiastic about racial genetics. In 1938 he earned a PhD in medicine on the grounds of a dissertation entitled *Sippenuntersuchungen bei Lippen-Kiefer-Gaumenspaltung* (A research project on genetic factors influencing the development of a cleft lip, palate, and chin).[7] Officially, he continued to be employed in von Verschuer's institute in Frankfurt until the summer of 1940.

His association with Nazism dates back to the time when he was in Munich, the movement's cradle. First he joined the SA, and in 1937 became a Nazi Party member. In May 1938 he joined the SS. The outbreak of the War and the start of Germany's campaign of conquest interrupted Mengele's promising scientific career. In 1940 he was called up like most young Germans, and first served in a Wehrmacht unit in Kassel. Earlier he completed a three-month training course, which had started on 24 October 1938, in a unit of *Gebirgsjäger* (mountain riflemen) in the Saalfelden--Tirol region. After his first month in military service he asked to be transferred to the Waffen-SS and his request was granted. From 1 August to 4 November 1940, he served in the Waffen-SS reserve medical battalion. Later he was appointed a medical expert for the SS Rasse- und Siedlungshauptamt (SS Race and Settlement Main Office), his job being to assess persons resettled by the German authorities as potential candidates for Germanisation. Next he was posted to "Posen" (Poznań) in occupied Poland, and employed in the Stabshauptamt Reichskomissar für die Festigung deutschen Volkstums.[8]

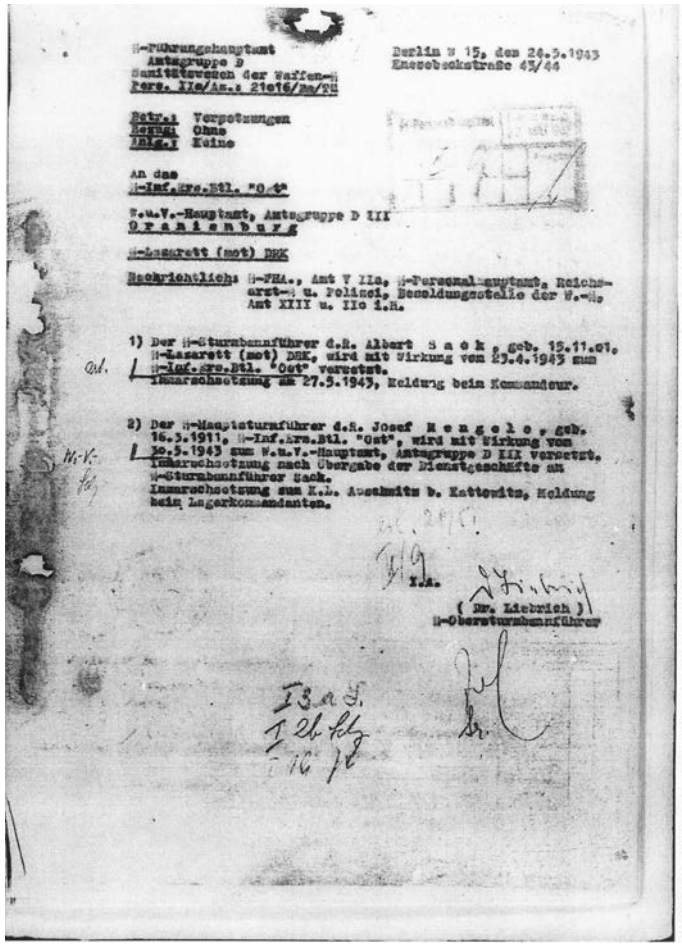
In January 1942, Mengele was posted to the medical unit of the Viking division of the Waffen SS and sent to the eastern front on the territory of the Soviet Union. In July, his division took part in heavy fighting during the Battle of Rostov, and Mengele was awarded the Iron Cross—First Class for valour. He saved the lives of two wounded soldiers, pulling them out of a burning tank under enemy fire and administering first aid to them. He was also awarded the *Verwundetenabzeichen* (Wound Badge) and the *Medaille für deutsche Volkspflege* (Medal for the Care of the German People).[9]

---

7 Klee (Polish edition), 438; Völklein, 79–80.

8 Reich Commissioner's Office for the Consolidation of German Nationhood, Zofka, 254.

9 Posner and Ware, 37–38 (Polish edition).



Berlin W 15, den 24.5.1943
Knesebeckstraße 43/44

Betr.: Versetzungen
Anlagen: Ohne
Abschr.: Keine

An das
SS-Inf.Ers.Btl. "Ost"

W.u.V.-Hauptamt, Amtsgruppe D III
O r a n i e n b u r g

SS-Lazarett (mot) DRK

Nachrichtlich: SS-FHA., Amt V IIa, SS-Personalhauptamt, Reichsarzt-SS u. Polizei, Bearbeitungsstelle der W.-A. Amt XIII u. IIc i.H.

1) Der SS-Sturmbannführer d.R. Albert S a o k, geb. 15.11.01, SS-Lazarett (mot) DRK, wird mit Wirkung vom 23.4.1943 zum SS-Inf.Ers.Btl. "Ost" versetzt.
Umarschsetzung am 27.5.1943, Meldung beim Kommandeur.

2) Der SS-Hauptsturmführer d.R. Josef M e n g e l e, geb. 16.3.1911, SS-Inf.Ers.Btl. "Ost", wird mit Wirkung vom 30.5.1943 zum W.u.V.-Hauptamt, Amtsgruppe D III versetzt.
Umarschsetzung nach Übergabe der Dienstgeschäfte an SS-Sturmbannführer Sack.
Umarschsetzung zum K.L. Auschwitz b. Kattowitz, Meldung beim Lagerkommandanten.

I.A.
(Dr. Liebrich)
SS-Obersturmbannführer

Photo 3. | Official notice (dated 24 May 1943) of Mengele's appointment to an *SS Lagerarzt* post in Auschwitz, taking effect on 30 May 1943. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

In late 1942 Mengele, who had been wounded, was declared unfit for further frontline military service, and was sent back to the Berlin headquarters of the SS Race and Settlement Main Office. In April 1943, he was promoted to the rank of *Hauptsturmführer* (equivalent to captain), which gave him the opportunity to resume his scientific work, especially as his mentor von Verschuer was now head of the Kaiser-Wilhelm Institut für Anthropologie, Menschliche Erblehre und Eugenik (the Kaiser Wilhelm Institute for Anthropology, Human Heredity Science, and Eugenics), a post he had held since November 1942.

Probably on discussing the matter with von Verschuer and with his encouragement, Mengele applied to be posted for medical service in Auschwitz. His request was granted and on 24 May 1943 an order was issued appointing him an *SS Lagerarzt* (SS concentration camp physician) for Auschwitz, the largest Nazi German concentration camp and the main centre for the extermination of the European Jews. He was due to report in the office of the camp's commandant and to SS *Standortarzt* Dr Eduard Wirths, the chief physician of the Auschwitz garrison, on 30 May.[10] Mengele's first appointment in the camp was the post of chief physician of the Roma camp (Sector B II e), which had been established in Birkenau in late February 1943, succeeding SS *Hauptsturmführer* Benno Adolph in the job. Mengele started his duties on 17 June,[11] and continued in the office (with a few brief intermissions) until this part of the camp was closed down (and its inmates killed) on 2 August 1944.

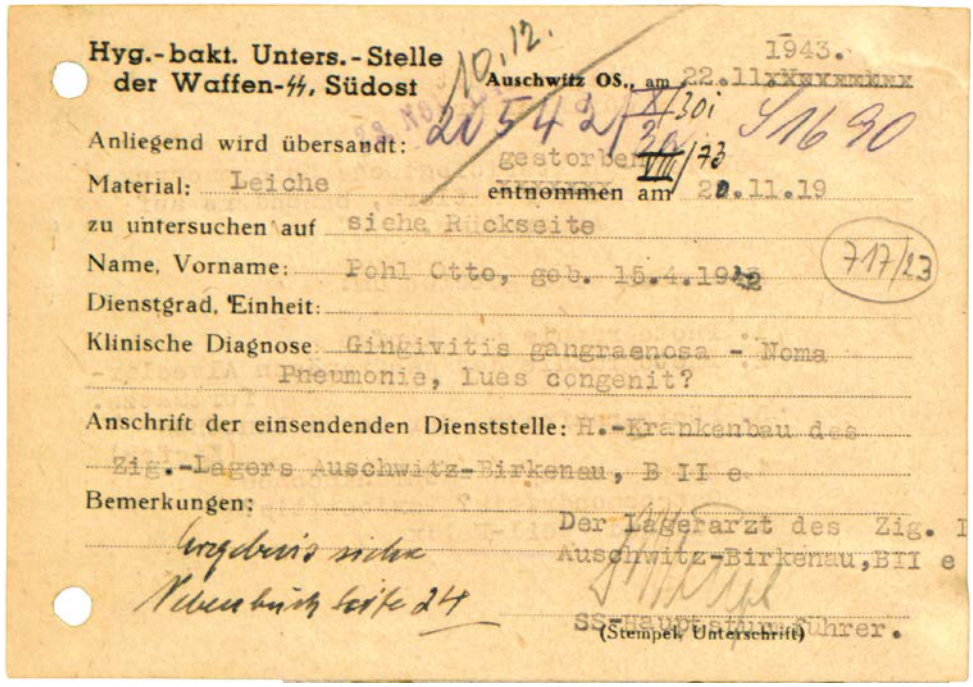
At the same time, like all the other SS physicians, he worked in the hospitals and medical dispensaries in other parts of Birkenau. So in practice he was a medical authority for the whole of Birkenau, especially when he was appointed First *Lagerarzt* of Auschwitz II (i.e. Birkenau) in 1944 and coordinated the work of all the other SS physicians in the diverse sectors of Birkenau.[12] As chief SS physician of Birkenau, he was himself subject to the authority of the chief physician of the

---

10 Archiwum Państwowego Muzeum Auschwitz-Birkenau (hereafter APMA-B; Archive of the Auschwitz-Birkenau State Museum), microfilm no. 1613/98. Official letter of transfer, appointing Dr Josef Mengele to a post in Auschwitz, dated 24 May 1943. The head of the medical services in Auschwitz (Department V in the camp's structure) was its *Standortarzt* (garrison physician), who directed the work of three branches: general medicine, dentistry, and the pharmacy. Each branch was sub-divided into a prisoners' unit and an SS unit. His subordinates in the general medical branch were the SS physicians (*SS-Truppenärzte*), who looked after the health of the camp's SS staff, and the SS physicians who were responsible for the medical conditions and hygiene in the prisoners' part of the camp. In reality they took part in the extermination campaign, drew up bogus death certificates, and selected prisoners who were already inmates in the camp as well as new arrivals for death. The subordinates of the SS physicians (both those for the SS staff and for the prisoners) were SS orderlies. In practice, sick prisoners could expect to receive medical treatment only from prisoners who were physicians themselves and worked as ancillary medical staff in the prisoners' hospitals and dispensaries on the premises of the concentration camp.

11 Dr Benno Adolph's last signature as chief physician of the Roma camp appears on a document dated 12 June 1943; while the first document signed by Mengele in this capacity is dated 24 June 1943; APMA-B. Zespół SS-Hygiene Institut, file 17a, p. 102, and file 17 b, p. 397.

12 The first documents signed by Mengele as First *Lagerarzt* of Birkenau are dated 18 May 1944.



Hyg.-bakt. Unters.-Stelle
der Waffen-SS, Südost

Auschwitz OS., am 22.11.1943.

Anliegend wird übersandt:

Material: Leiche entnommen am 20.11.19

zu untersuchen auf siehe Rückseite

Name, Vorname: Pohl Otto, geb. 15.4.1942

Dienstgrad, Einheit:

Klinische Diagnose Gingivitis gangraenosa - Noma
Pneumonie, lues congenit?

Anschrift der einsendenden Dienststelle: H.-Krankenbau des
Zig.-Lagers Auschwitz-Birkenau, B II e

Bemerkungen:

Der Lagerarzt des Zig. I
Auschwitz-Birkenau, BII e

(Stempel, Unterschrift)

Photo 4. | Document issued on 22 November 1943 by Josef Mengele, ordering a post-mortem of Otto Pohl, a child from the Roma camp in Birkenau born on 15 April 1942, who had died of noma (*cancrum oris*). It was to be done at the Raisko SS Hygiene Institute. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

Auschwitz SS garrison, and continued to serve in this capacity until December 1944, when he was appointed SS physician of the SS hospital in Birkenau, and held this post until the evacuation of Birkenau in January 1945.

Working in cooperation with the Institut für Rassenbiologische und Anthropologische Forschungen (Institute for Racial Biology and Anthropological Research) attached to the Kaiser Wilhelm Institute in Berlin-Dahlem, Mengele availed himself of the vast opportunities offered by the concentration camp to conduct anthropological research on diverse racial groups, starting with the Roma and twins, especially identical (monozygotic) twins. He was also interested in the physiology and pathological condition of dwarfs and persons with other anomalous inherited conditions (invalids, hunchbacks, etc.). He carried out experiments on individuals with different-coloured eyes (in the medical nomenclature the Latin term for the condition is *Heterochromia Iridum*), and persons with *Heterochromia Iridis* (Sectoral or Central Heterochromia, having one or both of their

eyes multi-coloured). In the summer of 1943, when a disease called *Noma Faciei* (a gangrenous condition of the face) appeared in the Roma family camp, especially affecting the children and young people, Mengele started research on the phenomenon and wanted to discover a method to treat the condition.

Mengele was particularly interested in the study of twins. Most of his subjects for this research were children. In October 1972, survivor Martyna Puzyna made a statement in the West German embassy in London at the request of the Landesgericht (Regional Court) of Frankfurt-am-Main.[13] She said the following about Mengele's criminal experiments:

Photo 5. | Martyna Puzyna, PhD, a Polish anthropologist and Auschwitz survivor (prisoner no. 54538), was employed by Mengele as an anthropological research assistant from the spring of 1944. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

> If I remember rightly, I started working in the spring of 1944, before the arrival of the big transports from Hungary. When they arrived I saw Mengele standing on the ramp in Birkenau and could hear him shouting, "Twins come forward." He seemed to be going out of his mind as he walked along the ramp, looking out for twins. This is how eventually about 250 pairs of twins were collected from the Hungarian transports. For those days in research on twins, it was an unbelievably huge number, which could be obtained in this way.[14]

13 Martyna Puzyna (aka Puzynina) held a PhD in anthropology from the University of Lwów and was the assistant of Professor Jan Czekanowski, a distinguished anthropologist and head of the Chair of Anthropology at that University. In March 1943, the Nazi Germans arrested her for her activities in the Polish underground resistance movement. In August 1943, she was sent from the prison in Lwów to Auschwitz-Birkenau II and registered as prisoner no. 54538. As of the spring of 1943, she worked as Mengele's assistant for his anthropological research. In January 1945, she was evacuated, leaving Birkenau on the death march for Ravensbrück. She was liberated in May 1945 from the Neustadt-Glewe sub-camp. After the War she emigrated to England and lived in London, where she died in 1986.

14 APMA-B. Zespół Oświadczenia (Statements Collection), Vol. 167, sheet 65 (the Polish text was translated from the German original).

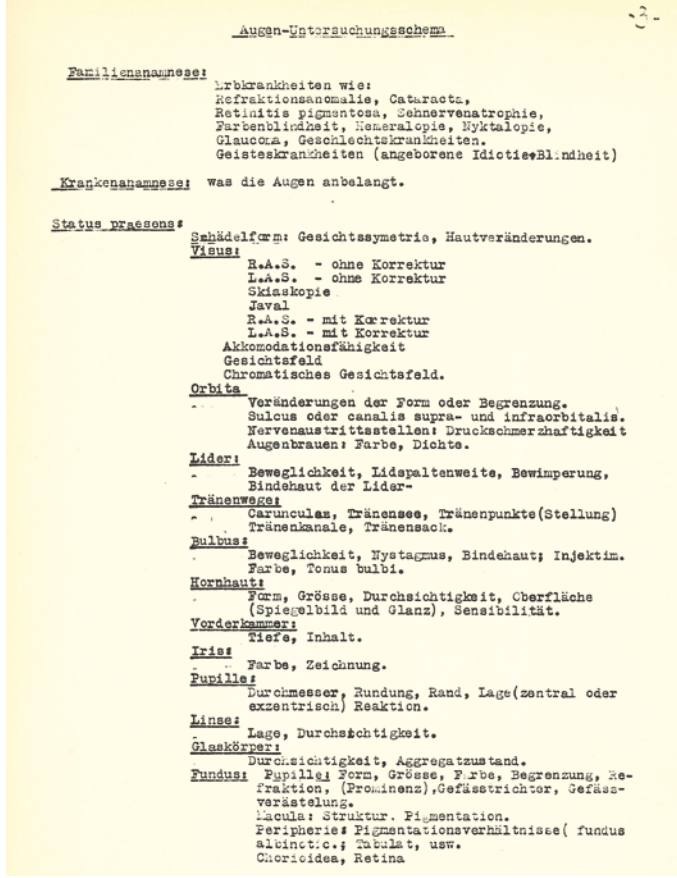
One of the documents in the Auschwitz-Birkenau Museum archives gives a handwritten list of the names of Jewish male twins and dwarfs who arrived from the Theresienstadt ghetto and were accommodated in Barrack No. 15 of the Birkenau prisoners' hospital. It contains 125 names, including 52 boys under 14. The list also gives their dates of birth and prison numbers. Unfortunately, we do not know who drew up the list, or where and when it was compiled. However, going by the prison numbers, we may conclude that it must have been made in the latter half of 1944, most probably in the hospital in the men's camp, after the Theresienstadt family camp had been closed down.[15] Specific tests were carried out on individual pairs of twins as a starting point for different kinds of experiments. Twins were subjected to anthropometric, morphological, X-ray, and psychiatric examinations. The anthropometric examinations were conducted in Mengele's laboratory, which was accommodated in two rooms in the Sauna on the premises of the Roma camp. In November 1944, the laboratory moved to the hospital in Sector B II f of the men's camp. The subjects had each part of their body measured with Swiss precision instruments. Twins were tested in pairs. During the measurements, which often went on for hours, they had to strip and were kept in an unheated room, which was exhausting especially for the small children, who were "scared, tired, cold and starving, and had to get up at six o'clock and walk one and a half kilometres from their block to the dispensary. …"[16]

The other tests—morphology, X ray examinations, eye and ear tests, dental tests, psychiatric examinations, dermatological and laryngological examinations—were done on Mengele's orders by men and women prisoners who were specialists in the respective branches of medicine. They were conducted in the hospital of the Birkenau men's camp, or the dispensary in the women's camp; and sometimes the twins were taken for tests in the maternity camp in Block 10, or to the Hygiene Institut der Waffen SS, Südost (Hygiene Institute) at Raisko. Some of the twins had dental casts made in the dental surgery.

---

15 APMA-B. Syg. D-AuI-3/26. Różne (Miscellaneous). This list was donated to the Museum's archives by Dr Robert Waitz, a French Jew, professor of haematology and an Auschwitz survivor (No. 157261), who worked as a doctor in the prisoners' hospital of Auschwitz III (Monowitz). In 1965 Dr Waitz served as Chairman of the International Auschwitz Committee.

16 Piekut-Warszawska, 205.



Augen-Untersuchungsschema

Familienanamnese: Erbkrankheiten wie:
Refraktionsanomalie, Cataracta,
Retinitis pigmentosa, Sehnervenatrophie,
Farbenblindheit, Hemeralopie, Nyktalopie,
Glaucoma, Geschlechtskrankheiten.
Geisteskrankheiten (angeborene Idiotie+Blindheit)

Krankenanamnese: was die Augen anbelangt.

Status praesens:
Sehädelform: Gesichtssymetrie, Hautveränderungen.
Visus:
R.A.S. - ohne Korrektur
L.A.S. - ohne Korrektur
Skiaskopie
Javal
R.A.S. - mit Korrektur
L.A.S. - mit Korrektur
Akkomodationsfähigkeit
Gesichtsfeld
Chromatisches Gesichtsfeld.
Orbita:
Veränderungen der Form oder Begrenzung.
Sulcus oder canalis supra- und infraorbitalis.
Nervenaustrittsstellen: Druckschmerzhaftigkeit
Augenbrauen: Farbe, Dichte.
Lider:
Beweglichkeit, Lidspaltenweite, Bewimperung,
Bindehaut der Lider-
Tränenwege:
Caruncula, Tränensee, Tränenpunkte(Stellung)
Tränenkanale, Tränensack.
Bulbus:
Beweglichkeit, Nystagmus, Bindehaut; Injektim.
Farbe, Tonus bulbi.
Hornhaut:
Form, Grösse, Durchsichtigkeit, Oberfläche
(Spiegelbild und Glanz), Sensibilität.
Vorderkammer:
Tiefe, Inhalt.
Iris:
Farbe, Zeichnung.
Pupille:
Durchmesser, Rundung, Rand, Lage(zentral oder
exzentrisch) Reaktion.
Linse:
Lage, Durchsichtigkeit.
Glaskörper:
Durchsichtigkeit, Aggregatzustand.
Fundus: Pupille: Form, Grösse, Farbe, Begrenzung, Refraktion, (Prominenz),Gefässtrichter, Gefässverästelung.
Macula: Struktur. Pigmentation.
Peripherie: Pigmentationsverhältnisse(fundus albinotic.; Tabulat, usw.
Chorioidea, Retina

Photo 6. Page 1 of a scheme of eye examinations to be done by prisoner ophthalmologists on prisoners who were Mengele's victims. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

Mengele conducted morphological experiments on pairs of twins, in which he carried out alternating blood transfusions on them and observed the way their bodies reacted. In many cases such experiments ended in serious complications for the subjects, because no crossover trials were done prior to the experiment. Mengele also performed skull operations on his test subjects to obtain samples of cerebrospinal fluid from their brain.[17]

17 APMA-B. Zespół Proces Hössa (Höß Trial Collection), Vol. 2/1, sheet 10, statement of survivor Maria Stoppelman, whom Mengele sent to work in the laboratory of the prisoners' hospital of the women's camp in Birkenau.

There is evidence that Mengele carried out horrific experiments on small children on no justifiable medical grounds. On 3 May 1963 Vera Alexander, a Slovak Jewish survivor (prisoner number 5236), testified as follows in the witness stand before the court in Frankfurt am Main:

> ... I want to say that when I was [working] in the so-called Twins' Block for a month, I kept trying to get permission to leave that place, and eventually I was successful. I could not stand the sight of the subjects of Dr Mengele's experiments. There were two small children in the block, a boy and a girl aged about 2 or 3. The little boy was a hunchback, but the little girl's back was straight. There were scars on the boy's back where it had been cut during Dr Mengele's experiments. Apart from that, there was something which was even more dreadful. The two children had their backs and wrists sewn together. It was probably done to create a shared blood circulation. Both of these children died while I was still working there. ...[18]

All the records made during the experiments and tests—photographs, drawings, descriptions of the various tests, results obtained from the tested samples etc.—were put in separate files for each of the tested subjects. The records in the women's hospital were registered and kept by a Polish prisoner, Halina Kinalska, who also wrote up Mengele's post-mortem reports for the twins who died or were killed in the women's camp. The last stage of Mengele's experiments on some pairs of twins or other people selected by him was a post-mortem examination of particular parts of their bodies, which he conducted during their autopsy. Twins earmarked for this kind of examination were killed by an injection of phenol into their heart and their bodies were sent to the post-mortem room.

His appointment as an *SS Lagerarzt* (SS camp physician) helped him conduct such a wide-ranging programme of experiments. One of the basic duties of SS camp physicians was participating in the extermination by attending and taking an ac-

---

18 APMA-B. Copy of a document from the records of the Frankfurt Trials (Strafsache gegen Mulka u.a.4 KS 2/63, Bd 83 Bl 15706-15906), statement made by Vera Alexander, sheet 15784-15790. The details given in this statement differ from the details the same witness gave in her statement made on 9 September 1974 at the request of the Frankfurt Landesgericht, in Safed, Israel, in the Office for the Investigation of National Socialist Crimes attached to the National Police Headquarters, for the preliminary investigation against Dr Josef Mengele. A copy of this statement (with a Polish translation) is kept in the Statements Collection of the Archives of the Auschwitz-Birkenau Museum (APMA-B. Zespół Oświadczenia, Vol. 167, sheet 51-61).

tive part in selections, both those of new Jewish transports arriving on the ramp as well as selections of prisoners already in the camp. Selections gave him the opportunity to choose "research material" for himself. He also had a whole army of prisoners who were medical specialists, some of them with a global reputation, but forced to be unwilling assistants completely at his disposal. He could tap their know-how and skills for his research purposes. The second duty SS physicians were expected to perform, exercising an ostensible type of healthcare over the entire camp, gave him unlimited access to all the specialist medical facilities and analitical labs, and to set up new facilities for his personal use.

Photo 7. Miklos Nyiszli, MD, a Hungarian Jew and Auschwitz-Birkenau prisoner (no. A-8450) was an anatomical pathologist who conducted post-mortems including written scientific studies for Mengele, starting in July 1944. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

Mengele performed his *Lagerarzt* duties very conscientiously, in fact he stood out from the rest of his colleagues in this respect, especially when it came to selections. He sent thousands to the gas chamber without so much as a blink. His face only lit up when he spotted a potential subject for his research. Like other SS doctors, he never examined or touched a patient during the medical reviews (or more precisely, selections) carried out in the prisoners' hospital. He was not at all interested in their state of health, but in their medical cards, which the prisoners who worked as ancillary medical staff had to keep and fill in very scrupulously. He was particularly interested in prisoners' temperature charts. All he was concerned about was the formal aspect of healthcare, and he was even more pedantic about it than other SS doctors. During selections he was ruthless, or even cynical. He enjoyed an exceptionally good reputation with his superiors, especially with Dr Eduard Wirths, who was *SS Standortarzt*, chief SS physician of the entire camp, as of September

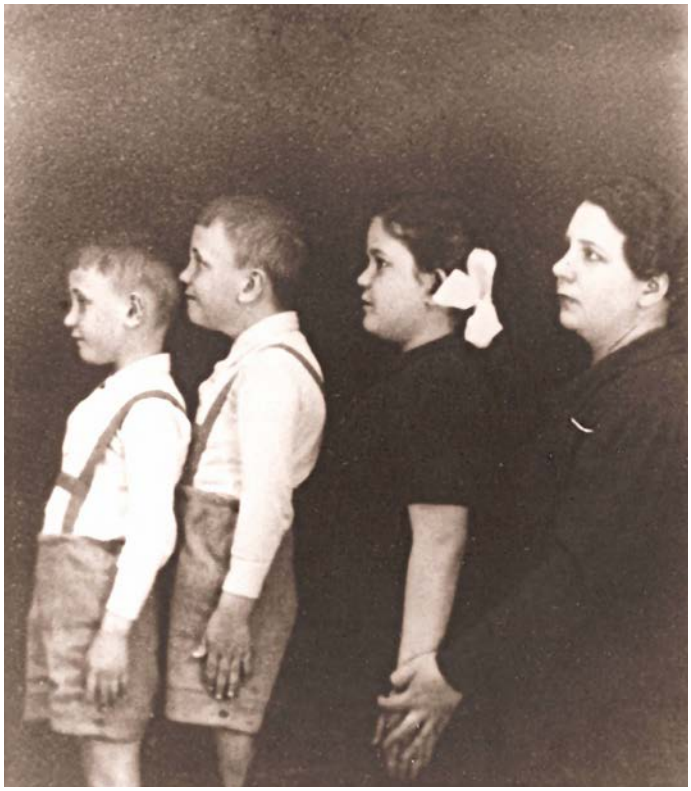


Photo 8. The Kleins, a family of Hungarian Jews, included twin brothers Otto (right) and Ferenz. After arriving in Auschwitz with their mother and elder sister, they were put at Mengele's disposal. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

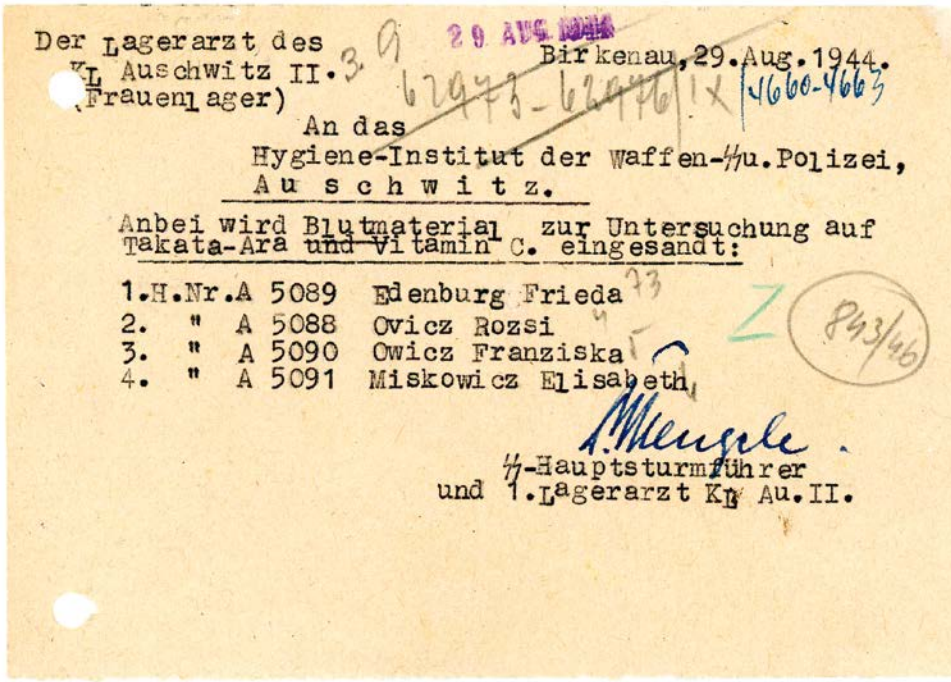
1942. Wirths was particularly impressed with the way Mengele handled a typhus epidemic. Mengele had been working in Auschwitz for just a few months when another epidemic of the disease broke out in the women's camp in the autumn of 1943. Mengele cleared the entire block, sending all the women in it to the gas chamber. Next he had the block thoroughly disinfected. The sick women from the next block were thoroughly disinfected out of doors, accommodated in the disinfected barrack, and given clean nightshirts. Mengele continued the procedure barrack by barrack until he had covered the entire hospital. The typhus epidemic in the women's camp was stopped, at the cost of the lives of hundreds of patients.[19]

19 APMA-B. Zespół Oświadczenia, Vol. 6, sheet 797—statement made by Dr Ella Lingens; see also Langbein , 360-361 (Polish edition).

Photo 9. | Berthold Epstein, paediatrician and professor at Charles University, Prague, was a Czech Jew whom Mengele appointed director of his experimental lab in August 1943. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

Later he applied the same method in other Birkenau sectors, for measures such as the eradication of an epidemic of scarlet fever among the Jewish women from Poland and Hungary in sector B II c. In July 1944, Mengele used fighting an epidemic of typhus as a pretext to close down the family camp for Jews from Theresienstadt. He supervised the operation himself in his capacity as an expert in radical measures to combat epidemics, and sent about 4 thousand men, women, and children to the gas chambers. In May 1944, he requested permission to close down the entire Roma camp, and when it was granted, put his plan into practice on 2 August, sending over 4 thousand of its inmates to the gas chambers.

Mengele's boss, Dr Wirths, appreciated his industriousness, good medical and scientific qualifications, and his management skills, and mentioned this in an application he wrote in February 1944 to his superiors asking for the award of a military



Der Lagerarzt des
KL Auschwitz II.
(Frauenlager)

Birkenau, 29.Aug.1944.

An das
Hygiene-Institut der Waffen-SS u. Polizei,
Au s c h w i t z.

Anbei wird Blutmaterial zur Untersuchung auf Takata-Ara ~~und Vitamin C.~~ eingesandt:

1.H.Nr.A 5089 Edenburg Frieda
2. " A 5088 Ovicz Rozsi
3. " A 5090 Owicz Franziska
4. " A 5091 Miskowicz Elisabeth

Mengele.
SS-Hauptsturmführer
und 1.Lagerarzt KL Au.II.

Photo 10. | Order signed by Mengele and dated 29 August 1944, for blood tests on four Romanian Jewish women from the Ovitz family of dwarfs, to be done at the Raisko SS Hygiene Institute. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

decoration—the *Kriegsverdienstkreuz* or War Service Medal—to Mengele.[20] The request was granted and Dr Mengele was awarded the *Kriegsverdienstkreuz* Class II with Swords, as we learn from the official opinion Wirths wrote of Mengele's work (19 August 1944):

> [I]n carrying out his duties as a physician in Auschwitz, Dr Mengele has applied his knowledge of the theory and practical know-how [of medicine] to combat serious epidemics. Despite conditions which have often been unfavourable, he has managed to fulfil all the tasks assigned to him prudently, vigorously and with a lot of determination, to the full satisfaction of his superiors. Furthermore, he is an anthropologist and has made use of every moment of the free time he has had after his duties for his own continuous edu-

20 Posner and Ware, 47. The supreme authorities of the SS treated service in a concentration camp as equivalent to front-line service, and granted the same awards for it as the military decorations soldiers received for combat. One of these decorations was the *Kriegsverdienstkreuz* with Swords (Class I or Class II).

cation. He has made a distinguished contribution to anthropology by using the *scientific material* available to him thanks to his official status. The results he has achieved are considered outstanding. While conscientiously carrying out his duties to control an epidemic of typhus fever, he contracted the disease himself. He has been awarded the *Kriegsverdienstkreuz* Class II with Swords in recognition for his special achievements. Alongside his knowledge of medicine, he also has exceptional qualifications as an anthropologist. He can be of service for any further duties assigned to him, as well as for further special tasks.[21]

Photo 11. | Hungarian Jewish girl (surname Lustig-Bleier or Brawer, first name unknown), aged about 2, photo taken at KL Auschwitz liberation. She was one of a set of triplets Mengele experimented on; only one out of those three survived. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

In letters to his wife Wirths referred to Mengele as "Mephisto." The same epithet or nickname, "Mengele, also known as Mephisto," appeared in the official statements made for the prosecutors by some of the SS men who had been his colleagues and collaborators in Auschwitz, as well as some of the survivors after the liberation of Bergen-Belsen.[22]

The Soviet offensive spelled the end of Mengele's promising career. The Germans started to evacuate prisoners, transfer them further west and close down the

21 APMA-B. Copies of records concerning Mengele from the Berlin Document Center—microfilm no. 1613/33.

22 Shlesak, 305 (Polish edition; p. 318 in the original edition). APMA-B. Materiały/606a, p. 58—statements made by Auschwitz and Ravensbrück survivors and SS staff for the United States National War Crimes Office (labeled as War Crimes Groupe United States in the archival materials) and later deposited in the Auschwitz-Birkenau Museum Archive on 10 June 1961 by Główna Komisja Badania Zbrodni Hitlerowskich w Polsce (the Central Commission for the Investigation of Nazi German Crimes Committed in Poland).

Photo 12. Group of surviving women and children under the care of the Polish Red Cross nurses after the liberation of Auschwitz, including Jewish twins and some of their mothers. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

concentration camps. So Mengele had just a short spell of time to close down his Birkenau laboratories, pack his experimental material, load it up on a truck and send it out. He left the camp on 18 January along with the rest of the SS men on the camp's staff and set off for the Gross-Rosen concentration camp in Lower Silesia, where he continued his work as an SS concentration camp physician (now chiefly involving selections).

He did not work there for long, because Soviet troops were advancing at a rapid pace and compelled the staff of that concentration camp to leave and head further west. Gross-Rosen was liberated on 25 February 1945, so presumably Mengele must have set off for Czechoslovakia some time in February, along with a retreating Wehrmacht unit.[23] He got rid of his SS uniform and turned into an officer of the

23 Dr Josef Mengele's postwar fate has been described in extensive and well documented biographies: *Mengele. The Complete Story* by Gerald L. Posner and John Ware, and *Josef Mengele. Der Arzt von Auschwitz* by Ulrich Völklein. Cf. also "A Report to the Attorney General of the United States from the Office of Special Investigations (United States Department of Justice," APMA-

Wehrmacht. In May 1945 in the Sudetes, Mengele joined a motorised field hospital, where he met Dr Hans Kahler, a colleague from the Frankfurt Institute. He travelled with the hospital to Saxony, and from there went to Bavaria, his home territory. He was caught near the town of Weiden and detained in an American POW camp. In early September, he was moved to another POW camp. In both these camps he gave his real name, but was not recognised as a war criminal on the wanted list, as the American authorities did not realise they had an SS man in their hands. Unlike most other SS men, Mengele did not have a tattoo with his blood group.[24]

In early September, Mengele was discharged from the camp and he and other POWs were taken to the town of Ingolstadt in Bavaria. He knew very well that if he fell into the hands of the Allies again, he would be sentenced to death, so he decided to hide. With the help of some friends from pre-war times, he obtained false documents for a Fritz Hollmann and went into hiding in a farm owned by Georg and Maria Fischer in the environs of Rosenheim. In April 1946, Mengele learned that Rudolf Höß, ex-commandant of Auschwitz, had mentioned him when he was testifying in court during the trial of Ernst Kaltenbrunner, the former head of the RSHA (*Reichssicherheitshauptamt*; the Reich Main Security Office). Mengele left the Fischers' farm in August 1948, and the following spring he left Europe. Thanks to his family's financial support, he obtained a passport for one Helmut Gregor, issued by the International Red Cross for emigrants. He travelled to Italy and from there fled to South America, where thanks to the support of many friends he lived in various countries.

He died of a cerebral stroke in 1979 while swimming in the sea off a place called Bertioga, about 100 km from São Paolo (Brazil). He was buried under the false name Wolfgang Gerhard in Embu cemetery on the outskirts of São Paolo. His memoirs and letters later discovered in São Paolo show that Mengele, one of the cruellest criminals of Auschwitz-Birkenau, spent the rest of his life in constant fear of being exposed and arrested. His political and cultural awareness stayed at its 1945 level to the end. In the last part of his life, he was lonely and persecuted by his own fury

---

B. Syg. Mat/1770, vol. 248. This report on Josef Mengele has been made public in October 1992; the set of archival materials includes also copies of documentation on Mengele from the Berlin Document Center, Bundes Archiv-Abteilung Potsdam.

24 Posner and Ware, 85–86 (Polish edition). In April 1945, Dr Josef Mengel was included on list no. 8 of the most-wanted Nazi war criminals.

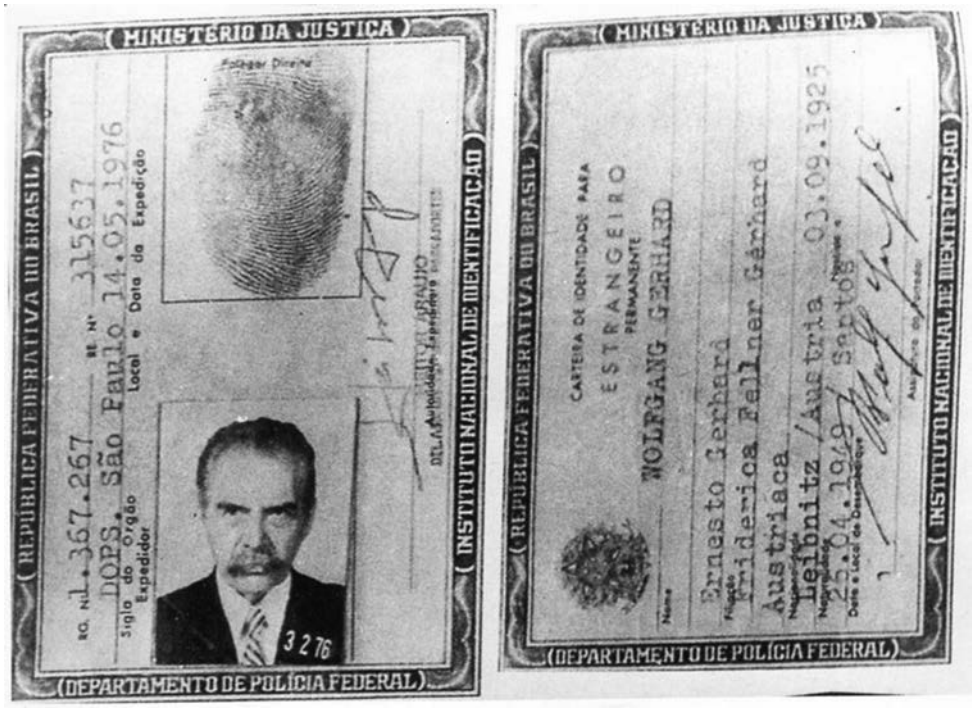


Photo 13. | ID card with Mengele's photo issued for a Wolfgang Gerhard, which Josef Mengele used in Brazil from 1975. APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections

and memories, but to the end of his life continued to believe in his pathological racial theories and had no pangs of conscience. He did not see anything wrong in his criminal experiments. He was a fanatical Nazi right to the end.[25]

So, it is a pity that the story of Dr Josef Mengele came to such a prosaic end and that he managed to evade this world's justice. If he had been brought to trial, those of his victims who managed to survive would no doubt have felt some sort of satisfaction, and the sentence he deserved would have been a warning to the world.

25 Two carton packages containing documents, including Josef Mengele's diary, letters, and a handwritten resumé, have been found in the federal police criminal investigation department in São Paulo. These documents were confiscated in 1985 in the family house of certain Bosserts when Mengele's secret stay and death under a false name in Brazil had been disclosed. The 20 months of service as an SS doctor in KL Auschwitz were not reflected in his personal records, and no letters or journals from this period have been found.

REFERENCES

APMA-B; Archiwum Państwowego Muzeum Auschwitz-Birkenau (Archive of the Auschwitz-Birkenau State Museum).

Klee, Ernst. 1997. *Auschwitz, die SS-Medizin und ihre Opfer*. Frankfurt-am-Main: Fischer Verlag. Polish edition: 2005. *Auschwitz. Medycyna III Rzeszy i jej ofiary*. Kraków: Universitas.

Langbein, Hermann. 1972 (first edition). *Menschen in Auschwitz*. Wien: Europaverlag. English edition: *People in Auschwitz*. The University of North Carolina Press, 2004. Polish edition: *Ludzie w Auschwitz*. Oświęcim: Wydawnictwo Państwowego Muzeum Oświęcim-Brzezinka 1994 (first edition).

Piekut-Warszawska, Elżbieta. 1967. "Dzieci w obozie oświęcimskim (wspomnienia pielęgniarki)." *Przegląd Lekarski – Oświęcim.* 204–205.

Posner, Gerald L., and John Ware. 1986. *Mengele. The Complete Story*. McGraw-Hill.

Schlesak, Dieter. 2006. *Capesius, der Auschwitzapotheker*. Bonn: Dietz.

Seidelman, William E. 1985. "The professional origins of Dr Joseph Mengele." *Canadian Medical Association Journal.* 133 (December 1, no. 11): 1169–1171.

Völklein, Ulrich. 1999. *Josef Mengele. Der Arzt von Auschwitz*. Göttingen: Steidl.

Zofka, Zdenek. 1986. "Der KZ-Arzt Josef Mengele zur Typologie eines NS-Verbrechers." *Vierteljahreshefte für Zeitgeschichte.* 34: 2.

Doctor Stefania Perzanowska, founder of the women prisoners' hospital at Majdanek concentration camp

Marta Grudzińska

Konzentrationslager Lublin, generally known as Majdanek, was in operation from the autumn of 1941 to July 1944, confining about 150 thousand prisoners, citizens of many countries and members of various professions and ethnic and social groups. About 80 thousand persons died in Majdanek, including nearly 60 thousand Jewish inmates, for whom Majdanek was a death camp. Majdanek's atrocious sanitary and existential conditions earned it the reputation of one of the worst concentration camps from the prisoners' point of view. It was also characterised by its high mortality rate due to the punishments and oppressive measures used against inmates, but also on account of the diseases, especially epidemics of typhus fever.

About the author: Marta Grudzińska is a historian and a curator, employed at the Research Department of the State Museum at Majdanek. The author of articles and books on the history of Majdanek concentration camp, the Lipowa slave labour camp in Lublin, and individual and collective memory in the accounts of witnesses. Co-author of museum exhibitions, including *Prisoners of Majdanek*, *Doctors in striped uniforms. The medical service in Majdanek concentration camp*. Her work at the museum is concerned with the camp's oral history preserved in the statements made by survivors and their families.

Photo 1. Aerial photo of Majdanek. APMM (Archives of the State Museum at Majdanek) collections

As in other concentration camps, in Majdanek, too, attempts were made to isolate prisoners who contracted an infectious disease, in the *Reviere* (prisoners' hospitals). One of the SS physicians in the camp was appointed head of its health service, with orderlies at his disposal. But in reality SS physicians did not carry out any of the fundamental duties of the medical care patients should get. Many hospital workers recruited from the concentration camp's staff were not qualified to conduct specialist medical treatment, which often led to the death of patients. The kapo of the prisoners' hospital was one Ludwig Benden (prisoner number 1), formerly a lathe turner and waiter. Polish prisoner doctors who worked in the prisoners' hospital knew that he performed surgeries despite having no medical qualifications at all, that he killed patients by administering Evipan injections straight into the heart, and that he took part in selections of prisoners for the gas chambers.

Those who dispensed real medical care to prisoners were prisoner doctors of various nationalities, and their ancillary staff, orderlies, nurses, paramedics, and

interpreters.[1] Prisoner doctors started arriving in Majdenek in November 1941, when it was just being set up. They were sent in from various concentration camps in Germany. At first they were put to work for the arrangements, in the storage facilities, or to bury the dead. The first hospital block was opened in the men's field early in 1942. More blocks were made available to the prisoners' hospital as more and more Jewish transports arrived from Slovakia, the Czech territories, and Germany.

Photo 2. | Stefania Perzanowska, 1960s photo. APMM (Archives of the State Museum at Majdanek) collections

Things were different with the women's camp. The first women prisoners arrived in Majdanek in October 1942, but shortly afterwards they were either discharged or transferred to the labour camp on the site of the former aviation factory in Lublin. The next female inmates, including political prisoners, started to appear in Majdanek as of January 1943, and were sent to Field Five, which was still under construction at the time. This is how Danuta Brzosko-Mędryk remembered that first night in Majdanek:

> There was snow [in the block], and something we didn't notice at first—there were no window panes. … [In the morning] Alina Wójcikowska couldn't get up, because her hair had frozen to the wall, but at first she didn't notice that, so she called out, "Someone's grabbed me by my hair!" It was still dark when we were woken up, and that's what our first night in Majdanek was like.[2]

1 Ciesielska and Grudzińska.

2 Archives of the State Museum at Majdanek (hereinafter APMM), Audiovisual recordings, D. Brzosko-Mędryk.

Dr Stefania Perzanowska arrived on 7 January 1943 in the first transport of women political prisoners. She was one of the most important persons in the history of Majdanek women's camp.[3]

Stefania Perzanowska née Juraszek was born in Warsaw in 1896. She went up to Warsaw University to read Medicine, but interrupted her studies during the First World War to serve as a physician for troops. In 1919 she married Waldemar Szwarcbart, the head of a medical insurance company. The couple had a daughter, Zofia, but after four years the marriage ended in divorce. In 1926, Stefania completed her studies and graduated, obtaining the degree of Doctor of Medicine.

In 1930, she married Dr Zygmunt Perzanowski, an ophthalmologist, who adopted Zofia, so both mother and daughter took the surname Perzanowska. The family settled in Radom, where Zygmunt was appointed head of the local military hospital and chief physician of its ophthalmic ward, while Stefania became chief physician of the internal diseases ward of the municipal hospital. When the War broke out, both she and her husband were called up for military service and evacuated east along with their respective hospitals. Zofia stayed behind and lived in Warsaw throughout the War, under a false name (Pawłowska). Zygmunt Perzanowski was taken prisoner in the part of Poland invaded by the Soviet Union and imprisoned by the Soviets in the POW camp at Starobelsk Derhachi. In April 1940, the NKVD killed him and all the other Polish officers held as POWs in that camp with a shot in the back of the head. The executions took place in the basement of the NKVD prison in Kharkov.

Stefania Perzanowska returned to Radom and worked as a doctor, taking an active part in the secret operations of the Home Army, the largest Polish underground resistance movement. She organised training programmes for the underground medical service, and helped with the transfer of arms and ammunition to starting points for sabotage operations. Her apartment served as a dead drop for the Home Army's Warsaw HQ.

The Gestapo arrested Dr Perzanowska on the night of 10/11 November 1942 during a mass roundup of members of the Polish educated class preceding the anniversary of Poland's independence. After two months of being held in Radom prison, she was sent to Majdanek in a transport of 571 male and 145 female pris-

3 Ciesielska, 2012: 19–28.

Photo 3. The women's camp in Field Five. APMM (Archives of the State Museum at Majdanek) collections

oners collected up from jails in Kielce, Skarżysko Kamienna, Częstochowa, Radom, and Piotrków.[4]

Years later she wrote the following about her first day in the camp:

> When we were brought here in early January 1943, there was no women's camp as such. The men's camp had been full of inmates already for a long time, but we were the first women to arrive in Majdanek. ... We were given one barrack; the rest of the barracks were empty and uninhabited.[5]

The barracks in Majdanek Field Five were not ready at all to accommodate women prisoners. They had neither the most rudimentary fittings, nor windows, floors, doors, or toilets. For a long time women prisoners had to use outside latrines, simply ditches dug beyond the barracks, which gave no protection against snow or freezing weather conditions. There was no water supply—the only well on the site of the women's camp was frozen up—to wash they had to use melted snow

4 Piątkowski and Kiełboń, 211 and 216.

5 Perzanowska, 1970.

or the "beverages" they got for breakfast. Insects were a constant plague—they were carriers of disease, especially of typhus fever.

Dr Perzanowska started looking after the sick as soon as she arrived in the camp. The first surgery she conducted, the incision and drainage of a peritonsillar abscess (a quinsy), was done with the kitchen knife the block senior used to cut bread. She sterilised the knife over a fire. The women's hospital at Majdanek was set up thanks to Dr Perzanowska's initiative a fortnight after the arrival of the first women prisoners, when the first cases of typhus emerged. As Wanda Ossowska recollected,

> One day, at the height of the typhus epidemic, Perzanowska said to me, "We're going to talk to the Germans, we must do something." And here, again, she made a stand, categorically and to the point, her argument was unchallengeable. She told them, "We must have a hospital. Not because *we* are dying, because that's what we've been brought here for, but because *you*, Sirs, will die, for you will go down with typhus as well." And we got a barrack for the hospital. That was our first success. Then came the details, such as thermometers, some sort of contact with the outside world, or one of those Germans actually supplied us with something or other, because of those specific demands, backed up with those wise words of hers, "If you don't, you'll be in for the same thing."[6]

But at the beginning the hospital was assigned just one barrack to accommodate patients, including those with infectious diseases. There was not enough medical equipment in the new hospital; there were not enough medicines or dressings to go round, either. Professor Sztaba, a physician and a Majdanek survivor himself, gave the following account of the prospects for medical treatment in the concentration camp:

> There was no laboratory at all. So we did not have even the simplest urine tests. There were no blood pressure meters, the most rudimentary instrument you can have. There was no question of blood tests of whatever kind, of cerebrospinal fluid tests, thoracenteses, or treating pleural effusions. There was no lab, there were no test tubes, no Petri dishes, no smears, no reagents. No nothing. Now that's not how you do diagnostics! Just looking at patients and reading their faces, diagnosing their disease by the way they look and

6 APMM, Audiovisual recordings, W. Ossowska.

> tapping them—that's very medieval… It's not medicine. We had no possibility to perform a diagnostic procedure. And if you can't get a diagnosis, you can't establish a treatment plan. Treatment… *What treatment?* There was no treatment…[7]

Dr Perzanowska worked non-stop. Apart from looking after her patients, she also acted as an intermediary in contacts with charity organisations, the Polish Red Cross and the Main Council of Relief. She did all she could to obtain the indispensable medications and equipment. She helped with passing secret messages in and out of the camp. In addition, she also gave lectures on anatomy and hygiene, and provided professional training for the young women working in the hospital. In December 1943, she wrote in a secret letter to her daughter, "I need an anatomy textbook, at secondary school or post-secondary level—not just an atlas, but it has to have a written account as well, because I'm giving training courses for nurses."[8]

Here's Krystyna Tarasiewicz's description of how Perzanowska worked:

> It's simply unimaginable. When they brought us to Majdanek Field Five, it was all frozen up, icebound, there was no water, the barracks were empty, with just some sort of paper mattresses which we had to fill with paper shavings… For instance, in our barrack half the roof was missing and the temperature was minus 25 degrees Centigrade [−16° Fahrenheit]. … But Dr Perzanowska set up a hospital, *a real hospital*, in the middle of nowhere, with no water, starting from scratch, she established a hospital, with beds, nurses, a nurses' college. … She made demands and managed to get things that were unimaginable, she managed to get all these things out of them [the concentration camp authorities], and anything she didn't manage to get from them, she would bring in presumably by secret, illicit means from the Red Cross in Lublin.[9]

Treating and helping the sick would have been practically impossible if Dr Perzanowska had not been so deeply committed. Professor Sztaba recalled:

> What could we give a sick prisoner sent to the hospital barracks? … All we could provide them with was a three-tier wooden bed, a mattress stuffed with wooden shavings or scrunched up straw shredded pretty well into chaff, a headboard and one or two blan-

7 APMM, Audiovisual recordings, R. Sztaba.

8 APMM, Prisoners' organisation archive, S. Perzanowska.

9 APMM, Audiovisual recordings, K. Tarasiewicz.

kets, two if they were lucky, usually it was one. Of course the blankets were full of fleas. And that was about all. We could not conduct any diagnostics. None at all. All we had to go by were our ears to auscultate patients, our eyes to examine the expression on their face, their appearance, behaviour, and symptoms. To observe what could be observed visually about them. It was the medieval method, tapping them, feeling their abdomen, chest, and head—and that was all we could do.[10]

Survivor Danuta Brzosko-Medryk gives a similar account of the therapy available in Majdanek:

> The hospital offered verbal therapy and miraculous hands. … That was the tremendous faith in words and the power of hands I experienced when Wanda [Ossowska] told me to massage a Belgian girl who had been transported from Ravensbrück with palsied legs. Wanda showed us how to administer the massage and then all she did was from time to time take a look how we were doing it, correct us, and then we would continue. … When the time came to leave in the patients' transport for Auschwitz, that woman got up on her feet. Wanda had told her, "Suzi, you must get up. You *must walk*." And when I met her in Ravensbrück, she told me, "Our Lady of Częstochowa, Wanda Ossowska, and those two girls worked a miracle—I started walking."[11]

On many occasions Dr Perzanowska put her own life at risk for the sake of her patients. Not only did she try to help them, but she also tried to save women due to die because they were extremely exhausted or facing a death sentence, hiding them in the hospital or writing bogus medical records for them. For instance, in the summer of 1943, the hospital staff were told that as of the next day "there would be no more typhus fever in the women's field."[12] When the crematorium manager killed a Jewish woman who had typhus with a phenol injection, the women realised what was in store for those patients.[13] Perzanowska and her assistants spent the whole evening and half the night rewriting their medical records, entering other conditions, such as pneumonia or nephritis, instead of typhus.

---

10 APMM, Audiovisual recordings, R. Sztaba.

11 APMM, Audiovisual recordings, D. Brzosko-Mędryk.

12 Ossowska, 280.

13 Perzanowska, 1968: 239.

Photo 4. | Medical artefacts donated to the State Museum at Majdanek by Perzanowska's grandchildren. APMM (Archives of the State Museum at Majdanek) collections

All the time she tried to help the Jewish prisoners. When the Germans ordered her to bring out all the wounded Jewish women into the roll call square, she said, "We're a medical service, and we have taken an oath to look after each and every patient right to the very end. We're not going to carry our Jewish patients out of the hospital into the roll call square when there's a selection," even though she knew very well what the consequences of refusing would be.[14] She showed courage on Christmas Eve [24 December] 1943, when she and her staff decided to hide a Jewish newborn baby in the hospital. The child was hidden in the loft of the hospital and survived right to the evacuation.

Perzanowska was considered a resolute professional in her relations with the staff of the concentration camp, and her fellow-prisoners looked up to her, treating her as a great authority. This is what Nurse Wanda Ossowska, a Majdanek survivor, had to say:

> Perzanowska's fellow-inmates, those crowds of women prisoners—people she had never seen before, all those people, some who were patriotic and involved, and some who were indifferent—they all called her "Mummy," or "Please, Doctor." They all treated her with

14 APMM, Audiovisual recordings, W. Ossowska.

Photo 5. | Secret letters and soft toys made by Perzanowska in the camp and sent to her family. APMM (Archives of the State Museum at Majdanek) collections

> the utmost respect, because they knew she could do an awful lot, even though she could do nothing. The psychological aspect was extremely important… Like, for instance, a talk with her, she'd tell you, "you'll hold out, you *must* hold out, I'll help you, just do this and it'll be all right." And *it was*… it was all right.[15]

That woman, outwardly so strong, a pillar of strength supporting others, disclosed her hidden face in secret letters smuggled out to her daughter:

> (1943) My Dearest, Darling, Most Beloved Daughter! I got your last, very, very loving letter. It would certainly not be enough just to thank you for it in a letter, because of course it was no ordinary letter—it was you yourself, all your heart and all your thoughts—so beloved, like nothing else in the whole, wide world. Dearest Child of mine, things can't be bad for me, no—never and nowhere, because I've got you, and the knowledge that you are there gives me such joy and makes me so happy even in the hardest moments and situations. If I'm a good mother for you, you are paying me back much more, you're

15 APMM, Audiovisual recordings, W. Ossowska.

> the best of daughters I could have ever imagined. … Dearest Child of mine, I kiss you and from the depths of my heart entrust you to God's care—O, God, how I long to kiss you in person! Your Mother.[16]

Just before the women's camp was evacuated, Perzanowska sent her daughter words of comfort:

> (25 March 1944) My Dearest, Darling daughter! Don't worry about me, right now there is no talk of us being removed, and even if that were to happen, it wouldn't be such a bad thing, and it is my belief that it'll be all right. Please look after yourself and take care, I beg you, and keep hoping that maybe soon we'll be together. I hug you and press you close to my heart, dearest Treasure of mine, be brave and strong like you have been, dearest Little Daughter of mine. Your Mother.[17]

When the women's hospital was evacuated, Perzanowska, her female staff, and her patients were sent to Auschwitz. In one of her secret letters to her family prior to their evacuation, she wrote,

> We concentration camp veterans are no longer the same as we were a year ago. We don't get scared or lose our temper so easily. All that we've been forced to see and go through here has blunted our sensitivity. … It is my profound belief that whatever is to happen, will be, and that it will be all right. *Above all, I want to protect my patients, because it's my fundamental duty.* We have some people here who are cracking up already, so we have to keep their spirits up. … Dear Jasiulek, all my heart and thoughts go out to you, I commend you and myself to God's care and am calmly looking forward to what is to come. Your Mother.[18]

The last Jewish women in Majdanek and the little boy born on Christmas Eve 1943 whose life was saved, were all sent out of the camp on this transport, bound for Auschwitz. On arrival, he and his mother, and all the other Jewish women were sent to their death in the gas chamber.

Dr Perzanowska was also a prisoner of Ravensbrück and Neustadt-Glewe. Wherever she went, she always dispensed medical assistance to her fellow-prison-

---

16 APMM, Prisoners' organisation archive, S. Perzanowska.

17 APMM, Prisoners' organisation archive, S. Perzanowska.

18 APMM, Prisoners' organisation archive, S. Perzanowska. Emphasis mine.

ers. She did not leave them even after the liberation of Neustadt-Glewe (May 1945), until she had forced the German commandant of a military hospital stationed nearby to take the emaciated and debilitated women prisoners into his hospital. Only then did she and her closest friends set off for home in Poland.

She returned to Radom, her hometown, in May 1945, and was appointed chief physician of the internal medicine ward at the local hospital. In her private apartment she opened a survivors' advisory centre—one of the first of its kind—offering assistance to concentration camp survivors and their families free of charge.

Even though in her fellow-prisoners' stories she featured as a first-rate physician and heroine, and as a mother, in this period she never talked about her concentration camp experience, not even with her closest collaborators.[19] This is how she recalled that difficult time of adjusting to post-concentration camp reality and the sense of not being understood:

> However, the beginning was hard, as I had feared. For although our insensitivity receded, there came an unnecessary touchiness and oversensitivity. Cast into this mental condition, it was not easy for us poor surviving wretches to find a common language with people who looked normal, well-dressed and affluent. Their cordiality irritated us at every step, their questions on how it was there made us relapse into a state of insensitivity and stubbornly keep ourselves to ourselves.[20]

In the 1960s, she started to deliver lectures and publish articles on concentration camp subjects, chiefly in *Przegląd Lekarski – Oświęcim* (*Medical Review – Auschwitz*). It was not until 1970 that she published her recollections of Majdanek in a book. She wrote that she hated Majdanek and the very thought of it still gave her sleepless nights, but that she had deep and fond memories of the hospital and all of its staff.[21] Of her nightmares about her confinement in concentration camps, she wrote,

> [T]hey have always been very clear and close to reality. … Each time they were different—there's such a vast repertoire of these nightmares, presumably as vast as the number

19 APMM, Audiovisual recordings, D. Anańko.

20 Perzanowska, 1970: 184.

21 Perzanowska, 1970: 180.

Photo 6. | Press cuttings related to Dr Perzanowska. APMM (Archives of the State Museum at Majdanek) collections

> of psychic traumas stored in my subconscious. So after a few days, I already knew that it wasn't going to be easy to shake off the nightmare of those years. All that we had to go through there, was still too deeply lodged in us. The nightmare of the concentration camp was forcing itself too brutally, too garishly upon our senses for us to be able to break free of it.[22]

She died in Warsaw in 1974. She received numerous awards and distinctions for her work, especially for her public service. In 1985 one of the streets near Radom's voivodeship hospital was named after her as a tribute to her work for that city.

* * *

The illustrations to this article come from a collection of over 500 documents and artefacts relating to the life and work of Dr Stefania Perzanowska, donated to the Majdanek Museum in 2017 by her grandsons, Andrzej and Krzysztof Korczak.

---

22 Perzanowska, 1970: 180.

REFERENCES

APMM (Archiwum Państwowego Muzeum na Majdanku: Archives of the State Museum at Majdanek), Zbiór nagrań audiowizualnych (Audiovisual recordings); XXII-50, D. Brzosko-Mędryk; XXII-117, W. Ossowska; XXII-9, R. Sztaba; XXII-119, K. Tarasiewicz; XXII-690, D. Anańko.

APMM, Archiwum organizacji więźniów (Prisoners' organisation archive), IV-91, S. Perzanowska (no pagination).

Ciesielska, Maria. 2012. "Stefania Perzanowska (1896-1974), lekarka więźniarka obozu w Majdanku." *Acta Medicorum Polonorum*. 2: 19–28.

Ciesielska, Maria, and Marta Grudzińska. *Doctors in Prison Uniforms. The Medical Service at Majdanek.* Available online at http://lekarze-w-pasiakach.majdanek.eu/en/.

Ossowska, Wanda. 1990. *Przeżyłam… Lwów-Warszawa 1939-1946*, Warsaw: Oficyna Przeglądu Powszechnego.

Perzanowska, Stefania. 1960. "Szpital kobiecy w obozie na Majdanku." *Przegląd Lekarski – Oświęcim*. 235–243. English translation available online: https://www.mp.pl/auschwitz/journal/english/223573,majdanek-womens-camp-hospital.

Perzanowska, Stefania. 1970. *Gdy myśli do Majdanka wracają*. Lublin: Wydawnicwto Lubelskie.

Piątkowski, Sebastian, and Janina Kiełboń. 2001. "Z badań nad radomskim," *Zeszyty Majdanka.* XXI: 211, 216.

Stefan Budziaszek, prisoner doctor in charge of the Auschwitz-Monowitz prisoners' hospital

Bogdan Musiał

Until late 1941, medically trained prisoners were prohibited from working as prisoner doctors in Auschwitz. Auschwitz was not an exception in this regard, as the situation was the same in the other German concentration camps. After the war, Rudolf Höß, ex-comandant of Auschwitz, testified in court that it was so on Heinrich Himmler's orders. Himmler feared that prisoners working as camp doctors would hide their colleagues—sometimes for several weeks—by claiming that they were sick and needed a rest, even if they were in fact perfectly healthy.[1] So the ban was needed to prevent such "abuses."

About the author: Bogdan Musial studied history, political science and sociology at the Leibniz University of Hannover (1990–1998) and the University of Manchester (1992/93). In 1998, he gained his doctorate with a work on the treatment of Jews in occupied Poland. Afterwards, he was a research fellow at the German Historical Institute in Warsaw (1999–2004) and later the Institute of National Remembrance in Warsaw (2007–2011). In 2004, he obtained his habilitation from the Cardinal Wyszynski University Warsaw, where he was a professor for Central and Eastern European Studies (2010–2015). In 2017 he returned to the Institute of National Remembrance in Warsaw, and began working on a research project focusing on prisoner physicians in Auschwitz.

1 AIPN, GK 196/103, pp. 124–141, here p. 126.

In the early stages of the medical service in the concentration camps, all the key jobs were held by infirmary capos, block seniors, and prisoner hospital seniors, all of whom were German. These prisoners were either criminals or political prisoners, and in general had no medical qualifications at all. The criminals were because they abused sick prisoners, while the political prisoners were notorious for using their position in the camp's medical system to save prisoners who held the same political views. However, neither group was able to provide effective medical care to the other prisoners. At best, they alleviated the suffering of the patients—or at least left them alone. At worst, they tried to conduct operations themselves, even though they had no medical qualifications.[2]

Although it was formally forbidden, Polish doctors did in fact work as prisoner nurses and assistants as soon as the first Polish prisoners arrived in June 1940.[3] As they held most of the junior posts, Polish prisoner doctors were able to gradually expand their influence with respect to the German prisoner functionaries. As a result, a rudimentary surgical ward was set up already in November 1940, and Polish prisoners who had been surgeons before their deportation undertook simple operations.[4]

By the end of 1941, the SS changed its policy on the medical system in Auschwitz. As the concentration camp expanded rapidly, a great number of prisoners fell victim to various diseases such as typhus, which showed there was a need for an effective if basic medical system. One of the measures was to formally allow imprisoned doctors to work as prisoner doctors and nurses—as long as they

---

2 From the witness statement by Dr Jan Grabczyński from 30 June 1946. AIPN, GK 196/85, pp. 170–173, here p. 172: "Pańszczyk conducted surgical operations even though he had no medical work experience." From June 1940, the Polish prisoner Mieczysław Pańszczyk worked as a nurse in the prisoner hospital of what would later become the main camp. See also Betlen, 1962: 99. Betlen, a Hungarian communist and an electrician by profession arrived at the prisoner hospital of Auschwitz-Monowitz in early 1943 and worked there as a prisoner nurse: "I apply bandages, give injections, cut open boils. Some of the prisoners call me 'doctor.'" See also the interrogation of Dr Stefan Buthner (Budziaszek) of 22 July 1971 (Fritz Bauer Institut, 4 Js798/65, Vol. 7, pp. 1270–1292). Dr Budziaszek described the situation in Monowitz prisoners' hospital as "unbearable" (p. 1272).

3 In the early stages, most of the inmates of Auschwitz were ethnic Poles. Large numbers of Jews did not arrive until much later. By the time Auschwitz was evacuated in January 1945, more than ten times as many Jews as Poles had been murdered there.

4 Fejkiel, 1994: 110–113.

were "Aryan," i.e. Polish.[5] Hence, early in 1942, SS physician Friedrich Entress, who was stationed in Auschwitz from December 1941 to October 1943, started to employ Polish prisoner doctors, thereby strengthening their position with respect to the medically unqualified German capos and their "favourites."[6]

This did not apply to Jewish prisoners. Initially, Jewish prisoners were not admitted for treatment in the prisoners' hospitals, let alone allowed to work there. Until late 1941, the Jewish prisoners who arrived in Auschwitz and were not immediately dispatched to the gas chambers (around 10% of all arrivals) were in most cases assigned to penal companies, where they were brutally mistreated and often outright murdered by the SS and capos on orders of the SS. This changed in early 1942. The surviving Jews were taken out of the penal companies and assigned to various work commandos along with the other Jewish new arrivals.[7] At the same time, Jewish prisoners were finally admitted to the prisoners' hospital for treatment, and by the summer of 1942, Jewish prisoner doctors and nurses were working there, treating Jewish prisoners.[8]

Early in 1942, thanks to their crucial role in fighting typhus and other infectious diseases as well as providing qualified medical care to injured prisoners, the prisoner doctors gradually acquired more leverage. For the most part, they were better trained and had more experience than the for the SS doctors working in Auschwitz, most of whom were quite young. The SS doctors noticed this and successively transferred many of their own responsibilities onto the prisoner doctors. Soon, it was the prisoner doctors who diagnosed patients, conducted surgeries, authored

5 Statement by witness Dr Stanisław Suliborski, 21 January 1947. AIPN, GK 196/161, pp. 307–308. Dr Suliborski arrived in Auschwitz as a prisoner on the 15 August 1940. In September 1940, he became a prisoner nurse and then a prisoner doctor in the main camp until his release on the 10 February 1942.

6 Jaworski, 6.

7 Pilecki, 2014: 135.

8 Jaworski, 1945: 141. In August 1942, two Czech-Jewish prisoner doctors were employed in the newly-established subcamp Jawischowitz. See also: APMA-B, Oświadczenia, vol. 88a, pp. 1–61. Already by early 1942 there seem to have been plans to employ Jewish prisoner doctors in the prisoners' hospital main camp. However, the SS camp doctor Dr Friedrich Entress prevented this. Cf. Jaworski, 88, 96.

medical and post-mortem reports. Some SS doctors, particularly surgeons, even asked prisoner doctors to train them.[9]

In the second half of 1942, the SS began to search for medical professionals and other specialists among the camp inmates. Dr Eduard Wirths, who was appointed SS Chief Physician (*SS-Standortarzt*) on 1 September 1942, put his trust in the professional skills of the prisoner doctors in the camp. Nevertheless, the mortality rate in Auschwitz was still extremely high, even when compared to other concentration camps. Confidential SS reports show that in the month of July 1942 alone, 8,329 prisoners died in all of Germany's concentration camps, including Auschwitz; considering that the total number of prisoners in concentration camps was on average around 98,000 throughout that month, the monthly mortality rate was at a shocking 8.5%.[10] Auschwitz was not like the other concentration camps, however. Despite accounting for only around 19% of concentration camp inmates, nearly half (4,125) of all the deaths registered in all the German concentration camps occurred in Auschwitz.[11] Naturally, this figure is only for officially registered inmates. Virtually all of the Soviet prisoners of war and above all the Jews who began to arrive in Auschwitz in large numbers in early 1942 were never registered as inmates. Instead, they were murdered straightaway and were never counted in the official figures.

Due to the "extraordinary difficulties" regarding the "worker question" in Germany at the height of the war,[12] the German concentration camp authorities and the SS soon realised that a staggering mortality rate was counter-productive. There were many complaints. Corporations such as IG Farben, which employed forced labour from Auschwitz in the Buna works at nearby Monowitz, regularly lodged complaints about the high "turnover." So, on Himmler's orders, it was "imperative

9 Fejkiel, 1994: 110–111.

10 AIPN, GK 196/117, p. 124.

11 From an analysis of the preserved records detailing the numbers of prisoners given in the evening roll calls between 19 January 1942 and 19 August 1942: AIPN, GK 196/92, pp. 1–118, here pp. 91–97.

12 On 23 June 1942, Viktor Brack from Hitler's chancellery approached Heinrich Himmler with the following concern: "I feel that among the ca. 10 million European Jews there are at least 2–3 million men and women who are able to work very well. Considering the extraordinary difficulties posed by the worker question, I believe that we have to pick out these 2–3 million. However, this can only happen if we stop them from procreating." AIPN, GK 196/119, pp. 4–5.

to lower"[13] the mortality rates in Germany's concentration camps. On 28 December 1942, the WVHA (*SS-Wirtschafts- und Verwaltungshauptamt*, the SS Main Economic and Administrative Office) issued a communiqué endorsing his position: "The Chief Camp Doctors have to do everything in their power to bring down the death rate as much as possible in the individual camps. The best concentration camp doctor is not the one who fancies he has to distinguish himself by misconceived harshness, but the one who makes sure that the camp's working capacity is kept high by monitoring its workplaces and sending in replacements to fill vacancies."[14] Thanks to these missives, Dr Wirths was able to prevail over Höß and his preference for German prisoner functionaries.

One of the first prisoner doctors recruited by Dr Wirths was Stefan Budziaszek (aka Buthner after 1953). Budziaszek was born in and completed his finals in Medicine in the Polish clandestine system of university education shortly after the German invasion and occupation of Poland. He got a job in a hospital in Kraków before he was arrested in June 1941. After spending several months in jail, he arrived in Auschwitz on 10 February 1942. Straight after he arrived, an SS soldier broke his arm, and he was admitted to the prisoner hospital, where he met some of his former colleagues from Kraków and was initially put to work in the laboratory. He was later assigned to other work commandos, including ones in Buna-Monowitz. In August 1942, his former colleagues helped him find employment as a prisoner nurse in the surgical ward of the prisoners' hospital in the main camp.[15]

On 17 September 1942, Wirths, the new SS Chief Physician, came to this hospital and interviewed all the prisoner nurses and doctors, asking about their work experience and why they had been sent to a concentration camp. He chose Budziaszek, and on the same day took him to Jawischowitz, a sub-camp where prisoners were forced to do hazardous work in an underground coal mine, and Budziaszek was to improve the medical facilities there. He was up to the task. Combining his medical skills with a talent for management, Budziaszek was able to set up a very

13 AIPN, GK 196/94, pp. 142–143.

14 AIPN, GK 196/94, pp. 142–143.

15 APMA-B, Oświadczenia, vol. 88a, pp. 1–61.

well-organised and efficient hospital—at least by Auschwitz standards. It did not take long for Wirths to take note of this.[16]

On 22 of June 1943, Budziaszek was transferred to the prisoner hospital in Buna-Monowitz to reduce the staggering death rate. The inmates suffered from many disorders: pneumonia, phlegmons (a purulent, diffusely spreading inflammation of the connective tissue), blood poisoning, starvation oedema and hunger diarrhoea, extreme emaciation, as well as various types of injuries such as broken bones or cuts, mostly from accidents during construction work. To make matters worse, the standard of medical care was extremely poor and around sixty percent of of the patients receiving "treatment" died.[17] Budziaszek knew very well about why he had been sent on that mission:

> It was because of the high demand for labour needed by German industry, which could not be satisfied by Germans, because they had been conscripted. So they decided to stop killing able-bodied concentration camp prisoners and get them to work for German industry before they died. The Germans took special care of the skilled labourers. In Buna, for example, hundreds of prisoner engineers were employed, where they were tasked with vital duties. That was why the factory and the camp's management wanted prisoners to stay healthy and keep working.[18]

"A HOSPITAL NEEDS DOCTORS"

The prisoners' hospital at Buna-Monowitz had been established just a few months earlier, in October 1942. Before Budziaszek's arrival, it was run by German political prisoners—mostly communists—who did not have much in terms of medical expertise. They were employed chiefly as barracks seniors, nurses and clerks. On pa-

16 APMA-B, Oświadczenia, vol. 88a, pp. 1–61. AIPN, GK 164/179/4, pp. 29–40; AIPN, GK 164/179/4, p. 60: "In 1942/3, Dr Budziaszek organized an exemplary efficient prisoners' hospital in Jawischowitz sub-camp." See also Bacon, 2017: 51–72.

17 AIPN, GK 164/179/4, pp. 29–40; AIPN, GK 151/460, pp. 358–363. GARF, f. 7021, op. 108, d. 46, pp. 36–40.

18 AIPN, GK 164/179/4, pp. 29–40.

per, they were in charge of the patients, but in reality they only looked after themselves and their comrades. As the political prisoners provided their own comrades with relatively safe jobs in the prisoner hospital—even if they were completely unqualified for them—there were very few qualified health workers in the prisoners' hospital. Unsurprisingly, the quality of medical care was abysmal and mortality was extremely high. In his witness statements after the war, Budziaszek was very critical of the conditions in the hospital and the devastating consequences for the seriously ill. He added:

> The camp's SS authorities transferred me to Monowitz to improve the conditions in the prisoners' hospital. I found it was controlled by a group of Communists who were not physicians. After a few weeks of observation during which I started working with Dr [Bronisław] Rutkowski and Dr [Berthold Epstein], I reported to Dr Entress and suggested a number of reforms. A hospital needs doctors. I knew there were more than enough doctors in Jawischowitz, so I asked for two of them, Dr [Leon] Cuenca and Dr [Adalbert] Robert, to be transferred to Monowitz. I also suggested all the block seniors working in Monowitz hospital at the time should be dismissed, and that is what eventually happened.[19]

With the backing of the SS camp doctors, Budziaszek turned to prisoners who had worked as doctors before their deportation to Auschwitz, but were now in other work commandos inside the camp. Furthermore, he also looked for doctors among new prisoners. He estimated that he had managed to employ over 40 prisoner doctors in the hospital,[20] some of whom were highly-trained medical professionals with decades of experience.[21] Most of these doctors survived Auschwitz in the relative safety of the concentration camp medical system. This was largely due to the fact that the work in the medical sector was much less harsh and that rations were more plentiful. In contrast, most of the "normal" prisoners died within a few months from exhaustion, hunger and disease. To make matters worse, prisoners who were deemed too sick or too weak to be able to return to the camp's workforce were regularly singled out by SS doctors during the infamous "selections" and then sent to their deaths in the gas chambers.

---

19 Fritz-Bauer-Institut, 4 Js798/64, vol. 7, pp. 1270–1292.

20 AIPN GK 164/179/4, pp. 29–40.

21 Cf. Makowski, 1975: 113–181.

Apart from turning to trained medical professionals, Budziaszek promptly started to expand the prisoners' hospital. Naturally, this was done with the approval and sometimes even outright support by the SS camp authorities. Even though this proved to be a very difficult task under these extraordinary circumstances, Budziaszek turned out to be a very good manager and soon achieved this goal. When he arrived in June 1943, there were just three barracks making up the hospital, and its resources consisted of the most rudimentary medical equipment. By late 1944, the hospital had more than tripled in size to 10 barracks that now included surgical wards, disinfection chambers, a laundry as well as bathing facilities. Furthermore, the barracks in the hospital had been equipped with running water as well as a sanitation system; they were also regularly renovated. All the necessary work was done by the prisoners themselves. As they were not provided with building materials, the prisoners had to "organise" i.e. steal the building materials themselves, mostly from the construction sites at the Buna works. Luckily for them, the SS camp authorities turned a blind eye to this practice, even though there were Draconian penalties for other types of theft.[22]

The hygienic and sanitary measures led to a dramatic reduction in the spread of disease in Buna-Monowitz. Typhoid fever, which by that time had killed thousands of prisoners in Auschwitz, was practically eliminated. The surgical wards had a high success rate, too. Experienced surgeons saved the lives of hundreds of sick and injured prisoners who would otherwise have been classified as not fit for work and sent to the gas chambers. The number of patients in stationary care rose from a monthly average of 380 in June 1943 to an average of 880 just a year later; by December 1944 it had soared to 1,120. Outpatient care was expanded as well: between June 1943 and June 1944, the number of outpatients more than doubled from 500 a day to 1,200 a day.[23]

The vastly improved medical and hygienic conditions led to a sharp improvement in the health of the prisoners. There was an additional effect as well: as the death rate fell, there was also a drop in the frequency of selections, in which SS doctors selected those prisoners they considered not fit for work or suffering from

22 Makowski, 1975: 118–120.

23 Makowski, 1975: 143.

an incurable disease, and had them exterminated.[24] This improved the chances of survival for "ordinary" Jewish prisoners. Polish and other "Aryan" prisoners had already been exempted from selections in April 1943.

As prisoner mortality continued to plummet dramatically, the number of prisoners in the Monowitz sub-camp rose considerably. It went from around 4,000 in June 1943 to 10,000 a year later; from then on, it remained more or less constant until the evacuation of Auschwitz in January 1945.

Buna-Monowitz was no exception in this regard. Similar measures were undertaken at the main camp (Auschwitz I), and in Auschwitz-Birkenau, and the hygienic and medical conditions improved considerably there as well. The same is true for surgical care, as surgical wards staffed with skilled professionals were established in the main camp and in Birkenau.

By 1944, the prisoner doctors had won the "battle" for Auschwitz's prisoner hospitals. Another important factor was the influx of mostly Jewish prisoners from all over Europe, especially from Poland, France, Germany, Czechoslovakia and Hungary, that began to intensify in the summer of 1942. The trained medical professionals among them took over many important posts in the prisoners' hospitals. Doctors who were not Jewish continued to arrive as well, although in far fewer numbers. They were mostly Czechs, French, Russians, and Germans.

There were hundreds of prisoner doctors employed in the entire Auschwitz complex, that is the main camp and all the sub-camps. However, it is virtually impossible to determine the exact number; this is chiefly because of a lack of sources as well as due to the fact that the fluctuation was quite high. Especially in the beginning, many doctors died of diseases, mainly typhoid fever. In the early stages some, mostly Polish, prisoner doctors were executed, while others were transferred to different concentration camps; some non-Jewish prisoner doctors were even set free.

Stefan Budziaszek was the first prisoner doctor in Auschwitz who was given authority over one of the prisoner hospitals. He held that position until the evacuation of Auschwitz in January 1945. In the main camp, Dr Władysław Dering, another Polish doctor, was put in charge of the hospital in August 1943. After he was released from Auschwitz in January 1944, he was replaced by Władysław Fejkiel, also

---

24 SS doctors considered prisoners to be "incurable" when their estimated recovery would take over 3 to 4 weeks.

a Pole. Auschwitz-Birkenau lagged behind in this regard, and it was not until March 1944 that the first medical professional was put in charge of its prisoners' hospital. The appointee was Dr Roman Zenkteller, yet another Pole. When he was transferred to Buchenwald on 7 of December 1944,[25] SS camp doctor Joseph Mengele appointed the Czech Jewish prisoner doctor Prof. Berthold Epstein as his successor.

Auschwitz was an exception. In no other German concentration camp were prisoner doctors allowed to play such an important role in the camp medical system as in Auschwitz. Despite their influence, prisoner doctors still had to contend with the SS, in particular with the SS doctors; they had to work alongside them and follow their orders. After the war they were accused of collaboration. The most famous case was that of Dr Władysław Dering, whose story became the subject of a high-profile court case and later even a TV series. However, he was certainly not the only one. In Poland a criminal investigation was conducted even against Dr Budziaszek, but it was soon dropped due to the evidently absurd charges brought against him. Nevertheless, this did not prevent German prosecutors from starting an investigation in 1961 in Hanover, to where Budziaszek had moved after the war. The German investigation was dropped for the same reasons as the ones in Poland, but only after the matter had dragged on for over a decade until 1974.

REFERENCES

AIPN (Archives of the Polish Institute of National Remembrance, hereafter AIPN), ref. no. BU-VI-55 141-51(2)/15.
AIPN, ref. no. GK 151/460, pp. 358–363.
AIPN, ref. no. GK 164/179/4.
AIPN, ref. no. GK 196/85, pp. 170–173.
AIPN, ref. no. GK 196/92, pp. 1–118.
AIPN, ref. no. GK 196/94, pp. 142–143.
AIPN, ref. no. GK 196/103, pp. 124–141.
AIPN, ref. no. GK 196/117, p. 124.

25 *KL Auschwitz, Häftlings-Personal-Karte von Roman Zenkteler [sic] (Kopie)*. From 1914 to 1918, Zenkteller had been an army doctor in the German army. After the German invasion of Poland, he was interned in Oflag Neu-Brandenburg because he was a lieutenant in the Polish army. On 5 September 1941 the Gestapo sent him to Auschwitz on the grounds that he was a member of the Polish intelligentsia and hence a political prisoner. AIPN, BU-VI-55 141-51(2)/15.

AIPN, ref. no. GK 196/119, pp. 4–5.

AIPN, ref. no. GK 196/161, pp. 307–308.

APMA-B (Archives of the Auschwitz-Birkenau State Museum) Collections, Oświadczenia [Statements Collection], ref. no. vol. 88a, pp. 1–61.

Bacon, E.K. 2017. *Saving Lives in Auschwitz. The Prisoners' Hospital in Buna-Monowitz,* West Lafayette; 51–72.

Fejkiel, W. et al. 1994. *Więźniarski Szpital w KL Auschwitz.* Oświęcim: Wydawnictwo Państwowego Muzeum w Oświęcimiu; 110–111.

Fritz-Bauer-Institut, ref. no. 4 Js798/64, vol. 7, pp. 1270–1292.

GARF archives, ref. no. f. 7021, op. 108, d. 46, pp. 36–40.

Jaworski, C.W. 1945. *Wspomnienia* [unpublished manuscript], APMA-B, Wspomnienia (Recollections), ref. no. vol. 4, p. 141.

Makowski, A. 1975. "Organisation, Entwicklung und Tätigkeit des Häftlings-Krankenbaus in Monowitz (KL Auschwitz III)." *Hefte von Auschwitz* 15, Verlag Staatliches Auschwitz-Museum; 113–181.

Pilecki W. 2014. *Freiwillig nach Auschwitz. Die geheimen Aufzeichnungen des Häftlings Witold Pilecki.* Zürich; 135.

Professor Antoni Kępiński on the concentration camp syndrome

Zdzisław Jan Ryn

"You can't understand something you have never experienced yourself, at least to a certain minimum extent." These are words Antoni Kępiński used to describe the subject and atmosphere of the world of schizophrenia, yet this could just as readily apply to his work on Auschwitz. Alongside its undeniable scientific value, his research on the Nazi German concentration camp of Auschwitz-Birkenau is striking for its profound authenticity and shows his personal attitude to the subject, as well as to the people who were incarcerated in the concentration camps. Today we know that Kępiński himself was an inmate of the Spanish concentration camp Miranda de Ebro, which cost him two years of his youth. So we may well be surprised that he never mentioned this period of his life in his conversations with friends, nor wrote about it in his publications.

About the author: Zdzisław Jan Ryn is Professor of the Chair of Psychiatry at the Jagiellonian University Medical College and of the Chair of Clinical Rehabilitation at the University of Physical Education in Kraków. A former Vice Dean of the Faculty of Medicine at the Kraków Academy of Medicine (1981–1984) and Head of the Department of Social Pathology in the Chair of Psychiatry at the Jagiellonian University Medical College (1984–2009), he is one of the most prominent Polish researchers into concentration camp pathology. Member of the editorial team of the scientific annual *Przegląd Lekarski – Oświęcim* and consultant of the Medical Review Auschwitz project.

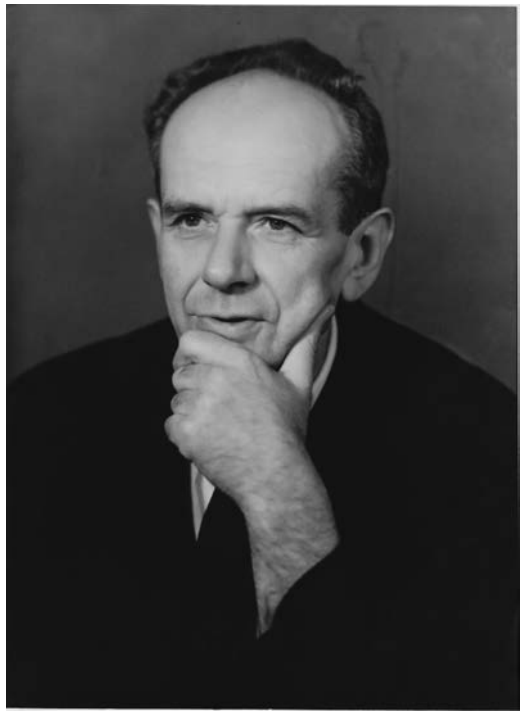


Photo 1. Prof. Antoni Kępiński. Photograph from the Author's private collection

INSPIRATIONS

Decades later, once Kępiński's letters sent from Miranda to his parents in Kraków had been rediscovered and published, and compared with the scientific work on concentration camps he had been conducting for such a long time, it was obvious that his personal experience of a concentration camp, which he chronicled in full detail in his letters, was the inspiration and starting point for his subsequent general scientific observations, which went far beyond the subject of concentration camps and medicine as such. Kępiński used to say that oftentimes extreme situations leave just as indelible a mark on the human personality as psychosis. He tried to conceal the trauma of the concentration camp he had been through, yet it had a permanent effect on his professional commitment. Kępiński launched the systematic research project that started in the early 1960s in the Psychiatric Clinic of the Kraków Medical Academy. The first papers published under the project were a pioneering endeavour, triggering a tide of scientific discussion and eventually leading to four doctoral dissertations on the following subjects: (1) the mental and psychological reactions observed in a hundred Auschwitz-Birkenau survivors under the impact of the psychosomatic stress they had experienced in the camp; (2) post-concentration camp asthenia in Auschwitz-Birkenau survivors; (3) socio-psychiatric aftereffects of confinement in a concentration camp; and (4) post-concentration camp personality changes observed in survivors. Kępiński's guiding principle was the deep conviction that, regardless of state of health, human individuals are integrated, supremely organised entities, and as such should not be examined from just one, narrow point of view. So he did not stop at examining just the psy-

chopathological aftereffects of concentration camp confinement. For him, human individuals meant an exceptional complexity of biological and sociocultural phenomena, associations, and influences subject to a dynamic process of change under the impact of the diverse factors acting on them in the course of their lives. Hence his insistence on the importance of observing and examining human individuals "lengthwise and crosswise," and treating such studies as components contributing to an endless diagnostic process.

MAIN ISSUES

The main issues in Kępiński's research on Auschwitz were the origins of the criminal ideology of Nazism; the psychology and psychopathology of its perpetrators and henchmen; the psychopathology of power, decision-making, and extreme situations; the situation of concentration camp inmates; psychosomatic integrity; the Concentration Camp Syndrome; and general reflections.

ORIGINS OF A CRIMINAL IDEOLOGY

In his book *Rytm życia* (Rhythm of Life), Kępiński examined the aims pursued by the death camps and the way they worked, and wrote that apart from their immediate political and economic purpose, there was a deeper sense: they were to purge the Germanic race of all that did not comply with the idea of the Germanic *Übermensch* (superhuman), of everything that did not fit in with the vision of a world of the healthy, the strong, and the beautiful, of everything that might be an obstacle—*Untermensche* (subhumans), the sick, the invalids, and the mentally impaired. So in line with the "aim justifies the means" rule, Germans were to do all they could to get rid of all that did not concur with that fine "ideal."

Man's ability to bring change into the world that surrounds him can be put into effect in many different ways. The Germans chose a criminal way to bring in change, by disseminating hate and committing murder and monstrous acts of cruelty on an unprecedented scale. This way of changing the world reflects the vast spectrum

of features that make up human nature and the paradoxes about them—ranging from altruism to unprecedented atrocity. If atrocity is the pattern to be followed, its implementation depends on the imposition of a power structure forceful enough to brainwash its executors and become the mainspring governing the way they think, feel, and behave.

THE PSYCHOPATHOLOGY OF POWER

Much of Kępiński's paper "*Anus Mundi*" is dedicated to a scrutiny of the psychopathology of power. In his opinion three concepts—responsibility, solitude, and dependence—put the attributes of power in a nutshell. Those subject to psychopathological power stop being themselves and follow their master, treating every gesture he makes as the epitome of truth and rectitude.

The ideology of Hitler's Germany was simple and straightforward, but never before had it been formulated and put into practice so systematically. The *Führer's* orders were the conscience of the Third Reich. Hence the notorious want of a sense of guilt observed in the war criminals for the atrocities they had perpetrated. Solitude is always an attribute of power. This comes from the "slanted" dimension of power with respect to its surroundings. The intentions the wielder of power has in mind may come up against obstacles, and if that happens, he will feel anxiety and aggression, which will inevitably lead to contention and destruction. Moreover, to keep himself in power he must distance himself off from the world around him.

In his paper "Z psychopatologii nadludzi" (Aspects of the psychopathology of the *Übermensche*), a study on the personality of Rudolf Höß, commandant of Auschwitz, Kępiński shows how far the internalisation of a criminal ideology can go, making its subjects blindly carry out orders. Although Höß had lived in an emotional vacuum ever since childhood, he was not an individual suffering from a psychic disorder. His world was segregated into enemies, leaders, soldiers, and prisoners. In the letters to his wife sent from the Polish prison, he wrote that only there had he learned what it means to be human. In his heart of hearts, he considered himself innocent—he had only been doing his duty. It was not on his own initiative, not by his own doings, that he had committed those crimes. Höß did not have a sense of humour. He thought

having a sense of humour could have posed a threat to his authority. He tended to compensate for his presumably sub-conscious inferiority complex, which is why he was ruthless in his determination to subordinate others to his power.

THE PSYCHOPATHOLOGY OF DECISION-MAKING

A salient part of Kępiński's reflections was devoted to the psychopathology of decision-making, which under concentration camp conditions was always connected with the exercise of power. Kępiński said there were three types of such decisions: 1) decisions on what is to happen to another person, 2) decisions taken by one who knew what was in store for him and decided to come out victorious, and 3) decisions made by those who did not know what lay ahead of them and took random and pointless action. These three types of decision-making occur in everyday life, too. But the question is whether and to what extent one has the right to take decisions concerning another person's life. There should be special standards established to regulate such decisions. But in the concentration camp situation, looking at another person from the point of view of standards might lead to an absurd conclusion, that what the SS did was "perfectly fair." Any standards adopted in connection with making decisions on another person's life call for a tremendous amount of commitment. The basic emotional decision—sympathy, antipathy, or nonalignment—involves a move closer to or away from that person. Of course, for SS men it was always a case of antipathy or detachment. If we take a detached, "technical" view of another person, we tend to lose sight of his human features, and that is probably one of the biggest dangers threatening contemporary civilisation. The work of the SS physician during selections on the ramp at Auschwitz marks the extreme end of the detached, "technical" view.

EXTREME SITUATIONS

In the concentration camp, extreme situations occurred on an everyday basis. Whenever inmates were put in situations where their lives were in jeopardy, they had to act quickly, and making the wrong decision meant death, the right decision

saved their life. In Kępiński's opinion, extreme situations do not give a good measure of a person's worth. Do we have the right to judge decisions inmates made when put in an extreme situation and compelled to weigh up the choices—oftentimes opposite choices—available to them? The conflict is due to the assumption we make that a decision is an act of will, and an individual's will is the supreme manifestation of his inner life. Such reasoning is based on an exceedingly Cartesian approach to the human person—a dualist model in which the body is guided and directed by the soul.

One of Kępiński's studies is entitled "Oświęcimskie refleksje psychiatry" (A psychiatrist's reflections on Auschwitz). In his opinion, everyday life in the concentration camp, with its roll calls and its dirt, its vilification of death and transformation of the human individual into a number, was the most insidious agent of destruction constantly assailing human nature. In the camps, Man's destructive inclinations released by the war reached their climax. The concentration camps were horrific not only for the massive scale of the cruelty in them, but also for their greyness, their negation of the colours of life. Their world was horrid, sad, and its hideousness and vacuity were repulsive—there was no flora or fauna, and the humans in them were segregated into those in uniforms and the rest in striped prison gear. Yet even in such a world there were faint, lingering signs of life, gestures of friendship, and above all prisoners could still escape into a world of dreams and memories of bygone times. These features were a genuine obstacle to the transformation of human beings into robots, which is what the oppressors wanted; because on the principle of contrast, the stronger the tendency to destroy becomes, the more intense the struggle to survive. The impact of such snippets of "heaven" in the concentration camp setting was so strong that oftentimes they determined an inmate's chances of surviving and still many years after the War marked the central highlight of his experiences in the camp.

THE CONCENTRATION CAMP SYNDROME

Kępiński's papers on the Concentration Camp Syndrome put the spotlight on the situation of the concentration camp inmate, emphasising the great difficulty—or in fact near impossibility—of those who have never experienced con-

finement in a concentration camp themselves to fully know what it was like for the prisoner.

He enumerates three crucial factors determining a prisoner's prospects: the huge range of experiences which the concentration camp had to offer, the integral nature of the human psychosomatic constitution, and something he called "concentration camp autism." Life in a concentration camp was a sort of "heaven and hell." Being sent down to that "hell" was a stress far surpassing any of the traumas inmates could have experienced in ordinary life. For many of them, it led to death, unless they managed to activate a special set of defensive mechanisms. In order to adjust to life in "hell," they had to become insensitive to everything that was going on around them—they had to adopt "concentration camp autism."

Kępiński's claim that the human psychosomatic constitution is an integrated entity finds its confirmation in the individual's situation at the beginning and end of his life, and also in any extreme situations he may happen to experience. At such moments, his subjective feelings overlap and combine with his objective experiences, and a mental breakdown may end in death or lead to the utter exhaustion of his physical powers. In Kępiński's opinion, nowhere was the significance and essential nature of psychotherapy, especially group therapy, so distinctly manifested, as in the concentration camps. Another instance of the psychosomatic unity of human nature was exemplified in the *Muselmann* condition. Wanting to survive the concentration camp was a necessary condition for survival. Prisoners who gave up the struggle for survival developed the *Muselmann* condition, which usually led to their death. A human individual whose world suddenly collapses is left lost and bewildered. Anxiety in all of its forms was part and parcel of the camp's everyday realities, paralysing prisoners' ability to activate mechanisms of self-defence. Nevertheless, those who were determined to survive were able to damp down the nagging thoughts of death on the front line. The prospects of an individual who is defiant in the face of death stretch out to a distant horizon, and he behaves as if death were far, far away. A soldier on the front line does not preoccupy himself with thoughts of death; neither were concentration camp inmates obsessed with thinking about death, instead they fixed their thoughts on how to survive. Kępiński's claim on this point seems debatable, because many survivors said that they never stopped thinking about death.

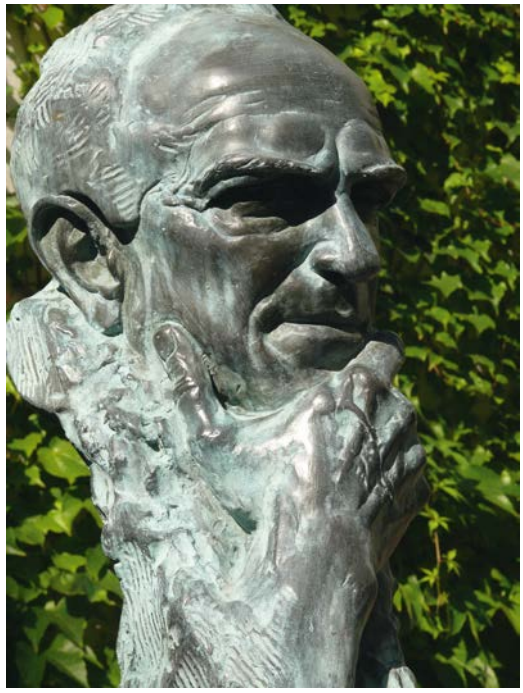


Photo 2. Bust of Prof. Antoni Kępiński in Zaułek Estreichera, Św. Anny 10, Kraków. Photograph by Z.J. Ryn

PERSONALITY DISORDERS

Most of the personality disorders observed in many survivors concerned three main aspects: the general dynamic of their activity, which they subjectively experienced as their mood; their attitude to other people; and their ability to control their increased level of irritability, irascibility, and distrust of others. The opposite traits determined by an increase in their activity dynamic, such as more trust in others or the ability to keep calm and poker-faced, were observed in some survivors. Most survivors kept in touch with each other, since they shared the same good and bad experiences and had a deep sense of empathy for one another. Yet there were others who kept themselves to themselves. Some visited the museums on former concentration camp sites, while others never attended such get-togethers. Survivors who avoided the company of other survivors were usually those who did not manage to "get over" the traumas they experienced in the camp, which they found too hard to recollect. Their hierarchy of values had changed and staked out a new set of aims. Survivors were often harassed by recurrent nightmares of their concentration camp experiences (the condition is referred to as the paroxysmal hypermnesia syndrome).

Kępiński's work on Auschwitz laid the foundations for a new philosophy of Man—a post-Auschwitz philosophy. One of the conclusions he drew from his studies on concentration camps was a ray of hope, all the more valuable because he had tried and tested it on his own experience. He wrote that what played the crucial role determining a prisoner's chance of survival in a situation of maximum

enslavement and degradation of his human dignity was his ability to exercise a choice and his determination to survive. Paradoxically, it was the inmates, not their oppressors, who had the option to make a choice. The individuals who were truly alive in the camp were those living on the verge of death.

A reflection of the paradoxes in Kępiński's personality is to be found in his publications:

— he was reserved and inscrutable, he didn't like talking about himself, yet he was brilliant at giving others the opportunity to express their emotions and bring out the best in them;
— he was concerned for the individual's freedom and autonomy, and at the same time he promoted a Christian humanitarianism which submits freedom to the requirements of responsibility;
— he was sceptic about the possibility of knowing all there is to know about the nature of Man, yet with his theory of energetic and information metabolism he pushed the limits to that knowledge out to a new horizon.

We cannot miss the link between these paradoxes and the story of Kępiński's life:

— he wanted to fight for his Country, but his patriotic feelings were frustrated when he was taken prisoner and confined in a concentration camp;
— he was prevented from putting his natural need for heroic deeds into practice, and instead had to bear with the complex of not taking part in what was going on in Poland;
— he dreamed of becoming a pilot in the Polish squadrons of the RAF, but was turned down on the grounds of being unfit for service in the air force; psychiatry was the option he was left with;
— he was a talented scientist and researcher, yet he suffered from a complex of psychiatry being an unscientific discipline, because he treated it as more of an art than a science.

REFERENCES

Kępiński, A. "Anus mundi." Bałuk-Ulewiczowa, T., trans. *Medical Review – Auschwitz*. August 3, 2018. https://www.mp.pl/auschwitz. Originally published in *Przegląd Lekarski – Oświęcim*; 1965: 150–161.

Kępiński, A. "A psychiatrist's reflections on Auschwitz." Bałuk-Ulewiczowa, T., trans. *Medical Review – Auschwitz*. May 20, 2019. https://www.mp.pl/auschwitz/. Originally published as "Oświęcimskie refleksje psychiatry." *Przegląd Lekarski – Oświęcim*. 1964: 7–9.

Kępiński, A. "Auschwitz reflections: "The Ramp." The psychopathology of decision." Jarosz, E., and Mizia, P., trans. *Medical Review – Auschwitz*. August 21, 2017. https://www.mp.pl/auschwitz. Originally published as "Refleksje oświęcimskie: rampa—psychopatologia decyzji." *Przegląd Lekarski – Oświęcim*. 1967: 52–60.

Kępiński, A. "Homo homini lupus est." Bałuk-Ulewiczowa, T., trans. *Medical Review – Auschwitz*. September 10, 2019. https://www.mp.pl/auschwitz. Originally published as "Homo homini lupus est." *Przegląd Lekarski – Oświęcim*. 1971: 165–167.

Kępiński, A. "Nightmare." Bałuk-Ulewiczowa, T., trans. *Medical Review – Auschwitz*. August 10, 2018. https://www.mp.pl/auschwitz. Originally published as "Koszmar." *Przegląd Lekarski – Oświęcim*. 1971: 54–58.

Kępiński, A. "Reflections on Auschwitz: The psychopathology of power." Jarosz, E., and Mizia, P., trans. *Medical Review – Auschwitz*. August 22, 2018. https://www.mp.pl/auschwitz. Originally published as "Refleksje oświęcimskie: psychopatologia władzy." *Przegląd Lekarski – Oświęcim*. 1967: 42–60.

Kępiński, A. "The so-called 'KZ-Syndrome': An attempt at a synthesis." Jarosz, E., and Mizia, P., trans. *Medical Review – Auschwitz*. August 21, 2017. https://www.mp.pl/auschwitz. Originally published as "Tzw. KZ-Syndrom. Próba syntezy." *Przegląd Lekarski – Oświęcim*. 1970: 18–23.

Kępiński, A., Kłodziński, S. "On the beneficial psychological activity of concentration camp prisoners." Kapera, M., trans. *Medical Review – Auschwitz*. August 27, 2018. https://www.mp.pl/auschwitz. Originally published as "O dodatniej aktywności psychicznej więźniów." *Przegląd Lekarski – Oświęcim*. 1973: 81–84.

Kępiński A., Masłowski J. "Dulce et decorum motif." Bałuk-Ulewiczowa, T., trans. *Medical Review – Auschwitz*. June 3, 2019. https://www.mp.pl/auschwitz/. Originally published as "Motyw Dulce et decorum." *Przegląd Lekarski – Oświęcim*. 1972: 71–76.

Long-term psychosomatic impact in Holocaust offspring: TreeGenes, a Multidisciplinary Research Study

Maria J. van Beurden Cahn and Jacques D. Barth

We acted crazy, we were sick and dirty, and we had become so very afraid.[1]

They knew that people were walking around with numbers on their arms, but there was nobody who saw this as particularly important. The Hunger Winter[2] had been truly terrible, I heard that over and over, so I kept my mouth shut because I was still alive.[3]

About the Authors: Maria J. van Beurden Cahn M.Sc., is Head of Historiography of the TreeGenes Study and Education Specialist at NIOD, Institute for War, Holocaust and Genocide Studies, University of Amsterdam, the Netherlands. Jacques D. Barth MD, PhD, FACC, FAHA, is a cardiologist and a professor at the Department of Cardiology of the Jeremiasz Research Foundation in Haarlem, Netherlands, as well as Professor of Family Medicine (Cardiology) at Keck School of Medicine, University of Southern California, Los Angeles, California, USA.

1 Citroen, 1999: 54.

2 Hunger Winter, aka Dutch famine, was a long-lasting period of food shortages in the Northern part of the Netherlands. See also https://liberationroute.com/the-netherlands/pois/t/the-hunger-winter and https://www.verzetsmuseum.org/museum/en/tweedewereldoorlog/kingdomofthenetherlands/thenetherlands/thenetherlands,june_1944_-_may_1945/the_hunger_winter [Accessed 10 August 2019].

3 Citroen, 1999: 111.

> After the war a strange optimism seized people. The pain of separation was still fresh. People were incapable of evaluating what had happened to them. The circulating blood knew more than the mind; nevertheless, there was a kind of optimism... The circulating blood already knew: the wound can no longer be sewn up. We are dry withered seeds; continuity will no longer come from us.[4]

> When I worked as a Docent at the Simon Wiesenthal Center (USA), survivors regularly came to talk about the Holocaust, usually accompanied by their own child, who always looked less healthy and less vital than the father or mother. An observation that in itself would not be so shocking, if it were not for the fact that at a reunion of my old high school class in 2006, at the only Jewish Lyceum in the Netherlands (the Maimonides Lyceum), I saw about the same. My companions, then in their early sixties, looked rather old and unhealthy.[5]

INTRODUCTION

Countless scientific publications on the Shoah from a myriad divergent disciplines have seen the light of day since 1945 and new ones are still appearing. But literature, personal observations, secondary sources and science rarely find a common denominator and acculturated perspective other than the topic the Shoah, which is extremely complex and seems to be hybrid.

A lot of research has been done both on the Shoah and on the aftermath of the genocide. Looking at all those publications, it is obvious that the concept of genocide as a somatic disease-causing phenomenon is quite rare and constitutes a rather unknown and underexposed theme. Studies on health issues of survivors do exist, but with the passage of time, they seem to be gathering dust on bookshelves. Research into the health of children of Shoah survivors (second generation, aka 2G) therefore seems a bridge too far. Nonetheless, children of survivors suffer from stress-related complaints directly connected with the Shoah and associated with severe illnesses. Diseases manifest in the descendants' bodies at a diverse, lower

4 Appelfeld, 1971: 82.

5 Interview with J. Barth. [Accessed 15 November 2014].

than average age and medical and biological researchers have been asking questions such as "why" and "how?"

Until now the 2G have been described merely in psychological terms.[6] Like their parent or parents (Shoah survivors), they may suffer from Post-Traumatic Stress Disorder (PTSD).[7] In general, symptoms of PTSD develop after the experience of (long-term) violent and life-threatening situations. The effects of PTSD may appear in descendants, as Rachel Yehuda, the best-known scholar on DNA and the transmission of genocide trauma to descendants, indicates.[8] This phenomenon has received the name of Transgenerational Transmission of Trauma (TTT) through epigenetic changes in DNA.[9]

This article touches upon the question of Transgenerational Transmission of Trauma in Dutch (Jewish) 2G. The physical effects of trauma in this particular group[10] are described as observed in the TreeGenes study.[11] The article shows the psychological perspective which determines and frames survivors and descendants.

There is no general data on the medical history of Jewish survivors and none on their children. Published research on the survivors' physical condition and diseases is scarce. The Netherlands is no exception to this rule. TreeGenes study started in this vacuum and had to create its own database to get insight into the (somatic) well-being of the 2G. In addition, this article gives its first written account of the measurements performed.

Instead of the more common term "Holocaust," the authors of this article prefer to use the word "Shoah" to describe the genocide of the Jews during the Nazi German occupation of Europe (1939–1945). This preference is based solely on the Jewish tradition of Zachor[12] and has no methodological consequences.

---

6 ICODO (now ARQ), https://www.de-basis.nl/over-ons/cogis [Accessed 15 November 2014].

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1297500/pdf/neh127.pdf [Accessed 10 February 2020] and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5126802/ [Accessed 9 February 2020].

8 Samuels, 2014.

9 Epigenetics refers to the study of alterations on genes that change the way the genes function. An epigenetic mark is literally a change to the gene or to the DNA environment that will then affect the way the DNA is read into RNA, and subsequently how RNA is expressed into a protein.

10 https://www.treegenes.nl/en [Accessed 1 September 2019].

11 https://www.treegenes.nl/en [Accessed 25 August 2019].

12 https://www.myjewishlearning.com/article/remembering-amalek/ [Accessed 25 August 2019].

PSYCHOLOGICAL PARADIGM

The history of survivors (the first generation, aka 1G) of the Shoah and their children (2G) has been described mainly from a psychological perspective. A general multinational overview on the children of Shoah survivors has yet to be written. Only Helen Epstein's *Children of the Holocaust*,[13] published in the late 1970s, examines the inter-generational transmission of trauma between sons, daughters, and parents who survived the Shoah.

Before Epstein's publication, the impact of the Shoah on survivors was already a topic for psychological and psychiatric research. Numerous studies were published on the KZ (*Konzentrationslager*) Syndrome[14] with its symptoms of anxiety, depression, sleep disorders, and reliving of provocative incidents. As such, an excellent overview of the psychological effects of the Shoah on 1G is *The Psychological and Medical Effects of Concentration Camps and Related Persecutions on Survivors of the Holocaust. A Research Bibliography*[15] and of a more recent date *The International Handbook of Multigenerational Legacies of Trauma*,[16] which mentions also the psycho-traumatic effects of the Shoah in 2G.

A study on the effects of the Shoah on children started shortly after the war. Psychiatrist Hans Keilson,[17] a Jewish survivor, researched the long-lasting effects of the war and genocide on war foster children (child survivors). His focus was primarily on the development of Dutch child survivors, their growing up, educational and emotional problems they encountered and how they were challenged by parenthood. In his conclusion he empathetically wrote that war foster children had to come to terms with a life without source family and their environment, i.e. Dutch society in general, had been pitiless to their special needs. They had had experiences incomparable to non-Jewish segments of the (Dutch) population.

A Dutch report in 2009 stated that in general 15% of the surviving Jewish population did not want to have children owing to the Shoah, and about 50% limited the

13 Epstein, 1979.

14 Kępiński, 2005: 141–155.

15 Eitinger, Krell, and Rieck, 1985.

16 Danieli, 1998.

17 Keilson, 1978.

number of children they had to one or two. These results differed from the demographic figures for the average (i.e. non-Jewish) Dutch population.[18] From a psychological perspective, a lot of survivors tended to parentify their child or children, Nathan Kellermann pointed out,[19] referring to the complex psychological phenomenon of role reversal of children (2G) becoming parents as a result of the inability of (child) survivors to function as guiding teaching individuals.[20]

It is common practice in psychology to characterize the 2G as people who act with great vigilance as a result of parentification. The 2G were not allowed to be weak and the children were under constant pressure to perform extremely well. Often all the attention went to the war experiences of the parent or parents, and the 2G grew up in an atmosphere of silence and secrecy: the conspiracy of silence.[21]

Israeli psychotherapist Dina Wardi described the 2G by employing the metaphor of "memorial candles," as having great power and being replete with feelings, carrying and expressing an emotional burden, but also being a source of light and hope.[22]

SOMATIC EFFECTS AND CONSEQUENCES OF THE SHOAH

As indicated earlier, the concept of genocide as a somatic disease-causing phenomenon is quite rare and for a lot of researchers even a bridge too far, as can be concluded from the fact that such a concept has never been high on the research agenda anywhere.

The medical world of 1945 was simply not prepared to deal with the aftereffects of the genocide unleashed upon the Jewish people. In addition, no reliable medical tools were available to treat people who survived the concentration camps or in hid-

18 Agsteribbe, 2009.

19 Kellerman worked as the Research Director at the Israeli treatment center for Holocaust survivors and their families, Amcha and lectured on Holocaust trauma at the International School for Holocaust Studies in Yad Vashem.

20 Kellermann, 2009: 21.

21 https://www.researchgate.net/publication/276849734_The_Danieli_Inventory_of_Multigenerational_Legacies_of_Trauma_Part_II_Reparative_Adaptational_Impacts [Accessed 27 August 2019].

22 Dasburg, 2000: x.

ing, not to mention the complex of unknown diseases in combination with the suffering as a result of loss of family members and continuing uncertainty about one's fate. *Auschwitz Survivors: Clinical-Psychiatric Studies*, edited by Zdzisław Jan Ryn, is an exception.[23] His book contains two articles on asthenia, an abnormal physical weakness and lack of energy,[24] and gives references to other medical articles.[25]

As a result of the complex new situation, most Jewish survivors lacked customized care. In the context of the Netherlands, after the war survivors came directly into the regular medical circuit. As the western half of the country had suffered from the Hunger Winter, a period of severe food shortage, hunger edema was the most common disease. It is estimated that between 25,000 and 50,000 died within a couple of months. Cases of hunger edema as well as tuberculosis automatically led to hospitalization. Supplementation with a protein-rich diet and bed rest was the prescribed therapy in both cases.

In the fifties, authors in France, Denmark, and Poland reported on the long--lasting physical damage to survivors, with some slight references to psychic effects. In the literature there is general agreement about the long-lasting effects of starvation, infectious diseases, torture, and massive trauma.[26]

The clinical findings of long-lasting somatic damage were corroborated in a well-controlled epidemiological study in Norway in the first generation. But the emphasis on somatic findings seems to remain characteristic of the literature from Eastern and Central European countries during the sixties and seventies.[27]

FACTS ON METABOLICS AND SOMATICS

From the physical viewpoint, it has been established that survivors tended to suffer more from different chronic diseases than the general population, though their mortality was relatively low. Many survivors reached old age, and the longevity

23 Ryn, 2005.

24 Szymusik, 2005. 69–82. Jakubik, 200: 299–308.

25 Ryn, 2005: 312–324.

26 Eitinger and Krell, 4.

27 Eitinger and Krell, 5.

and life expectancy of 1G was higher compared to the 2G, which was attributed to "survival of the fittest," additional medical and social care for the survivors and the (psychological) sacrifice of the 2G to keep their parents alive.[28]

Especially in Israel, some research has been done on the Shoah in relation to survivors and their offspring. In 2008, two Israeli doctors, Elizur Hazani and Shaul M. Shasha from the Western Galilee Hospital in Nahariya, were the first to raise the question of the effect of the Shoah on the physical health of survivors' offspring. In the review article "Effects of the Holocaust on the Physical Health of the Offspring of Survivors,"[29] they found that very little was known on the medical effects of the Holocaust on the second generation, and observed that

> The effects of the Holocaust on the second and third generations of the offspring of survivors have been discussed extensively in the scientific literature in Israel and abroad, particularly with regard to behavioral and mental aspects. However, very little is known about their physical health.[30]

It was suggested that pregnancy in times of hunger and stress, which were an integral part of life during the Shoah and affected the health of survivors, might have also affected the health of their offspring, and not only in the immediate postnatal period, but also throughout their adult lives.

Of particular interest is the possible emergence of medical problems, such as diabetes and cardiovascular and bone disease (osteoporosis), later in life. Moreover, there are indications that this effect does not stop at first-generation offspring but continues to affect the second and third generations as well. It is therefore possible that the Holocaust scarred not just the millions of people who lived through it, but its stigmata are passed on to their children and children's children.[31]

The authors asked a follow-up question, which was whether the changes caused by severe malnutrition during pregnancy are hereditary.[32]

---

28 Fund, Ash, Porath, et al. 2016: 232–244.

29 Hazani, Sasha, 2008: 251–255.

30 Hazani, Sasha, 2008.

31 Hazani, Sasha, 2008.

32 Hazani, Sasha, 2008.

Lital Keinan-Boker and her collaborators made the association between being born in Europe during the Second World War and the possibility of physical long-term outcomes in child-survivors (1G).[33] Relying on findings of studies addressing outcomes of war-related famine in non-Jewish populations in Europe during the Second World War, which confirmed the existence of association between prenatal or early-life exposure to hunger and adult obesity, diabetes, hypertension, cardiovascular heart disease and the metabolic syndrome, Keinan-Boker concluded that child survivors were a high-risk group for chronic morbidity.[34] Fetal programming was suggested as the explanatory mechanism.[35]

Neuropsychologist Rachel Yehuda, director of the Traumatic Stress Studies Division at the Mount Sinai School of Medicine (New York, USA) found that a much higher percentage of Shoah survivors' children and grandchildren suffer from certain specific physical complaints and issues when compared to control groups. Her research results from 2015 received mainstream media attention. For the first time the causative link between genocide survivors and epigenetic changes[36] in their children and grandchildren had been established.[37] Transgenerational Transmission of Trauma became a fact of science (see Figure 1).

---

33 https://www.ncbi.nlm.nih.gov/pubmed/26040044 [Accessed 27 July 2019].

34 https://www.hongerwinter.nl/publications/?lang=en [Accessed 25 August 2019].

35 https://www.ncbi.nlm.nih.gov/pubmed/26040044 [Accessed 27 July 2019].

36 https://www.researchgate.net/profile/W_Scheenen/publication/51527064_Epigenetics_DNA_demethylation_promotes_skeletal_myotube_maturation/links/569cd27e08ae5c9fe6bfb4fa.pdf [Accessed 9 February 2020] and http://www.molepi.nl/uploads/publicaties/2013/2013_mill_nat_rev_genet.pdf [Accessed 7 February 2020].

37 From an interview with Rachel Yehuda: "One of the first observations was that in women who had been exposed to starvation, they tended to have babies that were born with altered enzyme activity and were at subsequent risk for hypertension and metabolic syndrome, simply as a consequence of maternal starvation during the pregnancy. Now, the enzyme that was altered is also an enzyme that is related to glucocorticoid function. It's a very interesting enzyme. It's an enzyme that converts active cortisol to inactive cortisol. And cortisol is a glucocorticoid. So, we were very interested in that because we wondered how much of our effects in offspring in general had to do with maternal starvation. And we did a study where we looked at Holocaust survivors, and we found that within the Holocaust survivors themselves, there were alterations in this enzyme. So, we then looked at the children of Holocaust survivors and found alterations in the enzyme in the opposite direction in the children, but particularly this was based on the maternal age during the Holocaust. So, mothers who were younger during the Holocaust transmitted a different enzyme change to their offspring, compared to mothers who were adults during the Holocaust. … Women who were in the second or third trimester gave birth to babies that had low cortisol if that mother had PTSD. If they were in the early stage of pregnancy, the first trimester, we didn't see the low

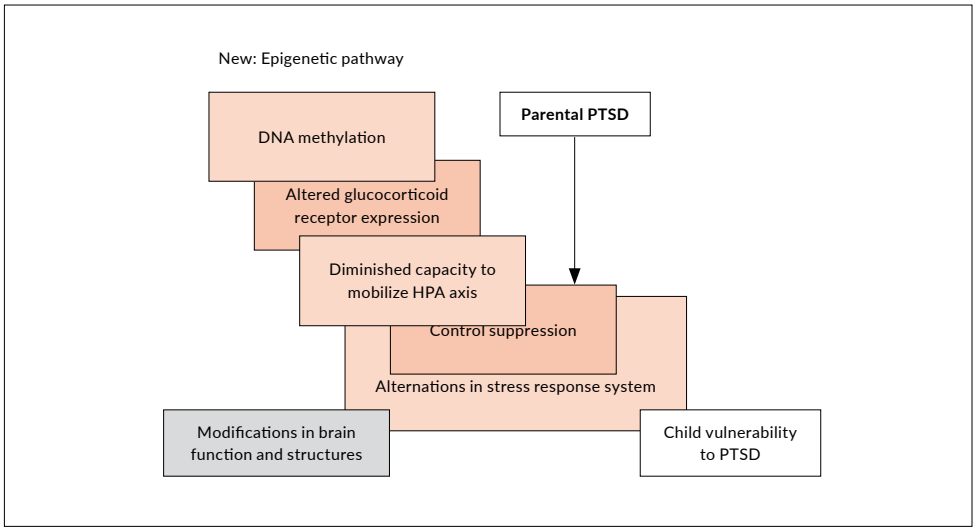


Figure 1. Proposed epigenetic pathway that may lead to changes in the 2nd generation (after Yehuda R, Lehrner A. "Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms." *World Psychiatry*. 2018;17(3):243–257. doi:10.1002/wps.20568)

To go from Keinan-Boker, Rachel Yehuda, other researchers mentioned above, and Kellermann, who wrote about a gap between the psychosocial paradigm and the somatic effects of the Shoah in "Epigenetic transmission of Holocaust Trauma: Can nightmares be inherited? and Past, present, and future perspectives of Holocaust trauma transmission,"[38] you only have to reason through theoretically to reach the TreeGenes study. As we did not have data on the physical health of the Dutch 2G, in the TreeGenes study we did not ask the "how" and "why" questions. Instead research had to be done to learn what the somatic, physical well-being of the Dutch (Jewish) 2G was.

cortisol effect. So, from this we learned that there must be some kind of an in-utero influence that interacts with the biology of PTSD, and a different result occurs." http://www.tabletmag.com/jewish-artsand-culture/books/187555/trauma-genes-q-a-rachel-yehuda. [Accessed 10 June 2018].

38 Nathan, Kellermann, 2011: 33–39.

THE TREEGENES STUDY AND THE 2G

Since the early 1970s the Dutch 2G have been reporting somatic complaints to medical authorities (mainly general practitioners). Sometimes, physicians and individual 2G related them to the Shoah. As the psychosocial paradigm ruled in the Netherlands as well, general practitioners referred 2G individuals to psychologists and psychiatrists.

Based on the the available results of the rare medical literature and personal observations (quote 3), the research question posed was very straightforward: do Dutch 2G have physical complaints and diseases similar to those of the 2G in Israel and the United States?

The TreeGenes study started in 2015, when more than two hundred 2G contacted the researchers independently, when they heard that a study was to be conducted within the small Dutch Jewish community (estimated at around 50,000 persons). The study raised enough enthusiasm and eagerness to find willing participants. The setup of the observational study was relatively simple. Potential research participants completed an exploratory questionnaire[39] on family background, physical complaints, career, hobbies, and feelings towards Israel. Subsequently a systematic database consisting of in-depth Oral History interviews was set up in accordance with the pioneering work of Dori Laub and his collaborators and the Fortunoff Video Archive for Holocaust Testimonies.[40] The format was in accordance with the description by Paul Thompson in *Voice of the Past*.[41]

Within a period of four and a half months, 66 audiovisual recordings of in-depth Oral History interviews were done by one historian, after which 38 participants were invited for a diversity of four noninvasive cardiovascular measurements.

As the medical research of Keinan-Boker has shown,[42] 65% of the 2G have an elevated high blood pressure. Already in the 19th century PTSD was described as "suffering in the soldier's heart," and the researchers decided to follow this intui-

39 The questionnaire was indirectly inspired by the Daniela Questionnaire. See: https://www.researchgate.net/publication/276849734_The_Danieli_Inventory_of_Multigenerational_Legacies_of_Trauma_Part_II_Reparative_Adaptational_Impacts [Accessed 25 August 2019].

40 http://fortunoff.library.yale.edu/about-us/our-story [Accessed 25 August 2019].

41 Thompson, 2000.

42 https://www.ncbi.nlm.nih.gov/pubmed/26040044 [Accessed 27 July 2019].

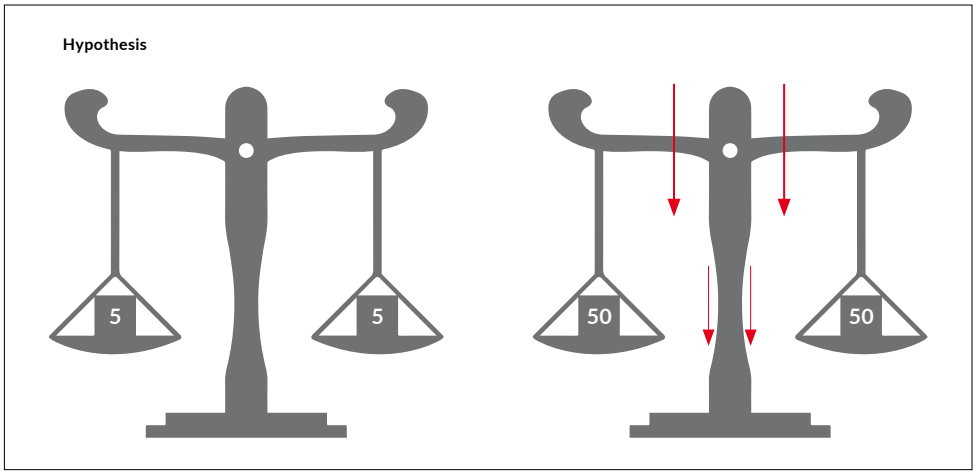


Figure 2. Proposed balance between resilience and trauma in a normal situation (left) and post-traumatic situation (right). The body is forced to generate more resilience to balance the effects of trauma, but both create a greater total burden

tion by performing noninvasive cardiovascular measurements as a preliminary examination intended to learn more about the physical condition of the study participants. Such measurements also meant that the burden on the participants who had already talked about their trauma and Shoah experience during the in-depth Oral History interviews would be relatively low.

The noninvasive cardiovascular measurements were performed by the cardiologist of the TreeGenes study (Jacques D. Barth). The following four parameters were assessed:

— Oxygen saturation,
— Heart Rate Variability,
— Blood pressure,
— Use of medication, including drugs.

OXYGEN SATURATION

This parameter measures the percentage of hemoglobin binding sites in the bloodstream occupied by oxygen. It is considered normal, at rest, if the values are between 93% and 97%. If the value is above 97% both left- and the right-side hyper-

ventilation should not be excluded. Chronic stress may be the culprit. If the value is below 93%, a lung disease, cardiovascular disease (or both) cannot be excluded.

HEART RATE VARIABILITY (HRV)

This measurement tool assesses how regular a beat to beat heart rate really is. Under normal conditions and in a healthy state of the heart, heart rate fluctuates in an oscilloscopic fashion. If the heart rate variability beat to beat is erratic or monotonous, there is a likelihood that the phenomenon is due to excessive stress. Some cardiologists consider this measurement a good estimate of the degree to which the heart is suffering from chronic distress.

BLOOD PRESSURE

Measurement of the systolic and diastolic blood pressure levels both on the right and left side indicate the level of blood pressure, hypertension, or both. In addition, the difference between systolic and diastolic values was measured, as this is another parameter of the absence of presence of distress. The higher this value is, the more likely stress will be.

USAGE OF MEDICATION

Participants were interviewed for their use of drugs and healthcare, as well as on their medical (family) history and sleep patterns.

Heart Rate Variability (HRV) was used as the standardized validated method to assess the level of chronic stress.[43] It is known that HRV is lowered both in PTSD

43 Saboul, Hautier, 2019: 45.

Results BP and BPM in TTT-offspring

	TTT-offspring (n=38)	Controls (n=38)	Significance level
Average systolic blood pressure (day)	160±32	159±21	NS
Average systolic blood pressure (night)	156±33	130±15	p<0.01
Average diastolic blood pressure (day)	96±26	91±11	NS
Average diastolic blood pressure (night)	91±29	80±16	p<0.05
Average heart rate (day) bpm	82±32	76±31	NS
Average heart rate (night) bpm	76±33	62±13	p<0.01

Table 1. Measurement results for the study group and the control group for blood pressure (BP) and heart rate (BPM = Beats Per Minute). TTT = Transgenerational Transmission of Trauma

Preliminary Results

Results in TreeGenes study in TTT-Offspring vs controls

	TTT-offspring	Controls	P
Chronic Cardiovascular disease	32/38	5/38	p<0.01
Psychotropic Medication	37/38	2/38	p<0.001

Table 2. Results for the study of TTT (Transgenerational Transmission of Trauma) for the study group and the control group

situations[44] and in metabolic syndrome.[45] Basic heart rate per minute was measured with an electrocardiogram. This measure appears to be a parameter for the Soldier's heart. It has been shown that PTSD veterans have an elevated basic heart rate (as found by the PRISMO Study[46] and DaCosta in his description of the Soldier's heart.[47]) Oxygen saturation was measured to exclude hyperventilating participants. The four measurements were supplemented with a medical interview.

CONCLUSIONS

Reviewing the charts between the control and the study groups, we found that several items showed a clear difference and may be related to the psychological

44 Shah et al, 2013: 1103–1110.

45 Stuckey, Chintale et al. 2014.

46 Van der Wal, Gorter, Reijnen, et al. 2019.

47 DaCosta, quoted after Thomas, 1918.

state of the 2G from 1980 until now. The amount and duration of psychoactive medication use is extremely high. Almost all participants in the study group were taking benzodiazepines with a clear predominance of diazepam at the time of their examination. Also other drugs were taken in abundance, notably the SSRI. Hardly any change in medication or dosage had been made for many years. In addition, almost all participants had been relying on psychological and or psychiatric support (for up to 40 years). The control population matched for age and gender did not rely on psychotropic medication or psychological support. In one aspect only did both the study and the control groups appear normal, namely there was only one smoker in each group. On the other hand, it would have been illogical not to expect chronic stress to induce physical problems.

The Dutch Hunger Winter study simply stated that the acute phase of the sudden and extreme winter of 1944/1945 resulted in damage to the mothers who gave birth at the time and their offspring, with both experiencing psychological and physical problems. Premature cardiovascular diseases occurred in this population with a significantly greater frequency. And although the TreeGenes Study is still a work in progress, the preliminary conclusions of the cardiovascular surrogate endpoints (see tables) can be linked to studies by Yehuda and Keinan-Boker and their respective research teams. The Dutch 2G are no exception to the rule of Transgenerational Transmission of Trauma, as the measurements brought the following findings:

The frequency of cardiovascular disease in the 2G participants is very high. It is significantly higher than would be expected as compared to a general population matched for age and gender. It is noteworthy that most cases are associated with an active disease.

The level of cardiac stress is very high, as almost all the patients had a higher than normal stress level as assessed by heart rate variability. This too was significantly higher than in a control group matched for age and gender.

Multiple cardiovascular risk factors, notably blood pressure, pulse pressure, and hyperlipidemia, are present and do not seem to be adequately addressed. It is of interest to note that hardly any of the participants were smokers.

Last but not least, there is an interesting observation of the high frequency of psychotropic medication use. Both benzodiazepines and SSRI usages were above average, and the dosage was extremely high. These drugs have been taken continuously for many years.

Preliminary Results
In TreeGenes TTT-Offspring has been suffering from significantly more **psychological problems** as compared to controls
TTT-Offspring has been using significantly more **psychotropic medication**
TTT-Offspring has had significantly more **Psycho-Social support**

Table 3. | The preliminary conclusions of the TreeGenes Study

Other somatic diseases present in almost all the participants may indicate the study population's desperate need to address other complaints, not to mention their need to rely on psychological and psychiatric assistance.

The preliminary findings of the TreeGenes study indicate that the participants' medical needs are not being met, given the number of complaints and diseases diagnosed. The overabundance of psychotropic medication use in addition to the need for long-term psychosocial support is noteworthy and should be addressed (see Table 3).

A synthesis of the in-depth Oral History interviews, the noninvasive cardiovascular measurements in conjunction with participants' medical history and their individual use of medication has not yet been accomplished. Such a combination of research on the phenomenon of genocide, medical data, and personal narrative has never been done before and proves to be a methodological challenge. It is an ongoing process. External experts from Israel and the USA are being consulted and deliver comments regularly. The content, reflection, methodology, and outcome of the in-depth Oral History interviews are not the subject of this paper. As the TreeGenes research is in process, more publications are to be expected.

REFERENCES

"About the Fortunoff Archive: Our story." http://fortunoff.library.yale.edu/about-us/our-story [Accessed 25 August 2019].

Agsteribbe, A. 2009. *Joods Maatschappelijk Werk report*. Amsterdam.

Appelfeld, A. 1971. *The Skin and the Shirt*. Am Oved; 82.

Barth, J.D. An interview. https://open.spotify.com/episode/33p8UeKneK2SAYUfMtv8nS. [Accessed 15 November 2014].

Citroen, M. 1999. *U wordt door niemand verwacht. Nederlandse Joden na kampen en onderduik*. Utrecht; 54.

Danieli, Y. (Ed.). 1998. *International Handbook of Multigenerational Legacies of Trauma*, New York.

Danieli, Y. 2015. "The Danieli Inventory of Multigenerational Legacies of Trauma, Part II: Reparative Adaptational Impacts." *American Journal of Orthopsychiatry*. 85(3):229–237. Doi: 10.1037/ort0000055. https://www.researchgate.net/publication/276849734_The_Danieli_Inventory_of_

Multigenerational_Legacies_of_Trauma_Part_II_Reparative_Adaptational_Impacts [Accessed 27 August 2019].

Dasburg, H. 2000. "Foreword." In: Wardi, D. *Memorial Candles. Children of the Holocaust*, London and New York; x.

Eitinger, L., Krell, R., and Rieck, M. 1985 *The Psychological and Medical Effects of Concentration Camps and Related Persecutions on Survivors of the Holocaust. A research Bibliography*. Vancouver.

Epstein, H. 1979. *Children of the Holocaust*. New York.

Fund, N., Ash, N., Porath, A., et al. 2016. "Comparison of Mortality and Comorbidity Rates Between Holocaust Survivors and Individuals in the General Population in Israel." *Neuropsychopharmacology*. 41(1): 232–244.

Greenberg, I. "Remembering Amalek." https://www.myjewishlearning.com/article/rememberingamalek/ [Accessed 25 August 2019].

Hazani, E. Sasha, S.M. 2008. "Effects of the Holocaust on the Physical Health of the Offspring of Survivors." *IMAJ*. 10: 251–255.

"Hongerwinter onderzoek." https://www.hongerwinter.nl/publications/?lang=en [Accessed 25 August 2019].

ICODO/ARQ. https://www.de-basis.nl/over-ons. [Accessed 10 February 2020].

Iribarren, J., Prolo, P., Neagos, N., and Chiappelli, F. "Post-Traumatic Stress Disorder: Evidence-Based Research for the Third Millennium." [Accessed 10 February 2020].

Jakubik, A. 2005. "The Treatment of Post-concentration Camp Asthenia." In Ryn, Z.J. (Ed.). *Auschwitz Survivors. Clinical-Psychiatric Studies*. Kraków; 299–308.

Keilson, H. 1978. *Sequentielle Traumatisierung. Deskriptiv-klinische und quantifizierend-statistische follow-up Untersuchung zum Schicksal der jüdischen Kriegswaisen in den Niederlanden*. Stuttgart.

Keinan-Boker, L., Shasha-Lavsky, H., Eilat-Zanani, S., et al., *Chronic Health Conditions in Jewish Holocaust Survivors Born during World War II*. https://www.ncbi.nlm.nih.gov/pubmed/26040044 [Accessed 27 July 2019].

Kellermann, N. 2009. *Holocaust Trauma. Psychological Effects and Treatment*.

Kępiński, A. 2005. "The So-called 'KZ-Syndrome.' An attempt at synthesis." In: Ryn, Z.J. (Ed.). *Auschwitz Survivors. Clinical-psychiatric Studies*. Kraków; 141–155.

Lancaster, C.L., Teeters, J.B., Gros, D.F., et al. 2016. "Posttraumatic Stress Disorder: Overview of Evidence-Based Assessment and Treatment." *J Clin Med*. 5(11): 105. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5126802/ [Accessed 9 February 2020].

Mill, J., Heijmans, B.T. "From promises to practical strategies in epigenetic epidemiology." http://www.molepi.nl/uploads/publicaties/2013/2013_mill_nat_rev_genet.pdf [Accessed 7 February 2020].

Nathan P.F. Kellermann, N. 2011. "Epigenetic transmission of Holocaust Trauma: Can nightmares be inherited?" *Israel Journal of Psychiatry & Related Sciences*. 50(1): 33–39.

Ryn, Z.J. (Ed.). 2005. *Auschwitz Survivors. Clinical-Psychiatric Studies*. Kraków.

Saboul, D., Hautier, C. 2019. "A New Algorithm to Reduce and Individualize HRV Recording Time." *J Med Syst*. 19; 43(3): 45. doi: 10.1007/s10916-019-1167-y.

Samuels, D. 2014. "Do Jews carry trauma in our genes?" *Tablet Magazine*, December 11, 2014. https://www.tabletmag.com/jewish-arts-and-culture/books/187555/trauma-genes-q-a-rachel-yehuda [Accessed 25 August 2019].

Scheenen, W. "Epigenetics: DNA demethylation promotes skeletal myotube maturation." https://www.researchgate.net/profile/W_Scheenen/publication/51527064_Epigenetics_DNA_demethylation_promotes_skeletal_myotube_maturation/links/569cd27e08ae5c9fe6bfb4fa.pdf [Accessed 9 February 2020].

Shah et al. 2013. "Posttraumatic stress disorder and impaired autonomic modulation in male twins." *Bio Psychiatry*. 1; 73(11): 1103–10. doi: 10.1016/j.biopsych.2013.01.019. Epub 2013 Feb 21. [Accessed 20 August 2019].

Stuckey and Chintale et al., *Heart rate variability and the metabolic syndrome: a systematic review of the literature*. First published: 10 May 2014. https://doi.org/10.1002/dmrr.2555 [Accessed 25 August 2019].

Szymusik, A. 2005. "Progressive Asthenia in Former Prisoners of the Auschwitz-Birkenau Camp." In Ryn, Z.J. (Ed.). *Auschwitz Survivors. Clinical-Psychiatric Studies*. Kraków; 69–82.

"The Hunger Winter.": https://liberationroute.com/the-netherlands/pois/t/the-hunger-winter. [Accessed 10 August 2019].

"The Hunger Winter." https://www.verzetsmuseum.org/museum/en/tweedewereldoorlog/kingdomofthenetherlands/.

thenetherlands/thenetherlands,june_1944_-_may_1945/the_hunger_winter [Accessed 10 August 2019].

The TreeGenes Study. https://www.treegenes.nl/en [Accessed 1 September 2019].

Thomas, L. 1918. *The Soldier's Heart and Effort Syndrome*. London.

Thompson, P. 2000. *Voice of the Past*. Oxford.

Van der Wal, S., Gorter, G., Reijnen, A., et al. 2019. "Cohort profile: The Prospective Research In Stress-Related Military Operations (PRISMO) study in the Dutch Armed Forces." *BMJ Open*. 5; 9(3): e026670. doi: 10.1136/bmjopen-2018-026670.

Yehuda, R. An interview. http://www.tabletmag.com/jewish-arts-and-culture/books/187555/traumagenes-q-a-rachel-yehuda [Accessed 10 June 2018].

Resilience and the role of the doctor: The Auschwitz experience

Rael Strous

F.S. was born in 1927 as the second of seven children to a religious Jewish family. He received a traditional Jewish education in Budapest until the age of seventeen. On July 7, 1944, F.S.'s entire family was sent together with approximately 850,000 Hungarian Jews to Auschwitz-Birkenau.

After a traumatic journey in a sealed livestock wagon, he arrived in Auschwitz-Birkenau. He joined the crowd and heard, "Zwillinge raus!" (twins out). Because F.S.'s brother and he were strong and healthy and looked very much alike, although his brother was one year older, he was separated out by Jewish camp workers who whispered to them, "Stay on this side; you at least have a chance to stay alive." Soon he was taken to the medical laboratories of Dr Josef Mengele who headed the medical experimentations in Auschwitz. Since his brother had a beautiful singing voice while F.S. had a hoarse deep voice and could not sing, Mengele and his physicians decided to perform medical experiments on their vocal cords. They injected some unknown substance into the anterior neck of both boys, which immediately led to swelling, high fever, vomiting, hoarseness, and muteness, and a state of exhaustion for several days. His brother was incapable of swallow-

About the author: Rael Strous, MD, MHA, is a psychiatrist. He is the Director of the Department of Psychiatry, Maayenei Hayeshua Medical Center, and is full professor of psychiatry at Sackler Faculty of Medicine, Tel Aviv University, Israel.

ing for a prolonged time. These injections were repeated every 4–5 days for over 3 months, until Dr Mengele fled Auschwitz in October 1944. After the Death March (*Todesmarsch*) from Auschwitz, followed by 10 days in the freezing cold of winter in sealed livestock wagons, he was liberated from Sachsenhausen by the Russian army on May 5, 1945.[1]

In Prague, on their way back to Budapest, F.S.'s brother was hospitalized for complications resulting from the medical experiments; he lost his voice and underwent removal of one of his lungs. In June 1946, after a lengthy hospitalization, he died. F.S. returned to Budapest, however found no surviving family members. Due to severe respiratory complaints he too was hospitalized in Budapest for 7 months.

Following traumatic experiences during the Holocaust with the loss of his entire family including the death of his "twin" brother and his own severe medical complications after Mengele's experiments, F.S. recalls being faced with a dilemma: either to mourn for the rest of his life or to reconstruct his devastated life. He chose the latter. He emigrated to Israel in 1948, married and rebuilt his life. However, as a direct consequence of Mengele's experiments, he suffered from breathing and swallowing difficulties with constant hoarseness. In 1965, he became voiceless and communicated only in writing. At the sites of Mengele's injections, he developed malignancy with hyperkeratotic papilloma of the larynx and malignant deterioration to squamous cell carcinoma involving his oesophagus. He underwent extensive surgical intervention with over 20 surgeries. After 19 voiceless years, in 1984 he began to use an innovative external voice amplifier, enabling him to speak with an artificial voice. His family grew to include 2 children, 5 grandchildren and several great-grandchildren. He never developed any signs of depression, anxiety or PTSD. He expresses no anger or bitterness toward Dr Mengele and the other Nazi doctors. He attributes his ability to overcome adversity and even thrive after Auschwitz, to "his warm family upbringing despite poverty, his love of life and his ability to improvise and to find meaning in experience." He stated that in Auschwitz "one had to adapt accordingly." He feels that "survivors" of trauma need to "take control of their situation, mobilize inner strength and move on." He often quoted Primo Levi, whom he reports he knew in Auschwitz, who proclaimed, "The aims of life

1 Gesundheit et al., 2011.

are the best defense against death."[2] He also quotes his surgeon who, following his intensive restorative surgery, informed him that he had accomplished 50% of what was required—now F.S. had to complete the rest. Reflecting words of the psychiatrist Viktor Frankl (1905–1997, Vienna, Austria) who also survived some time in Auschwitz, he felt that ultimately finding meaning in every stage of his life is what enabled him to survive in a positive manner. His message of hope to the next generation was always "to look life in the eye with a smile." He states that he has not ignored his experience and feels that he constantly analyses it. However, when faced with traumatic experience, one can turn to tears or actively decide to grow; he maintains he opted for the latter.[3]

F.S.'s experience and response reflect a paradigm shift amongst many in a contemporary approach to psychiatric disorder focusing on the "healthy" rather than the "illness." This may be observed in several contexts including, but not limited to, the positive psychology movement. This approach to mental health emphasizes positive aspects of manifestations of human experience that make life worth living. Thus, instead of maintaining a focus on maladaptive behavior and negative thinking of the individual under periods of past or present stress, it encourages the influence of happiness, well-being, and positivity on the individual's psychological status. The increasing prominence of positive psychology, as noted in the individual case of F.S., claims to be shifting the agenda in the field.

Thus, despite inhumane experiments and a profoundly traumatic experience in Auschwitz, F.S. seems to have actively managed his experience and retained a positive outlook on life. This phenomenon epitomizes the concept of resilience which, one may argue, in many ways mirrors principles of positive psychology.

Resilience represents the transformative strength of the individual and the capacity to overcome adversity. Just like the case of F.S., the resilient individual believes, be it subconsciously or consciously, that traumatic experience strengthened him or her and resolves to survive and even thrive, despite the distressing exposure. In this manner, resilience may be defined as the "ability to adapt optimally following adversity, trauma, stress or threats to the self." It requires "flexible adaptation" to expected inevitable changes as a result of an adverse experience—be it a single

2 Levi, 2017.

3 Gesundheit et al., 2011.

or a chronic one—and the decision to move on. This optimally, but not necessarily, inculcates improvement because of the experience.

Resilience is a concept that is not fully understood and remains relatively uninvestigated and unexplored in psychiatry. However, an awareness of the phenomenon has been increasing since more sensitivity has been extended over the past few decades to the existence and profound influence of trauma in the life of individuals. For example, the existence of the diagnosis of "post-traumatic stress disorder" (PTSD) did not even exist prior to the 1980s. The question remains why the concept or phenomenon of resilience has been ignored.

Part of the reason lies with the fact that the field of psychiatry deals with illness and not with health. Epstein and Krasner have stated that resilience is the ability to react to stress in a healthy way, such that goals are achieved at minimal cost—be it emotional or otherwise. Thus the resilient person will function despite challenges while also potentially strengthening oneself. For the physician, resilience becomes critical to maintaining and promoting the excellence of health care.[4] Zwack and Schweitzer have indicated that resilience in physicians requires "mindfulness, self-monitoring, limit-setting, and attitudes that promote constructive and healthy engagement with (rather than withdrawal from) the often-difficult challenges at work." This would also include "acceptance of professional and personal boundaries, a focus on positive aspects of work, and personal reflexivity."[5]

While it is easy and even understandable to focus purely on the unspeakable horrors and trauma of Auschwitz, which dwarfs any other related psychological response associated with the hell of Auschwitz, the phenomenon of resilience as a prominent response cannot be ignored. Thus, while much has been written about the Holocaust and the almost inevitable PTSD, less is known about those who experienced extreme trauma (physical and psychological) but survived with a positive attitude.

Along these lines, it may be suggested that there are several potential outcomes following severe traumatic experience. These include chronic dysfunction, recovery, resilience, post-traumatic growth and various delayed reactions.[6] There are no

4 Epstein and Krasner, 2013.

5 Zwack and Schweitzer, 2013.

6 Bonanno, 2008.

rules or firm predictors of how individuals or communities will respond to trauma. Moreover, individuals may exhibit various aspects of each of these responses at different times and even simultaneously.

Regarding mechanisms of response related to resilience, based on the work of Rosenbaum and Covino amongst Vietnam prisoners of war, Kent and Davis list several components associated with resilience. These include "optimism, altruism, existence of a moral compass, a steadfast belief in something, faith, and spirituality, a sense of humor, presence of role models, mission or meaning in life, an ability to face fears, and a background of some training to become resilient."[7]

Interestingly, while resilience is often considered to the best response to previous or ongoing trauma, some have suggested that a simultaneous or alternative process of "posttraumatic growth" may even be more conducive to positive long-term outcomes. Posttraumatic growth refers to functioning and well-being over and above pre-trauma levels. Those exhibiting posttraumatic growth have a more fulfilling awareness of themselves and the world. This may include improved life appreciation, a sense of personal strength and a deeper spiritual life. Perhaps most importantly, posttraumatic growth may be expressed in more meaningful interpersonal relationships.[8] While resilience and posttraumatic growth may appear to be parallel and even complementary processes, it has been suggested that there is an inverse correlation between resilience and posttraumatic growth.[9] This would be so in cases where due to a strong resilience to trauma, no emotional response is engendered. This would therefore preclude any option of posttraumatic growth, since the trauma "is essentially ignored."

While the suffering of those at Auschwitz is well known and has been discussed, as described above, the phenomenon of those who exhibited resilience and posttraumatic growth is less appreciated. However, the experience of Jewish and non-Jewish doctors who were prisoners at Auschwitz and whether they exhibited any level of resilience, posttraumatic growth, or both, has been even less explored. Along these lines, there are two aspects to be considered. First, doctors' resilience to trauma in Auschwitz, and second, the doctor's role in helping other victims de-

7 Kent and Davis, 2010.

8 Tedeschi, 2004.

9 Levine et al., 2009.

velop resilience in the face of trauma at Auschwitz. Thus, the questions that need to be asked include: how did doctors manage to cope through the terror and dread of Auschwitz? How did they manage while functioning in their profession, while they themselves were suffering to the extent that all prisoners did in Auschwitz? These are questions that few have addressed. Most notably, Dr Ross Halpin superbly addresses the discussion. By means of his extensive in-depth research on the subject, he has detailed how doctors in Auschwitz survived—with an average of 20 months.[10] During this time, while many continued to practice their profession of medicine, they were in addition subjected to beatings, torture, and threat of death. Many survived and several did record their experiences. Halpin describes common elements from these doctors' memoirs. Following an exploration of these doctors in Auschwitz, the question must be asked—how did these doctors survive and even thrive to the extent that many did?

It appears from the doctors' behavior and responses that many utilized several characteristics, in order to cope. These included an intense, single-minded will to survive, various adaptive personality features, and several specific defense mechanisms.[11] They very seldom made any mention of self-pity. On the contrary they often downplayed their own suffering in order to find the strength to help others, thus not dwelling on their own suffering hell. Thus, they were able to concentrate on the condition and suffering of others. It is manifest that many so-called ordinary physicians, with their calling to be held to a high standard of professionalism despite the intense adversity of their situation in Auschwitz and other concentration camps, rose to the occasion, assisting and comforting fellow prisoners while practicing their noble calling in medicine.

Thus, even though they were suffering themselves in Auschwitz from the nature of their work experience and camp conditions and treatment, many physicians did manage to embrace resilience and at times even appear to thrive under the adverse conditions, despite their own misery. It may be suggested that traits of resilient doctors included the observation that these doctors used their calling in the field of medicine to find meaning in their lives. Thus, being preoccupied with their profession became a defense against their own psychological anguish.

---

10 Halpin, 2014.

11 Halpin, 2014.

Their single-minded resolute behavior to assist patients appeared to prevent their descent into depression and functional impairment. Ross Halpin, once again in his important work exploring the mindset of the Auschwitz doctors, suggested that there are several cardinal personality features of the resilient doctor. These include "hardiness, determination, responsibility, self-esteem and perseverance." He notes that these are personality traits that are generally attained early in life, but also develop over time. They are most usually associated with "family experiences and family values."[12] Being respected as physicians amongst both oppressors and the oppressed (victims) and maintaining the company of others in the same situation also contributed to the ability to survive under such adverse circumstances. This latter aspect can be noted, for example, in the case of Dr Giselle Perl, who spoke of her "team" of medical helpers.[13] Dr Louis Micheels, a Dutch doctor who survived Auschwitz, described how the better conditions enjoyed by physicians in Auschwitz were shared between everyone and that the relationships between doctors gave them a "sense of being human." Thus, he states that "when human values can be preserved in a small group, this protects against disappearance of all sense of refined conduct and thus gave a reason to survive."[14] Similarly, along these lines, Dr Margita Schwalbova, another physician prisoner in Auschwitz, noted, "I was only able to function in Auschwitz by working with my colleagues."[15] Dr Sima Vaisman reported that "[she] tried to gain humanity despite hate [she] had for [her] SS tormentors. This [she] did by maintaining an atmosphere of gossiping and laughing amongst themselves."[16] From the perspective of patients, Halpin quotes Staub, who noted that interaction with patients gave the physicians a "positive identity" which appeared to encourage their development of resilience and survival ability.[17]

Other traits that Halpin has associated with resilience in doctors include constructive "early family relationships", with the doctors describing their childhood

12 Halpin, 2014.

13 Perl, 1948.

14 Micheels, 1989.

15 Halpin, 2014.

16 Vaisman, 2005.

17 Halpin, 2014; Staub, 2003.

in a positive fashion. Family factors included cohesion, warmth, a sense of humor and harmonious surroundings. He notes that the families of these resilient doctors were not wealthy, but were successful in some manner. Their parents set boundaries and limits for their children and expected their children to complete their education. In this manner, Halpin maintains that from a young age the doctors developed self-esteem, determination and compassion.[18]

Furthermore, in order to cope, Halpin has suggested, on the basis of the work of several psychoanalysts including, most notably, George Vaillant, that the doctors made use of defense mechanisms in their resilient behavior. These included the defenses of altruism, sublimation, anticipation, rationalization, fantasy, hatred, and passive aggression.[19] All these may have assisted the doctors in performing their duty by reducing anxiety, increasing self-esteem, and providing a meaning and a reason to survive. Interestingly, physicians most likely were faced with ethical conflicts, often being forced into situations where they were required to function with minimal, or no resources. Survival and even thriving under such conditions of conflict is not an easy task. Physicians were required to weigh up the best interests of their patients and fellow prisoners and the conditions which they were facing. At times they were confronted with the threat being punished themselves or killed while caring for others. Often they required moral distancing in order to detach from their patients suffering patients, suffering as prisoners and because they were ill. The doctors thus required their own inspiration. Dr Lucie Adelsberger reported that she had kept a copy of *Robinson Crusoe* with her in the labor camps. Crusoe's ingenuity, hope, and ability inspired her to survive, thus engendering resilience and motivation to survive.[20]

If the doctors suffered so much, how could they have assisted their patients in developing their own resilience? There were many reports of the Jewish (and several non-Jewish) doctors who did just this—many of whom did not survive their time in Auschwitz. They practiced their profession of medicine while instilling resilience in their patients to the best of their abilities in those circumstances. It has been said that they did this with courage and compassion.

---

18 Halpin, 2014.

19 Vaillant, 1992.

20 Adelsberger, 1995; cited in Halpin, 2014.

A central trait that has also been described in these doctors at Auschwitz was comforting patients in situations when that was all that the physicians had by way of resources and equipment. For example, Dr Giselle Perl comforted hysterical patients and told them that they would be OK, even though they were about to die.[21] Similarly, Halpin mentions several other examples of physicians giving phenomenal comfort when that was all they had available to assist patients. For example, Dr Alina Brewda would comfort and reassure pseudo-medical research subjects in Block 10. In doing this, it appeared that she even gained respect from some SS doctors. A witness at the libel case brought by Dr Dering against Leon Uris reported the following: "Because of the pains I screamed. … Dr Alina Brewda put her hand on my cheek and consoled me, then she said 'Don't worry my child, it will pass quickly.'"[22] Another physician in Auschwitz, Dr Rosenzweig, noted, "[W]e cured mainly with good words, sitting with patients and listening to their complaints." Dr Louis Micheels described how by hating and resisting their guards but at the same time assisting prisoners in an altruistic way, they were able to maintain a modicum of "dignity and self-esteem."[23]

Dr Viktor Frankl, the psychiatrist who spent time in Auschwitz, but practiced medicine in other circumstances as a prisoner in other labor camps, described one particular experience as follows:

> I made a quick last round of my patients [just before I intended to escape]. … Suddenly I decided to take fate into my own hands for once. I ran out of the hut and told my friend that I could not go with him. As soon as I had told him that I had made up my mind to stay with my patients, the unhappy feeling left me. I did not know what the following days would bring, but I had gained an inward peace that I had never experienced before. I returned to the hut, sat down on the boards at my countryman's feet and tried to comfort him; then I chatted with the others, trying to quiet them in their delirium.[24]

Dr Giselle Perl fought hard not to fall into despair and wanted to find "hope in hopelessness."[25]

---

21 Perl, 1948.

22 Halpin, 2014.

23 Micheels, 1989.

24 Frankl, 2006.

25 Perl, 1948.

Many of the doctors who were confined in Auschwitz for a long time, were faced with the dilemma of how much to tell other prisoners, especially the new ones, about the nightmare of Auschwitz. Many agreed that in order to keep their spirits up, encourage resilience and diminish despair, it would be better not to explain their fate to those on their way to the gas chambers. Dr Sima Vaisman stated, "What good would rebellion be? Their action would serve no gain, their moral and physical torture would only be greater."[26] There were also doctors who encouraged patients to behave in accordance with the moral principles despite the conditions, thus inspiring fellow victims to distance themselves from what Primo Levi termed the "gray zone."[27]

The doctors attended to all that they could—for example, they worked diligently to dress wounds and set broken bones, even though often their efforts were futile. Halpin describes how they refused to to allow fellow prisoners—their patients—to be deprived of their dignity. They tried to remember their names and motivate them to look after their health the circumstances.[28]

The phenomenon of resilience in physicians functioning in their profession in Auschwitz presents a focus on a unique population of members of the profession. Interestingly, research on physicians' resilience is being conducted, however, the focus has always been on their burnout versus their ability to be resilient in the face of workload, administrative demands and time management.[29]

Research on physicians' burnout has documented various factors associated with the phenomenon. For example, Neufeld and Malin have shown that in medical students "satisfaction of competence, but not autonomy or relatedness, predicted an increase in their resilience." They suggest that what is required to sustain resilience and wellbeing is the promotion of motivation, and they emphasize competence.[30] Others, such as Mahmoud and Rothenberger, emphasize the development of stress management strategies in fostering resilience as well as medical environments maintaining a joint "culture of wellness and engagement."[31]

---

26 Vaisman, 2005.

27 Levi, 2017.

28 Halpin, 2014.

29 See e.g. Morali et al., 2018; Andolsek, 2018; Moorfield and Cope, 2019.

30 Neufeld and Malin, 2019.

31 Mahmoud and Rothenberger, 2019.

Interestingly, the fostering of togetherness and mutual respect amongst the doctors who worked in Auschwitz has been cited by many as a factor in their survival and resilience as physicians. Others have referred to personal and collective resilience, which is also reflected in the reports written by physicians who survived Auschwitz.[32] It may be suggested that the unique features of the character of the physicians imprisoned in Auschwitz, together with their training and professional values, were the factors which allowed them to develop resilience and perform at the highest professional level despite the circumstances.

The concentration camps in general and the doctors in particular proved Freud wrong. Freud stated, "try and subject a number of very strongly differentiated human beings to the same amount of starvation. With the increase of the imperative need for food, all individual differences will be blotted out, and, in their place, we shall see the uniform expression of the one unsatisfied instinct."[33] This was definitely not the case with many of the doctors and other prisoners in Auschwitz. Rather, the critical factor in human behavior is that individuals make their decisions based on their own values. Thus, despite being in a state of severe adversity, as described above, many doctors actively decided to live a life of meaning despite living in such horrendous conditions, thus opening up the way toward something bigger than themselves. This could have been expressed in their profession (in this case medicine), their religion, values, etc. The core of their resilience therefore was not the "what" but "how"—not so much what they were able to do, but instead how they behaved under the conditions.

Sherri Mandell, the mother of 13-year Kobi who was murdered near their home in Tekoa in May 2001, states that resilience is about becoming, not overcoming. To get over a traumatic experience, she says, you need to "expand to contain the new you," even though you may feel shattered. She notes that we always need to become greater, bigger, better, and that the "sense of vulnerability and fracture can lead you toward connecting to something greater than yourself, connecting to others and to the divine."[34] This sentiment of resilience can be reflected in the statement of Dr Giselle Perl, who, following Auschwitz, recalled that in Auschwitz she

32 Cf. Koh et al., 2019.

33 Cited in Frankl, 1963.

34 Mandell, 2015.

said to herself, "I will remain a human being to the last minute of my life … whenever that will come."[35]

The essence of this approach taken by physicians in Auschwitz, which made them responsible and resilient, is echoed in the words of Dr Viktor Frankl, who, based on his own experiences in Auschwitz and other Nazi labor and concentration camps, stated, "When we are no longer able to change a situation—we are challenged to change ourselves."[36] This is the power of reframing, as he goes on to say, "everything can be taken from a man but one thing—the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way." Thus, Frankl observes, "Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom."[37]

Eli Wiesel perhaps summed it up best by stating, "When I think about the Nazi doctors, the medical executioners, I lose hope. To find it again, I think about the others, the victim-doctors; I see again their burning gazes, their ashen faces. Am I naive in believing that medicine is still a noble profession, upholding the highest ethical principles? For the ill, doctors still stand for life. And for us all, hope. …"[38]

REFERENCES

Adelsberger, L. 1995. *Auschwitz: A Doctor's Story.* London: Robson Books Ltd.

Andolsek, K.M. 2018. "Physician Well-Being: Organizational Strategies for Physician Burnout." *FP Essent.* August (471): 20–24.

Bonanno, G.A., Mancini, A.D. 2008. "The human capacity to thrive in the face of potential trauma." *Pediatrics*. 121: 369–375.

Epstein, R.M., Krasner, M.S. 2013. "Physician resilience: What it means, why it matters, and how to promote it." *Acad Med*. 88(3): 301–303.

Frankl, V. 2006. *Man's Search for Meaning.* Beacon Press.

Frankl, V. 1963. *The Doctor and the Soul.* New York: Bantam Books.

Gesundheit, B., Reichenberg, E., Strous, R.D. 2011. "Resilience: Message from a 'Mengele Twin' survivor." *Psychiatr Serv.* 62(10): 1127–1129.

35 Perl, 1948, cited in Halpin, 2014.

36 Frankl, 2006.

37 Frankl, 2006.

38 Wiesel, 2005.

Halpin, R. 2014. *The Essence of Survival: How Jewish Doctors Survived Auschwitz.* Darlinghurst: Sydney Jewish Museum.

Kent, M., Davis, M.C. 2010. "The emergence of capacity-building programs and models of resilience." In: Reich, J.W., Zautra, A.J., Hall, J.S. (Eds.). *Handbook of Adult Resilience.* New York: The Guilford Press.

Koh, M.Y.H., Hum, A.Y.M, et al. 2019. "Burnout and Resilience After a Decade in Palliative Care: What Survivors Have to Teach Us." *J Pain Symptom Manage.* [Epub ahead of print].

Levi, P. 2017. *The Drowned and the Saved.* Simon and Schuster.

Levine, S.Z., Laufer, A., et al. 2009. "Examining the relationship between resilience and posttraumatic growth." *J Trauma Stress.* 22(4): 282–286.

Mahmoud, N.N., Rothenberger, D. 2019. "From Burnout to Well-Being: A Focus on Resilience." *Clin Colon Rectal Surg.* 32(6): 415–423.

Mandell, S. 2015. *The Road to Resilience: From Chaos to Celebration.* Toby Press.

Micheels, L. 1989. *Doctor 117 641: A Holocaust Memoir.* Yale University Press.

Moorfield, C., Cope V. 2019. *Interventions to Increase Resilience in Physicians: A Structured Literature Review.* New York: Explore.

Murali, K., Makker, V., Lynch, J., Banerjee, S. 2018. "From Burnout to Resilience: An Update for Oncologists." *Am Soc Clin Oncol Educ Book.* 38: 862–872.

Neufeld, A., Malin, G. 2019. "Exploring the relationship between medical student basic psychological need satisfaction, resilience, and well-being." BMC Med Educ. 19(1): 405.

Perl, G. 1948. I Was a Doctor in Auschwitz. International Universities Press.

Staub, E. 2003. *The Psychology of Good and Evil: Why Children, Adults, and Groups Help and Harm Others.* New York: Cambridge University Press.

Tedeschi, R.G., Calhoun, L.G. 2004. "Posttraumatic growth: Conceptual foundations and empirical evidence." *Psychological Inquiry.* 15: 1–18.

Vaillant, G.E. 1992. *Ego Mechanisms of Defense: A Guide for Clinicians and Researchers.* Washington: American Psychiatric Press.

Vaisman, S. 2005. *A Jewish Doctor in Auschwitz: The Testimony of Sima Vaisman.* Melville House Publishers.

Wiesel, E. 2005. "Without Conscience." *N Engl J Med.* 352: 15.

Zwack, J., Schweitzer, J. 2013. "If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians." *Academic Medicine.* 88: 382–389.

Julian Aleksandrowicz, physician of the hospital in the Kraków Ghetto, initiator of the Righteous Among the Nations Medal

Aleksander B. Skotnicki

Julian Aleksandrowicz was born in Kraków on 20 August 1908. In 1926, on finishing grammar school (VI Gimanzjum im. T. Kościuszki) he went up to the Jagiellonian University and enrolled in the Faculty of Medicine. In 1933, he graduated as a medical practitioner, and in 1934 obtained the degree of Doctor of Medicine on the grounds of a biopsic research project on bone marrow, which he had started when he was still an undergraduate.

In 1933–1939, he worked in St. Lazarus Hospital in Kraków, as an assistant to Professor Tadeusz Tempka, who was chief physician of the hospital's Ward One. In this period Aleksandrowicz's scientific and research activities focused on the properties of the anticoagulant heparin and ways to preserve and store blood.

About the author: Aleksander B. Skotnicki is a haematologist, internist, and transplantologist. A Jagiellonian University Professor, he is Head of the Chair of Haematology, Head of the Department and Clinic of Haematology of the University Hospital, Vice-President of the Kraków Medical Society, and a member of the Polish Academy of Arts and Sciences. He has been involved in social projects such as the provision of medical care to the Holocaust survivors from pre-war Kraków.

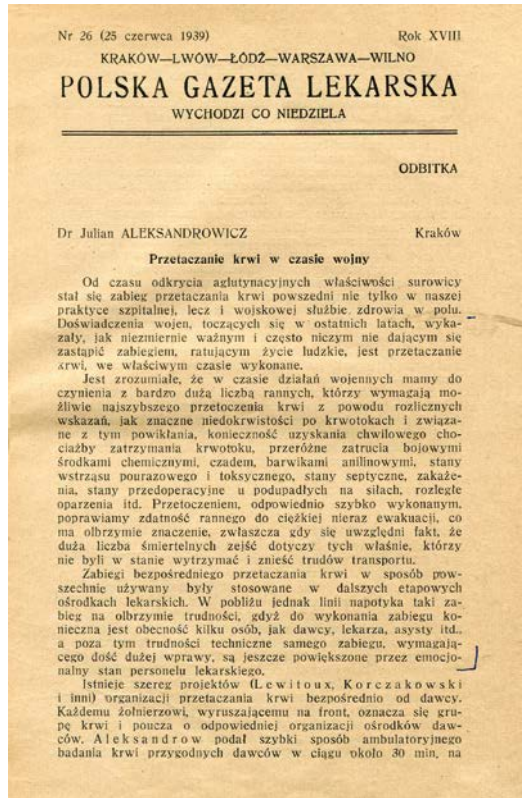
Photo 1. Julian Aleksandrowicz, 1938. All pictures in this chapter come from the Author's private collection

In 1935, at the age of 27, he published a paper entitled "O pośrednim przetaczaniu krwi konserwowanej" (On blood transfusion) in *Polska Gazeta Lekarska* (a major Polish medical journal). Two years later he patented a blood transfusion apparatus he had designed (Patent No. 27514, Republic of Poland 1937), and published a paper in the Warsaw medical journal *Lekarz Wojskowy*, with a full description of the application of this device in the military medical service.

On 25 June 1939—just a few months before the outbreak of the War—his article "Przetaczanie krwi w czasie wojny," on blood transfusions under wartime conditions, appeared in the medical weekly *Gazeta Lekarska*. In it he wrote,

> The wars fought in recent years have shown the crucial importance of blood transfusion, a treatment for which there is no viable alternative and which, if carried out at the right time, saves lives.
>
> Quite obviously, during combat there are many casualties requiring blood transfusion as fast as possible, for many reasons such as heavy loss of blood following haemorrhage and its associated complications, the need to stop a haemorrhage at least temporarily, poisoning due to a variety of substances used in chemical warfare, carbon monoxide or aniline dyes, post-traumatic toxic shock, septic conditions, infections, preoperative conditions in debilitated patients, extensive burns, etc. A blood transfusion done quickly improves a wounded patient's condition, giving him or her a better chance of enduring evacuation, which is often an exhausting procedure. This is particularly important in view of the fact that many fatalities occur because wounded people are incapable of surviving the hardships of transportation.

Hitherto blood transfusions have been performed in medical stations at a considerable distance from the front. It is extremely difficult to conduct a transfusion near the front line, because it requires the presence of several persons, the donor, the physician and his assistants etc., and because of the technical problems associated with the procedure, which calls for a considerable amount of experience on the part of the medical staff. An additional obstacle aggravating the situation is the emotional state of the medical team.



Nr 26 (25 czerwca 1939) Rok XVIII

KRAKÓW—LWÓW—ŁÓDŹ—WARSZAWA—WILNO

POLSKA GAZETA LEKARSKA

WYCHODZI CO NIEDZIELA

ODBITKA

Dr Julian ALEKSANDROWICZ Kraków

Przetaczanie krwi w czasie wojny

Od czasu odkrycia aglutynacyjnych właściwości surowicy stał się zabieg przetaczania krwi powszedni nie tylko w naszej praktyce szpitalnej, lecz i wojskowej służbie zdrowia w polu. Doświadczenia wojen, toczących się w ostatnich latach, wykazały, jak niezmiernie ważnym i często niczym nie dającym się zastąpić zabiegiem, ratującym życie ludzkie, jest przetaczanie krwi, we właściwym czasie wykonane.

Jest zrozumiałe, że w czasie działań wojennych mamy do czynienia z bardzo dużą liczbą rannych, którzy wymagają możliwie najszybszego przetoczenia krwi z powodu rozlicznych wskazań, jak znaczne niedokrwistości po krwotokach i związane z tym powikłania, konieczność uzyskania chwilowego chociażby zatrzymania krwotoku, przeróżne zatrucia bojowymi środkami chemicznymi, czadem, barwikami anilinowymi, stany wstrząsu pourazowego i toksycznego, stany septyczne, zakażenia, stany przedoperacyjne u podupadłych na siłach, rozległe oparzenia itd. Przetoczeniem, odpowiednio szybko wykonanym, poprawiamy zdatność rannego do ciężkiej nieraz ewakuacji, co ma olbrzymie znaczenie, zwłaszcza gdy się uwzględni fakt, że duża liczba śmiertelnych zejść dotyczy tych właśnie, którzy nie byli w stanie wytrzymać i znieść trudów transportu.

Zabiegi bezpośredniego przetaczania krwi w sposób powszechnie używany były stosowane w dalszych etapowych ośrodkach lekarskich. W pobliżu jednak linii napotyka taki zabieg na olbrzymie trudności, gdyż do wykonania zabiegu konieczna jest obecność kilku osób, jak dawcy, lekarza, asysty itd., a poza tym trudności techniczne samego zabiegu, wymagającego dość dużej wprawy, są jeszcze powiększone przez emocjonalny stan personelu lekarskiego.

Istnieje szereg projektów (Lewitoux, Korczakowski i inni) organizacji przetaczania krwi bezpośrednio od dawcy. Każdemu żołnierzowi, wyruszającemu na front, oznacza się grupę krwi i poucza o odpowiedniej organizacji ośrodków dawców. Aleksandrow podał szybki sposób ambulatoryjnego badania krwi przygodnych dawców w ciągu około 30 min, na

Photo 2. J. Aleksandrowicz's article on blood transfusions under wartime conditions in *Polska Gazeta Lekarska* (25 June 1939)

On the eve of the outbreak of the Second World War, Dr Aleksandrowicz, who had only recently graduated from the Jagiellonian University's Faculty of Medicine, not only proved his mettle as a knowledgeable, imaginative, and committed researcher (he had already published numerous papers in several international scientific journals), but also showed his profound sense of responsibility and concern for the health of Polish servicemen, who would soon be defending their Country on the battlefields.

In August 1939, 2nd Lieut. Aleksandrowicz was called up for service in the 72nd Infantry Regiment and took part in combat. He managed to escape from a POW camp and was back in Kraków by January 1940, but in 1941 he was confined in the Jewish ghetto, where he set up one of the four hospitals, the one designated for convalescents and the chronically ill, at Number 10 on the Józefińska, doing all he could to help patients.

Photo 3. | 2nd Lieut. J. Aleksandrowicz (standing first l.) during Poland's defence campaign, September 1939

During the deportation of the ghetto's inhabitants and the closing down of the Józefińska hospital, he saved the lives of several people, including Nurse Rega Jurowicz, whom he simply hid under his coat and reported that there were no more people in the hospital—knowing full well that he was risking his own life.

> Then came that fateful day, 13 March. The windows of my apartment looked out onto the street that bordered on the boundary of the wartime ghetto. Around five o'clock in the morning, I heard some hollering unusual for that time of day, hushed voices, and orders issued in German. I took a careful look. There were guards lining the wall—more of them than usual, crowds. I knew very well what was about to happen. Again there'd be yells from families that were being parted; again drunken soldiers would be playing their pranks, putting gun barrels to victims' heads and shooting point-blank; again the roads and pavements would be full of shattered skulls and spilled brains.
>
> I realised that with such a huge level of troops around, this deportation spelled the end of many centuries of the history of Kraków's Jewish community.

Photo 4. A Nazi German roundup of civilians outside St. Joseph's Church, Rynek Podgórski, Kraków, 1943

I'd been through several such operations. I knew they meant the mass murder of children, the feeble and unable to work, the slaughter of the sick, for whom there was no mercy in the Nazi German recipe to save the world.

I dressed as fast as I could. We notified the medical staff of what was going on, exchanging speculations. We had a quick talk and took an instant decision. The chief physician and the rest of the staff advised the patients to take whatever measures they could to save their lives, since the situation seemed dangerous. If the alert turned out to be a false alarm, they could always return. "Anyone who can make it should get out of the ghetto immediately." There was chaos, a most extraordinary tumult. Patients were dressing quickly, the nurses were busy helping them as much as they could. After a while, there was silence. Our little hospital was practically empty, all that was left were the bedclothes scattered in a disorderly way, pillows and sheets lying on the floor, boxes and papers which all said that a gale forecasting a tempest had passed by.

Four absolutely powerless persons were still in their beds. Four bedridden beings. Four pairs of helpless yet trusting eyes were staring into my face, looking for help. What was I to do with them? How and where to hide them? They were on their own, helpless, and had no strength left. There was a young labourer with pulmonary TB, a talented musician with

a precoma uraemic condition, an old man with a stoma bag following surgery for intestinal cancer, and another bedridden and blind old man.

What to do with them?

In my mind's eye I see a replay of the episodes I was an unwilling witness of on that Bloody Thursday. I get a rerun of those nightmarish scenes—patients terrified out of their wits, brutally thrown out of their beds, dragged by the legs along the corridors and down the stairs, their heads bumping up and down, the blood. …

"Now you must not let the helpless bodies of our patients, with the last drops of life and consciousness still lingering in them, be chucked like sacks of rubbish onto the platform of a lorry, dumped into a mass grave and buried alive." That was an order from my conscience.

I had this thought, "You know it's your duty to spare them the suffering, even at the expense of their lives. If you have not been able to get them to recover, you must help them pass away." Yet on the other hand, I felt that a physician was not allowed to terminate a life, even of an incurably sick person. After all, the assessment of the incurability might be wrong, unexpected recoveries may occur. But what other way out was there?

"Nurse! Please bring me a small glass of water," I said in a detached, matter-of-fact manner, once I had managed to calm down. I opened a tightly sealed test tube, extracted a pinch of its contents and dropped it into the glass of water. There was a faint waft of bitter almonds. "Please give each patient forty drops of this medicine. To all four at once." The nurses were dumbfounded and stared at me and at the chief physician with terror in their eyes. "Do it straightaway, on my responsibility," I said in a hoarse but resolute voice. "They'll pass away, at least spared the terror of death and the sight of the torturers. They'll fall asleep in their beds, and it'll be a great kindness."

On 13 March 1943, the day the ghetto was closed down, Julian Aleksandrowicz, his wife and his son got across "to the Aryan side" of the city via the underground sewerage canals. He spent the next year hiding in Kraków and its environs, thanks to the help of his former patients, co-workers, and Home Army and PPS (Polish Socialist Party) underground resistance units.

In the spring of 1944, Aleksandrowicz was transferred to Home Army underground combat units in the Kielce and Radom area, where he organised a medical

service for the Jodła Corps and took part in the fighting himself, as the commander of a platoon. He was later awarded the Virtuti Militari Cross for valour, the *Krzyż Walecznych* (Cross of Valour), the *Krzyże Zasług z Mieczami* (Crosses of Merit with Swords), and other military distinctions.

Dr Krzysztof Hoffman (*nom de guerre* Cyprian), a major in the 72nd Home Army Infantry Regiment, recalls Aleksandrowicz's bravery:

> I met Professor Aleksandrowicz when he was Lieutenant Twardy,[1] serving as our regimental doctor. I did not know his surname at the time, nor was I aware of his pre-war scientific achievements. He did not catch my notice until an operation in the environs of Radom in the autumn of 1944. The village in which his unit was located was attacked by a considerable German force. When artillery shells hit the village and started a fire, several of our wounded boys were stranded in burning cottages. Twardy and a few of his orderlies went out to save them. I remember him rolling about on the ground to put out the flames on his uniform, which caught fire twice, and afterwards running to fetch the other wounded men still left in the burning cottages. These and other instances of courage earned him the Virtuti Militari Cross, which the regiment's commander conferred on him after the War.

When the War was over, Dr Aleksandrowicz set up a survivors' treatment centre in Kraków. At the same time he started work as an assistant in the Internal Diseases Department, which was still directed by Professor Tempka.

While in the ghetto (1941–1943), Aleksandrowicz wrote a monograph on haematology and managed to take the manuscript with him when he escaped from the ghetto. He buried it in the ground when he joined the resistance forces fighting the Germans. After the War, he retrieved it and published it in 1946. His book, a fine publication of 263 pages with 12 colour illustrations and 45 microphotographs, was the first Polish postwar textbook of haematology.

In 1947 he obtained his postdoctoral habilitation degree from the Jagiellonian University Faculty of Medicine on the grounds of a dissertation entitled *Schorzenia narządów krwiotwórczych w świetle badań bioptycznych* (A biopsic study of diseases of the haemapoietic organs), which he had written during his period in the Kraków ghetto.

---

1 "Twardy," Aleksandrowicz's *nom de guerre*, can be roughly translated into English as "Hardy" [Editor's note].

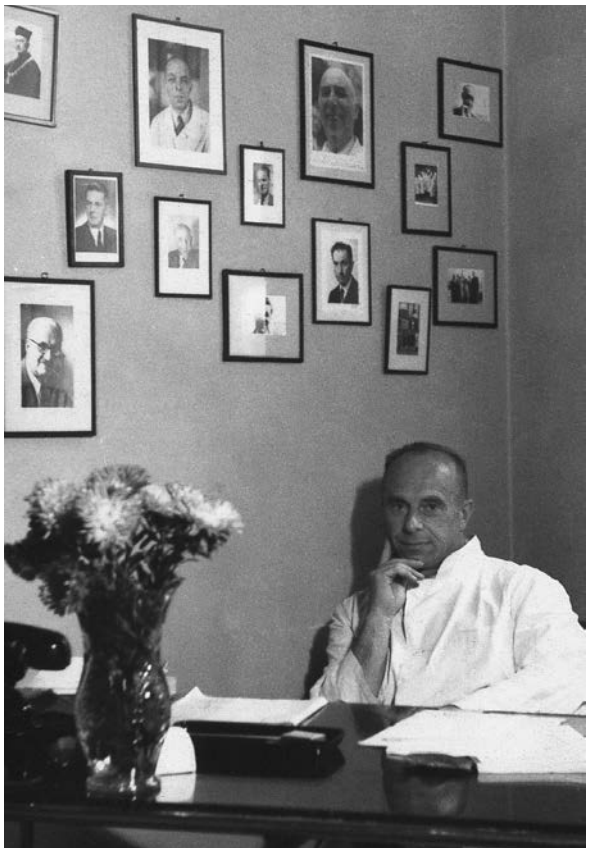


Photo 5. Prof. Aleksandrowicz, director of the Third Internal Diseases Department of the Kraków Medical Academy in his office

In 1949, the Polish Haematological Society (now known as the Polish Society of Haematology and Blood Transfusion) was founded on the initiative of Professors Tempka, Jakubowski, and Aleksandrowicz. It was the sixth organisation of its kind in Europe, after counterparts in France (founded 1931), Italy (1933), Germany (1937), Russia (1937), and Switzerland (1946). The American Society of Haematology was founded in 1958; the British Society for Haematology and the Hungarian Society of Haematology were founded in 1960. The Polish society held its first national congress of haematologists in Kraków in May 1950. 70 papers were delivered, and a 400-page volume of proceedings was published.

In 1950, Dr Aleksandrowicz was appointed head of a new medical unit in Kraków, the Third Internal Diseases Clinic, which was later transformed into

Photo 6. | Jewish citizens of Kraków performing forced labour near the Barbican

the Haematology Department. In 1951 he became a professor extraordinary, and was promoted to full professor in 1956. He was head of these institutions for 28 years, and when he retired, continued to work for another decade with what was then the Haematology Department of the Institute of Internal Medicine at the Kraków Medical Academy.

* * *

In the Kraków ghetto, Julian Aleksandrowicz not only saw hatred and cruelty, but there was also empathy, and individuals were ready to help their fellows on the verge of death.

> With every day, life in the ghetto became harder and harder. We were menaced by a dreadful sense of hopelessness. For another three years, the Allies would not be ready for action. Meanwhile … only work and bringing relief to the sick—those less fortunate than ourselves—let us keep some sort of psychological balance. Once a week, we were forced to do

manual labour. We swept the snow off the streets. Doing this chore, we took a lesson in practical psychology for everyday life. What a marvellous lesson! One day, a group of street urchins appeared and started to mock us, throwing snow and lumps of horse dung at us. A boy of eight joined them and was about to chuck a snowball at us, when his mother ran up and whispered something in his ear. The little one hung down his head and went away ashamed. The hooligans frowned in disbelief, resentment, and disappointment.

I recalled Gebirtig's poem "It hurts." Nonetheless, the bitterness of his words could not diminish my trust in human nature. I have always thought it shameful to ascribe an individual's bad behaviour to the whole of the social group he or she came from, and to blame that entire community for an individual's misdeeds. And this attitude to people and the world at large has never let me down.

One frosty afternoon, when we were out in the street again, sweeping the snow away, my patient, Mr Mroziński, a city councillor, who happened to be passing by, stopped in front of us surprised, and after a moment of hesitation came up to me. He tried to take my spade away. I resisted and said, "You're taking a risk of being insulted or offended. What if someone should notice you…" "Please, Doctor, let me stay just for a while. I feel an inner urge to do this. I have to show you and the others what I feel." So he stayed with us for a long time and swept the pavement on the Augustiańska, and whispered all the news broadcast from London into my ear.

Ardently patriotic Poles like the pharmacist Tadeusz Pankiewicz, Dr Ludwik Żurowski, and others, realised they would not be able to beat the invaders on their own, because the invaders' military potential far surpassed the forces of many of the Great Powers. So they chose another type of action—doing good and keeping up our hopes. They risked their own lives and those of their families and were unstinting with their money to save many people, getting them out of the ghetto and helping them to live in the "Aryan" part of the city. Their inexhaustible goodness went even further, right up to the Plaszow camp, whose inmates they helped by sending in food and medicines. By doing this, they risked their lives. Their warm-heartedness encouraged the unfortunates to keep hoping and trusting they would survive. And victory was theirs—for many, they restored faith in humanity, and that is why many survived.

Yet the psychological methods applied by the Nazi German system to influence and manipulate human nature and individual characters started to take their toll in the Kraków ghetto. Some Jews, such as Blodek, Foerster, Diamand, Gutter, the Handl brothers, Kleinberger,

Loeffler, Spitz, Streimer, Symche Spira, Ignacy Taubmann and others, turned into disgusting Gestapo informers.

But at the same time, we also observed the exact opposite. There were a few Germans—Oswald Bousko, Julius Madritsch, Oskar Schindler, Raimund Tisch and a couple of others—who saved hundreds of lives. There were many such people, but unfortunately, I don't remember all their names.

But why has the world forgotten them? Should we just be voicing reproof for the evil, but keeping an embarrassed silence about the goodness? Should we not be showing the right way to behave to all people—to all the miserable inhabitants of this planet lost in their hatred, in their desire for reprisal and revenge? Should we not do this, at least to educate society?

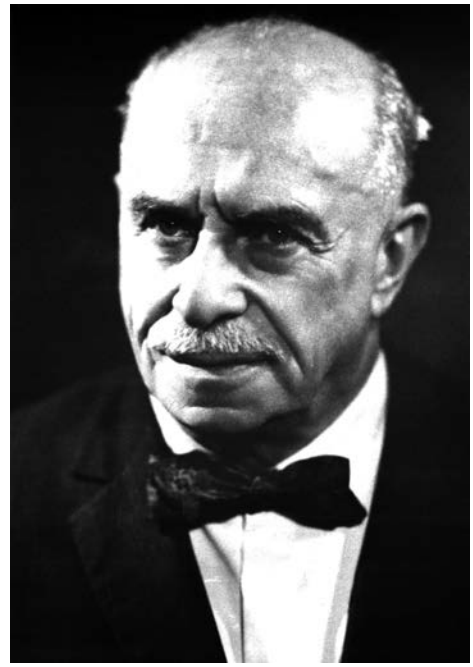


Photo 7. Prof. Julian Aleksandrowicz, Chair of the Commission for Mental Health Hygiene of the Polish Academy of Sciences. 1960s photo

Mindful of the fact that (in the words of Konstanty Gebert) "All over the world there were thousands of Jews alive because one day, decades ago, someone decided to risk their life to save a human being who was being oppressed by the most unrelenting death machine the world has ever known"—with this in mind, ten years after the War, Julian Aleksandrowicz appealed to the government of Israel to found a decoration to be awarded to those who proved their Humanity by heroically helping people whose lives were threatened, despite the danger imposed by the German invaders.

Aleksandrowicz wrote his letter to Prime Minister David Ben-Gurion in 1961, two years ahead of the Israeli government's decision to found the Righteous Among the Nations Medal, which has been conferred on over 27 thousand persons. Maybe

his letter prompted the government of Israel to make its 1963 decision? Here is what he wrote:

> Dear Prime Minister,
>
> On the eve of the Eichmann Trial, an event of major significance for social education worldwide, I would like to make the following suggestion:
>
> The condemnation of evil will be more pertinent if it is attended by the honouring of the humanitarian values latent in humankind, such as noble-mindedness, goodness, readiness to make sacrifices for the sake of the most honourable human criteria. Therefore, we venture to suggest that now, with the trial of Adolf Eichmann pending, the government of Israel as the best empowered authority, launch a project to pay tribute to those who, risking their own lives and those of their families, saved the lives of other people who were threatened with extermination.
>
> The intention behind the project would be to show young people all over the world that the concordant advancement of humanity is determined by the attitude a human individual takes with respect to his fellows—an attitude of sympathy and even of heroic assistance granted by the stronger to the weaker. … We should realise that in its definition of the complex criteria for good conduct, world opinion tends to castigate evil and neglect the bestowal of honours for righteousness. There is an inherent error in this from the point of view of moral education. … It is our profound belief that the condemnation of evil about to be expressed in the imminent court proceedings will not be as effective an educational instrument as it could be if at the same time evidence of Righteousness be not manifested to the world. In our opinion, this may be achieved, for instance, by the foundation of a special distinction to be conferred on those who have proved their supreme humanity and humanitarianism.
>
> We feel authorised to present this suggestion to you on the basis of an idea embraced by the members of the Kraków branch of the Society of Mental Hygiene, scholars representing diverse disciplines of science. We believe that the world's future depends on how much we know about harmonious co-existence with other people, and on the worldview we give the young generation. Displaying the small group of the TRULY HUMANE may serve as an example for future generations to follow.

During the Second World War, the lawyer and distinguished judge Leon Berenson was one of the inmates of the Warsaw ghetto. In 1905–1908, when Poland was under Russian rule, Berenson had acted as defence counsel for members of the Polish Socialist Party (one of them was Józef Piłsudski), who were on trial in the tsarist courts. In the ghetto, Berenson kept a diary, and the entries he made in it were successively smuggled out of the ghetto. He died of a heart attack on 22 April 1943, the third day of the Ghetto Uprising, leaving a request in his will that after the War Jewish people should erect a monument of gratitude in tribute to those Poles who smuggled food into the ghetto. He suggested the monument should take the shape of a loaf of bread mounted on a marble plinth.

On 19 August 1963, the Knesset passed a resolution to adopt an Act of Law on the commemoration of the Shoah, honour the bravery of the Righteous, and found Yad Vashem, the International Institute for Holocaust Research, which has its headquarters in Jerusalem.[2] This Act defined the tasks to be pursued by Yad Vashem in the newly created State of Israel.

The duty of Yad Vashem is to conduct a comprehensive range of research on the extermination of six million Jews in Europe under Nazi German occupation in 1939–1945. The basis for the activities of Yad Vashem is the postulate defined in the Act "to commemorate the Gentiles who provided assistance to Jews under Nazi German occupation." As of 1963, Yad Vashem has been paying tribute to persons who helped Jews during the years of Nazi German terror. It honours such individuals by conferring the honorary title of Righteous Among the Nations on them. Persons who have been honoured with this title have the right to plant an olive tree in the garden on the Mount of Remembrance in Jerusalem, with a plaque giving the name, surname, and country of the honoured person.

On 25 March 1985, the Knesset adopted an amendment to the Act, under which the Righteous among the Nations may be granted honorary citizenship of the State of Israel.

In the course of 26 years (1963–1989), Yad Vashem conferred 1,936 individual and group medals on 3,012 Polish people. To 2013, 6,394 Polish citizens received

2 The name "Yad Vashem" (Hebrew for "place and name") is symbolic and comes from the Scriptures (Is. 56: 5), from the passage where the Lord makes a promise to foreigners who keep the Covenant: "I will give to them in my house, and within my walls, a place, and a name better than sons and daughters: I will give them an everlasting name which shall never perish."

the distinction, and another 200 to 2018. Today (27 January 2020) the figure is over 6,600, nearly a quarter of the people in Europe who have received the medal.

According to the distinguished Jewish historian Professor Feliks Tych, ethnic Poles saved the lives of about 50 thousand Jews on territories under German occupation.

Righteous Among the Nations are still being identified and honoured—75 years after their generous, heroic deeds. Nowadays their medals are usually collected by their descendants.

We still know very little about the persons who risked their lives to save others. The objective of this meeting, like many similar events, is to save their stories for posterity, and to make their unprecedented acts of altruism a challenge and an example for us in the present times.

Those who saved Jewish lives deserve our respect and admiration. The purpose of this meeting is to inspire our listeners and readers with these altruistic deeds, and to pay homage to all the Righteous among the Nations, those whose names we know and those who are still anonymous. It is our intention to encourage people to say no to the passive attitude and become active citizens, trusting that our individual action means a lot. It will mean a lot, for instance if we react to every instance of intolerance that we encounter.

Chaim Hefer: Poem dedicated to the Righteous Among the Nations

Translated from Hebrew to Polish by Eva Aharonson, and from the Polish version into English by Teresa Bałuk-Ulewiczowa

I hear this title and I try
To think of those who stood me by.
"Dearest God," I ask and I peruse,
"Could I have done *that* if *I* were in their shoes?"
If torrents of fire and hatred my gate bestrode,
Could I have harboured foreign sons safe in my abode?
Could I have been prepared with all my kin
At all times to risk the unexpected ill?
Through sleepless nights always on the lookout be
For the sound of the tyrant's boots creeping up to me.
Could I have read every sign, never missed a hint,

Could I have walked upright, honest and distinct,
Amid the crowd of toadies, tossed by the tide of liars,
Not for a day or a week, but for so many years?
Here a beady-eyed neighbour, there a wave of whispered gossip expands,
For just the lending of warm and friendly hands…
Not for any profit, not for any clever plan,
Only 'cos a man must be human to his fellow Man,
'Cos a man proves his worth at life's hardest time.
So again I'll ask, I'll put this question of mine:
Could *I* defy as *they* defied?
Every day of the war they managed to stand firm,
They are the ones who saved my world,
Those pillars of strength, that Righteous throng,
Cornerstones that keep the world secure and strong,
For your brave stance, for the help you never spared,
I stand before You, Righteous Ones, and thankful bow my head.

In 1993 Mordecai Paldiel, later (1984–2007) Director of the Department of the Righteous Among the Nations at Yad Vashem, published a book entitled *The Path of the Righteous: Gentile Rescuers of Jews* (KTAV Publishing House). In the introduction to the book's Polish edition (*Sprawiedliwi wśród Narodów i ich znaczenie*), Dr Moshe Bejski, a judge of the Israel Supreme Court of Justice who originally came from Kraków, wrote the following words:

> [O]nly a Jew who was hunted like an animal threatened by danger on all sides, with no door opening to offer him shelter for the night before the curfew set in—only such a person can appreciate the significance of someone's readiness to give him a hideout in a corner of his cellar, stable or barn, and some soup or a glass of tea to stave his terrible hunger.

Dr Paldiel presents a broad spectrum of ways of saving Jews, and the dangers facing persons of good will who helped Jews, and the perils for the Jews they helped. They used a variety of hideouts, shelters, bunkers, hidey-holes, in lofts, cellars, stables, in the fields, on graveyards, for one person, for a couple, for dozens of people, in the city, behind special walls masking a secret room, in the countryside, with or without "Aryan" identification documents.

Over the years, many more books were published on the Righteous, such as Eric Silver's *The Book of the Just: The Unsung Heroes Who Rescued Jews from Hitler*, Aleksander Bronowski's *Było ich niewielu*, Peter Hellman's *Avenue of the Righteous*, Arieh L. Bauminger's *The Righteous Among the Nations*, and *Las Sprawiedliwych* by Szymon Datner of the University of Warsaw, director of the Jewish Historical Institute in Warsaw (English version: *Forest of Polish Heroes: Poles Murdered by Germans for Saving Jews during World War II*).

Datner examined the way people behaved when a Jewish stranger on the run knocked on the window of a peasant's cottage in the middle of the night and asked for some food or a place to warm himself up for a short while. He found there were four possible types of response:

— behaving in compliance with the "law" imposed by the Germans and handing the Jewish fugitive over to the henchmen, which was tantamount to sending them to their death;
— not handing them in, but not giving them any assistance, either;
— giving them some short-term assistance;
— taking care of them and giving them sanctuary for a considerable time.

What really came up to the peasant's cottage and knocked on the window was a moral problem, the problem of a human being denied the right to be human. What was there outside that cottage was a huge humanitarian issue.

In his book, Datner gives the stories of many people who died for helping Jews. Here are some of them:

On 6 December 1942 at Ciepielów Stary in the Voivodeship of Kielce, an SS unit burned alive 23 Poles, members of the local farming community suspected of harbouring Jews. The victims were 3 women, 5 men, 15 children including 2 babies, and 3 adolescents. Those who died were Władysław and Karolina Kosior and their 6 children, sons Aleksander, aged 18; Tadeusz, 16; Mieczysław, 12; and Adam, 6; and daughters Władzia, aged 14; and Irenka, 10; Adam Kowalski, his wife Bronisława and their five children, sons Stefan, aged 6; Henryk, 4; and Tadzio, 1; and daughters Janina, 16; and Zosia, 12; Piotr and Helena Obuchiewicz and their four children, sons Władysław, aged 6; a 7-month baby boy; and daughters Zosia, 3; and Jasia, 2; and two unidentified Poles.

On 10 December 1942 at Wola Przybysławska in the Powiat of Puławy, German gendarmes shot 8 local Poles for harbouring Jews. The victims were Władysław Abramek, 20; Aniela Aftyka, 52; Józef Aftyka, 54; Zosia Aftyka, 17; Marianna Aftyka, 14; Czesław Gawron, 20; Leonard Gawron, 21; and Stanisław Kamiński, 21. The Germans made the rest of the villagers bury the bodies in a mass grave dug on the site of the execution.

Photo 8. | Prof. Aleksandrowicz slicing wholemeal bread to promote a healthy diet

In January 1944 in Warsaw, the Germans discovered a shelter under a greenhouse in the garden of Number 84 on the Grójecka. There were 43 Jews hiding in the shelter, one of them was Emanuel Ringelblum, who had recorded the history of the Warsaw ghetto. While hiding in the shelter, he left a written account of the friendship that developed between the fugitives and their carers:

> There are more of these shelters in the "Aryan" part of the city, and the people hiding in them feel an everlasting friendship and gratitude to those who have saved them from the clutches of the fascist monster. We will always cherish the names of these people, who should all be decorated with an order for humanitarianism awarded by the future Polish State. They are heroes who fought against the greatest enemy of humankind and saved thousands from certain death.

When the shelter was discovered, all the people in it were arrested, taken to the Pawiak jail, and shot in the ruins of the ghetto on 7 March 1944. Their Polish carers—Mieczysław Wolski, who had suggested the idea to build the shelter; Władysław Marczak, the owner of the garden; and one of the members of his family who happened to be on the property when the shelter was discovered—were

Photo 9. A publicity flyer for the Julian Aleksandrowicz Foundation for the Prevention and Treatment of Blood Diseases

shot with the Jews they had been looking after.

On 24 March 1944 at Markowa in Sub-Carpathia, the Germans murdered 8 Jews and the Polish couple who had harboured them, Józef Ulme and his wife Wiktoria, who was 9 months pregnant. The atrocity was committed in front of their six children, all aged under eight (the youngest was one-and-a-half), who were shot after their parents. One of the German gendarmes yelled, "Watch them Polish pigs die for harbouring Jews!"

In his book published in 1968, Szymon Datner enumerated scores of other incidents of this kind. He identified the names of 343 Poles (including 64 women and 42 children) killed by the Germans for harbouring Jews. By 1988, the research carried out by the Polish Institute of National Remembrance established a list of about 800 Poles killed for helping Jews.

* * *

The Julian Aleksandrowicz Foundation for the Prevention and Treatment of Blood Diseases (*Fundacja Profilaktyki i Leczenia Chorób Krwi im. prof. Juliana Aleksandrowicza*) was founded on 12 July 1990. The Foundation's aim is to support research on the pathogenesis and prevention of blood cancer, and to develop new methods of treatment, including bone marrow transplants and diagnostics in the Haematology Clinic of Kraków University Hospital. Alongside its regular activities, the Foundation acts as patron for the commemoration of the times when its own patron, Professor Julian Aleksandrowicz, saved lives—the lives of his patients

and soldiers' lives, notwithstanding the fact that he himself could have fallen victim to a criminal ideology merely on account of his ethnic background.

There is a link between Holocaust survival and leukaemia survival, and that link is Professor Aleksandrowicz, who made an active contribution to both.

REFERENCES

Aleksandrowicz, J. 1967. *Kartki z dziennika doktora Twardego*. Kraków: Wydawnictwo Literackie, Kraków.

Blicharski, J., Skotnicki, A. 1989. "Wspomnienie o prof. Julianie Aleksandrowiczu." *Acta Haematologica Polonica*. 20: 126–129.

Myśl i dzieło prof. J. Aleksandrowicza jako znaczący wkład w rozwój nauki służącej zdrowiu społecznemu [Professor Aleksandrowicz's intellectual legacy and its importance to the development of medicine and public health science]. 2008. Proceedings of a memorial conference organised at Jagiellonian University Medical College on the 20th anniversary of the death of Julian Aleksandrowicz, 12 September 2008.

Skotnicki, A.B. 2013. *Szpital Gminy Wyznaniowej Żydowskiej w Krakowie, 1866–1941*. Kraków: Stradomskie Centrum Dialogu.