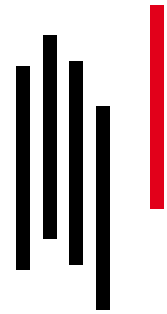

Medical
Review
Auschwitz

Medical Review Auschwitz: Medicine Behind the Barbed Wire

Conference Proceedings 2022

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Contents

Introduction

Maria Ciesielska, Piotr Gajewski,
Mateusz Kicka, Jakub Antosz-Rekucki

This publication is the proceedings volume of the 4th international conference Medical Review Auschwitz: Medicine Behind the Barbed Wire, which was held in Kraków on 19–21 September 2022, for the first time since the outbreak of the COVID-19 pandemic. The Russian invasion of Ukraine has been going on for six months. The pandemic and the war have brought new challenges for health care professionals, once more putting their loyalty to the Hippocratic Oath to the test. The lesson how we should behave in the face of extreme challenges may be drawn from the history of medicine during the Second World War. We hope that the papers presented in this volume will help today's health workers choose the right attitude and persevere in it.

This year's conference started with the premiere of a documentary film on the Medical Review Auschwitz project, which marked its fifth anniversary. The film shows the project's origins, the story of the journal *Przegląd Lekarski – Oświęcim* and the work done behind the scenes to create the English versions of the articles published in the journal and now posted up on the project's website, https://www.mp.pl/auschwitz/.

This volume of conference proceedings contains papers by researchers from Poland, the Netherlands, Israel, Germany, Norway, the United Kingdom, the United States, and Japan. Dr Teresa Wontor-Cichy of the Research Department

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About the authors: Maria Ciesielska, MD, PhD, Piotr Gajewski, MD, PhD, FACP, Mateusz Kicka, PhD, and Jakub Antosz-Rekucki, MA, are members of the Organizing Committee of the 4th international conference Medical Review Auschwitz: Medicine Behind the Barbed Wire.

of the Auschwitz Museum writes about Dr Stanisław Kłodziński, a medical practitioner, social activist, and Auschwitz survivor who was a member of the editorial board of *Przegląd Lekarski – Oświęcim* and a witness in the postwar court proceedings against the German criminal physicians.

Dr Agnieszka Zajączkowska-Drożdż of the Jagiellonian University Institute of European Studies tells the story of the endeavours made by the Jewish doctors of Kraków to provide medical care and sanitary facilities to the inhabitants of the city's ghetto. All too often they were forced to make difficult decisions affecting the lives of the people in their care.

Dr Miriam Offer of Western Galilee College, Akko, Israel, was another of our speakers who addressed the subject of the dilemmas facing Jewish doctors during the Holocaust. Her paper highlights the unprecedented professional and ethical challenges they encountered. Dr Offer drew special attention to the moral tragedies health workers had to go through when they were forced to choose whether to save their patients or their own lives, or when they were put in a situation where they had to take part in the selection of persons due to be killed, or when they had to administer euthanasia to their patients.

Professor Paul J. Weindling of Oxford Brookes University (UK) presented his unpublished research results from a project to identify the victims of the Third Reich whose mortal remains (specimens of their brains) were preserved as anatomical exhibits and sent from occupied Poland to the Kaiser Wilhelm Institute for Brain Research in Berlin. The human dignity of these persons should be acknowledged and respected, and their bodies should be given a decent burial.

Professor Hans-Joachim Lang of the Eberhard Karl University of Tübingen, Germany, presented a paper based on surviving records including a set of X-ray photographs of women subjected to sterilisation experiments in Block 10 in Auschwitz. He showed the immense extent of the criminal practices of Dr Carl Clauberg and his colleagues.

The observations in the paper delivered by Professor Knut Ruyter of the University of Oslo, Norway, supplement Professor Lang's article. On the basis of an examination of Carl Clauberg's statements and personal papers as well as other source materials, Professor Ruyter presented an image of Clauberg as a man who was convinced that not only was there nothing wrong with his "research," which killed his human "research subjects" or left them permanently injured, but that his work was beneficial to science and humanity in general. The second part of Profesor Ruyter's

paper tells the story of how the German postwar judiciary did everything it could to see that Clauberg would never be brought to justice.

In the next article, the Polish historian Professor Bogdan Musiał argues that the Kaiser Wilhelm Society for the Advancement of Science (currently the Max Planck Society) had an "external field station" for anthropological research in Auschwitz and sent Dr Josef Mengele to run the unit on the Society's behalf. Professor Musiał shows how Auschwitz inmates with medical qualifications worked for Mengele to survive.

Marie Judille van Beurden Cahn and Professor Jacques D. Barthes from the Netherlands present the results of their research project to examine the consequences of post-concentration camp trauma in the offspring of survivors. Their work shows that psychiatric and somatic disorders could have been transmitted to the children, or even the grandchildren of concentration camp survivors.

At the 2021 conference, Dr Giichiro Ohno, a surgeon from the Hokkaido Prefectural Teuri Clinic in Japan, presented the story of Dr Mitsuo Kaneda, thanks to whom a selection of articles from *Przegląd Lekarski – Oświęcim* were translated into Japanese and published in Japan. This time, Dr Ohno described the activities of Unit 731, a secret military department of the imperial army which conducted barbaric medical experiments on prisoners-of-war during the Sino-Japanese War.

Professor Matthew K. Wynia of the University of Colorado (USA) gave a synopsis of what every medical student should learn about the history of the contribution health workers made to the Holocaust. Professor Wynia's approach offers an alternative to a mere description of the main medical perpetrators such as Mengele, suggesting that instead we should be considering how the most unpalatable facts concerning the history of medicine during the Second World War could help prospective physicians to face up to and resolve the problems in medicine today, and resist the contemporary temptations and trends tending to dehumanize patients.

The articles published in this volume underpin the current efforts to study and understand the question of criminal medicine. Their authors look at the physicians who engaged in criminal practices but they also consider the health workers who provided genuine medical care in the concentration camps, ghettos, and during combat. The attitude they took should be an inspiration to today's health workers. We do not have the moral right to pass judgement on the inmates of death camps or those confined in the ghettos. We may reflect on their ethical dilemmas with refer-

Photo 1. Winners of the Zdzisław Jan Ryn Award on the stage of Stary Teatr in Kraków, the venue for the 2022 Conference, left to right: Prof. Knut Ruyter, Ava Bąk, Adam Bąk, Prof. Matthew Wynia, Prof. Susan Miller, Dr Tessa Chelouche, and members of the Organising Committee, Dr Maria Ciesielska, Dr Mateusz Kicka, and Dr Piotr Gajewski (Photo by Magda Rymarz)

ence to today's psychology of extreme situations, psychiatry or medical deontology, but these disciplines do not give us any clear-cut answers. All we can hope for is that if we are ever put to the test, we will not come out of it disappointed with ourselves.

The author of our last article, the Polish sculptor Karol Gąsienica Szostak, tries to answer the question whether art can exist without a soul, with reference to the art of Nazi Germany. He is also the maker of a statuette (see page 161) commemorating Professor Zdzisław Jan Ryn, the initiator of the Medical Review Auschwitz project, who died in February 2022. Professor Ryn was Co-Editor of the original journal *Przegląd Lekarski – Oświęcim*, and if it hadn't been for his persistent efforts, the project would probably have never come into being. Karol Gąsienica Szostak's statuette carries a warning: we must never forget what physicians working for an inhumane ideology were capable of, and we must do everything in our power to prevent such atrocities from happening again.

The Zdzisław Jan Ryn Award for the best lecture at the 2022 conference went to Professor Knut Ruyter of the University of Oslo; and the winners of the Award for unique contribution to the Medical Review Auschwitz project were Ava and Adam Bąk (USA), Dr Tessa Chelouche (Israel), Professor Susan Miller (USA), and Professor Matthew Wynia (USA), as well ad Professor Rebecca Brendel (USA) and Krzysztof Strzałka (Poland), who were unable to attend the Conference.

Stanisław Kłodziński: Auschwitz survivor, medical practitioner, social activist, and journalist (1918–1990)

Teresa Wontor-Cichy

The Polish periodical *Przegląd Lekarski – Oświęcim*, which came out as an annual from 1961 to 1991, holds a special place among the books and publications dedicated to the history of concentration camps. Stanisław Kłodziński, an Auschwitz survivor, medical practitioner, and social activist, served as its chief editor.[1]

Kłodziński was born on 4 May 1918 into a Cracovian family deeply attached to the Polish patriotic tradition. He attended the Bartłomiej Nowodworski Grammar School in Kraków, and Antoni Kępiński was one of his school friends. When

About the author: Teresa Wontor-Cichy, historian, associate of the Research Centre at the State Auschwitz-Birkenau Museum, Oświęcim. Research interests: the history and fate of various groups of Auschwitz prisoners, such as Jehovah's Witnesses and members of the Bible Student Movement, Christian clergymen, Roma, and political prisoners from various European countries. Carries out research on the medical atrocities committed in Auschwitz. Publishes on these subjects and disseminates the results of her work in general interest lectures and educational workshops on Auschwitz. Also conducts guided tours of the Memorial and Museum site within the framework of the Museum's regular programmes and for special study visits.

1 Photo courtesy of Archiwum Państwowego Muzeum Auschwitz-Birkenau w Oświęcimiu (the Archive of the State Museum Auschwitz-Birkenau, Oświęcim; hereinafter APMA-B).

he finished school in 1936, he went up to the Jagiellonian University to read Medicine. His choice of a field of study must certainly have been inspired by his maternal grandfather Franciszek Murdziński, who was a physician and head of the children's hospital on ulica Strzelecka in the city of Kraków; while the academic community of the Jagiellonian University offered a good milieu for the intellectual development of its students.

Photo 1. Stanisław Kłodziński: Auschwitz survivor, medical practitioner, social activist, and journalist (1918–1990)

WORKING FOR PATRONAT

In September 1939, when Poland was invaded by Nazi Germany and the Soviet Union and the Second World War began, the Polish Red Cross sent Stanisław Kłodziński to work in the military hospital set up in Father Kuznowicz's student hall. In October 1939 this hospital was closed down, but Kłodziński continued to work for the Polish Red Cross and was detailed to Sekcja Pomocy Jeńcom Wojennym, Wysiedlonym i Więźniom Politycznym, its welfare section for the provision of aid to prisoners-of-war, displaced persons, and political prisoners. Most of the refugees were Poles whom the Germans were evicting and resettling from the Poznań region and other parts of Poland incorporated in Germany. The section's work focused on running outpatient treatment centres, collecting and dispensing medications, food, and clothing. Initially, it was conducted in the city of Kraków, but later also in Polish Red Cross units in areas in its Kraków division before the war but now incorporated in Germany. The German occupying authorities permitted the section to visit Polish political prisoners the Germans held in the Montelupich

Photo 2. | Stanisław Kłodziński's bilingual (Polish and German) ID card issued by the Kraków municipal branch of the Central Welfare Council confirming his employment with Patronat. Courtesy of APMA-B

prison. During their official visits for the dispatch of food, medications, and clothing, the section's staff made an unofficial record of inmates in the jail, which they hid in a matchbox, and acted as go-betweens for contacts between prisoners and their families.

The extent of the aid dispensed in the Generalgouvernement was growing at a rapid rate, and in January 1941 the welfare section for prisoners and their families (Sekcja Opieki nad Więźniami i ich Rodzinami), known for short as Patronat, joined the RGO (Rada Główna Opiekuńcza, the Central Welfare Council, the only Polish welfare organisation the Germans recognised and tolerated). The staff of Patronat, including Kłodziński, received bilingual Polish and German work permits issued by the Kraków municipal branch of the Central Welfare Council. Henceforth they were employees of Patronat Towarzystwa Opieki nad Więźniami (German *Patronat der Obhut über Gefangene*—the Patronage Association for Aid to Prisoners).[2]

2 Kłodziński, 1985: 161–162.

There was no change to the duties the staff of Patronat were expected to carry out—they continued to supply prisoners with food, clothing, and medications. What did change was the area their activities covered: now they visited other prisons and labour camps the Germans had established in the environs of Kraków. Patronat's staff were a well-organised team offering mutual support to one another. Zygmunt Klemensiewicz was their group leader, and one of its members was Teresa Lasocka, a lady who would turn out to be a very important person in Stanisław Kłodziński's circle of friends in the next years.

In June 1940, the Germans opened a new concentration camp on the outskirts of the city of Oświęcim, henceforth dubbed "Auschwitz" by the Germans, who used the same name for the concentration camp. The first Polish political prisoners arrived from Tarnów prison, and the next batch was sent in from Nowy Wiśnicz. Patronat created a new unit called Grupa Oświęcim (the Auschwitz Group), and Kłodziński was assigned to work in it.

In the autumn of 1940, he was sent to Auschwitz to collect information on the prisoners' situation. He had a lot of experience of relations with prison staff, as he had visited the Montelupich jail in Kraków as well as prisons in Nowy Wiśnicz, Tarnów, and Rzeszów. Equipped with the indispensable documents: a permit to cross the border, which he needed to travel from Kraków and the Generalgouvernement to Auschwitz, because the camp was in an area incorporated in Germany, his International Red Cross ID, and a letter of reference explaining that he wanted to dispense aid to prisoners, he arrived in the city and went to see Father Jan Skarbek, the parish priest of the Roman Catholic Church of the Assumption of the Blessed Virgin Mary. Father Skarbek was in touch with the Central Welfare Council, supplying its representatives with news on the concentration camp.

Kłodziński got into the camp through an unguarded area and spoke to the commandant, SS *Lagerführer* Karl Fritzsch. He wrote the following report on the meeting:

> I had my letter of recommendation in my hand as I was led into the barrack accommodating the *Blockführer's* office, which was located next to the main entrance to the camp. . . . Inside, I was brought before SS *Lagerführer* Karl Fritzsch, who of course asked who I was and what I wanted. I introduced myself and presented the letter I had from the Kraków branch of the Polish Red Cross. The letter said we wanted to supply prisoners held in Auschwitz with aid in the form of parcels. Fritzsch read the letter and asked how we in-

> tended to organise this parcel dispatch. I said that first we wanted to send in a supply of personal hygiene items for prisoners, followed by food parcels. . . . Fritzsch did not seem to be delighted to see me in the camp because at the end of the meeting he said that if I continued to visit Auschwitz, I would end up in it for good. At any rate, the atmosphere of the meeting was normal and Fritzsch was fairly courteous though he checked my credentials very carefully. . . . I left with his assurance that it would be possible for us to organise aid for prisoners and that we would receive an answer in writing on the matter.[3]

In November Kłodziński's group started getting parcels ready in Kraków's philharmonic hall and continued in December 1940 and January 1941. They contained basic food products such as hard tack and a piece of bacon, with a traditional Polish Christmas wafer at Christmastide, and were sent to the camp's address. Another parcel permit was issued to the priests of the local parishes, who had seen Fritzsch in December 1940 and presented a letter from Archbishop Sapieha asking for permission for the Church to supply aid. Local people from Oświęcim and its environs handled the delivery of the parcels.

IN AUSCHWITZ

Stanisław Kłodziński was arrested in Kraków on 18 June 1941. The day before he went to Nowy Targ to collect an official consignment of flour and eggs for prisoners. He was accompanied on the journey by Stanisław Głowa, a Patronat employee. On the road to Kraków, police stopped their car and took their ID documents away but allowed them to take the food to Kraków. Next day, both of them reported at the German police station for the return of their IDs, but instead they were detained and handed over to the Gestapo. After an initial round of interrogation, it seemed that Kłodziński would be released, however, the Gestapo found a kite on him from a prisoner held in the Montelupich jail and addressed to Kłodziński. The Gestapo accused him of maintaining illegal contacts with political prisoners and put his name on the list for transportation to Auschwitz.

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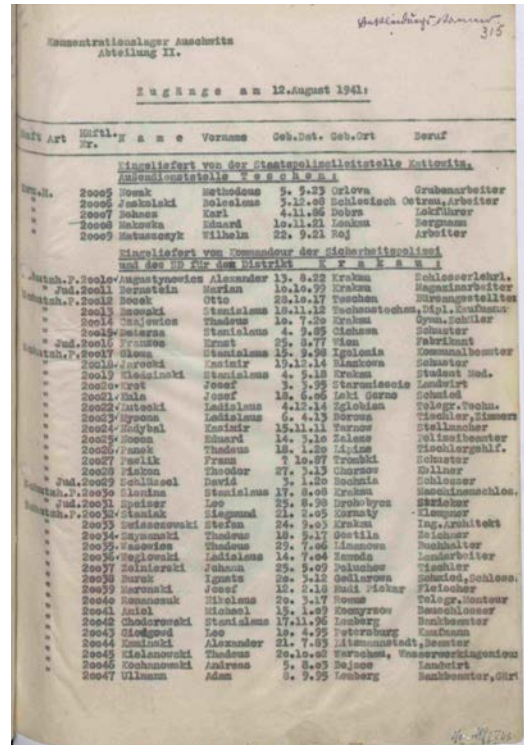
3 APMA-B, Zespół oświadczenia (Statements Collection), statement by Stanisław Kłodziński, Vol. 104, pp. 5–6.

He arrived on 12 August 1941 along with 38 other men. He was registered as No. 20019.[4] Stanisław Głowa was on the same transport and was registered as No. 20017. Kłodziński's family tried to procure his release. The board of the Polish Red Cross issued a letter of recommendation describing his commitment to his work, but this did not bring about the required effect.



Konzentrationslager Auschwitz
Abteilung II.

Zugänge am 12.August 1941:

Kart	Art	Häftl.-Nr.	Name	Vorname	Geb.Dat.	Geb.Ort	Beruf
			Eingeliefert von der Staatspolizeileitstelle Kattowitz, Zweigstelle Teschen:				
Ausw.H.		20005	Nowak	Methodeus	5. 5.23	Orlova	Grubenarbeiter
"		20006	Jaskolski	Bolcslaus	3.12.08	Schlesisch Ostrau	Arbeiter
"		20007	Bohnes	Karl	4.11.86	Dobra	Lokführer
"		20008	Makowka	Eduard	10.11.21	Lonkau	Bergmann
"		20009	Matuszczyk	Wilhelm	22. 9.21	Roj	Arbeiter
			Eingeliefert von Kommandeur der Sicherheitspolizei und des SD für den Distrikt Krakau:				
Auswth.P.		20010	Augustynowicz	Alexander	13. 8.22	Krakau	Schlosserlehrl.
"	Jud.	20011	Bernstein	Marian	10.10.99	Krakau	Magazinarbeiter
Auswth.P.		20012	Bocek	Otto	23.10.17	Teschen	Büroangestellter
"		20013	Bocoski	Stanislaus	10.11.12	Teschen/Stechow	Dipl.Kaufmann
"		20014	Chojnacius	Thadeus	10. 7.20	Krakau	Dreh.Schüler
"		20015	Deterna	Stanislaus	4. 9.85	Cichsen	Schuster
"	Jud.	20016	Franzos	Ernst	29. 8.77	Wien	Fabrikant
Auswth.P.		20017	Głowa	Stanislaus	15. 9.98	Igolomia	Kommandeurfer
"		20018	Jarocki	Dmitrij	15.12.14	Blankowa	Schuster
"		20019	Kłodziński	Stanislaus	4. 5.18	Krakau	Student Med.
"		20020	Krot	Josef	3. 7.95	Staromiescie	Landwirt
"		20021	Kula	Josef	18. 8.06	Leki Gorne	Schmied
"		20022	Lutecki	Ladislaus	4.12.14	Zglobien	Telegr.Techn.
"		20023	Lyczon	Ladislaus	6. 4.15	Borowa	Tischler,Zimmerm
"		20024	Madybal	Kasimir	15.11.11	Tarnow	Stellmacher
"		20025	Mogon	Eduard	14. 7.10	Zelasz	Feinmechaniker
"		20026	Panek	Thadeus	18. 1.09	Lipize	Tischlergehilf.
"		20027	Pawlik	Franz	? 10.07	Trzebki	Schuster
"		20028	Piskor	Theodor	27. 3.13	Chorzow	Kellner
"	Jud.	20029	Schlissel	David	3. 1.20	Bochnia	Schlosser
Auswth.P.		20030	Slondna	Stanislaus	17. 8.08	Krakau	Maschinenschlos.
"	Jud.	20031	Speiser	Leo	25. 8.98	Drohobycz	Bäckermeister
Auswth.P.		20032	Stanlak	Siegmund	21. 2.05	Kornaty	Klempner
"		20033	Swissczowski	Stefan	24. 9.03	Krakau	Ing.Architekt
"		20034	Szymanski	Thadeus	18. 9.17	Goetzis	Zeichner
"		20035	Tuszynski	Thadeus	29. 7.06	Limanowa	Buchhalter
"		20036	Weglowski	Ladislaus	14. 7.04	Kenada	Lederleiter
"		20037	Zolnierski	Johann	25. 9.09	Poluchow	Tischler
"		20038	Burek	Ignatz	20. 3.12	Gedlarowa	Schmied,Schloss.
"		20039	Maronski	Josef	12. 2.18	Rudi Pickay	Fleischer
"		20040	Romanczuk	Wilhelm	20. 3.17	Nowue	Telegr.Monteur
"		20041	Antol	Michael	15. 1.09	Kozuyrzow	Bauschlosser
"		20042	Chodorowski	Stanislaus	17.11.96	Lemberg	Bankbeamter
"		20043	Glodgowd	Leo	10. 4.95	Petersburg	Kaufmann
"		20044	Kmiinski	Alexander	21. 7.93	Litzmannstadt	Beamter
"		20045	Kielanowski	Thadeus	20.10.02	Warschau	Wasserwerkingenieur
"		20046	Kochanowski	Andreas	5. 8.03	Bojsce	Landwirt
"		20047	Ullmann	Adam	8. 9.95	Lemberg	Bankbeamter,Offz

Photo 3. List of prisoners who arrived in Auschwitz on 12 August 1941. Stanisław Kłodziński is No. 20019 on the list. Courtesy of APMA-B

On leaving quarantine, he was sent to the construction commando like most of the other new arrivals and set to work transporting building materials for new prisoners' blocks. He kept in touch with his family in letters sent from the camp, in which he asked them to send him warm clothing, food, and also a pair of glasses as the ones he had had been smashed during his arrest.[5] In October 1941, he developed pneumonia in the right lung and was admitted to Block 28, the prisoners' hospital.

After a partial recovery, he was again sent to work in a construction commando, first as a bricklayer's assistant in the Neubau commando and later as an assistant plumber for the installation of a water supply network. He also worked as a night watchman in Hospital Block 19.

In the autumn of 1942, his health deteriorated again due to starvation diarrhoea, and again he was admitted to the prisoners' hospital. After recuperating,

4 *Księga pamięci…*, Vol. 1, 628–644.

5 APMA-B, Zespół oświadczenia (Statements Collection), statement by Stanisław Kłodziński, Vol. 119, pp. 1–2.

he was lucky enough to be put on the hospital's staff list, working as an assistant orderly in Block 20. He wrote the following account of the conditions in that block:

> I was sent to work in one of the blocks making up the *Häftlingsrevier* (prisoners hospital), actually it was Block 20. I worked in room No. 3 of the *Isolierstation* (isolation section), the last room on the left side of the corridor. This block was out of bounds, as it was intended for prisoners with infectious diseases. The SS were panic-stricken at the thought that they might catch one of these diseases, so they tried to avoid going to and staying in Block 20, which was good for us. There was always a prisoner on *Pförtner* (porter) duty at the entrance to the block. His job was to guard the entrance and stop unauthorised persons from coming in. Of course, the *Pförtner* could not stop an SS man who wanted to come in, but on such occasions there would be a loud *Achtung* (German for "Attention!"), and for me that was an alert.[6]

Later, Kłodziński worked on his own as an orderly, keeping records of prisoners' hospital stay.

There was an underground resistance movement operating in Auschwitz, which sent news out of the camp on the situation and the atrocities committed by the SS.[7] There were many prisoners engaged in these activities, and so was a large group of people outside, handling the transfer of kites (secret messages) and other packages and getting them to their destinations. Stanisław Kłodziński joined in these operations. He established contact with the resistance movement in Kraków and sent encoded messages to Teresa Lasocka, his acquaintance in Patronat. He used the alias "Stakło," while Lasocka's pseudonym was "Tell." The messages were written or edited by Józef Cyrankiewicz, another prisoner in the camp resistance movement. The words of the church hymn *Kto się w opiekę* (Psalm 91) served as the basis of their cipher, and in the secret messages they asked for things prisoners needed:

> . . . In the kites he asked for things like food, medicines and medical dressings, and had parcels containing such items brought into the camp and shared out in a fair way. It was a drop in the ocean of the needs of emaciated and sick prisoners, nonetheless it

6 APMA-B, Zespół oświadczenia (Statements Collection), statement by Stanisław Kłodziński, Vol. 119, p. 4.

7 More on the resistance movement inside Auschwitz in Świebocki.

> was an extremely important operation reassuring them psychologically, proof of the solidarity and aid they could count on from outside.[8]

Kłodziński joined an operation to send illegal copies of documents out of the camp. One of these records was a list of Jewish women prisoners registered in Birkenau and murdered in the gas chamber. Prisoners compiled a list of 32 Polish women and girls from Bydgoszcz registered and subsequently killed in the gas chamber. Another of these documents, entitled "Katy Oświęcimia" (The Butchers of Auschwitz), listed the names of members of the camp's staff who committed atrocities against prisoners. A collection of photographs clandestinely taken by *Sonderkommando* prisoners in the summer of 1944 was an invaluable item documenting the atrocities perpetrated at that time. Kłodziński wrote in the secret message serving as the covering letter to this collection:

> I am sending you photos of the Birkenau gassing operation. They show one of the piles of corpses burned in the open air because the crematoria could not cope with the volume of bodies that had to be disposed of. In front of the pile there are bodies waiting to be thrown into the fire. Another photo shows one of the sites in the wood where people undress, ostensibly to take a bath but in fact they are taken to the gas chamber.[9]

A register known as the Bunker Book was kept for Block 11 (Death Block), recording data concerning prisoners incarcerated in the Bunker cells, with information on what happened to them. The Bunker Book was sent out of the camp in early 1944. The camp mortuary also kept a register recording the prison numbers of those who died or were killed, including many murdered with a phenol injection. One of the prisoners managed to make a copy of this register and hand it over to Kłodziński, who sent it out of the camp. Another document clandestinely copied and sent out of the camp contained a list of prisoners in receipt of parcels and their address in the camp (i.e., the number of the block in which they lived).

There were more people than just local inhabitants in the network of helpers providing aid for prisoners. One of them was Maria Stromberger, an Austrian

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8 Opoczyński.

9 APMA-B, Materiały ruchu oporu (records of the resistance movement), passage from a kite sent to the commanding unit of the Brzeszcze branch of the underground PPS (Polish Socialist Party), Vol. II, p. 136.

nurse in the German Red Cross and on the staff of the camp who volunteered to deliver kites. Nurse Stromberger was the *Oberschwester*, the matron of the nurses employed in the SS hospital. She didn't speak Polish and used a set of secret passwords to communicate with others in the network and deliver secret messages for prisoners.[10]

Stanisław Kłodziński stayed in touch with members of the resistance movement, especially Teresa Lasocka, practically to the end of his time in Auschwitz. His last kite is dated 12 December 1944.

EVACUATION TO MAUTHAUSEN

In the autumn of 1944, when the eastern front was getting closer and closer to Auschwitz, the Germans started to evacuate inmates to other concentration camps in Germany. In mid-January 1945, they set about clearing the camp completely and evacuated walking prisoners on foot.[11] Stanisław Klodziński was put into a column of prisoners who were marched first to Wodzisław Śląski (then known by a German name, Loslau), a distance of 63 km (39 miles) away from the camp. There they were loaded up on a freight train and taken to Mauthausen, a concentration camp in Lower Austria, where he was held until 5 May 1945, when American troops entered the camp. On being liberated, Kłodziński joined in the work of the Polish committee looking after sick survivors. He returned to Poland in July 1945, when the committee's work was over.

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10 Maria Stromberger delivered the secret reports drafted by prisoners to a shop where she rendezvoused with liaison girls. One of the girls, Helena Datoń, aged 17 at the time, wrote the following recollection of her meetings with Sister Stromberger: "She used to come to *Haus* 7 in a nurse's white uniform to do her shopping. Her serenity and self-control inspired people's confidence, and this was probably what made them like and respect her. The illegal messages she handed over to me were always packed in matchboxes or hidden in a pile of ration cards and never looked suspicious. I always admired her."

11 Strzelecki, 140–188.

PHYSICIAN, COURT WITNESS, SOCIAL ACTIVIST, AND JOURNALIST

On his return home, Kłodziński resumed his studies at the Jagiellonian University's Faculty of Medicine and worked for the Kraków Municipal Social Welfare Committee (Miejski Komitet Pomocy Społecznej w Krakowie) providing medical care for concentration camp survivors.

On graduating and completing his national service, Dr Kłodziński started work as a pulmonologist (a specialist for the treatment of lung diseases). He was employed by the Voivodeship Tuberculosis Outpatients' Clinic at the Students' Day Centre for the Treatment of Tuberculosis (Wojewódzka Przychodnia Przeciwgruźlicza w Akademickim Półsanatorium Przeciwgruźliczym). Many of his patients were survivors left with serious health problems after their concentration camp confinement. He continued his academic career tutored by Professor Stanisław Hornung and wrote a PhD dissertation on TB in Auschwitz and Occupied Poland in 1939–1945. He obtained his PhD in 1962. Dr Stanisław Kłodziński was a member of the Kraków Medical Society and the Polish Pulmonological Society. He worked as a medical practitioner until 1969, when he retired from medical practice.

Dr Kłodziński was a court witness in several trials of members of the staff of Auschwitz. He appeared in court at the trial of Rudolf Höß, the commandant of Auschwitz, which was held in Warsaw before the Polish Supreme Court. He testified as a witness on 21 March 1947, the ninth day of the trial. In November of the same year, another Auschwitz trial, this time of 40 of the camp's staff, started in Kraków, and again Dr Kłodziński was summoned as a witness. In 1959, his statement was part of the evidence collected for a second trial against SS Dr Johann Paul Kremer. Numerous members of the Auschwitz staff were put on trial in Frankfurt-am-Main in 1963–1965, and many of the witnesses testifying were Auschwitz survivors. Dr Kłodziński's statement concerned the prisoners' hospital in Auschwitz, the methods used to kill prisoners, and the conduct of the German doctors.

Dr Kłodziński was a member of very many organisations and associations and made an active contribution to their work. In 1968, he was appointed to the Chief Commission for the Prosecution of Nazi German Crimes in Poland and served on its medical team for the investigation of wartime pathology. He belonged

to the International Auschwitz Committee, which has a membership of survivors from various European countries.

He joined the Polish veterans' association ZBoWiD (the Society of Fighters for Freedom and Democracy), served on its Supreme Council, and organised sanatorium treatment for survivors in several health resorts in and beyond Poland. For several years, he ran a doctor's surgery for survivors at Klub Oświęcimiaków w Krakowie (the Kraków Auschwitz Survivors' Club). Later, the surgery moved to his private apartment.

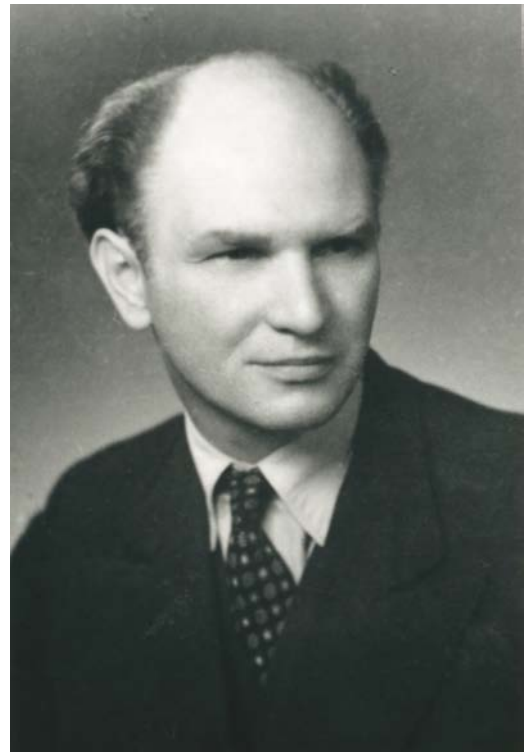

Photo 4. | Dr Stanisław Kłodziński. Postwar photo. Courtesy of APMA-B

When the museum and memorial site were opened on the premises of the former Auschwitz and Birkenau concentration camp, Dr Kłodziński joined a group of survivors (including Prime Minister Józef Cyrankiewicz and Minister Lucjan Motyka) who pioneered the campaign to have the Auschwitz site entered on the UNESCO World Heritage List. Auschwitz was put on the list in 1979.

Dr Kłodziński was engaged in the work to preserve and commemorate the material evidence of Auschwitz. He sat on the council serving as the Auschwitz Museum's advisory body. He was a member of the Kraków branch of Towarzystwo Opieki nad Oświęcimiem, the Society for the Care of the Auschwitz Site, which was founded in 1983 and had a large membership of survivors. He also helped to establish, and later worked in the International Youth Meeting Centre, an educational institution located in Oświęcim. He supported the work of Aktion Sühnezeichen Friedensdienste (Action Reconciliation Service for Peace), a German church organisation whose members engaged in voluntary service on behalf of the Auschwitz Museum;

and made a vigorous contribution to the activities of Maximilian-Kolbe-Werk, another German church organisation engaged in charity and humanitarian projects.

Dr Kłodziński corresponded with very many people all over the world and acted as a consultant for numerous history projects. He attended numerous conferences and helped many of his fellow survivors by writing letters on support of their applications for housing, medical treatment, or disability pensions.

He published over 300 scholarly papers, starting with medical issues (usually on TB or epidemiology) but later went on to subjects connected with concentration camps, especially the medical, psychiatric, and social after-effects of confinement in them. Some of his work is available in a five-volume publication in Polish entitled *Okupacja i medycyna*, as well as in other books in Polish, *Oświęcim nieznany* and *Więźniowie Oświęcimia*.

Every January from 1961 to 1991, the Kraków branch of the Polish Medical Society issued a special publication edited by Dr Kłodziński on matters concerning medicine in Auschwitz. He contributed over 140 articles to the series, dozens of them presenting the biographies of prisoner doctors and other medical staff imprisoned in Auschwitz. In his articles, he addressed some of the key issues concerning life in Auschwitz. He enjoyed the trust and confidence of fellow survivors who were happy to respond to his requests for information with as many details as they could remember. His colleagues on the team editing the series were Antoni Kępiński, Zdzisław J. Ryn, Zenon Jagoda, Jan Masłowski, and Danuta Wesołowska. Dr Stanisław Kłodziński died on 1 November 1990 and was laid to rest in Rakowicki Cemetery, Kraków, in a funeral attended by his family and friends, and a large number of fellow concentration camp survivors.

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The Jewish medical institutions in Kraków during the Holocaust and their activities: the early years in occupied Kraków

Agnieszka Zajączkowska-Drożdż

According to Hitler's initial plans, the General Government was supposed to be a "huge Polish labor camp,"[1] with a very low standard of living. It was to be the place where all the Jews and Poles would be sent from the German territories.[2] This resettlement policy had a very bad effect on the Jewish residents of Kraków: their numbers increased dramatically, from 56 to 68 thousand.[3] The resettled Jews were poor and had no prospects for a decent life because all their belongings had been left behind and they had to depend on help from the local Jewish

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1 Browning, 98; Hilberg, 205–208.

2 Polubiec, 1970: Vol. 1, 119–120.

3 Agatstein-Dormontowa, 1957: 197.

community. There wasn't enough room or food for them in Kraków, and the sanitary conditions weren't good enough for such a drastic rise in the number of newcomers, so the risk of epidemics spreading grew substantially. This was not only because of the influx of Jewish refugees but also due to the fact that the living conditions of the city's Jewish inhabitants were getting worse, as the Germans had deprived them of their jobs and livelihoods, evicted them from their homes, and canceled the state benefits of many groups of Jews, including pensioners and people with disabilities.[4] The general situation for all of the Jews living in Kraków was considered unbearable, so the Jewish authorities and medical personnel decided to organize aid for the community. They started by creating a number of institutions to protect the Jewish community against hunger and epidemic typhus, as well as to help Jewish people organize their lives and manage better under wartime conditions.

First, the medical service created a special unit known as the sanitary commission. The initiator and head of this institution was Dr Maurycy Haber, who was also a member of the *Judenrat*.[5] At the beginning of the war, the sanitary commission worked in three areas of the city, Kazimierz, where the Jewish district was located, Stradom, and Podgórze, where most of the Jewish residents lived. The activities of this commission were overseen by a specific German sanitary doctor to whom Dr Haber reported monthly status updates. Thanks to Dr Haber's efforts, 156 doctors and 110 ancillary medical personnel started work on a voluntary basis and carried out efficient health and hygiene inspections among the Jewish residents. A project was launched to provide free medical care, medications, and advice on hygiene for the Jewish refugees in temporary accommodation.[6] To improve the living conditions of the newcomers, the sanitary commission obtained the consent and support of the *Judenrat* to introduce a new regulation which required Kraków's indigenous Jewish residents to share their water supply with the refugees. This was necessary to maintain basic standards of hygiene and prevent outbreaks of infectious disease. There were penalties for those who failed to comply.[7] Additionally,

4 AŻIH (Archive of the Jewish Historical Institute in Warsaw, Poland; hereinafter AŻIH), 301/448; Bieberstein, 1986: 29; AŻIH, 301/5093.

5 Löw and Zajączkowska-Drożdż, 2016: 192–193; Zajączkowska-Drożdż, 2015.

6 Bieberstein, 1986: 176.

7 AŻIH, 218/4.

both a disinfection station and public baths were established and made available not only to Jews in the city, and later from the Ghetto, but also Jews from nearby *Judenlager* (camps).

In mid-1940, Dr Jakub Kranz founded an infirmary for the elderly and sick who had residence permits for the city but had been evicted from the temporary shelters which were closed down, and had been left homeless. This institution had 60 beds and was located on ulica Miodowa. It was able to operate thanks to donations from the Jewish community and charges collected from its patients. The patients were generally very ill and most of them were over 70.[8]

The sanitary commission and infirmary moved into the Ghetto and continued operations until the Ghetto was liquidated in March 1943. The sanitary commission's most significant achievement was that no epidemic ever broke out in Kraków while it was in operation.[9]

The other medical institution which played a very important role during the war in Kraków was the main Jewish hospital on ulica Skawińska, which had been founded in the mid-19th century.[10] Before the war, the hospital was constantly being expanded and new equipment acquired. Just before the war, 64 doctors, including 15 full-time staff and 46 interns, worked in it.[11] As soon as the Germans occupied Kraków, they took over this Jewish hospital. For the first two months of the war, the hospital was closed due to lack of funds and because a substantial number of Jewish doctors had left the city. However, the rising number of Jewish people made it necessary to reopen the hospital. Again, this was only possible thanks to the work of voluntary medical personnel; just eight out of the hospital's 42 physicians were paid a salary by the *Judenrat*.[12] The conditions were extremely difficult, financial resources were scarce, and the German authorities made doctors leave their medical duties to join in the manual labor such as snow clearance which all the other Jewish inhabitants had to do.

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8 AŻIH, 176–177.

9 AŻIH, 175.

10 For an overview of the history of this hospital, see Sosnkowski, Zajączkowska-Drożdż, et. al., 2017.

11 Bieberstein, 1986: 179.

12 Bieberstein, 1986: 180.

When the Kraków Ghetto was opened, the hospital was moved into it and located on ulica Józefińska. The building in which it was accommodated was much smaller than its previous premises. It was constantly overcrowded and sometimes two patients had to share a bed.[13]

Before the war, the main Jewish hospital did not have an infectious diseases ward, so the Jewish doctors had to work with Polish hospitals. Under German occupation, it was no longer possible to continue this cooperation; moreover, the escalating numbers of Jewish refugees meant a greater risk of diseases spreading in the city. Thanks to financial support from the Jewish community, in April 1940 Dr Bieberstein was able to establish a small infectious diseases hospital located on ulica Rękawka. It only had 15 beds but there was also a children's ward. This hospital was in a precinct later incorporated in the Ghetto, and when the area of the Ghetto was reduced, the hospital was relocated to plac Zgody. Dr Bieberstein recalled that not only Jews from the city but also those from its environs were treated there, and sometimes patients from as far away as Kielce were sent to this hospital. The German authorities didn't look into this hospital very often, as they were afraid of catching an infectious disease, so it was possible to hide clandestine food supplies and even a small number of weapons for resistance units there.[14]

In late 1941, Dr Aleksandrowicz and Dr Bernard Bornstein founded another hospital, this time for the chronically ill. It was established after the creation of the Ghetto and had fifty beds. All three hospitals continued operations until the Kraków Ghetto was closed down.

WHAT HAPPENED IN THE HOSPITALS DURING THE DEPORTATIONS TO EXTERMINATION CAMPS

During the first deportation in June 1942, hospital patients were exempted from selection. The doctors knew of this order in advance, so they admitted numerous healthy individuals and saved many lives.

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13 Bieberstein, 1986: 204. Testimony of Michał Fallek, AŻIH, 301/4113.

14 Bieberstein, 1986: 187.

Just before the deportation, there were only nine patients in the Jewish infectious diseases hospital; however, when Dr Bieberstein learned that patients would be exempted from the deportation order, he admitted 350 Jews to his hospital.[15]

Dr Aleksandrowicz, who ran the hospital for the chronically ill, also tried to help Jewish people as much as he could, and hid over 5 hundred in his hospital. Unfortunately, someone denounced him to the Ghetto police, and they ordered him to reduce the numbers down to just 30. Later, Dr Aleksandrowicz wrote that he was so overwhelmed with emotions, he didn't know what to do, as he was expected to select 470 people and send them to their deaths. The situation was too much for him. When the first patients started to leave the hospital, evidently in a bad condition, they began to mix in with the crowd of healthy individuals already selected for deportation and waiting in the street. It looked as if everybody out in the street had been evacuated from the hospital. That's what Dr Aleksandrowicz told the Gestapo and they believed him, so he avoided the dilemma of having to decide who would survive from a vast number of people, and the result was that 470 people were saved (for the time being) from deportation to a death camp.[16]

During the first deportation to Belzec extermination camp, the German authorities allowed Jewish doctors to organize a medical station on plac Zgody, where those due to be deported were assembled. Doctors and nurses, including Dr Bieberstein, provided assistance and medicines to those in the worst condition.[17] The only pharmacy in the Ghetto was located on plac Zgody and was run by Tadeusz Pankiewicz, an ethnic Pole.[18] It played a very important role in supplying medicines both to the medical staff and people gathered in plac Zgody. [19] Later Pankiewicz recalled that most of the drugs he distributed were tranquilizers and painkillers, which were provided free of charge.[20]

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15 Bieberstein, 1986: 190.

16 Bieberstein, 1986: 183, Pankiewicz, 107–108, Aleksandrowicz, 2001: 63, 68.

17 Bieberstein, 1986: 59, 63; Kuwałek, 2010: 107.

18 Löw and Roth, 2014: 54–55.

19 Another organization which provided medicines to the Ghetto was Żydowska Samopomoc Społeczna (Jewish Social Self-Help; head: Michał Weichert); Kroll, 1985.

20 Pankiewicz, 2003: 82, 88.

Patients were to be included in the selection for the second deportation to Belzec: the German authorities had decided Jews who were not in good health were of no use to them, so they had to die.

This time, there was no medical station on plac Zgody, nonetheless, the doctors tried to find a way to save as many lives as possible. Since physicians were not on the list for selection, Dr Bieberstein had some of the patients put on doctors' white coats, which saved many lives, and the same procedure was carried out at the main Jewish hospital.[21] Additionally, doctors and nurses hid some sick children outside of the hospital for the duration of the deportation.[22]

Another example of doctors' courageous behavior during the second deportation was that they encouraged all the walking patients to leave the hospitals and save their lives. In 1947, Michał Fallek testified that in September 1942 he was a patient at the main Jewish hospital with a leg injury and had problems with walking. During his stay in the hospital, news of an imminent deportation spread in the Ghetto, and on the day before the deportation, the German police came into the Ghetto, surrounded the hospital and ordered the patients to be ready by the next morning. Fallek said that during the night a doctor saw every patient and tried to get them to dress and pretend they were healthy and, if possible, leave the hospital. He also stated he wasn't able to leave his bed that night; however, next morning he had the chance to leave the hospital and the good luck survive; all the other patients who stayed in the hospital were either deported or killed on the spot.[23]

Most of the bedridden patients in the hospital for the elderly and the infirmary were brutally murdered. The majority of the patients from the main Jewish hospital were transported to Belzec for extermination. Witnesses' memoirs give detailed descriptions of the extraordinary brutality the Germans used to kill hospital patients; these atrocities were accompanied by torture, humiliation, violence, verbal abuse, and terror. Tadeusz Pankiewicz wrote in his book that during this deportation, German soldiers pulled patients including those in a very poor condition, out of their beds in the infirmary, beat them up violently, and threw them down

21 Bieberstein, 1986: 73.

22 Bieberstein, 1986: 73.

23 Testimony of Michał Fallek, AŻIH, 301/4113.

the stairs. In the courtyard, all the victims were lined up against the wall and shot. Samuel Erlich said that he saw two German soldiers killing the patients who had been brought out of the infirmary.[24] Aleksander Bieberstain wrote in his book that this was one of the most heinous atrocities the Germans committed in the Kraków Ghetto.[25] After this deportation, the infirmary ceased to exist.

Contrary to the regulations which exempted medical personnel from selection, many doctors were also sent to Belzec.

During the liquidation of the Kraków Ghetto in March 1943, the Germans organized a third deportation, when all the Jews who were selected as unfit for work were to be sent to Auschwitz-Birkenau. All the medical staff were ordered to leave the hospitals and were sent to Plaszow. Tragically, all the patients left in the medical institutions in the Kraków Ghetto were either deported or killed on the spot.

This deportation was also a very stressful time for the doctors in the hospitals in the Ghetto because they realized that they had an unenviable choice. They could either let their patients and the sick members of their family die peacefully by administering poison to them, or keep them alive and let the Germans murder them savagely. Dr Bieberstein wrote that he knew of three doctors who poisoned their parents because they knew they had no chance to survive. In addition, Dr Aleksandrowicz wrote in his memoirs that once he was sure that the bedridden patients in his hospital would be killed, he gave them cyanide to spare them that ordeal. In his memoirs he wrote that he was well aware that as a physician he had to endeavor to maximize the lifespan of his patients, but on the other hand he also knew that he had to minimize their suffering. He claimed that this was one of the most difficult decisions in his life. His second most difficult decision was when he decided to escape from the Ghetto with his wife and child, however, his parents refused to join them, so he had to leave them to die in the Ghetto.[26]

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24 Testimony of Samuel Erlich, AŻIH, 301/1660.

25 Bieberstein, 1986: 73–74, 196–197.

26 Aleksandrowicz, 2001: 84–85.

MEDICAL INSTITUTIONS IN PLASZOW

Three of the barracks in Plaszow were set aside as a hospital area. The conditions in them were deplorable, the work to construct these barracks had not been completed, there was no electricity or running water, and they were unfit for human habitation. Straight on arrival, the medical personnel started to gradually adapt the barracks for their patients' needs. Three wards were created: a general ward, a surgical ward, and a ward for infectious diseases. There was also a first aid room in one of the barracks in the hospital area, with a general health center, a dental surgery, and a pharmacy.[27]

The chances the doctors in Plaszow had to save lives were far fewer in comparison to what they could do in the Ghetto because of the activities of Dr Leon Gross, a Jewish doctor appointed head of the hospital by the camp's commandant Amon Göth. Dr Gross collaborated with the Nazi officials and carried out all the German orders without demur, and punished any doctors who dared to disagree and protest against his orders. He was not concerned for the welfare of the patients.[28] The testimonies of Plaszow survivors show that Dr Gross drew up lists of people due to be killed, while at the same time taking bribes to cross patients off the list. He had no empathy for the sick and even poisoned some of his patients.[29] His activities made the work of the other doctors much more difficult, as they could not do anything without his consent. Even though the doctors were under extreme pressure, some of them tried to counteract Dr Gross as much as possible, sometimes even jeopardizing their own lives trying to help patients. One of these brave physicians was Dr Ferdynad Lewkowicz, who worked in the surgical ward. Dr Lewkowicz's patients and coworkers said in their testimonies that he always gave his patients proper medical care and often negotiated with Dr Gross to keep patients in the hospital until they were ready to return to work, also he had the courage to treat prisoners with gunshot wounds, which was against the orders issued by the Germans.[30]

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27 Aleksandrowicz, 2001: 124–125.

28 Aleksandrowicz, 2001: 126–127.

29 AŻIH, 301/1600, 301/1589, 301/4578, 301/1576, AŻIH, 301/1574, AŻIH 310/1573, AŻIH 301/4575, AŻIH 301/4525, AŻIH 301/4522. After the war, Dr Gross was sentenced to death by the Polish court for collaborating with the Germans. The sentence was carried out in 1946. See Bazyler and Tuerkheimer, 2014: 199.

30 Testimony of Edmund Klein, AŻIH, 301/2394.

CONCLUSION

The Jewish medical personnel in Kraków under German occupation were deeply committed to maintaining a basic level of hygiene and organizing medical assistance for the city's Jewish community and new arrivals. Their chief aim was to prevent outbreaks of epidemics, and they achieved this because they worked on a voluntary basis to organize hospitals and other medical facilities despite constantly deteriorating conditions. During the three deportations, Jewish hospitals played a very important role in helping to save lives or at least reduce suffering. A large percentage of the Jewish medical personnel took an active part in this operation; very often they had to make difficult decisions regarding the plight of the Jewish people in the Ghetto. This extraordinary work was extremely important and consequently helped to keep Ghetto inmates alive for as long as possible.

There were also exceptions, for example Dr Gross, whose behavior made assisting the Jewish inmates of Plaszow much more difficult. Nevertheless, the majority of the doctors made a huge difference to the chances for survival for the whole Jewish community, whenever they were able to make independent decisions and take responsibility for their actions and the institutions they ran. As Miriam Offer emphasizes in her book,

> Studies on Jewish medicine in the Holocaust illuminate the phenomenon of the establishment by the persecuted Jewish victims of an independent medical system endowed with modern professional characteristics. . . . No such self–organization appears to have taken place in other cases. . . . In many cases of persecution and genocide, we generally witnessed a collapse of the medical system of the persecuted and the replacement of its services, if at all, mainly by international organizations. . . . The Jews themselves, that is, the persecuted society, and not the Germans or any outside party, established the system. . . . This phenomenon seems to be unparalleled in any other case of genocide.[31]

31 Offer, 2020: 637–639.

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Thoughts on the ethical dilemmas of Jewish physicians in the ghettos in Poland during the Holocaust and their relevance for today

Miriam Offer

INTRODUCTION: ETHICAL DILEMMAS THAT FACED THE JEWISH MEDICAL STAFF IN THE GHETTOS: SOME REMARKS ON THE STATE OF THE RESEARCH

The cruel reality in the ghettos presented the medical staff with unprecedented professional and ethical challenges. In the dehumanizing conditions imposed on

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the Jews by the Germans in the ghettos that were established during the Nazi occupation of Poland, serious infectious diseases were rampant, and thousands of Jews died. The Jewish medical staff were challenged with providing medical services under genocide conditions—a challenge that confronted physicians and nurses with inconceivable professional ethical tests. The problematic ethical nature of the situations that we are about to discuss is not retrospective but was recognized as such at the time. The medical staff, like others in the ghetto administration, were sometimes torn between their moral conscience and the professional and humane obligations imposed on them by their role.

In the third millennium, we are seeing genuine expansion in the field of bioethics and medical law, on ethical and legal aspects of varied scientific and medical innovations that are developing at a rapid rate. Ethical debates and decisions arise surrounding the feasibility of applying medical technologies. What can be applied properly and appropriately from an ethical viewpoint? Should application of knowledge that may violate ethical codes be permitted or forbidden? Health service workers are increasingly engaged in ethical aspects of medical activity, alongside growing sensitivity to the issue among the patient population at large.[1] The outbreak of the COVID-19 pandemic placed medical ethical issues in more intensive focus. The need and interest among the public and health professionals to revisit medical ethics principles became more pressing, with constant examination of the current, individual, and public implications. Many countries implemented triage for the treatment of COVID patients.[2]

The discussion on ethical issues from the Holocaust period is attracting great attention because of the desire to understand the roots of the ethical crisis that occurred under Nazi occupation, in general and particularly in the medical world. Learning in this area is essential for examining medical ethical challenges today, and all of us—physicians and patients—are responsible for preventing a repeat of the medical experiments and for constructing a cautious, protected process of humane and beneficial medicine for all people. Attempts have been made to analyze

1 Siegal, 2015: 9–12.

2 See, for example, the Israel Medical Association position paper: https://www.ima.org.il/userfiles/image/prioritySickPeopleDocument.pdf [Accessed August 8, 2022]. See also an article on the Jewish *halakhic* aspects of triage regarding treatment with a limited number of ventilators. Irit Offer-Stark, 2022.

the dynamics of the decline and development of the Nazi medical crimes among physicians and medical institutions. Studies have examined the relationship between scientific perceptions that developed at that time. Examples include the science of heredity, eugenic ideas, and their implications for the development of the criminal enforced sterilizations of people with serious illnesses and "euthanasia" (the murder of patients "unworthy of life") that were perpetrated to extremes in Germany under the Nazi regime. An attempt has been made also to examine these developments and their influence on the formation and acceleration of the Final Solution to the Jewish Question and the Holocaust.[3]

THE CHALLENGE OF STUDYING ETHICAL DILEMMAS IN THE GHETTOS

In contrast to the study of criminal medicine during the Third Reich, the discussion of the ethical problems that faced the Jewish medical staff in the ghettos has generally not been studied from the developmental aspect but has revolved around climactic moments in which a specific ethical dilemma was identified. In lectures and learning material, a collection of such dilemmas is often used outside of the general context, as these dilemmas apparently exist in and of themselves. This stand-alone perception of dilemmas leads to a distorted understanding of the decisions and actions taken—in addition to hindering the development of complex and significant insights and to the occasional injustice toward the medical staff who were forced to deal with these painful dilemmas. For example, when discussing ethical dilemmas of physicians in the Lithuanian ghettos regarding the German anti-childbirth decree, the testimony of Dr Aharon Pik from the Šiauliai Ghetto is used in which he describes, at first hand, his participation in the homicide of babies born despite the decree, thus endangering the lives of the mother and of all the ghetto inhabitants. However, an accurate, in-depth study reveals the rarity of

3 For an example of the public and medical interest and of the professional ethical discussion and its implications for today, see Roelcke, Hildebrandt, Reis. Much has been written on the topic, e.g., Friedlander, 1995; and Rotzoll, Richter, Fuchs, et al., 2006: 17–29.

these cases (apparently three in Šiauliai) and they occurred very late in the course of the ghetto after the Lithuanian ghettos had become camps under Gestapo control. At this stage, Jewish women who had managed to conceal their pregnancies turned to the physicians for aid in aborting and killing the newborns, having lost any chance of either hiding or saving them. Any discussion of a dilemma that faced the Jewish physicians must include the historical context and details, its scope, and stages of occurrence. Needless to say, exposing the whole picture places insights in a different light. When researching the development of the dilemmas and examining the elements that influenced them, it is important also to study the Jewish physicians' activities. A description of an isolated climactic event is insufficient.[4]

To discuss the ethical dilemmas, we must understand the Jewish physicians' perceptions and the experience and education that they acquired before the Holocaust, and how all of this influenced their coping with the ethical dilemmas, as individuals and as a professional group. First, it is noteworthy that many Jewish physicians who operated in the ghettos in Poland had taken part during the interwar period in the establishment of a medical system to serve the 3.5 million Jewish citizens of Poland that included a Jewish medical association called Towarzystwo Ochrony Zdrowia Ludności Żydowskiej (TOZ). This organization embraced public health principles, aspiring to provide an accessible, professional medical service to all Jewish residents of Poland, especially weak populations, the poor, women, and children, with emphasis on preventive medicine. Drawing on these principles and on those of Jewish tradition, which holds the saving of life as a supreme and sacred value, greatly influenced their ability to cope with the dilemmas imposed on them in the ghettos.[5]

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4 On coping with the dilemma surrounding the anti-childbirth decrees, see, for example, Offer, 1993; and Prais, 2001: 23–38.

5 On Jewish medical activity and the roots of its growth and development, see Offer, 2020: 51–102; Offer, 2019; Ohry and Ohry-Kossoy, 2013: 445–462. On the influence of *halakhic* principles on medical dilemmas in the ghettos, see Kelly, Miller, Polak et al. (Eds.), 2001, "Rabbinic Responsa During the Holocaust: The Life-for-Life Problem," in Hildebrandt, Offer, and Grodin (Eds.), *Recognizing the Past in the Present: New Studies on Medicine Before, During, and After the Holocaust*, 82–103.

SHOULD A MEDICAL SERVICE BE CREATED UNDER CONDITIONS OF GRADUAL DESTRUCTION?

A META-DILEMMA

The broad historical context leads us to examine the initial, central medical dilemma that faced the physicians: in the difficult ghetto conditions, when every family was affected by morbidity and mortality, was there any point in creating a medical service for the public? Furthermore, from an ethical perspective, was this not unavoidable in view of the numerous challenges that far outweighed the chances of success due to a shortage of all the basic necessities for a medical service to exist? I call this a "meta-dilemma" in the sense that it transcends the dilemmas that arose during the medical activity. It is a fundamental ethical question, and its answer was at the basis of all the medical activity in the ghettos and the dilemmas described below.[6]

The word "ethics" is derived from the Greek "ethos," meaning "custom." Ethics, as a perception, attempts to answer the question as to the moral principles that guide our behavior, pertaining to all our actions, but especially to those affecting someone else. In his book *Studies in Ethics*, Professor Asa Kasher defines professional ethics as a perception of the appropriate behavior in that field, a perception that can be a value system or a system of principles that expresses values. Both values and principles provide a basis for distinguishing between appropriate and inappropriate behavior, with explanations and justifications.[7] Examining the ethical aspect in the field of medicine in the ghettos requires a macro–perception alongside the isolated dilemmas of individual physicians. The apparent resolve of the physicians and nurses, as a collective, to form a professional medical response for the ghetto residents stemmed from their professional ethical perception. The physicians in the ghettos recognized the critical need to assist the establishment

6 Metaethics deals with the question of the ethical field and not with attempts to formulate a general ethical theory. For example, are "good and bad," "permitted and forbidden" issues of objective facts or of personal taste? Is there such a thing as moral knowledge and, if so, what makes it distinctive? What, if any, is the relationship between moral stances and our motivations to act? I have chosen this definition because it relates to moral questions beyond pragmatic ethics. See, for example, Wilson, 2006.

7 Verbin, February 2021. See also Kasher, 2009.

of medical systems in the situation created in the ghettos. Many of the modern medical institutions established by the Jewish communities during the interwar period had been left outside the ghetto boundaries delimited by the Germans. The Jewish physicians in the ghettos—victims themselves—chose to mobilize to establish alternative medical systems to those that had been forcibly taken from them. The medical staff suffered from the ghetto decrees like the rest of the Jewish population. Their choice to create medical systems as a part of the "enforced community" that had been robbed of all sources of livelihood and was suffering from gradual destruction, indicates a reaction pattern drawing on principles of professional responsibility to preserve health under all circumstances, including extreme conditions such as these. Dr Chaim Einhorn expresses this in his memoirs:

> [W]e often asked ourselves whether it was worth continuing to give medical care under such conditions. Despite it all, however, the doctors stayed at their posts until the last moment of the ghetto. And many of them continued their medical work, of this I am sure, to the last moment of their lives, some in the bunkers, some in concentration camps, and some in the ghetto uprising.[8]

This phenomenon is unique compared to other cases of genocide where the victims' medical systems usually collapse, *inter alia*, because of the speed of the massacre. The Jewish physicians made a moral, professional, humane, and ethical choice to establish medical services in conditions seen only in cases of mass atrocities. Even in impossible conditions, the medical staff worked and succeeded in setting up a medical system based on modern professional conceptions that included preventive medicine and hospitalization services, medical research, training, and medical studies.[9] Some of the services were legal and others were underground and involved risk to life.[10]

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8 Einhorn, 1958: 13.

9 Almost every large Jewish center had a healthcare system. The existence of a Health Department in many *Judenräte* attests to this. See Trunk, 1972, Chapters. 4 and 7. See also studies on the Jewish medical systems under Nazi occupation, e.g., Elkin, 1993: 53–91; Schwoch, 2009; van den Ende, 2015; Korek Amorosa et al., 1996: 503–508; Weiskopf, 81–84; Hájková, 2018; and Nadav, 2010: 53–64.

10 Many illegal activities took place in numerous ghettos. On clandestine activities in the Warsaw Ghetto, such as establishing the underground medical school and the underground hunger study, see Offer, 2020: 347–371.

CHARACTERISTICS OF THE DILEMMAS: MORAL DILEMMAS AND TRAGIC DILEMMAS

The medical work in the ghettos naturally presented physicians with the most difficult dilemmas. Medical staff in normal times encounter dilemmas daily, and certainly in emergency medicine or in mass-casualty incidents. However, the dilemmas facing the doctors in the ghetto were incomparably more serious. Among other things, they were required to perform selections from among their friends and patients, and to draw up lists of hundreds of people for extermination in Treblinka or for work in the ghetto. Physicians in normal life circumstances do not face such dilemmas.

One can distinguish between several types of dilemmas, even though the differences between them are not always absolutely clear. In this article, we will look at three groups of dilemmas: involving personal risk, conflicting obligations, and tragic ethical dilemmas. The first group includes dilemmas in which the medical staff were required or expected to help patients in distress while risking their own lives, to some degree. The overarching question here is the extent to which medical personnel should endanger themselves either to save or to provide help to the needy. The second group of dilemmas does not include risk to medical staff but involves a conflict of values or moral norms. These are moral dilemmas, in the accepted sense, in contemporary philosophical discourse. In this sense, dilemmas are situations presenting two conflicting obligations, which cannot both be fulfilled. The philosophical literature has fiercely debated the question of whether these dilemmas exist; that is to say, is it possible to have two conflicting obligations, from which the person has no way out, because either option will leave them morally deficient? A study of the difficult dilemmas facing the Warsaw medical staff casts a doubt on the validity of the philosophical stance that denies the tangibility of these dilemmas. The third group of dilemmas is tragic dilemmas, when the physician is faced with two very bad alternatives. In his book, *Moral Dilemmas*, Daniel Statman attempts to understand the concept of tragic dilemmas as referring to a moral choice between two bad options that may come at the cost of either destroying the decision-maker or strongly undermining their life. Such choices were not unusual for physicians in the ghettos, especially during the selections. In the tragic situations described, even though some of the medical staff

worked according to the "lesser of two evils" principle, it is clear from the sources that, after the event, they were troubled about whether they had acted appropriately. Some expressed guilt and remorse for their decisions, despite having acted involuntarily in enforced situations and having made the best possible decision for the specific dilemma.[11]

In essence, some of these ethical problems during the Holocaust affected many officeholders in the ghettos, especially *Judenrat* members, as well as rabbis. They included medical ethical dilemmas that raised issues surrounding medical treatment, while others did not involve medical considerations but confronted physicians in their roles in the *Judenrat* or Jewish Self-Help services in the ghetto. Both these types of dilemmas were part of the fate of the physicians and their challenges in the ghetto. These dilemmas were more central and pressing to the medical staff, who encountered them daily. Their lot included dilemmas that were unique to their position, e.g., the dilemma of active homicide, as they were sometimes forced to make decisions that would directly cause the death of Jews. I will present examples of these types of dilemmas from the Warsaw Ghetto, even though they arose in one way or another in nearly all the ghettos.[12]

DILEMMAS INVOLVING PERSONAL RISK AND DILEMMAS INVOLVING CONFLICTING OBLIGATIONS.

ABANDONING PATIENTS TO SAVE ONESELF

The closer the Germans advanced toward Warsaw in September 1939, the greater was the fear of occupation and of how they would treat the Jews. From then on, the medical personnel faced the dilemma of whether to continue to care for patients—and thus put their own survival at risk—or to think of themselves and abandon their patients. This was relevant to the physicians and nurses through

11 See, for example, Statman, 1995, Chapter 1.

12 For details of these examples of dilemmas, see Offer, 2020: 577–626.

different phases of ghetto life. With the outbreak of war, on the eve of the German occupation, many respected professionals tried to save themselves. On September 27, when the Germans invaded Warsaw, the hospital workers were afraid and anxious. At that time, Dr Amsterdamski and Nurse Sabina were working in the Czyste Hospital: "Now hell will gape before us," said Nurse Sabina, to which he replied: "Do not despair—Not all the Jews will be destroyed. . . but the Jewish people will not be destroyed. . . and therefore we must be strong and save whoever we can. . . ." Amsterdamski worked incessantly throughout that period. "It was a question of honor for us to help the doctors and together save those that could still be saved," wrote Sabina.[13]

These dilemmas were especially prominent immediately before and during the *Aktion*, when, like everyone else, the medical personnel wanted to save themselves. Nurse Sabina, in the Czyste Hospital, described her own dilemma of conflicting obligations: "In my heart, two great forces waged war: the duty of a nurse, who has sworn to live and die together with her patients and the hospital workers, and the mothering instinct that demanded that I preserve my life at all costs in order to save my daughter." After the January *Aktion*, she sent her daughter to the "Aryan" side, while she remained in the ghetto with her patients.[14]

Nurse Ala Gołąb-Grynberg showed exceptional dedication during deportations from the ghetto and rejected opportunities to save herself. She contacted Christian acquaintances outside the ghetto, to find refuge for Jewish children in Polish orphanages and churches. During the Uprising, Gołąb-Grynberg was sent to the Poniatów labor camp near Lublin, where she worked in the hospital, organized a children's corner, and took the children under her protection. "I am not entitled to leave the poor and helpless lambs," she said. She remained faithfully at her post until the end, together with the children and the 15 thousand remaining Jews from the Poniatów camp, and perished on November 8, 1943.[15]

Dr Anna Braude-Heller, the director of the children's hospital, relinquished the chance to save herself over her patients and her medical tasks in the ghetto.

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13 Gürfinkel-Glocer, 588.

14 Gürfinkel-Glocer, 587–590.

15 Turkow, 123–124, 291, 304.

In the end, she perished, together with her patients, during the ghetto Uprising.[16] During the deportations to the extermination camps, some of the medical staff risked their lives to rescue as many Jews as possible.

Dilemmas in which medical personnel are required to treat patients while risking their own lives are discussed also today. The Ethics Board of the Israel Medical Association has formulated its stance on endangering the medical staff. It is written that in an emergency, when physicians are forced into life-threatening situations by caring for patients, then the physician, together with other safety authorities, will evaluate the risk of entering the scene of the incident versus the obligatory need to save lives.[17] In other words, the Medical Association does not take an unequivocal stance regarding the most appropriate response in such a case. The historian Emanuel Ringelblum expressed his appreciation of medical staff who chose not to abandon their patients in their final moments:

> Earlier we mentioned the passive and quiet heroic stand of the educators and primarily that of Dr Korczak. We recounted how they went willingly to their deaths, accompanying the children. . . . The conduct of the doctors and nurses at the Jewish hospital was similar. . . . Everyone knew that the hospital would not be excluded from the deportation. Therefore, a number of the doctors and nurses left. However, a group of a few dozen doctors and nurses stood guard and did not abandon the patients until the very last moment. When this tragic moment arrived, and more than a thousand patients were loaded onto the train cars, a small number of doctors and nurses went with them. Such was the behavior of the people who were viewed as subhuman by the Nazis.[18]

RISK BEING INFECTED BY PATIENTS OR STOP WORKING WITH THEM?

The work of physicians and nurses in the ghetto carried the risk of contracting very serious illnesses to which they would not normally be exposed. Therefore,

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16 Waller; Gürfinkel-Glocer, 595.

17 "ההיבטים האתיים באירוע רב-נפגעים" [Ethical Aspects of a Mass-Casualty Event].

18 Ringelblum, 1994/1988: 37.

the medical staff were faced with the dilemma of whether to continue their medical duties. Between 30 and 40 percent of the physicians contracted typhus, and many of them died. The living quarters of the thousands of refugees who streamed to the Warsaw Ghetto were a hotbed of disease and mortality. Dr Lensky's descriptions provide a glimpse of the dilemmas. After the health department proposed that he work in the refugee center, he described his deliberations:

> Typhus was still rampant. It seemed foolish to put my head in the noose to engage in medical work at a facility where poor hygiene made infection a near certainty, of my own free will, especially when I was under no financial or moral pressure and certainly was not lacking work.[19]

When he returned home from visiting the refugee center, his wife tried to convince him not to take the post and succeeded. The decision pricked his conscience, however:

> Mixed feelings raged in me, my love for my family was at odds with my conscience . . . still I was obliged to be with the refugees, to offer them comfort, encourage them. . . . I couldn't fall asleep that night . . . tossed and turned, but to no avail.[20]

The Israeli Medical Association's paper on the physicians' risk of exposure while treating infectious patients, reads as follows: "Should the system be unable or unwilling to provide the means . . . the doctor is not obliged to endanger themself beyond the limits they shall voluntarily set upon themself along with their colleagues and other experts." Limits are not defined, and the dilemma remains.[21]

REFUSING TO REPORT CASES OF TYPHUS TO THE AUTHORITIES

As the Germans were afraid of infection with typhus if it were to spread outside the ghetto, they demanded that the physicians report all typhus cases, under threat of deportation if they failed to do so. Reporting would lead to isolation of

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19 Lensky, 2009: 80.

20 Lensky, 2009: 86.

21 See the section on ethical principles for a biological event in "ההיבטים האתיים באירוע רב-נפגעים".

the patient, the entire family, and all the building's inhabitants, including cruel and ineffective disinfection processes, which led to more disease and even increased mortality. Therefore, after diagnosing typhus cases, physicians were faced with the moral dilemma of whether to report them. Testimonies show that many doctors in the ghetto violated the Germans' orders and treated typhus patients in their homes. This issue involved indecision, danger, and many difficulties, and some physicians cooperated with patients in exchange for bribes.[22]

TRAGIC ETHICAL DILEMMAS

When the Germans began deporting the Jewish ghetto population to the extermination camps, the physicians' tragic dilemmas became more intense in deciding between two bad alternatives. One of the most difficult tragic dilemmas facing officeholders in the ghettos related to selections—whether to cooperate with the Germans' demands to draw up deportation lists and, if so, how to organize these lists; in other words, how to determine who would live and who would die.

PHYSICIANS FORCED TO MAKE SELECTIONS: WHO WILL LIVE AND WHO WILL DIE?

In the ghetto, directors of Jewish hospitals, senior physicians, and other medical staff sometimes had to perform selections from the hundreds of medical personnel and their families employed in the various medical institutions, as well as from among the hospitalized patients. This meant implementing the Nazi decrees, and physicians' direct and personal involvement in sealing the fate of their colleagues.

Every department had to report the number of its patients and staff. Dr Marek Balin wrote:

> The Jews themselves had to surrender their brethren to death, and turn over people who were unfit, fragile, unable to walk. . . . They struggled to keep the secret from the pa-

22 Lensky, 2009: 12, 103–104.

tients, who nevertheless instinctively sensed the encroaching danger. That day, the patients were despondent and there was fear in their eyes. Muffled sobbing was heard from the women's cells. . . .

The department directors had to decide which patients would be included in the list of deportees: "They had to place one of two marks next to each name: (+) meant death, and minus (–) indicated remaining in the hospital. . . ."[23]

In the final stages of the *Grossaktion* for deporting the Warsaw Ghetto's Jews to Treblinka, every *Judenrat* department received a quota of people exempted from deportation, who were recognized as workers needed by the Germans. Under these circumstances, senior physicians had to decide which of the workers would be included among those who received a "life number," and those who would be deported. The exemption selection criteria were different in each department. For instance, it was decided that senior physicians should be left to serve as department heads; another criterion was professional seniority, and another was to save entire families rather than individuals. When it was decided to spare the department heads, their wives and children were given life numbers as well. This made sense, but the maintenance workers and some of the ordinary doctors paid the price. Some felt that as many workers as possible should be spared, and specifically individuals without children, but it seems that no principle was adhered to absolutely, with deviations that benefited some and not others. Dr Polisiuk was a gynecologist in the Czyste Hospital, who perished following the ghetto Uprising. In his notebooks, he addressed the ethical considerations that accompanied the decision-making in this tragic situation. He writes that, on the eve of the *Grossaktion*, the Germans allowed 35 thousand out of the 350 thousand Jews to remain in the ghetto. According to this, the *Judenrat* established a quota for each department, and the department directors had to supply a list of names. The quota for the hospital wards, which held some 800 people, was a mere 220. In this situation, people frantically sought connections and favoritism. According to Dr Polisiuk, the view of the general public was that the council and the department heads should not have undertaken this task. They should have left it to the Germans, even though this would have cost them a larger number of victims. It is clear from his words that when permitted to

23 Balin.

leave such a limited number of people in the ghetto, with the best will in the world, there was no just solution to such a tragic problem.

Dr Polisiuk was on the list to remain in the hospital. Since none of the members of the *Judenrat* wished to read it out, and as many of the workers had requested his assistance with the task, he agreed with a heavy heart:

> It was the most tragic moment in my life. As I read out the list, I announced the death sentence of six hundred innocent people, close friends, comrades and workmates, and even my former boss. . . . I consoled them with the hope that there would be another list, although I myself did not believe it.[24]

WHOM TO SAVE FIRST

Many of the medical personnel included in the list of workers, and who had not been deported to Treblinka in the initial stages, risked their lives to try and save as many Jews from the Umschlagplatz as possible, taking advantage of their medical role. The survivors' testimonies suggest that the medical staff in the ghetto had to decide who should be saved. The testimonies indicate preference for work colleagues, family members, and members of the underground over any random person who requested assistance. In addition, preference was given to members of the intelligentsia, who the medical staff thought should be saved at all costs.

Compared to medical dilemmas today, it is interesting to note that Dolev and Priel examine the ethical considerations guiding activity during mass-casualty incidents, which raise dilemmas with a certain similarity to the situation in the ghetto regarding the question of priorities in medical treatment. They claim that this has scarcely been addressed in medical ethical literature and suggest that it may simply be to avoid a painful subject that has no easy solution.[25]

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24 Polisiuk.

25 Priel and Dolev, 2001: 574–577.

EUTHANASIA BY PHYSICIANS AND NURSES DURING THE *AKTIONEN*

When the Germans broke into the hospital and cruelly evicted the patients, when all hope of saving them was lost, some physicians and nurses performed "euthanasia" on their family members, as well as on old people and children who lay in the hospital. Adina Blady-Szwajger, a pediatrician in the hospital, wrote as follows in her memoirs:

> I got two large containers of morphine. . . we took a spoon. . . . And just as, during those two years of real work . . . I bent down over the little beds, so now I poured this last medicine into those tiny mouths. . . . I told them that this medicine was going to make their pain disappear. They believed us and drank the required amount from the glass. And then I told them to undress, get into bed and sleep . . . the next time I went into that room, they were asleep. . . .[26]

"This is very problematic behavior," argues Prof. Steinberg, and goes on to say that

> Any act of homicide, even if committed with humane intentions, is murder, nevertheless. The morphine that was injected caused certain death, and had it not been injected, who knows? Maybe the patients would have managed to go into hiding, maybe the Germans would not have arrived, maybe something would have happened at the last moment.[27]

The American physician Ralph Yodaiken disagrees:

> I believe that Dr Szwajger, staring into the well of life and death and knowing what was expected, chose the only option for the patients whom she loved and allowed them to die in dignity. Her actions should be seen as a full-fledged act of rebellion. She denied the murderers the pleasure of slaughtering those under her care.[28]

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26 Blady Szwajger, 1990: 53–58.

27 Negev and Koren, 2003: 53–56.

28 Negev and Koren, 2003: 53–56.

KILLING INDIVIDUALS TO SAVE THE GROUP

During the *Grossaktion*, many people tried to hide. Some diaries and memoirs describe a difficult ethical problem regarding the decision to kill individuals who endangered others in the hideout. Although these dilemmas were not directly related to the medical staff and occurred outside the hospital, physicians and nurses were sometimes asked to assist in carrying out these procedures by virtue of their professional backgrounds. The physician Adina Szwajger testified to assisting in the homicide of a woman with mental illness whose behavior endangered the lives of those hiding with her.

> I don't know, perhaps I should have refused. After all, it wasn't a job for a doctor. Except that no one understood this. There was no other doctor among us at that time. And so I didn't have anyone to talk to, to tell that I would rather die than . . . carry out euthanasia on someone who was mentally ill. . . . She posed a mortal threat for the landlords and for the half a dozen or so young people hiding in the house, among them her own daughter. . . . But I did it. At the request of her daughter.[29]

CONCLUSION

In this article, I have addressed research on ethical dilemmas that faced the medical staff in the ghettos. I have drawn attention to the great interest evoked by the topic today, expressed also in the Medical Association's contemporary position papers as an increasingly emerging issue, especially in light of the prominent medical ethical dilemmas that arose during the COVID-19 pandemic. I have pointed to the need to examine the dilemmas in broad historical contexts rather than discussing isolated climactic events while disregarding the events in the ghetto and of the historical period, which were an important factor in coping with the dilemmas. The influence of the pre-Holocaust Jewish society's medical activity on the Jewish medical activity in the ghettos must be included and examined. I have pinpointed

29 Blady-Szwajger, 1990: 150.

the relationship between the prevailing medical perceptions in the Jewish interwar medical services and the medical staff's coping patterns with dilemmas they confronted in the ghettos. The ghetto physicians drew inspiration from the developed professional and social values that characterized the TOZ organization in Poland between the world wars. Many of its member physicians operated later in the ghettos within the spirit of these values.

I have reviewed a small sample of ethical dilemmas that were recognized as such by medical workers in the ghettos, from the outbreak of the war until the liquidation of the ghetto. Some dilemmas involved the threat of death hovering over the heads of the medical staff, some entailed a clash of obligations, and others were tragic dilemmas that demanded a decision between two bad options. Dr Lensky wrote in his memoirs:

> It must be noted that of the 830 doctors present in the ghetto, very few did not measure up morally. Some doctors abused their patients' trust, out of greed . . . but such cases were rare, and the number of doctors whose deeds would have been condemned by any society was negligible.

According to the philosopher Nagel, people sometimes find themselves in situations of bad circumstantial luck.[30] Some withstand these moral tests and others fail. Among the Jewish physicians and nurses in Warsaw and in other ghettos, some endured the difficult tests admirably, working incessantly while risking their lives to offer help to their suffering brethren. At the other extreme were the few who acted out of corruption and neglected their professional obligations, and there were many others in between.

According to the diaries and testimonies, the ethical question seems to have been high on the agenda of officeholders in the health field. The medical staff worked relentlessly until the final stages of the ghettos. On the upcoming 80th anniversary of the Warsaw Ghetto Uprising in 2023, we must remember the Jewish physicians who chose to stay with their patients and offered medical assistance to the thousands of Jewish civilians fighting in the bunkers and to the rebel groups fighting in the ghetto. Despite these efforts, hundreds of thousands of Jews lost their lives due to starvation and to other appalling ghetto conditions that had been

30 Nagel, 1993: 57–71.

created by the Germans. Nonetheless, until the start of the deportation to the extermination camps, most of the ghetto inhabitants survived, thanks to the medical services, and they had hoped to survive the war. The fate of most of the Jewish medical staff was the same as that of the Jews in the ghetto. After their prolonged, exhausting, and dangerous work in serving the community, most of them were deported for extermination.

From the ethical perspective, the picture emerges of the medical staff as a collective which chose to make a valiant effort to provide a professional, ethical, and humane medical service in impossible conditions. In many ways, this medical system indicates the possibility of remaining physicians who are loyal to the noble medical mission, even under extreme circumstances. This possibility is an important legacy that the Jewish doctors have left to the world in general, and to the history of medicine in particular.

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The Polish brains transferred to Germany in 1939–1940 and Series M in the Kaiser Wilhelm Institute for Brain Research

Paul J. Weindling

On 25 May 1990, the Max Planck Society commemorated a collection of brain specimens which it had finally buried. The brain specimens had come into the collections of its Institute for Brain Research, Institute for Psychiatry, and a few from Institute for Neurology.[1] The burial was collective, and

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1 Weindling, 2012: 237–242.

the two preliminary listings made for the Brain Research Institute by the neurologist Wolfgang Schlote and neuropathologist Elisabeth Rothemund were inaccurate and incomplete. The question arises what exactly was buried and what happened to the brains listed as "Series M."

Another relevant question is whether items from the list of "M" (*Militär*) brains were also buried on this occasion. Information on these brains comes from a list of 1,500 brains described as "M" (*Militär*). The list only gives diagnoses, family names, and location.[2] The fact that some specimens are clearly Polish and female indicates that civilian brains were also received during the Second World War. The neuropathologist Jürgen Peiffer, author of a biography of Julius Hallervorden, deduced these brains came from the Warsaw Ghetto, an assumption endorsed by Hans-Walter Schmuhl.[3] This was a mistaken belief, as the historical reality is much more complex.

When the war broke out in 1939, neuropathologist Julius Hallervorden established Sonderstelle zur Erforschung der Kriegsschäden des Zentralnervensystems, a special military research centre at the Kaiser Wilhelm Institute for Brain Research, Berlin-Buch, for the study of injuries to the central nervous system sustained by war casualties. One of the reasons why Hallervorden wanted to have such an establishment, which was placed under the Academy for Military Medicine in Berlin, was to retain his research staff.[4] By early 1940, more and more brains were being transferred to the new research unit,[5] and Hallervorden was appointed *Kriegsassistenzenarzt* (assistant military physician).[6]

What exactly were the brains collected and how many of them came from civilians in German-occupied Poland? When the Max Planck Society launched a provenance project, I recommended a full study of these brains, along with the brains of

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2 AMPG (German *Archiv der Max-Planck-Gesellschaft*, Archive of the Max Planck Society, hereinafter AMPG), Ref. No. III, Rep. 55, No. 55-7, Schrank 524.

3 Schmuhl, 2000: 36.

4 AMPG, Ref. No. I. Abt., Rep. 1 A, 1583, Spatz an KWG, 21 December 1939.

5 BAMA (German *Bundesarchiv-Militärarchiv*, Military Archive Department of the German Federal Archives in Freiburg, hereinafter BAMA), Ref. No. RH 12-23, No. 571, Julius Hallervorden's scientific progress report on the first two years of the Special Office for the Research of War Damage to the Central Nervous System, 1941 (see comment 2).

6 Weindling, Hohendorf, et al., 2021.

Allied (including Polish) prisoners-of-war and prisoners (including Polish forced labourers) executed following death sentences handed down on them under the Nazi VGH (*Volksgerichtshof*, People's Court) system of "summary justice." The extraction and use of these brains violated the Geneva Convention requirement that bodies should remain intact. Michał Palacz, with whom I am collaborating on the brain provenance project at Oxford Brookes University, has researched records of the autopsies conducted at Czyste hospital, Warsaw, before it was moved into the Ghetto. Dr Palacz found that the German military administration ordered Czyste hospital to conduct autopsies, which were carried out under German supervision. In our project, Dr Palacz researches Polish-held sources, while I examine German documents preserved in the Max Planck and other German archives and in France, concerning the transfer of human brains by the Wehrmacht. Records held in the Bundesmilitärarchiv (Military Archive Department of the German Federal Archives in Freiburg) prove that the German military carried out autopsies for the removal of brains from the bodies of civilian (mainly Jewish) victims. There are extant receipts signed by Hallervorden and his assistant Bernhard Patzig. These documents are held in a large collection of records for brain autopsies, filed under diagnosis. Series RH 12-23 in the German Military Archives contains documents concerning the organization of and publications on the brain specimen series denoted as "*Militär*" with the letter "M" followed by numbers (the designation for 1,500 brains in Hallervorden's collections, described as "military brains") and pathology reports on individuals in German-occupied Poland, many with a report by Hallervorden and Patzig.

In 1945 Leo Alexander, an American neurologist on a military mission to describe German military innovations in physiology, psychiatry, and neurology, put these brains from Warsaw in a report he compiled on Hallervorden's description of "euthanasia" brains. Alexander's report is often cited, but there are few (if any) mentions of the Polish brains, of which he made fairly detailed records in a macaronic mix of German and English. In his logbook, Alexander noted down all the official titles Hallervorden prided himself on, presenting himself as the man in charge of the military department for nerve damage studies:

> Dillenburg, Schloss Hotel. *Untersuchungsstelle der Kriegsschäden des Zentralnervensystems, Heer. Dr Hallervorden, Julius: Prof., Abteilungsvorsteher am KWI für Hirnforschung, histopathologische Abteilung. 1939–1943 als Sonderführer, Leutnantsrang, Heer. Oberfeldarzt* was in charge.

As the war was drawing to a close and Allied bombing raids intensified, Hallervorden's team left Berlin, taking "a large part of their histopathological collection" with them on a westward evacuation route:

> Evacuated from Berlin to Dillenburg in May 1944, *wegen Bombardment. Ein großen Teil* [*sic*] *der histopathologischen Sammlung hergebracht*, including Dr Bielschowsky's collection.

Alexander met Hallervorden and conducted several interviews with him. He sleuthed out the figures in Hallervorden's records, and in one of his logbook entries wrote of "countless" brains collected from typhus patients, with two hundred cases "to start with" from "the Jewish Hospital in Warsaw." He then went on to question Hallervorden's remarks on "cortical damage" (*Rindenschäden*):

> *"Ungezählte" Fleckfiebergehirne, am Anfang 200 Fälle aus d. Jüdischen Krankenhaus in Warschau*. Estimated 300 total. Confirmed Spielmeyer's findings. *Rindenschäden*: early changes, more to pretext than fully developed. None with real softenings. No cases who had the interesting parkinsonism changes during life, considers them due to vascular changes.
>
> Reports (1940/41): *Knötchen* [nodules], sometimes with necrotic centre. Possibly as reactions to dispersions of blood and plasma. . . .

Alexander noted the results of a histologic examination and that there were

> [n]o cases from KZ. Here only histologic preparations. The brains are in *Berlin-Buch*.

He was also interested in the publications which Hallervorden's research team was working on, and mentioned a paper by Walter Volland on encephalitis, which was stopped by the military censor. Another paper, by W. J. Eicke on meningitis in children, was due to appear in *Virchows Archiv* in 1945. The third paper Alexander cites, by Hallervorden himself, was published in 1944.

> W. Volland: *Zur Frage der parainfektiösen (perivenösen) Encephalitis (Impf- und Masern-Encephalitis). Virusinfektion oder alergische Krankheit? ("Gesperrt" vom Oberkommando der Wehrmacht*, because vaccinal encephalitis was mentioned [26-IV-44]).
>
> W. J. Eicke: *Gefäßveränderungen bei Meningitis und ihre Bedeutung für die Pathogenese frühkindlicher Hirnschäden*. In press, *Virchows Archiv* 1945.

J. Hallervorden: *Infektiöse Granulome und Blastomencephalitis*. In preparation. Pseudotumors. . . .[7]

After pausing to mention Jewish colleagues who had emigrated, Hallervorden then plunged into a highly revealing account of how he received batches of "euthanasia victim brains."[8]

Hallervorden's frank account of the "euthanasia brains" appeared in Alexander's printed report, which in turn was cited at the Nuremberg International Military Tribunal. This caused Hallervorden considerable problems from 1945 onwards.[9] However, as the specimens from Warsaw and other places in occupied Poland as well as "civilian" brains were generally overlooked, let me now review the small number of surviving documents.

Michał Palacz and I have found 211 *Fleckfieber* (typhus) brains in Series M, including 188 from Warsaw. Of these, 125 came via Czyste Jewish hospital to the Kaiser Wilhelm Institute for Brain Research at Berlin-Buch through the Academy for Military Medicine. At least 160 of the 211 brains were from Jews. In addition, nine brains were from Lublin, two from Częstochowa, and one from Radom. One was from a Soviet POW, and eleven others were sent by German pathologists from France, the Soviet Union, and Romania.

Hallervorden and his assistant Bernhard Patzig acknowledged the receipt for most of these brains with a short report in their file. Berlin-Buch was the original location of Hallervorden's department. After he left in 1944, the brains were stored in a chapel and were subject to an interzonal exchange agreed on 5 January 1950 for Walter Friedrich's radiation research equipment at the Institut für Strahlenforschung. With this agreement in place, Hallervorden's brains arrived in Dillenburg. The brain specimens were then transferred to Giessen and finally to Frankfurt.[10]

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7 Duke University Depository for Medical Center Records, 65th General Hospital, Leo Alexander Papers, box 3, Leo Alexander's diary, pp. 171–173. Weindling, 2004: 82–84.

8 CIOS (Combined Intelligence Operations Subcommittee), Ref. No. XXVII-1. Leo Alexander, *Neuropathology and Neurophysiology, including Electroencephalography, in Wartime Germany*, completed 20 July 1945.

9 AMPG, Ref. No. II 1A PA, Julius Hallervorden 5, note by W. Kruecke, 9 May 1983.

10 Bielka, 1997.

German medical researchers established a central storage system to distribute and provide access to copies of field autopsies. In this case, the brain specimens were sent in as well. Although Hans Schleussing, *Prosektor* (specialist in dissection) at the Munich German Research Institute/Deutsche Forschungsanstalt for Psychiatry, served in Warsaw for a period, he did not send any specimens to Hallervorden.[11] In addition to some documents from Warsaw, there are also military registers for German-occupied Poland with records of autopsies carried out on Polish civilians. The German Military Medical Academy emerges as a key institution for the supply of brain sections. To complement Dr Palacz's research on Polish sources, I am researching the military autopsy reports that provide full names and other details.

Epidemic typhus had been a problem in German-occupied Poland since December 1939. The expulsions from the western part of Poland which was directly annexed and incorporated in Germany as the "Warthegau" meant that Jews were evicted and most of the impoverished ones were "resettled" in refugee shelters in Warsaw. Lists of all patients suffering from infectious diseases in Warsaw hospitals were regularly submitted to Kurt Schrempf, the *Amtsarzt* (German medical officer) for the City of Warsaw.[12] The German military and health authorities required autopsies of typhus cases. 197 specimens from Warsaw are listed in the Kaiser Wilhelm Institute for Brain Research under M-numbers, including 188 cases involving brain inflammation. Ironically, the Warsaw Ghetto was established just when the incidence of typhus was at a low point.

We used patient records from Czyste Jewish hospital and Chocimska hospital for infectious patients, and managed to identify 149 (79%) typhus victims by name, gender, and age at death. This figure included 129 Jews (78 men and 51 women) and 20 non-Jewish Poles (12 men and 8 women).[13] Additional cases were reported by the German pathological and anatomical military investigation units in Warsaw

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11 See BAMA for Schleussing's military autopsies in Warsaw and the Caucasus.

12 State Archive in Warsaw, Ref. No. 483, Der Obmann des Judenrates in Warschau, 1940–1942, records of infectious diseases patients from different hospitals in Warsaw, 1939–1940, No. 46–66.

13 State Archive in Warsaw, Ref. No. 483, Der Obmann des Judenrates in Warschau, 1940–1942, patient records of typhus victims from Czyste Jewish hospital in Warsaw, 1939–1940, No. 57 and 66; Ref. No. 1293, Spuścizna dra Mikołaja Łąckiego, Epidemiological data on typhus, 1940–1943. See also BAMA, Ref. No. RH 12-23, No. 3081-4147, Autopsy records sent to the Military Medical Academy in Berlin, with enclosed brain autopsies conducted by Hallervorden and Patzig.

and Kraków.[14] Overall, additional 40 persons can be identified from the index to the Military Medical Academy pathological and anatomical records, where they are classified by disease. Although that still left 15 Series M brains from Warsaw anonymous, we have managed to identify two more by name. The autopsy records, which were transferred to the Federal German Military Archive in 2002, will help us make further identifications.[15]

LUBLIN

There are 43 brain specimens from Lublin in the military series of M-numbered specimens, including 13 typhus cases. Open cases can be identified by means of the index of names. For example, M-658, Nudelstejn, diagnosed with "endocarditis," can be identified as Mania Nudelstejn, a Polish-Jewish woman, aged 36 years, from Nałęczów. Based on her preserved autopsy record, Hallervorden and Patzig compiled a histologic report and diagnosis for her on 25 September 1942.[16] We have identified a total of eight brains from Jewish typhus victims from the Lublin region.[17]

Leichenöffnungsbefundsberichte (autopsies) were carried out in peripheral locations. The largest number of these were conducted in Czyste Jewish hospital, Warsaw, before the hospital moved into the new Ghetto. Multiple copies were made of the autopsy reports. One was held by the pathology department of the Military Medical Academy, the headquarters for the autopsy records. These documents are now in the Federal German Military Archive.

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14 BAMA, Ref. No. RH 53-23, No. 107 and 108, Pathologisch-anatomische Heeresuntersuchungsstelle Krakau, Sektionstagebuch, 1940 and Pathologisch-anatomische Heeresuntersuchungsstelle Warschau, Sektionstagebuch, 1941.

15 Cf. AMPG, Ref. No. III. Abt., Rep. 55, No. 55-8, M-418 and M-427; BAMA. Ref. No. RH 12-23, No. 3147, *Militär* with autopsy records for Paweł Garliński (K.II.2 47) and Stanisław Pado (K.II.2 48), 1941; State Archive in Warsaw, Milanówek branch collections, Ref. No. 657-20612 and 657-22540 (prison records of Stanisław Pado and Paweł Garliński, 1940–1941). I carried out the Berlin and Freiburg research and Dr Palacz conducted the research in Warsaw.

16 AMPG, Ref. No. III. Abt., Rep. 55, No. 55-8, M-658, M.II 1034, *Militär* with autopsy record for Mania Nudelstejn, 1941–1942; BAMA, Ref. No. RH 12-23, No. 3341.

17 BAMA, Ref. No. RH 12-23, No. 3146 and 3147, autopsy records for typhus cases.

Brains were sent variously by the German Army Pathological Laboratory in Warsaw. The neuropathologists who sent the brains included:

— Dozent Dr Gerhard TÖPPICH (1892 – ?),
— Dr Carl Paul BÖHNE (1900 – after 1972),
— Prof. Edmund RANDERATH (1899–1961),
— Dr Walter HERZOG (1913–1997),

Autopsy protocols, fixed organs, and tissue sections were sent to the Military Medical Academy in Berlin:

— The brain specimens of 147 Series M victims of the first typhus epidemic in Warsaw have been identified so far.
— Emminger carried out the autopsy of Stefan Szajer in the Seuchenlazarett (Szpital Miejski) on 12 January 1940. Another body was autopsied there by Dr J. Sekomski.
— Overall, Emminger transferred 199 brains to Berlin. One was from France but the rest were from German-occupied Poland. In 1943, Randerath was appointed head of the Wehrpathologisches Institut (the German Institute for Military Pathology). The system of sending reference reports was in use almost until the end of the war in 1945.

Scientifically speaking, Hallervorden did not subscribe to the racist view that a Jewish brain was different from an "Aryan" brain. The "military" brains of German soldiers and brains derived from Polish civilians, most of whom were Jewish, were just as good for his purposes. The publications include both. He told Alexander of a number of them, along with further details relating to the brain specimens and how he and Patzig processed them.

After the wartime evacuation of May 1944, in 1950 there was an exchange agreement between East and West Germany for the transfer of the brain specimens. The brains were transferred from Dillenburg to Giessen and thence to the Edinger Institute in Frankfurt. Brains from the M-list were moved to the Neurological Institute in Frankfurt and deposited in *Schrank* (cabinet) 524. The records are far from complete. Were the Series M specimens buried in the Waldfriedhof cemetery in 1990, or were they disposed of earlier? Were the records disposed of earlier, or simply not archived in or around 2006 when Hallervorden

and Spatz's materials were transferred to the Max-Planck-Gesellschaft Archive in Dahlem?

On 5 August 2019, when Gerald Kreft, the Edinger Institute's archivist, sent me a list of M-numbered (but not named) wet specimens, I could link the specimen number to a family name, and the name to an autopsy report in the German military archive in Freiburg. We managed to identify two out of the 17 specimens carrying M-numbers as brain specimens derived from the Jews who died in Warsaw in 1940. These included specimen No. M-58, which we identified as belonging to Icchak (Izak) Wesołek, a Polish Jew aged 45 years (probably a refugee), who died of typhus in Czyste Jewish hospital in Warsaw on 27 February 1940. He lived at Leszno 66 in a home for Jewish refugees. Wesołek was admitted to Czyste hospital on 23 February 1940 and died there on 27 February 1940. His autopsy was carried out on 28 February 1940 by *Ass. Arzt d. R.* Dr Carl Böhne of the Pathologisch-anatomische Heeres-Untersuchungsstelle in Warsaw.

Most of these typhus victims had been deported from or had fled the German-annexed Warthegau. M-64, the brain belonging to Israel Szlachtur (also known as Izrael Schlachtuz), was another specimen from Warsaw. His pathology report is filed under "*Krieg und Hautkrankheiten*" (wartime and dermatological diseases), as the diagnosis was "*pemphigus vulgaris*." He was born in 1887, lived at Hoża 62/31, and died on 28 March 1940.[18]

We were very surprised to learn that there could still be specimens in the *Schausammlung* (collection on display) at the Edinger Institute in Frankfurt-am-Main in 2019. The Edinger Institute was founded in 1883 and is the oldest brain research institute in Germany with donations from a Jewish family. It became part of Frankfurt University when the University was founded in 1914. After a decision was made in 2019 that the specimens were to belong to the Max Planck Society, they were moved to the Ernst Strüngmann Institute for Neuroscience, Frankfurt, under an agreement for cooperation with the Max Planck Institute, which adopted the Vienna Protocol principle endorsed at a 2017 symposium at Yad Vashem, which says that historical provenance research should precede religious burial.

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18 AMPG, Ref. No. Abt. III, Rep. 55, No. 55-8 Militär, M.64, Nachlass Julius Hallervorden; Edinger Institut Schausammlung, Case G32. BAMA, Ref. No. RH 12-23, No. 3774, Militärärztliche Akademie.

This raised the still unresolved question of the disposal of the Series M human remains. Clearly some brains had been retained because they were considered to have an "enduring scientific value." The M-numbered "military" brains are on a 1965 shelf list drafted by the Neurological Institute, but not on Wolfgang Schlote's list, which was drafted prior to the Munich collective burial. Some issues of identification and scientific utilisation of Series M are still to be reconstructed.

I would like to extend my sincere thanks to Dr Michal Palacz for providing information for this paper.

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Carl Clauberg's forced sterilizations in Auschwitz. New findings from little-noticed original documents on the human experiments conducted in Block 10

Hans-Joachim Lang

In 1967, authentic evidence documenting criminal human experimentation arrived at the Chief Commission for the Investigation of Nazi German Crimes Committed in Poland [Polish: Główna Komisja Badania Zbrodni Hitlerowskich w Polsce—Translator's note].[1] The evidence consisted of 26 X-rays that were found in a warehouse by the Red Army after they had liberated the German Concen-

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1 The collection is now in the archives of the IPN (Instytut Pamięci Narodowej—Poland's Institute of National Remembrance).

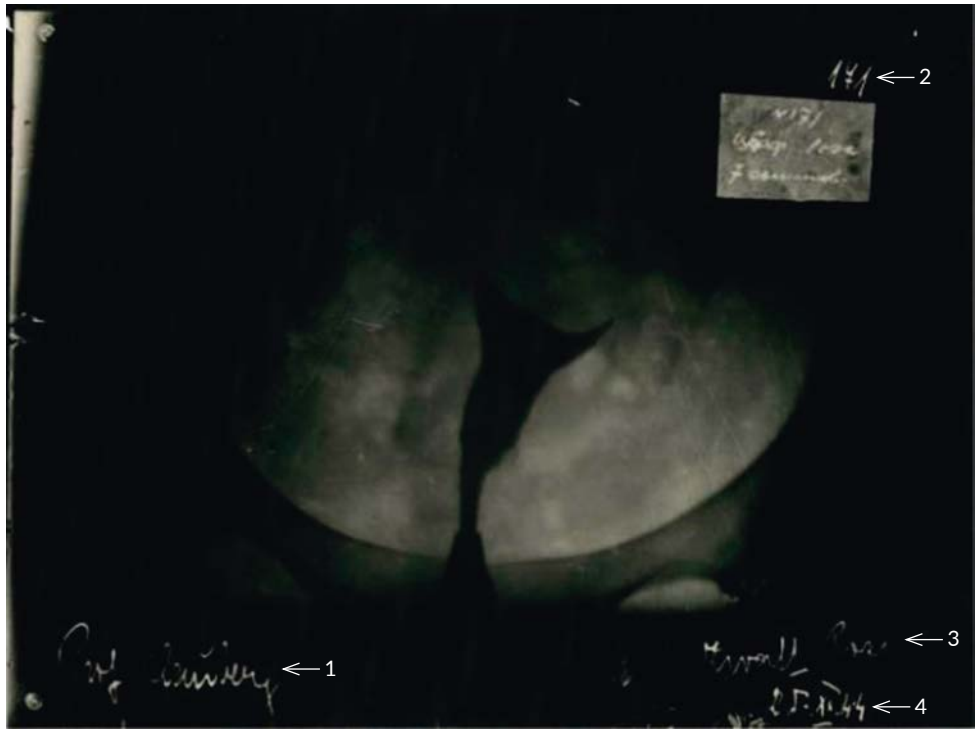

Photo 1. A hysterosalpingogram of prisoner Rosetta Zwaaf with information referenced in the main body of the text marked: 1—the name of prof. Clauberg; 2—the three-digit identification code. 3—the name of the prisoner; 4—the date. Source: Archives of the Main Commission of Investigation of Nazi Crimes in Poland (Archiwum Głównej Komisji Badania Zbrodni Hitlerowskich w Polsce), ref. No. DDM 15428, now in the possession of the Polish Institute of National Remembrance

tration Camp Auschwitz-Birkenau. A small segment of the public learned about the findings nine years later in a report that appeared in the Polish journal of the Kraków Medical Society, *Przegląd Lekarski – Oświęcim*. The author of the report was the gynecologist and Auschwitz survivor, Czesław Głowacki. Using these pieces of medical evidence, Głowacki was able to shed light upon the sterilization experiments that the German gynecologist, Carl Clauberg, had undertaken upon female prisoners.[2] Głowacki's first publication on this subject appeared just three years before the publication of the journal article.[3]

2 Głowacki, 1976: 85–90.

3 I would like to thank Dr Maria Ciesielska for the information she provided on this point. See Ciesielska, 2021: 363–380.

According to Głowacki, the X-rays were the world's only remaining original piece of evidence that documented Clauberg's criminal experiments. All of the radiological images are the same size: 18 centimeters high and 25 centimeters wide. Each image shows a uterus. To the lower left of the images appears the name "Prof. Clauberg" and to the lower right, a woman's name appears with the date "1944" just below it. In the upper right corner, a three-digit code is given. In total, there are seven different women's names and seven different codes. The codes and the numbers clearly correspond to each other. On nine of the 26 images, the company name "Agfa" can be seen along the left side of the image. According to the historical records, no less than 2 and no more than 7 such images were taken of each person between February 28 and November 26, 1944. The last of these images were produced on November 25 and 26, a Saturday and Sunday. These were presumably Clauberg's last X-rays from Auschwitz.[4]

1.

The radiological images were produced as a part of a hysterosalpingographic procedure, during which the Fallopian tubes are examined.[5] Towards the end of the 1920s, this gynecological procedure had become established as a reliable diagnostic method for ascertaining tubular blockage. Between 1928 and 1929, during his training as a medical consultant at the University Hospital of Kiel (Germany), Clauberg had become familiar with this technique. Clauberg's experiments, particularly those on hormonal therapies for tubal occlusion, were published in numerous scientific journals and made him well-known both inside and outside of Germany.

Through such research, Clauberg was perfectly aware of the possible side effects that could accompany hysterosalpingography. The contrast medium could,

4 During his interrogation, on August 22, 1956, Clauberg stated that he believed he had conducted follow-up examinations "until November 1944." Landesarchiv Schleswig Holstein (hereinafter LASH), Abt. 352, Nr. 16460, Pg. 5.

5 This work is based on further investigations published by the author. For more, see in particular: Lang, 2019. A revised and expanded version appeared in German in 2011.

for example, lead to chronic inflammation which in turn could result in complete blockage of the Fallopian tubes. Given that fact, it was logical, albeit unethical, to reason that the same procedure could be used in reverse to intentionally cause tubular blockage. Between 1933 and 1940, a similar method involving electrocoagulation of the Fallopian tubes had already been used in animal experiments conducted by Clauberg's supervisor, Felix Mikulicz-Radecki, at the University Hospital in the city of Königsberg (now Kaliningrad). Clauberg reasoned that the lessons learned from this animal experimentation could be applied to humans.[6]

What began as intellectual musing, Clauberg put into action. In his writings, he used eugenics or, more precisely, the so-called "racial hygiene" program of the Nazi Party, as a medical indication for the sterilization of women. After an appointment with Heinrich Himmler on March 22, 1940, Clauberg set about turning his theory into action. His goal was to develop a minimally invasive sterilization technique that could be used *en masse*. In accordance with Himmler's administrative policies, such a medical procedure was to be integrated into the Nazis' militaristic plans to dominate Eastern Europe. Fertile women who were classified as "racially inferior" could then be quickly, reliably, and surreptitiously sterilized in large numbers. From the Nazis' perspective, an added bonus of this large-scale forced sterilization method was that it made it possible to exploit the victims as slave laborers for as long as possible while leading to the gradual elimination of entire unwanted populations. Himmler himself coined the term "*negative Bevölkerungspolitik*" or "negative growth population policy" to label the special future the Nazis had in store for Eastern Europe.[7]

2.

Clauberg held a double appointment as the head of not only the Knappschaft Gynecology Clinic but also the Women's Ward of the St. Hedwig's Catholic Hospital in the Upper Silesian city of Könighütte (now Chorzów, Poland). After conducting

6 Wilking, 2016: 179.

7 Wetzel, 1958: 297–324.

clinical trials with rabbits, in February 1940 Clauberg was ready to test his method on people. Plans to conduct the sterilization experiments in Auschwitz, under Clauberg's supervision, began in August 1942 and were concretized in April 1943. It was then that the first Jewish women were selected from Birkenau and sent to Block 10 in Auschwitz I. Afterwards they were selected directly at the ramp.

Explained briefly, Clauberg's plan was to employ a modified version of the traditional hysterosalpingography. The first step was to use X-rays to document how open the women's Fallopian tubes had been before the procedure. Then, in the second step, instead of a pure contrast medium, a solution which contained formalin was injected. The purpose of this admixture was to first cause tubal adhesions and then make them visible on the radiological image. In the third step, Clauberg tested the extent to which the tubes had become blocked. Throughout the entire trial, multiple examinations were conducted to monitor the process.

From the spring of 1943 until June 1944, Jewish women were continuously selected from various deportation locations and sent to Block 10. During this period of time, the number of women is estimated to be approximately 850. However, it is important to keep in mind that the degree of fluctuation was relatively large. This variation was due to women refusing to participate in the experiments as well as other factors that impeded the progression of the clinical trials. It is unclear if the original plan called for the women to be selected for the exclusive use of the gynecologist from Könighütte. What the plan might have been, in reality, was that the women requisitioned for Block 10 were to be also used, either exclusively or additionally, by other medical researchers. After June 1944, Block 10 was used for other projects. Of the 350 women who lived in Block 10 during that period of time, approximately 150 were sent to Auschwitz-Birkenau where they were assigned to various labor commandos. The remaining 200 women were transferred to the newly constructed Block 1 of the so-called Extension Camp, or *Erweiterungslager*. In October and November of 1944, the SS sent approximately 150 more women, principally from deportations from Hungary, to Block 1. During this period, Clauberg continued his experiments much as he had before, however, with assistance from two other people. The first was Johannes Goebel, a chemist who was working on a new substance that could be used in place of iodine, which, thanks to the war, had become increasingly scarce. The second assistant was the medical orderly, Wilhelm August Bünning.

3.

In the past, one question that sparked a great discussion was "How many women did Clauberg sterilize?". According to the statement given by Clauberg during his interrogation by the Public Prosecutor of Kiel (Germany), until the autumn of 1942 he had personally sterilized 23 women. Goebel had, according to Clauberg, sterilized another 127 women by the late autumn of 1944.[8] The numerical codes that appear on the recovered X-ray images (Nos. 138, 171, 173, 205, 219, and 223) now held in the archives of the Polish Institute of National Remembrance (Instytut Pamięci Narodowej, IPN) could possibly give some indication of just how many women in total were on Clauberg's list. Based on Clauberg's recollection, this list apparently contained between 180 and 250 numerical codes:

> The list contained the first names and surnames, whether they were married or not, the number of children, age, nationality, a meticulous record of the weeks and months, the pre-operative radiological imaging, menstruation records, sterilization, and the post-operative radiological imaging weeks and months after the procedure as well as the post-operative images made many months later.[9]

The list was said to have started with the first case and was continued from that point on. According to Clauberg, his assistant, Sylvia Friedmann, registered the names; all of the other details, he reportedly recorded himself.

Taking identification numbers of the recovered X-rays as a starting point, the highest number on the list of the 3-digit codes is "223." This would mean that the number of sterilizations that Clauberg himself performed could be far higher than the 150 he mentioned. However, it is important to keep in mind that Sylvia Friedmann's list might also have included trials that Clauberg initiated but did not complete. Sylvia Friedmann was a Slovakian prisoner who, at the start of Clauberg's medical experiments, had been recruited to serve as an assistant. Friedmann operated the X-ray machine and performed administrative duties for Clauberg. It is unclear whether or not the list that Friedmann maintained still exists

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8 LASH, Abt. 352.3, No. 16434. Criminal proceedings against Carl Clauberg. Interrogation by the Public Prosecutor, December 19 and 20, 1955.

9 LASH, Abt.352.3, No. 16460. Interrogation by the Public Prosecutor, October 17, 1956.

somewhere. During a deposition that took place in Prague on July 3, 1957, Friedmann guesstimated that the number of people who were used as experimental objects was "about 300."[10] Spurred by a statement made by Rudolf Brandt during the Nuremberg Doctors' Trials, some have speculated that the numbers of victims could reach well over 1,000.[11] Such speculations are somewhat dubious, however, especially because the number of women who were sent to Block 10 and then later to Block 1, was only just over 1,000. Also, it has been proven that a certain number of the Block residents were smuggled in.

Based on the eye-witness statements of female survivors who lived in Block 10 and Block 1, not all of the women fell victim to Clauberg. Some women, for example, were deemed by Clauberg to be unsuitable for the medical trials and were sent to Birkenau. Other exceptions included women who remained in the blocks, but were able to avoid being sterilized by Clauberg by taking on some function such as a nursing assistant. Still other women managed to evade Clauberg but then fell victim to Horst Schumann's sterilization experiments which involved radiation exposure. It is only with the help of objective historical documents such as the 26 X-rays and their IDs that more precise inferences can be made.

In the document, seven women were named and assigned a case-number: Hedwig Cohen (No. 205), Fanny Ettinger (No. 190), Sara Noord[12] (No. 219), Barbara Smolensky (No. 138), Selma Spijer (No. 173), Jetta Vosch (No. 223) and Rosetta Zwaaf (No. 171). In response to initial inquiries made in the Warsaw archives, on May 29, 1967, the Director of the Auschwitz Museum in Oświęcim indicated that the archival files only contain information about Fanny Ettinger. According to their records, Fanny had apparently been born on February 18, 1895 in Kyiv and on July 20, 1943 she arrived in Auschwitz in a deportation transport from Drancy. This piece of information was ascertained from surviving transportation lists. Neither Ettinger's camp number nor her fate are known. What is known, however, is that several women from that transport were sent to Block 10. In re-

10 Examination of Witness, Silvia Veslá, nee Friedmanová, conducted on July 3, 1957 by the Public Prosecutor of Prague. The Wiener Library, Nr. 1656/3/8/659.

11 NO-440, Rudolf Brandt, Statement on Sterilization, October 19, 1946, Nuremberg Doctors' Trial.

12 The name is spelled as Noord according to the online database of Auschwitz prisoners of the Auschwitz-Birkenau Memorial and Museum at https://www.auschwitz.org/en/museum/auschwitz-prisoners/ [Editor's note].

sponse to a subsequent inquiry made seven years later, the Auschwitz Archive provided additional information about Hedwig Cohen. She was apparently born on May 11, 1895 in an unknown location. On January 24, 1943, she arrived in Auschwitz as a part of a deportation from Theresienstadt. Some information was also supplied about Barbara Smolensky who was recorded as having been born in Berlin on June 21, 1921. On June 23, 1943, she arrived in Auschwitz.[13]

Based on where the X-rays were discovered (i.e., Auschwitz) and the inscription "Prof. Clauberg" which appears upon them, it is justifiable to infer that the women's names recorded pertain to Auschwitz prisoners. However, without definitive sources, the seven names should not automatically be ascribed to specific women who were imprisoned in Auschwitz. Some of the names appeared more than once in different contexts; a few of the names even appeared quite frequently. It appears that details the Museum provided about a Fanny Ettinger were correctly ascribed to the Fanny Ettinger who was transported from Drancy to Auschwitz, because there is clear evidence that many women who were sent to Block 10 came from this transport. Nevertheless, the fate of Fanny Ettinger still remains unknown. Among the 26 X-rays, five carry the name "Ettinger, Fanny" and are dated November 25 and 26, 1944. As for Hedwig Cohen, the case must remain open as the information provided cannot be verified at this time.[14]

It was not indicated which sources the Auschwitz Museum could have used to provide information about Hedwig Cohen and Barbara Smolensky.[15] In the case of Barbara Smolensky, the abovementioned information nevertheless fits as the details can be verified through another source. The corroboration came from a woman who was a citizen of Berlin. The woman was interviewed as an eyewitness victim in the investigation against Clauberg on July 24, 1956 in Montreal, Canada. According to her testimony, she was given the camp number 47588. As a part of the experi-

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13 Instytut Pamięci Narodowej (IPN), BU 3062/608.

14 According to an email sent on June 15, 2022 to the author by Dr Wojciech Płosa, the head of the archive at the Auschwitz-Birkenau Memorial and Museum in Oświęcim, the archive has "no new documents with additional information about Hedwig Cohen or Fanny Ettinger." I would like to express my gratitude to him for his assistance.

15 The surname "Smolensk**a**" appears on the X-ray. However, the actual spelling the woman from Berlin used for her signature was "Smolensk**y**." On this point, see the witness statement given on July 24, 1956 in Montreal. LASH, Abt. 352.3, Nr. 16462.

ments conducted in Block 10 or in Block 1, the woman was given two injections: one by Clauberg himself and the other by the orderly Wilhelm August Bünning. The survivor even recalled Bünning asking Clauberg's assistant, Sylvia Friedmann, what type of injection he had just given. The witness stated that Friedmann answered, "As far as I can remember, 'Citobarium' or 'Citobalium' or something similar."[16] Citobarium was, at the time, a common but not unproblematic contrast medium. As a result of the injection, the eyewitness was unable to have children.

As for the four remaining names on the radiological images, in 1974 the Auschwitz Museum had no information on them. However, based on other sources, it is possible to determine with some degree of certainty that the four persons were Dutch women who survived Auschwitz. Sara Noord and Rosetta Zwaaf arrived in Auschwitz on August 26, 1943 in a transport from Westerbork. Sara Noord (born December 12, 1915 in Amsterdam) was tattooed with the camp number 56003, and Rosetta Zwaaf (born February 19, 1904 in Leiden) was tattooed with the number 56016. Selma Spijer and Jetta Vos arrived in Auschwitz on September 23, 1943. Like Sara Noord, they had also come as part of a transport from Westerbork. Selma Spijer (born February 19, 1921 in Utrecht) was issued the camp number 63235, while Jetta Vos (born March 27, 1908 in Amsterdam) received number 63252.

All four Dutch women testified after their liberation that they had been given a sterilization injection in Block 10 or in Block 1. Selma Spijer and Jetta Vos were never able to have children. Rosetta Zwaaf, however, bore one son and Sara Noord had two sons.

The historical potential of the radiological images with regard to victim research has, up to now, not been taken into consideration. This oversight is true not only for the few documents that have been stored in Poland, but is even more so for those still archived in Moscow. Repeatedly, during his interrogations in 1955 and 1956, Clauberg reported that upon his arrest his X-ray images had been confiscated and had been taken to the Soviet Union. The record of the search that was performed when he was taken into custody also lists the seizure of radiological images, which further suggests that the images were from Auschwitz.[17]

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16 LASH, Abt. 352.3, Nr. 16462. Examination of Witness, Barbara Smolensky, July 24, 1956 in Montreal.

17 For more on this point and Clauberg's period of imprisonment in the Soviet Union, see Ebert, Andreas, et al. 2019, 927.

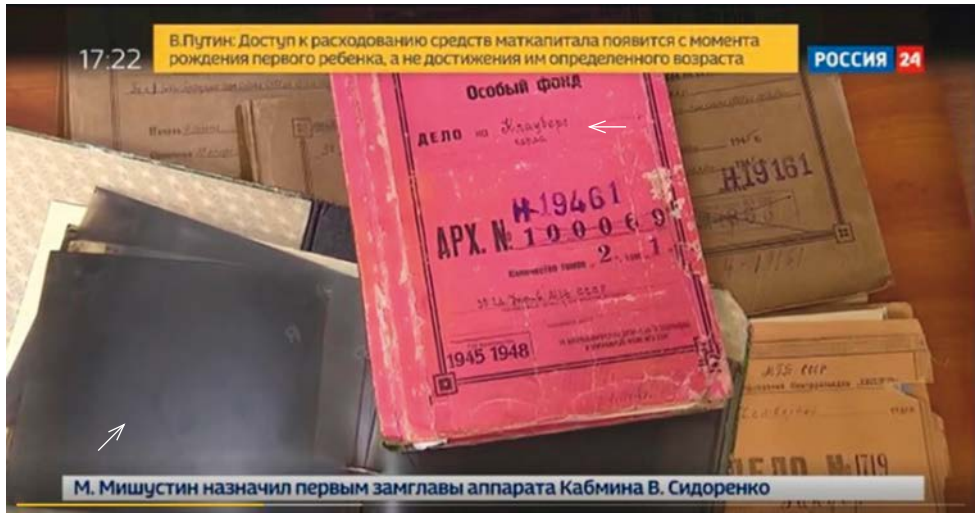

Photo 2. | A screenshot from the TV broadcast of the Rossija 24 TV station, February 24, 2020, taken by the Author. The white arrow to the left indicates the X-ray images, while the one to the right points to the words "Клауберг Карл" ("Clauberg Carl") in the title of the file

4.

At the end of the war, Clauberg fled Poland and escaped to Germany. His identity was hidden by family members in a town called Schinkel, in the district of Eckernförde. For a certain period of time, he even had contact with English occupation forces, unbeknownst to them. On June 8, 1945, he was finally arrested by the Soviet military police who appeared in the company of an English lieutenant. Clauberg was then transferred to Moscow. Later, on June 23, 1948, he was transferred to the Lefortovo Prison in Moscow. On July 4, 1948, he was sentenced to 25 years in prison. After serving ten years of his sentence in the Soviet Union, Clauberg became one of the 10,000 German civil and war prisoners who were released after the re-commencement of diplomatic relations between the Soviet Union and West Germany. On October 11, 1955 Clauberg arrived in Kiel; only to be taken into custody again on November 21—this time on the arrest orders of the German District Attorney. Already on November 14, his indictment had been issued. However, before the trial could begin, Clauberg died on August 9, 1957 while in protective custody.

According to the prison records, Clauberg tried without success to retrieve his wealth of documentation from the Soviet Union. His last attempt was on April 8, 1957. The fact that these materials are still being held in Moscow was confirmed

by the Moscow TV station, Rossija 24, on February 24, 2020 in a TV broadcast. In the program, a Clauberg file is shown along with a large collection of X-rays as well as a section of a Russian document with the names of nine women from Block 10. After six of the names there is a note written in Russian stating "not suitable." After one of the names, "naturally fertile" is added; behind another name the note says "unclear but interesting." It can be assumed that in this collection of documents, there are other biographical details which unfortunately have not been made available to the victims' families or to researchers. The release of these documents is therefore an ethical imperative and necessity.

I would like to thank Iman M. Nick for the German to English translation.

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Prosecuting evil: the case of Carl Clauberg. The mindset of a perpetrator and the reluctance and procrastination of the judiciary in Germany (1955–1957)

Knut W. Ruyter

The title of this article is taken from a film in honour of the currently last Nuremberg prosecutor alive, the 102-year-old Jewish attorney Benjamin Ferencz, who can testify to the difficulty of prosecuting evil, not only of having perpetrators admit their wrongdoings, but also of conducting the prosecution in a fair manner, upholding the rule of law, without recourse to revenge or retaliation.

This article is a close scrutiny of the court case against Professor Carl Clauberg in Kiel in 1955–1957, examining his own ethical defence (and mindset) and the re-

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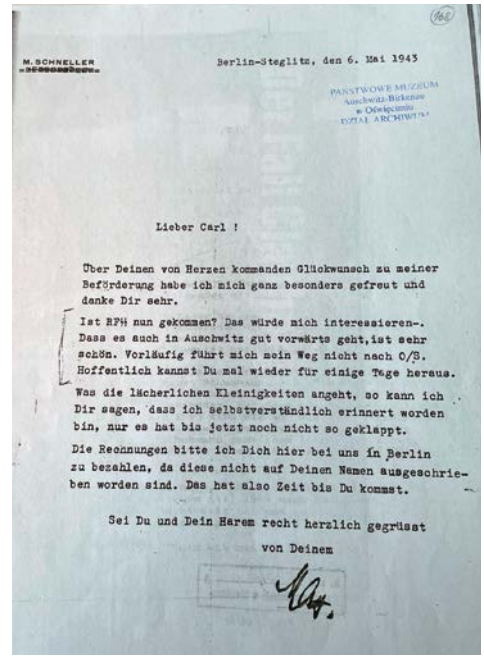
Photo 1. | Carl Clauberg, physician, ca 1942. Wikimedia Commons



M. SCHNELLER

Berlin-Steglitz, den 6. Mai 1943

PAŃSTWOWE MUZEUM
Auschwitz-Birkenau
w Oświęcimiu
ARCHIWUM

Lieber Carl !

Über Deinen von Herzen kommanden Glückwunsch zu meiner Beförderung habe ich mich ganz besonders gefreut und danke Dir sehr.

Ist RFH nun gekommen? Das würde mich interessieren-. Dass es auch in Auschwitz gut vorwärts geht,ist sehr schön. Vorläufig führt mich mein Weg nicht nach O/S. Hoffentlich kannst Du mal wieder für einige Tage heraus.

Was die lächerlichen Kleinigkeiten angeht, so kann ich Dir sagen, dass ich selbstverständlich erinnert worden bin, nur es hat bis jetzt noch nicht so geklappt.

Die Rechnungen bitte ich Dich hier bei uns in Berlin zu bezahlen, da diese nicht auf Deinen Namen ausgeschrieben worden sind. Das hat also Zeit bis Du kommst.

Sei Du und Dein Harem recht herzlich gegrüsst

von Deinem

Photo 2. | Letter from Clauberg's friend and mentor, SS-Gruppenführer Max Schneller. Facsimile: APMA-B, Clauberg's file

luctance of the judiciary to prosecute and indict Clauberg for his experiments in Block 10 in Auschwitz.

A letter of May 1943, from the SS-leader of Wehrkreis III (Berlin), Max Schneller, to his friend Carl (Clauberg) can set the tone, revealing a mixture of frivolity and callousness in Schneller's praise of Clauberg's efforts and progress in Auschwitz. The letter concludes with the greeting: "*Sei Du und Dein Harem recht herzlich gegrüßt*" [German "Greetings to you and your harem"—Editor's note].[1] Max Schneller was instrumental in introducing Clauberg to Himmler, which gave Clauberg the opportunity to present his plans for the implementation of "his own" method of non-surgical sterilization. The "harem" was the means to find the most effective method for the mass sterilization of "degenerated" people.

1 Letter from M. Schneller to Clauberg, 6 May 1943. APMA-B (Archives of the Auschwitz-Birkenau State Museum, hereinafter APMA-B). Clauberg, file 2, item 168. The reference to RFSS (i.e., Reichsführer-SS) indicates that Schneller was interested in knowing whether Himmler had followed up and visited Clauberg in Auschwitz.

After his arrest in 1955, when Clauberg was confronted with charges of using these women as mere means to a greater end, with serious harm and even death following the experiments, he reacted with dismay and contempt—and put on a show of virtue and importance.

Photo 3. | Professor Carl Clauberg, portrait, ca. 1942. Photo: LASH, Abt. 352.3/16466

"I AM NOT A TORMENTOR OF HUMANS"

Just like Rudolf Höß, the commander of Auschwitz,[2] Carl Clauberg was not evil in his own eyes, despite attempts by the media and survivors to portray him as a tormentor of human beings (*Menschenschinder*), a vile doctor (*Unarzt)*, a murderer, by turning white into black. In a letter to Mrs Zurhausen—and to many others he had known—he asked the addressee to vouch for his virtues as a doctor.[3] He reminded her that he treated all patients, be they Polish or Jewish, with the same respect (regardless of the fact that others refused to treat them), and they expressed their deepest gratitude to him by reaching for his hands and kissing them (though he tried to dodge the gesture).

This unobtrusive letter reveals some of his mindset which permeates his defence during the interrogation and in numerous letters to just about anyone who he thought could help him further his cause. It seemed impossible for him to admit any kind of evildoing.

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2 Broszat, 1989: 159.

3 Letter from Clauberg to Mrs Zurhausen, 24 February 1956. LASH (Landesarchiv Schleswig-Holstein; hereinafter LASH), Abt. 352.3: 16434.

The facts of the sterilization experiments in Block 10 and the fate of about 900 Jewish "harem" prisoners are well known today, through the excellent works, starting with Sehn's 1959 study to Weinberger's 2020 article.[4] Survivors' and prisoner physicians' testimonies collected in preparation for the trial contributed much new knowledge about the consequences to the victims of his evildoing—of experiencing devastating harm, of being humiliated, ignored, abandoned, and always under the threat of death—and of the long-term physical and mental consequences for those who managed to survive.[5] Some of the accounts and memoirs written by research subjects and female prisoner doctors have also been published.[6]

"I AM A LIFE SAVER"

Clauberg considered all these testimonies and allegations outrageous and defamatory slander by Jews and Communists. His sole aim, after having seen the conditions in Birkenau, was to save as many lives as possible, in which he succeeded,[7] and for this purpose the experiments were only a pretext of no importance in themselves.[8] During the interrogation, he stressed that he had in fact established a life-saving institute. The magazine *Stern* asked Clauberg if he had any apologies

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4 Sehn, 1959; Lifton, 1986; Weinberger, 2009; Lang, 2011; Strzelecka, 2016; Cymes, 2016; Wilking, 2016; Sliwinski, 2017; Ciesielska, 2019; Weinberger, 2020.

5 The indictment listed 61 survivor witnesses. LASH, Abt. 786: 2544.

6 See, for example, Shelley, 1991 for twenty prisoners' accounts, for accounts by female prisoner doctors, Dr Slavka Kleinova (Dorota Lorska) (Lorska, 1965); Dr Alina Brewda (Minney, 1967); Dr Adélaïde Hautval (Hautval 1991); and Dr Froukje de Leeuw (Lang, 2021; based on her report of 68 pages held by the Dutch Institute of War Documentation).

7 Statement by Clauberg, 10 March 1957. LASH, Abt. 761: 9570.

8 This is also the line he fed to his fellow prisoners in the Soviet Union, like Generalfeldmarschall Ferdinand Schörner; Minister Adolf Beckerle, Hermann Pörzgen, a journalist for *Frankfurter Zeitung* (and later for *Frankfurter Allgemeine Zeitung*); Landgerichtsdirektor Hesch; and Otto Schlegel. Some of them were summoned to Kiel. Otto Schlegel from Salzburg testified that Clauberg had told them that he had had Jewish women at his disposal for experiments, but that he had done it for the sole purpose of saving their lives. What the experiments were, Clauberg did not really remember. He had been assigned to a task he could not refuse, and he was not aware that the purpose was to advance or hinder fertility. According to Schlegel, Clauberg was intensely disliked by other inmates, who nicknamed him "the poisonous dwarf" (*Giftzwerg*). Testimony of Otto Schlegel, 3 December 1955. LASH, Abt. 627: 2462.

to offer the women he had used for the experiments. On the contrary, he answered, instead they were the ones who should be grateful to him for having saved them from the furnace (*Verbrennung*).[9]

These women were, however, only a means to a much bigger end. The method, non-surgical sterilization, was being tested for prospective implementation in large-scale mass sterilization on any people considered biologically subordinate to the Germans—first and foremost, Jews (if there were any left, as Dr Brack flippantly remarked) or those who could threaten the superior German heritage, among whom the Slavs, especially Poles, Czechs, and Russians were targeted.

During an interrogation, Clauberg claimed he had no knowledge of this at all, though he might have overheard something of that nature. When he was confronted with his own initiatives and preliminary reports to Himmler,[10] sketching the possibility of sterilizing a thousand women a day, after having perfected his method, he vacillated between denying that he had ever written such a letter and dismissing it as a white lie—it was only meant as a sop (*Lockspeise*) to please Himmler.[11] Later, he did admit that the method allowed for effective mass sterilization, though the only thing he had done was to make scientific knowledge and unique methods available for greater political goals.[12] There is no doubt that these goals had been discussed with Clauberg, and were looked forward to with satisfaction in a letter from Himmler to Dr Pokorny about the prospects of the "benevolent" consequences of Clauberg's new methods for mass sterilization: "We have three million prisoners-of-war from the Soviet Union. What a glorious prospect. We will sterilize them and have three million workers who cannot reproduce but whose work we can exploit until they die."[13]

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9 A copy of the article in *Stern*. APMA-B, Clauberg, file 1. Also in LASH, Abt. 352.3: 16463.

10 Letter of 7 June 1943 to Himmler. LASH, Abt. 352.3: 16434.

11 Interrogation, 20 December 1955. Protocol. LASH, Abt. 352.3: 16434.

12 Interrogation, August 1956. LASH, Abt. 352.3: 16444. In a letter to Niels, the chief surgeon of the Auschwitz hospital complained about Clauberg's very difficult personality (*characterlich sehr schwieriger Mann*), always claiming privileges for doing research on behalf of the Reichsführer SS and never fulfilling any other tasks. Letter to Niels, 12 March 1944. APMA-B, Clauberg's file, doc. 165.

13 Referenced from Władysław Fejkiel's report to the international conference in May 1956. *Bericht von Doz. Dr Wladyslaw Fejkiel. Über die sogenannte "Negative Demographic". Tagung des Internationalen Auschwitz-Komitees, Auschwitz, 24.u.25. Mai 1956*. APMA-B, Clauberg's file.

Philosophers like Vetlesen and Alford underscore that evil presupposes and is supported by strong influencers and eagerness to please the powers that be—often for private gain—and is often done in subtle, frequently clever, professional ways, inconspicuous to outsiders, but it is still profoundly destructive to those targeted by way of subordination, force, humiliation, neglect, used as a means for a higher goal.[14]

"I AM A HOMECOMING SCIENTIST OF WORLD REPUTE"

To understand Clauberg's mindset, it might be helpful to understand the context of his homecoming as part of a negotiated prison exchange between Germany and the Soviet Union in 1955, when almost 10 thousand prisoners came home (*die Heimkehrer*). After the war, Clauberg had been detained by British Military Police in Kiel in June of 1945, handed over to Soviet officials, and sentenced to 25 years in prison for his part in the annihilation of Soviet prisoners.[15] On his return, he received a personal welcome from Minister President [of Schleswig-Holstein—Editor's note] Kai-Uwe von Hassel, to which Clauberg responded with profuse gratitude for the princely welcome and reception.[16] He felt pardoned and rehabilitated—and was ready to make his findings known to the world and be acknowledged for his superior scientific achievements. He appeared on television, in radio broadcasts and newspapers without so much as a trace of admitting he had done anything wrong at all. So it came as a tremendous shock when he was arrested after being recognized by one of the survivors, and his Auschwitz experiments earned notoriety in the press.[17]

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14 Vetlesen, 2005; Alford, 1997. In a superb dissertation Lydia Sliwinski has reconstructed Clauberg's biography and some of the most important influencers and collaborators. Sliwinski, 2017.

15 For the best review of his imprisonment, see Wilking, 2016: 518ff.

16 Letter of 3 November 1955, LASH, Abt. 786: 2544.

17 Lang, 2011: 15–26. Many of the newspaper articles were collected for the trial. Pressehefte. LASH, Abt. 352.3: 16463–16464.

A letter to the German Foreign Ministry is quite revealing. He sought the Minister's help to access journals and X-rays left behind in the Soviet Union, which he said were of the greatest scientific value for his task. He argued that he needed the material for two reasons: to justify his work against dirty and deceitful allegations from Jews and Communists—and for the future of a scientific undertaking which would be of international political importance—and, most of all, for the implementation of an international population policy.[18] During his detention in the Soviet Union, he had drafted three books on infertility which were ready for publication.

Counter to these scientific pretensions, it is worth noting that he never published anything on his revolutionary findings and methods, which his former boss, Professor Felix von Mikulicz-Radecki, observed in his affidavit was incomprehensible for such an ambitious researcher.[19] Up to a certain point, Clauberg had only worked on problems related to infertility, and was especially known for his work on hormones, but his last scientific paper on the subject was published in 1938.[20] He had developed a progesterone test (sometimes called the Clauberg test)[21] and had cooperated closely with the pharmaceutical company Schering-Kahlbaum to develop hormone products like Progynon and Proluton. Later assessments of Clauberg's scientific work are not that impressive. It is seen mostly as a confirmation of accepted indications and applications of sex hormones leading to their dissemination.[22]

Shortly after joining the Nazi Party (NSDAP) and SA, as well as the NSDÄB (National Socialist German Doctors' League), he was strongly influenced by the Nazi reproductive policy[23] and shifted his scientific interest towards steril-

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18 Letter from Clauberg to Heinrich von Brentano, the German Foreign Minister. LASH, Abt. 352.3: 16439.

19 Interrogation protocol, 9 January 1956. LASH, Abt. 352.3: 16435. Felix von Mikulicz-Radecki was Professor of Medicine in Königsberg and a member of the NSDAP. He claimed he had been very sceptical about Clauberg's efforts to develop methods using chemical reagents for non-surgical sterilization.

20 Clauberg, 1938.

21 Simmer, 1971: 3: 10. The test demonstrated that oestradiol (administered as oestradiol benzoate) fully sterilized mice. Clauberg found the corpora lutea in the ovaries of the test animals. In this sense, he could achieve temporary sterility as a form of contraception. See Clauberg, 1933; Clauberg, 1936.

22 Gaudillière, 2004. Cf. Simmer, 1971.

23 Bock, 1986. Cf. the German Law for the Prevention of Genetically Diseased Offspring (*Das Gesetz zur Verhütung erbkranken nachwuchses*) of 1933, and the central role of physicians for reporting and judging cases, and performing surgery.

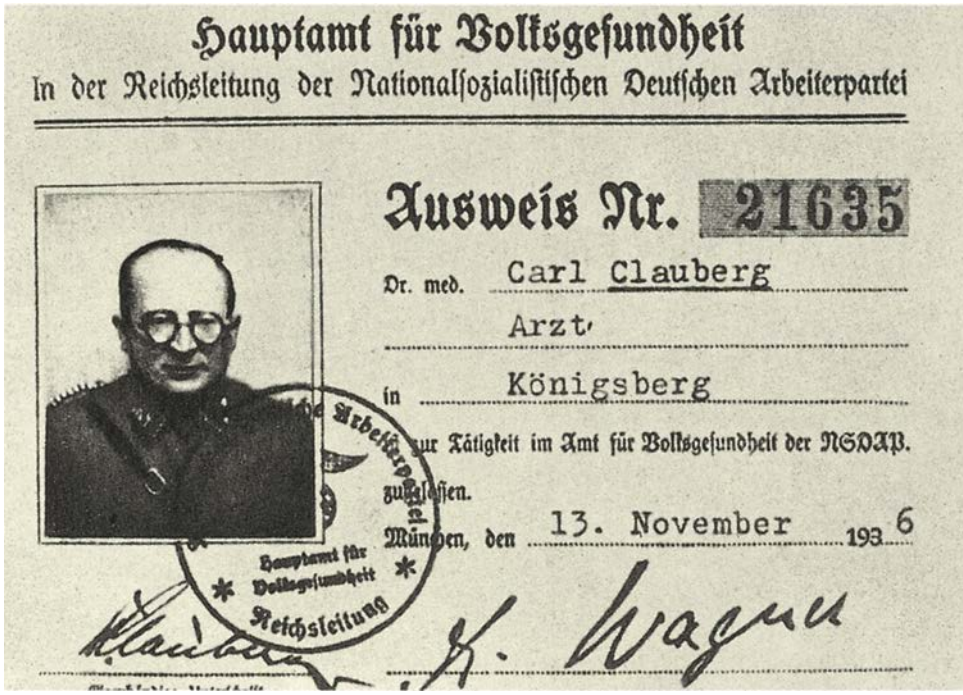

Photo 4. | The identification card of Clauberg as a member of NSDAP. One of very photos with Clauberg in uniform. Photo by: Photo 12/Universal Images Group via Getty Images

ity to resolve the so-called problem of degeneration. He had gained experience with surgical sterilization on a large number of women in clinical practice[24] but, as he said during an interrogation, began to test alternative bloodless (*unblutige*) methods by intrauterine intervention on animals and also on patients.[25] On this basis, in 1935 he contacted the Minister of Health, Dr Hans Conrad Reiter, with

24 Bock, 1986: 453.

25 Interrogation of Clauberg, 2 December 1955. LASH, Abt. 352.3: 16457. His claim that he was the only one working on intrauterine methods is questionable. He must have known the work of his colleague Mikulicz-Radecki on transcervical sterilization experimenting with cauterization (on animals) and compression (on humans) to achieve tubal occlusion (Mikulicz-Radecki, 1927; 1933: 95; 1936: 116); he knew about utero-salpingography (he had used the device for the procedure for other purposes as well); Clauberg, 1935. The only new thing he contributed was the development of a chemical reagent (formaldehyde) and the supporting "carriers" (adhesives) to achieve effective occlusion. He would not divulge the exact composition of "the first ever' chemical substance consisting of a 10% formalin solution, Neorönthium, as the carrier, a solvent, and two correctives, because he intended to apply for a patent. LASH, Abt. 352.3: 16447. Mikulicz-Radecki had also used formalin solutions or carbolic acid to "clean" the uterus after curettage (Mikulicz-Radecki, 1933: 49).

a proposal to establish a research institute for reproductive biology to resolve all of these specific questions.[26] To Clauberg's great dismay, Reiter was sceptical. It was not until he contacted Himmler in 1940 (with the help of Schneller) that his plans were enthusiastically embraced, especially the prospect of sterilization for the masses, and Clauberg could proudly declare that the time was ripe to test his method of non-surgical sterilization on humans as a much better option than surgery or X-rays.[27] By 1942, Clauberg had the formula for the chemical reagent "*fix und fertig*"[28] ["ready and waiting"—Editor's note] and suggested to Himmler that he could do the necessary clinical research in Auschwitz, which was conveniently close to Königshütte, with sufficient resources, equipment, and manpower. Himmler gave his consent and was excited about the prospects.[29] A few months later, Block 10 was set up to test the method.

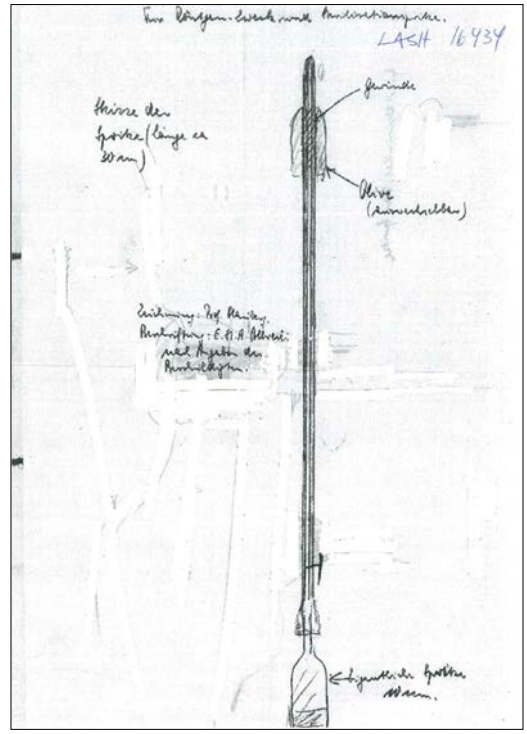

Photo 5. | Clauberg's own drawing of the syringe (about 30 cm long) used to sterilize the women. An attachment to Clauberg's interrogation of 19 December 1955. LASH, Abt. 352.3 Nr. 16434

26 Ibid.

27 Clauberg was also strongly supported by SS physicians like Dr Adolf Pokorny, Dr Viktor Brack, Dr Ernst-Robert Grawitz, Dr Heinrich Gebhardt, and Dr Karl Brandt. Some of them were especially enthusiastic about the prospect of keeping a strong workforce of sterile Jews and Bolsheviks, as Brack put it, to exploit their work without permitting them to reproduce and spread like the Plague in the Middle Ages. Though Clauberg is sometimes described as an SS-*Brigadeführer*, there seems to be no evidence that he was a member of the SS. Cf. The indictment. LASH, Abt. 786: 2544.

28 Letter of 19 June 1957 to Kloppenborg. LASH, Abt. 352.3: 16447.

29 See note of 8 July 1942, copied in the indictment, LASH, Abt. 786: 2544.

Photo 6. | The Black Execution Wall, with Block 10 on the left. Its windows are boarded up, just as they were for the secret experiments. Photo taken after the liberation, 1945. Photo: LASH, Abt. 352.3 Nr. 16466

"BY OFFERING A GENTLE TREATMENT, I ACTED WITH THE WOMEN'S CONSENT"

From Clauberg's letters to and from Himmler, we know that one of the most important reasons for the choice of Auschwitz was that there were enough women easily available to prove the efficiency of the method.[30]

Still, Clauberg claimed under interrogation that he always acted with the women's consent (*Einverständnis*). He even had the impression that the women longed to come to his life-saving institute,[31] as if they had any information or a real choice.

30 Interrogation, 2 December 1955. LASH, Abt. 352.3: 16433.

31 Interrogation, 21 November 1955. LASH, Abt. 352.3: 16433.

The claim was rebutted by numerous survivors in their testimonies: "I was never asked and I never gave permission."[32] "It was more like a razzia. We were raided and threatened with the gas chamber if we were reluctant to participate in the experiments."[33] "We were forcibly (*mit Gewalt*) strapped to the operation table."[34]

Photo 7. Clauberg, left, at the operating table with Dr Horst Schumann, probably 1943. Photo: Jewish Virtual Library

In Clauberg's opinion, the treatment was very gentle (*schonend*) and carried hardly any risk of injury or suffering, or if it did, the pain was transient.[35] He explained that the level of pain was insignificant (*bedeutungslos*), but nonetheless he was aware of it and made improvements in the method with the chemist Dr Göbel in order to achieve a totally pain-free procedure.[36] A very small dose of the anaesthetic Novocain was added to the mixture. A large number of testimonies from doctors rebutted this on the basis of examinations of the survivors.[37] There were also a few notable German medical experts who contested his claim.[38] The only harm that Clauberg admitted to have caused was infertility (*Unfruchtbarkeit)*, but he argued it could not really be understood as

32 Augusta Amran. 3 November 1955. LASH, Abt. 352.3: 16433.

33 Rywka Najhaus. 20 August 1956. LASH, Abt. 352.3: 16440.

34 Berta Landskroner. 13 July 1956. LASH, Abt. 352.3: 16440.

35 Police interrogation. 22 November 1955. LASH, Abt. 627: 2462.

36 Interrogation. 19 November 1955. LASH, Abt. 352.3: 16433.

37 Medical examinations by many doctors around the world. LASH, Abt. 352.3: 16447.

38 Prof. Dr Karl Junkmann on behalf of Firma Schering. Use of formaldehyde will cause serious necrotic destruction. Stellungnahme. 13 January 1956. LASH, Abt. 352.3: 16435. Also Dr Steyn testified that Clauberg's work was totally "irresponsible" research. LASH, Abt. 352.3: 16463.

harm, but rather as a positive outcome, a benefit, helping women not to have more children.[39] On this basis, it comes as no surprise that he considered it preposterous to be charged with murder. The women were directly asked in a questionnaire if they could testify to Clauberg's complicity in murder. Some of the women died following the procedures.[40] Frederika Springer observed the death of many patients, some of whom (especially young Greek women) had been transferred from other types of experiments.[41] Some were transferred to other types of experiments (involving removal of ovaries, X-rays, and cancer) and died with intestines completely burnt.[42] Some were discharged when they were unwilling to participate, did not meet the criteria for inclusion, were too sick, or had become useless (*nutzlos*).[43] The assumption was that after six to seven weeks, most of the women were deemed useless and transferred to Birkenau to be killed or gassed (*zur Vergasung*),[44] or, as Rywka Najhaus testified, "Clauberg always said that women who had completed their treatment were ready (*reif*) for the gas chamber."[45] Clauberg decided who was to be sent there,[46] as confirmed by the prisoner doctors Adélaïde Hautval and Alina Brewda, who testified that Clauberg only discharged prisoners when they were no longer considered to be of any use (*tauglich)* for experimentation,[47] knowing well that they were being discharged to be sent to the gas chamber.[48] The prosecutor's office has records of a very detailed discussion about the likelihood of Clauberg being an accomplice to murder, especially in connection with the decision-

39 Interrogation, 19 November 1955. LASH, Abt. 352.3: 16433. Letter to Kloppenborg. LASH, Abt. 352.3: 16447.

40 Bluma Rosenberg. 24 June 1956. LASH, Abt. 352.3: 16441. Her friend Klara Zickenoppasser-Dormits died as a direct result of the injections.

41 6 August 1956. LASH, Abt. 352.3: 16441.

42 Ima Spanjaard van Esso, LASH, Abt. 352.3: 16437.

43 Fofo Murdoch. LASH, Abt. 352.3: 16443, jf. 16451.

44 Augusta Amran. 3 November 1955. LASH, Abt. 352.3: 16433.

45 Testimony, 20 August 1956. LASH, Abt. 352.3: 16440. Also Greta Goldsmith: "Alle heraus, ihr geht ins Gas." Testimony, 8 April 1956. LASH, Abt. 352.3: 16438.

46 Bluma Rosenberg. 24 June 1956. LASH, Abt. 352.3: 16441.

47 Dr Adélaïde Hautval, 2 July 1956. LASH, Abt. 352.3: 16443. Cf. Dr Brewda 20 December 1956. LASH, Abt. 352.3: 16446.

48 Testimony by Dr Herman Langbein, who administered the lists for the SS camp doctor Wirths. 24 September 1956. LASH, Abt. 352.3: 16443.

making involved in discharging and the discrepancies in the lists of research subjects.[49]

"I AM NOT ASHAMED"

It seems Clauberg was capable of doing his work without a sense of shame or empathy. His interrogations are void of any kind of regret or concern for the women he injured. As he said during the first interrogation, although he had done everything in his power to protect the women and treat them gently, he considered it very important *not* to be guided by feelings or legal regulations, which, as far as he was concerned, did not exist.[50] Such feelings, which he spoke of with contempt, were only a sign of weakness standing in the way of the opportunity to excel for a person with only scientific goals in mind, even if working under duress. In any case, Jewish women were degenerate (*entartete*) objects and as such were not meant to be protected by any legal regulations.[51]

Photo 8. On a road trip with his children, Maria Ilse, b. 1940 and Carl, b. 1943, ca. 1944. Prisoners observed that Ilse Geyer and children accompanied him in his sports car to Block 10 (the prisoner doctor Brewda in Minney 1967: 109, Greta Goldsmith. LASH, Abt. 352.3: 16443). Photo: LASH, Abt. 352.3 Nr. 16466

49 E.g., by comparing the list entitled *Häftlinge und Pfleger für Versuchszwecke* (prisoners and nurses for research purposes) starting from 30 April 1943 with discharge lists (presumably for the gas chamber, but also some for a labour camp and some to the brothel).

50 Interrogation. LASH, Abt. 352.3: 627: 2462.

51 Interrogation of Clauberg. LASH, Abt. 352.3: 2462.

I think Clauberg's lack of shame is a powerful key to understanding evil. It resembles Hanna Arendt's reference to the perpetrator's inability to think, the disastrous failure of his conscience, and his lack of shame.[52]

In a lecture given in 2019 [at the 2nd international conference Medical Review Auschwitz: Medicine Behind the Barbed Wire—Editor's note], Susan Miller reminded us of the psychological mechanisms of splitting and doubling to contain contradictory beliefs in separate spaces in which the research doctor uses science to objectify violence and remain detached from any human attachment to the subjects of his research.[53]

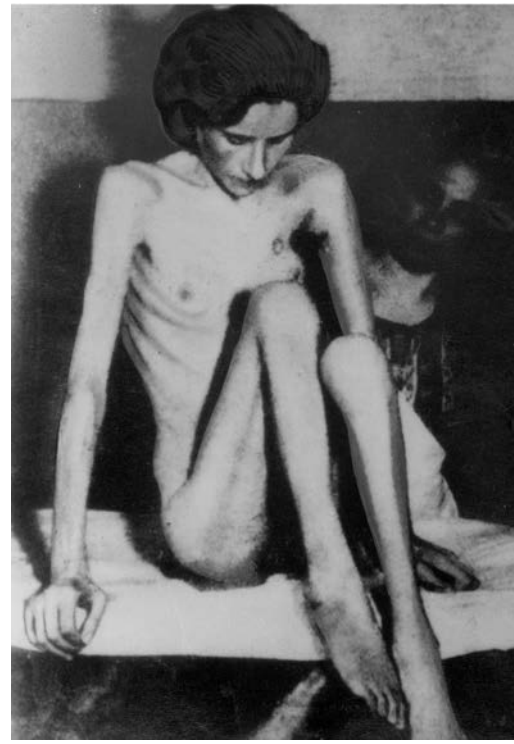

Photo 9. | Survivor from Block 10, photo taken after the liberation of Auschwitz, 1945. Photo: LASH, Abt. 352.3 Nr. 16466

To do evil in contained spaces without restriction and oversight has a long precedence in the history of research—from vaccination experiments in orphanages, through sugar experiments on people with mental disabilities, to experiments with detergents on prisoners.

Many of the women could not recall that Clauberg had ever done any kind of a follow-up after the procedures.[54] He was totally indifferent to their suffering.[55] Everyone was dead scared (*totbang)* of Clauberg.[56] This is also confirmed by the tes-

52 Arendt, 1978.

53 Miller, 2019.

54 Berta Landskroner. 13 July 1956. LASH, Abt. 352.3: 16440.

55 Bluma Rosenberg. 24 June 1956. LASH, Abt. 352.3: 16441.

56 Frederika Springer. 6 August 1956. LASH, Abt. 352.3: 16441.

timony of one of the prisoner doctors, Adélaïde Hautval, who emphasized that he never cared about any of the prisoners. He showed a complete lack of interest in their wellbeing.[57]

Clauberg's claim of gentle treatment is contradicted by the callousness of his behaviour. In her testimony, Greta Goldsmith reinforced this by recollecting an episode in which Clauberg was furious about the early release of some of the "patients," screaming, "They are *my* women. I *bought them*."[58]

I think that from the moral point of view, we assume that shame and conscience will prevent the commission of evil, and if they are absent, then there are no barriers to stop evil.

Photo 10. | Survivor from Block 10, photo taken after the liberation of Auschwitz, 1945. Photo: LASH, Abt. 352.3 Nr. 16466

"I HAVE BEEN WRONGED—AND SO HAVE THE GERMAN PEOPLE"

In the end, Clauberg tried to turn the tables on his accusers. It was not the women who had been harmed by his "gentle research." It was Clauberg himself who had been wronged, and in every respect.

57 Adélaïde Hautval. 2 July 1956. LASH, Abt. 352.3: 16443.

58 Testimony, 8 April 1956. LASH, Abt. 352.3: 16438.

As he stated to Judge Beier during an interrogation, "My psychological pain has been caused by the stupidity of the world, which I do not understand, and which has put a heavy burden on me, a burden that needs to be removed".[59]

Additionally, there was the harm brought about by the German judiciary when Clauberg's sterilization methods were made publicly accessible to permit others to use them for their own gain. He had spent years working on the theory and practical applications of his scientific research.[60] A five-page note entitled *Probleme* detailed his own contributions, including three scientific books written in the Soviet Union and his own original patentable scientific findings, including non-surgical sterilization (ready to apply for a patent for the active substance of formalin and other undisclosed substances). Clauberg wanted to claim damages for the infringement of his rights. In addition, he claimed his sentence was a miscarriage of justice and that he had served ten and a half years as an innocent man. Not only had he been pardoned but also rehabilitated,[61] and now he was being prevented from enjoying a reputation as a scientist and teacher of world repute. In Clauberg's opinion, the trial was not

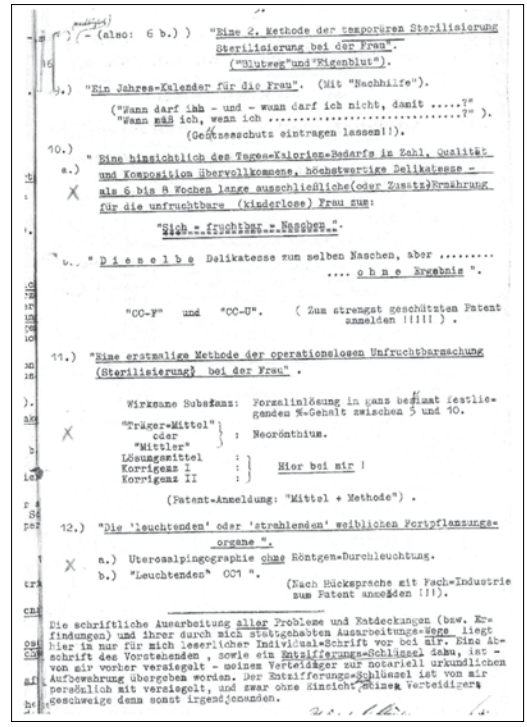

Photo 11. Excerpt from Clauberg's statement about his research results, detailing the content of the chemical substance he developed for his unique method. Prepared for the judiciary under strict secrecy to protect his rights for patency. Facsimile: LASH, Abt. 352.3 Nr. 16447

59 Interrogation. LASH, Abt. 627: 2462.

60 Letter to the Attorney General, 13 April 1957. LASH, 352.3: 16447. In a letter a couple of months later, he explained that he had toiled day and night and invested his whole scientific acumen in the endeavour to create a new method. Letter of 19 June 1957 to Mr Kloppenborg. LASH, Abt. 352.3: 16447.

61 Letter to the Attorney General. 3 June 1957. LASH, Abt. 352.3: 16447.

only harmful to himself but also an immense injury to the German people, an ongoing miscarriage of justice "*am laufenden Band*" [German "on a continuous basis"—Editor's note].[62]

And if this was not enough, he was convinced that the promotion of his scientific findings would be of immense importance for an international population policy.[63]

THE RELUCTANCE OF THE WEST GERMAN JUDICIARY

To understand the reluctance of the West German judiciary to take up cases of alleged crimes committed in the Nazi period, we must take note of the political context in 1955. That year, the Federal Republic of Germany attained full sovereignty as a state. It had negotiated the return of 10 thousand prisoners of war from the Soviet Union. The so-called transfer contract implied that convicted prisoners who had served their time could not be charged again for the same crimes. Moreover, there were statutes of limitations determining that offences committed over a decade earlier could not be prosecuted. Suggestions were being made in the Bundestag to offer a general amnesty to all the returnees. This was never granted, on the grounds that serious murder crimes should remain prosecutable.[64] There are also reasons to believe that the campaign for a general amnesty was caused by the fact that many prosecutors, judges, and attorneys were heavily influenced by their own Nazi background and were interested in a statute of limitations.[65] This was also true of the *Oberstaatsanwalt* [German Attorney General—Editor's note], Dr Paul Thamm, who had been a member of the NSDAP since 1934.

In the case of Clauberg, reluctance to admit the case was evident.

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62 Letter to the Minister of Justice. 20 June 1957. LASH, Abt. 352.3: 16447.

63 Letter to the Minister of Foreign Affairs, 30 December 1955, to explain the need to obtain all the research material left behind in the Soviet Union in order to be able to show the world the importance of his scientific findings. LASH, Abt. 352.3: 16439.

64 Eichmüller, 2012.

65 Godau-Schüttke, 1993; Jakobczyk, 2003.

At the beginning, there was a temptation to have him declared insane. It seems easier to understand evil as somehow pathological. The report the German police drew up of Clauberg's interrogation said they had found him quite weird. He was described as belligerent, obstinate, rude, grandiose, characterized by pathological behaviour of manic proportions.[66] Clauberg was referred for psychiatric consultation. The conclusion drawn from this medical examination was clear: he was not insane (*geisteskrank*) and could stand trial (*vernehmungsfähig*),[67] but the evaluation was morally disturbing. It characterized Clauberg as "a deeply abnormal personality with a conglomerate of intellectual megalomania, serious character faults, and organic anomalies. His high self-esteem is caused by his irrational, inconsistent, and destructive nature which makes him antisocial and dangerous if irritated."

With Clauberg being declared fit for trial, the Attorney General Willi Rosga stated that the judiciary was "forced" to take up the case to uphold the international reputation of the German judicial process (in anticipation of deep political and international consequences if it failed to do so), under the impact of the global publicity triggered by the international conference held in Hamburg on the Clauberg case organized by the newly established International Auschwitz Committee,[68] with the help offered by the Council of Jews (*Zentralrat der Juden in Deutschland*) and the Association of the Persecuted by the Nazi Regime (*Bund der Verfolgten des Naziregimes*) to supply witnesses and evidence. Rosga said Clauberg would be given a fair trial according to German law (not the law of any foreign state or transnational body). It should be pointed out that under German law the charges would be restricted to bodily harm, possibly leading to death, but would not make Clauberg accountable under a superior law—the law of inalienable human rights, breaches of which are evil in themselves (*malum in se*).

But once the judiciary decided to admit the case, the proceedings looked thorough enough and special efforts were made to obtain affidavits from survivors, prompted by strong external, often Jewish, promoters, not only from the Council but also from some very active Jewish lawyers like Henry Ormond. A good number

66 LASH, Abt. 627: 2462.

67 LASH, Abt. 761: 9570.

68 *Tagung des internationalen Auschwitz-Komitees Auschwitz, 24. u. 25. Mai 1956*. Reports (in German) from Judge Jan Sehn, the physician Dr Władysław Fejkel, and Kazimierz Smoleń, the director of the Auschwitz Museum. APMA-B, Clauberg, file 1.

of materials about Clauberg were already known and made available to the judiciary, from the Nuremberg Tribunal, the collections compiled by Mitscherlich and Mielke, and by Bayle, and the relevant material from the Supreme National Tribunal of Poland was translated.[69]

It seems, however, that Clauberg was not kept in custody on the grounds of the charges of "causing serious bodily harm to thousands of prisoners" but because of serious threats to his wife and his secretary, with whom he had two children.[70]

Photo 12. | The secretary of Carl Clauberg, Ilse Geyer, and the mother of "his" son, Carl, b. 1943. Photo taken in Königshütte in 1944. Geyer was also employed in Block 10, as secretary and assistant by the experiments. Witness statement by Ilse Geyer. 18 June 1956. LASH, Abt. 352.3. Nr. 16438. Photo: LASH, Abt. 352.3 Nr. 16466

During the proceedings, there was a nagging and recurring concern that it would be very difficult to prove beyond reasonable doubt that Clauberg had been an accessory to murder. The prosecution claimed it did not have sufficient documentation (*Aktenmateriale*), which made it difficult to reconstruct what had actually happened. They were dependent on witnesses who could not say for sure that the deaths they observed

69 The judge presiding at that trial, Jan Sehn, also testified in Kiel. A year later, Sehn compiled the documents from Auschwitz. Sehn, 1957. Chapter VIII details the scientific experiments of Clauberg. Cf. Mitscherlich & Mielke, 1948; Bayle, 1952.

70 The piquancy of this situation, in which his wife, Frieda, née Rimmel, wanted to divorce him but his secretary ("the mother of my children"), Ilse Geyer, refused to marry him, infuriated him so much that he encouraged them to buy ropes to commit suicide. "If you don't do it, worse things will happen to you." At the same time, he invited both of them to "come as soon as you can, I am ready to be recognized by the public of the world!" Letter to Frieda, 15 October 1955. LASH, Abt. 627: 2462. For a detailed analysis of his mindset towards these women, see Wilking 2016: 468ff, 619ff.

were the direct outcome of Clauberg's procedures, which was coupled with strong reservations about the reliability of witnesses and the possibility that they might exaggerate or extrapolate to take revenge and seek compensation.

This was also the main argument of the public counsel for the defence Theodor Fündt: none of the testimonies could confirm with certainty that a given death was due to Clauberg's procedures. All the other types of offences could no longer be prosecuted due to the statute of limitations.[71]

Many were concerned that Clauberg would never stand trial. The German section of the Auschwitz committee organized a meeting in January 1956 to put pressure on the judiciary to indict Clauberg and take him to court. They claimed that the Attorney General was seeking any means to trivialize the crimes committed by Clauberg, the so-called helper and doctor of humankind. They invited a French survivor to the meeting.[72]

The medical association of Schleswig-Holstein kept a protective umbrella over Clauberg. The association did issue a temporary ban preventing him from practising as a doctor (which, as they noted, was a very small interference since he was in custody anyway), but did not revoke his licence.[73] There was also a formidable amount of resistance from medical experts to testify at the trial, despite the efforts to contact and recruit them. They had their reasons and excuses, from strenuous schedules, through "impressionable minds" (*sic*) to dangers to their own health and wellbeing,[74] but none of them stated the obvious, namely that they did not want their own background exposed. Eventually, one of them, Professor Heinrich Martius of Göttingen, agreed to testify.[75]

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71 Statement, 2 March 1957. LASH, Abt. 352.3: 16446.

72 The pamphlet *Wir klagen Clauberg an!* LASH, Abt. 627: 2462.

73 Letter of 8 April 1957 from Ärztekammer Schleswig-Holstein. LASH, Abt. 761: 9570.

74 E.g., Prof. H. Runge, chairman of the Deutsche Gesellschaft für Gynäkologie. LASH, Abt. 352.3: 16446, letter from Prof. Naujoks. LASH, Abt. 352.3: 16453. For many more examples of hesitation, see Wilking 2016: 657ff.

75 LASH, Abt. 786: 2544. No record was made of the fact that he was one of the signatories of the statement entitled *Deutsche Wissenschaftler hinter Adolf Hitler*, nor of his membership of the Deutsche Gesellschaft für Konstitutionsforschung. See Klee, 2003: 393.

Photo 13. | Entrance to Block 10. Photo taken after the liberation. Photo: LASH, Abt. 352.3 Nr. 16466

PROCRASTINATION

At the beginning of 1957, the Ministry of Justice noted that the pre-trial procedures and the indictment were defective in several respects. It was doubtful whether murder could be proven, most witnesses would not attend in person, some of the charges seemed too crass and unsubstantiated, which raised serious questions about the credibility of the testimonies. But to put things in the right perspective, the Ministry regretted that the indictment contained too many spelling mistakes to be accepted by the court. The Ministry proceeded to suggest new preliminary investigations (*Voruntersuchungen*) to establish whether Clauberg had committed the alleged offences of murder as a public official (*Amtsträger*), whether it was likely to prove murder, and if not, then whether the other offences would fall under the statute of limitations. And then a revised indictment free of spelling mistakes was to be presented.[76]

I think it is fair to conclude that the reluctance and procrastination would probably have led to a dismissal. The case would never have been tried. But before

76 Note of 28 April 1957. LASH, Abt. 786: 2544.

any of these new investigative steps could be taken, Clauberg died of stroke and let the Ministry and the judiciary off the hook; perhaps they breathed a sigh of relief. The decision came swiftly: with his death the investigations and the trial found its (final) solution.[77] The Jewish Council requested access to the evidence collected during the preparations for the trial,[78] but this was flatly refused for reasons of confidentiality.

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Abt. 627 Kriminalpolizei. Ermittlungsverfahren gegen Prof. Dr Carl Clauberg. Nr. 2462,

Abt. 761 Sozialministerium. Berufsrechtliche Untersuchung gegen Prof. Dr Carl Clauberg. Nr. 9570.

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77 Notification of 9 August 1957. LASH, Abt. 786: 2544. Aptly expressed in German: "Mit dem Tode Prof. Claubergs hat das gegen ihn eingeleitete Ermittlungsverfahren seine Erledigung gefunden."

78 Letter of 3 November 1957. LASH, Abt. 786: 2544.

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The Auschwitz Branch of the Kaiser Wilhelm Institute, 1943–1945

Bogdan Musiał

Dr Josef Mengele (b. 1911) is generally regarded as one of history's most notorious criminals. Mengele was a camp doctor in Auschwitz from June 1943 to January 1945 and it was his duty to combat the spread of infectious diseases—and to select the prisoners deemed sick or "unfit." These prisoners were to be killed in the camp's gas chambers. He thus oversaw tens if not hundreds of thousands of murders, yet it was something else that gave him the epithet of "the Angel of Death" he has gone down with in public memory.

During his time in Auschwitz, Mengele conducted a number of gruesome human experiments and anthropological "studies" for the Kaiser Wilhelm Institute of Anthropology, Human Heredity, and Eugenics (KWI). Countless prisoners, includ-

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ing many children, were killed in the course of his "research," which he sometimes conducted personally but frequently delegated to others. Mengele was not only an ordinary SS camp physician in Auschwitz, he was also a scientific associate of the Institute for Anthropology, Human Heredity and Eugenics in Berlin-Dahlem (KWI-A), a component institution of the Kaiser Wilhelm Institute (the KWI, founded 1911).

Mengele's transfer to Auschwitz was no random development. On the contrary, Mengele moved to Auschwitz as an SS camp physician on May 30, 1943 in consultation with his scientific mentor Prof. Otmar von Verschuer, the head of the KWI for Anthropology, in order to carry out extensive anthropological and medical examinations and experiments on prisoners held there on behalf of the KWI.

The choice of Auschwitz was not arbitrary, either. Not only was it the Third Reich's largest concentration and death camp, but also the place which, since the beginning of 1943, held "material particularly suitable" for anthropological and medical experiments. This was the place where women prisoners had been held since March 1942, and whole families had been confined there together with their children since the spring of 1943. In February 1943, the Roma Family Camp had been set up in Auschwitz-Birkenau, followed in September 1943 by the establishment of a Family Camp for Jewish prisoners sent to Auschwitz from the Theresienstadt concentration camp. SS camp physicians "interested in scientific research" were given the right conditions and a free hand to carry out any "scientific projects" they liked on new arrivals, the Jewish victims who constituted their "research and experimental material."

THE AUSCHWITZ-BIRKENAU EXTERNAL BRANCH OF THE KAISER WILHELM INSTITUTE FOR ANTHROPOLOGY

Straight on arrival in Auschwitz (on May 30, 1943), Mengele set about organizing an "anthropological research institute," searching for and recruiting the specialists and individuals with the right professional qualifications he required from among the mass of prisoners. Within a couple of months he assembled a number of "research teams" out of the inmates of Auschwitz to conduct a broad range

of elaborate experiments and research projects, including experiments on human subjects, on orders from him and under his guidance. Alongside ancillary staff such as nurses and guardians who looked after the children who were his "research subjects," he also had highly qualified male and female physicians and scientists with an international reputation working in his "teams."

Two of the first prisoners he recruited for his "research institute" were the Czech Jewish physician Dr Rudolf Weisskopf and Professor Berthold Epstein from Prague. Dr Weisskopf admitted that he had been "so to say Mengele's personal assistant" as of the summer of 1943 until the camp's evacuation in January 1945. The dermatologist Rudolf Weisskopf (b. 1895) arrived in Auschwitz on October 28, 1942, on the first transport from Theresienstadt, along with 1,866 Jewish men, women, and children, including his wife Eleonora, his daughter Susanne, and his sons Robert and Harry. During the selection on arrival, his wife was immediately sent to the gas chamber, while his daughter was put in the Birkenau women's camp, where she later lost her life. Dr Weisskopf and his sons were sent to the Monowitz subcamp, where his sons died, too. In Monowitz, Dr Weisskopf worked as a nurse, and in June 1943 he was moved to the Roma camp and given a job as a prisoner doctor in the infectious diseases ward.[1]

In August 1943, Dr Weisskopf and Professor Epstein were sent to the "Department for Noma Research and Treatment," which Mengele had established in the Roma camp and which was still in the process of construction. An epidemic of noma, not a very prevalent disease in Europe today, had broken out in the Roma camp. Also known in the official medical terminology as necrotizing ulcerative stomatitis, gangrenous stomatitis, or *cancrum oris*, noma is a serious bacterial infection which usually starts with an outbreak of boils on the buccal mucosa (the tissue lining the inner cheeks), spreading to other parts of the face and mutilating its soft tissue and bone structure. The exact cause of this disease is still unknown, but

1 Statement made by Dr Rudolf Vitek (aka Weisskopf) during the court proceedings against Dr Horst Fischer in March 1966, Bundesarchiv für Stasi-Unterlagen (Stasi Records Archive, hereinafter BStU), MfS HA IX/11 ZUV No. 84, Vol. 169, 114–124, p. 115. Statements made by Dr Rudolf Vitek during his interviews on January 20, and March 10, 1966, ibid., Vol. 17, 114–124 and 125–130. Statements made by Dr Rudolf Vitek before the Polish prosecutors during his interview on May 8, 1967, now in the records held in the Kraków Branch of the IPN (Polish Institute of National Remembrance), 51/05/Zn, Vol. 20, 3907–3917 [old reference No.] .

malnutrition, bad sanitary conditions, and other infectious diseases are considered risk factors.[2] The Roma camp met all of these conditions.

Noma attracted Mengele's attention and he decided to have a research project carried out on it. He spoke to Dr Weisskopf and Prof. Epstein, asking them whether they were interested in doing scientific research and inviting them to join his noma research project. Both agreed. Weisskopf (aka Vitek) later said in a statement that Mengele had chosen the two of them out of a large group of prisoner doctors, "probably because of our excellent knowledge of German."[3]

Mengele appointed Prof. Epstein head of his "research establishment." Epstein enjoyed an international reputation as a pediatrician; before the War he had been head of the children's clinic of Prague's university hospital. When German forces entered Prague in March 1940, he fled to Norway, where he found himself a job. In October 1942, the Norwegian police arrested him and his wife on German orders and handed them over to the Germans. He arrived in Auschwitz via Stettin (now Szczecin, Poland) in a group of 532 Jewish men, women, and children on December 1, 1942.[4] During the selection on arrival, his wife was allocated to the "incapable of work" group and sent straightaway to the gas chamber, while Epstein was put in the group of prisoners deemed "capable of work," registered, and transferred to the camp on December 17, 1942. He was given a job in the prisoners' hospital, first as a nurse and later as a prisoner doctor.

EVADING DEATH: PRISONER DOCTORS WORKING FOR MENGELE

Prof. Weisskopf and Dr Epstein became Mengele's principal working associates. They were the real authors of the "scientific" work Mengele conducted in Ausch-

2 Wiese, Merten, et al., 40–44.

3 Statements made by Dr Rudolf Vitek before the Polish prosecutors during his interview on May 8, 1967, now in the records held in the Kraków Branch of the IPN (Polish Institute of National Remembrance), S 51/05/Zn, Vol. 20, pp. 3907–3917 [old reference No.], 3909.

4 Czech, 347; statement made In court by witness Berthold Epstein, April 7, 1945, AIPN, GK 196/99, 23–36.

witz on commission from the KWI for "his" research on noma and on twins.[5] With time, Mengele recruited more prisoners to the scientific staff of his rapidly expanding "research station."

In the recruitment policy for his diverse research projects, Mengele laid great store in giving prospective members of his staff the chance to make a "voluntary decision"— if the term "voluntary" can be applied at all to the conditions prevalent in Auschwitz. First, we should bear in mind that for many of the prisoners who worked on Mengele's "research projects," joining them substantially improved their chances of survival, and in fact saved many from imminent death. They became members of the *Prominente* (privileged) group of prisoners and generally enjoyed better living conditions, no longer having to go hungry. In point of fact, starvation was the most common cause of death in Auschwitz among prisoners who were confined in the camp. Another key consideration prompting such decisions was the fact that prisoner doctors and nurses working for Mengele were exempted from the selections for the gas chambers which took place at regular intervals in the prisoners' hospital and the camp. This exemption covered Mengele's Jewish staff as well. Employment on any of Mengele's "research projects" meant a much better chance of survival.

The anthropologist Martina Puzyna of Lwów (now L'viv, Ukraine) owed her survival to the fact that Mengele (or officially the KWI) had her work on his twin research project. Puzyna was arrested in March 1943 for her involvement in the Polish underground resistance and in August 1943 she was sent to Auschwitz, where at first she was put in various work commandos for hard labor. However, she rapidly lost her physical strength and soon fell seriously ill. A woman prisoner doctor drew Mengele's attention to her when she was effectively bedridden in the prisoners' hospital. Mengele ordered the hospital's staff to get Puzyna back on her feet, and once she had recovered he gave her an anthropologist's appointment on the KWI twin research project. He procured a special set of anthropological measuring instruments for her and made arrangements for her to have a room to herself, as well as two assistants. Puzyna and her assistants took a set of anatomical measurements from the group of twins and the people with dwarfism.

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5 Szymański et al., 93, 98.

TWIN RESEARCH IN AUSCHWITZ-BIRKENAU

Twin research is the best known of the scientific projects Mengele pursued in Auschwitz for the KWI. It was a field of study his mentor von Verschuer had been deeply committed to since the 1920s. Mengele had a kindergarten set up in Blocks 29 and 31 on the premises of the Roma camp for "his" twins and all the Roma children under six. This was the place where he gathered and kept all of his human "experimental and research material" for the KWI-A. The children designated for the study were brought to a specially arranged research facility where they had medical and anthropological examinations carried out on them and were forced to undergo a variety of experiments. Mengele devoted special attention to the monozygotic (identical) twins, and had records made for at least 17 pairs of them.[6] When his experiments on these children had finished, Mengele had his human subjects killed, or he killed them himself, to have their bodies autopsied "for scientific purposes" and to preserve some of their organs, e.g., their eyes, and keep them as "scientific exhibits."

In September 1943, another family camp, B IIb, was set up in Birkenau, this time for Jews deported from the Theresienstadt ghetto who were not designated for immediate death during the selection on the ramp and instead were sent with their entire family to the new family camp. Mengele kept records and conducted research on about 10 pairs of twins in this group, too.[7] He had some of them accommodated with their mothers in separate living quarters. As of mid-May 1944, when mass transports of Hungarian Jews started to arrive in Auschwitz, there was a rapid rise in the number of twins subjected to Mengele's experiments. Mengele personally picked out his experimental "material" on the ramp, or he had other SS physicians and SS men do it for him during selections on the ramp. Apart from twins, he was also on the lookout for individuals with dwarfism or physical disabilities.

There are no records for the exact number of twins Mengele selected for his live research and experimental material and had accommodated in separate living quarters. There is a considerable difference in the figures survivors give in their

6 Kubica, 381–384.

7 Minutes of the Polish prosecutors' interview of Hana Novakova née Seinerova, of July 10, 1947; Archives of the Kraków Branch of the Polish Institute of National Remembrance, S 51/05/Zn, Vol. 20, pp. 3794–3800, 3796. In the spring of 1944, Hana Seinerova and her twin brother were in the group of Mengele's human subjects.

statements. Martina Puzyna said a total of about 250 pairs of twins were picked out of the Hungarian transports.[8] However, the majority of the Jewish twins survived the war because they constituted important research material for Dr Mengele and the KWI-A.

Mengele certainly did not restrict the broad range of his experiments on twins merely to anthropological observations. In particular, the postmortem forensic examinations he carried out on the corpses of his subjects made up a salient component of his project. He set up a separate research team to handle these autopsies, headed by Dr Miklós Nyiszli, a Hungarian Jewish physician and forensic pathologist from Oradea (now in Romania).

Nyiszli arrived in Auschwitz with his wife and daughter in a "Hungarian transport" on May 22, 1944. All three of them were designated "capable of work" and sent into the camp. Nyiszli was assigned to the concrete layers' commando working in the Buna industrial plant in the Monowitz subcamp of Auschwitz. About a fortnight later, Mengele learned of him and employed him as one of his pathologists. Later, Nyiszli was given two assistants. He and his colleagues conducting the autopsies were allocated a workplace on the first floor of Crematorium I in Auschwitz-Birkenau. According to Nyiszli's post-war recollections, it was a "state-of-the-art," well-equipped autopsy facility with three microscopes and access to the latest issues of the specialist journals.[9]

Over the next few months, the team of pathologists under Nyiszli carried out numerous autopsies for Mengele. They also had to preserve specific organs from the corpses of Mengele's "research subjects" who had been killed. For instance, they had to remove and preserve the eyes from the bodies of murdered Roma children, the heads of children with noma, and the skeletons of Jewish "research subjects," turning them into "scientific exhibits." Mengele sent most of these exhibits to the KWI headquarters in Berlin-Dahlem.

Mengele established at least three research teams in Auschwitz consisting of prisoners to conduct a variety of "research projects" for him and under his supervision. The largest was Prof. Epstein's team for diverse kinds of medical research

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8 Statement made by Martina Puzyna in London on October 31, 1972, HHStAW, (das Hessische Hauptstaatsarchiv Wiesbaden) 461zZ/37976, Vol. 13, pp. 12–19, 1.

9 Nyiszli, 27–29.

projects and experiments. There was an anthropological team led by the anthropologist Martina Puzyna, and a team of forensic scientists carrying out autopsies under the leadership of Dr Miklós Nyiszli in a special postmortem room in Crematorium I. In addition, there were also other prisoner doctors who were inmates of Auschwitz-Birkenau who had to conduct a variety of individual "research projects" for Mengele.

THE KWI-A'S "CENTRAL COLLECTION FOR HEREDITARY PATHOLOGY"

In his report of December 1940 on the KWI-A's activities, Eugen Fischer (1874–1967), the Institute's founder and first director, declared that phenogenetics[10] was its new task in genetic research, and went on to say that

> [P]henogenetic research, especially on humans, needs . . . an abundant store of embryological material. . . . It will take a lot of time to collect it. . . . A central collection should be built up by systematically assembling human and animal embryos derived from pathological lines and diverse races; the potential such a collection will offer should then be made freely accessible for the purpose of research.[11]

By the end of 1939 phenogenetics had become the KWI-A's "new paradigm," and Otmar von Verschuer, his successor as head of the KWI-A (October 1942), continued to promote it.[12] But the key question in connection with Mengele's Ausch-

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10 Phenogenetics is a scientific research field that deals with the mechanisms of development of living organisms, and combines a genetic, ontogenetic, and phylogenetic approach. Phenogenetics plays a part in the phenocritical phase of developmental biology, but it is chiefly applied in comparative ontogenetic research, i.e., observations on the course of embryonic development in close relatives, or in the original and mutant forms, by comparing specific traits. See http://www.spektrum.de/lexikon/biologie/phaenogenetik/50871 [Accessed April 18, 2019]. Phenogenesis is the physiological and biochemical process of growth which leads to the development of hereditary traits.

11 "Bericht des Direktors Eugen Fischer über die Tätigkeit des KWI für Anthropologie vom 04.12.1940." *Archiv der Max-Planck-Gesellschaft*, Abt. Rep. 1A, No. 2400, pp. 159–179.

12 Quoted after Schmuhl, 327.

witz appointment is what kind of "human exhibits" the KWI-A wanted for its "Central Collection for Hereditary Pathology." This is the list of the kind of "human exhibits" it was interested in:

— "Twins: (1) Monozygotic and dizygotic fetuses, embryos, and neonates; (2) body organs of mono- and dizygotic children and adults; (3) all kinds of conjoined twins. . . ."
— "European races: fetuses, embryos, neonates and body organs: (1) races derived from the German People; (2) races representing other European peoples; (3) Jews."
— "Non-European races: as above. . . ."
— "Hereditary diseases: fetuses, embryos, neonates and body organs of siblings with particular defective hereditary traits. . . ."[13]

Thus one of Mengele's most important duties in Auschwitz was to "obtain" and "secure" the above-listed human exhibits, and send them to Berlin-Dahlem for the "Central Hereditary Pathology Collection." To do this, Mengele had human beings (adults as well as children, most of them Jewish) killed, and he took part in the killings himself. Then he had the bodies and particular organs dissected, the head or skeleton preserved, and dispatched to the KWI-A in Berlin-Dahlem.

Mengele commissioned Dr Nyiszli and his fellow prisoners and gave them orders to carry out the autopsies. He decided which body parts he wanted to keep from the dissections on the basis of the requirements of the various KWI-A research projects, especially its twin and phenogenetic studies. The rest of the dissected bodies were sent to the crematorium.

Nyiszli wrote in his book that the body parts Mengele wanted "for scientific purposes" were set aside for him to see. "In addition, I had to preserve the items which Dahlem might be interested in. Eventually they were packed and shipped. . . . I dispatched countless packages of this kind to Berlin-Dahlem during my time in the crematorium."[14]

Apart from these prisoner doctors and other specialists whom Mengele recruited and appointed for his particular "research tasks," he also had other of the camp's

13 "Bericht des Direktors Eugen Fischer . . .," 194.

14 Nyiszli, 47.

facilities at his disposal for his projects. In May 1943, an institution officially known as the "Hygienisch-bakteriologische Untersuchungsstelle der Waffen-SS und Polizei Süd-Ost, Auschwitz, Oberschlesien" (the Southeastern Waffen-SS and Police Hygiene and Bacteriological Experimental Station, Auschwitz, Upper Silesia) was set up at a place called Rajsko, a few kilometers away from Auschwitz main camp. The Rajsko unit was an external department of the Berlin Waffen-SS and Police Institute for Hygiene. In 1944, about 100–110 prisoners, including 50 scientists, some with an international reputation, worked in the Rajsko hygiene institute.[15]

At Rajsko, Mengele had laboratory tests conducted on blood, urine, stool, spittle, and tissue samples. In the summer of 1943, the bodies of deceased noma patients were autopsied in Rajsko's bacteriological department. Rajsko also handled the preservation of the heads of Roma children who had contracted noma.[16]

Mengele had Wilhelm Brasse, a Polish prisoner working in the identity service of the Politische Abteilung (Political Department, i.e., the camp's on-site Gestapo unit) photograph his research subjects. From the fall of 1943 to the spring of 1944 Brasse photographed about 1,500 Jewish women prisoners on commission from Mengele. In the spring of 1944, he started photographing twins and triplets, as well as people with dwarfism, both children and adults. In his postwar statement for the Polish authorities, Brasse said that he had to take fully naked frontal photos as well as from the back of the pairs of twins, and in addition of the heads of some of them, as instructed by Mengele.[17]

Mengele has been described as elegant and good-looking, as well as friendly to the children, only to have them killed and dissected shortly afterwards to let him pursue one of the scientific problems he was interested in. He never directly used violence against any of his subordinates yet he was generally feared in the hospital

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15 Statement made by witness Gesa Mansfeld to the Polish prosecutors (March 1945; no day date, but probably on March 8). AIPN, GK 196/99, pp. 12–23. Prof. Mansfeld was one of the prisoner scientists working at Rajsko.

16 Statement made by witness Mieczysław Kieta in the Polish court proceedings against the SS staff of Auschwitz concentration and death camp, on November 26, 1947 (the third day of the trial), pp. 224–245, esp. 235f. Kieta was an Auschwitz survivor who worked as a lab assistant in the Rajsko hygiene institute.

17 Statement made by Wilhelm Brasse on July 10, 1972, in the Archives of the Kraków Branch of the IPN, S 51/05/Zn, Vol. 16, pp. 3017–3021 [old ref. No.].

blocks because whenever he conducted selections, he was the most ruthless and intractable of all the SS physicians on that job. He sent thousands to their deaths in the gas chamber without so much as blinking an eye—and spared just a few individuals for reasons which were not at all clear to them. He was meticulous in matters concerning science—as he understood it—and the scientific records he kept, always seeing to it that even the most minor details were registered. Shortly before the camp was evacuated, he is believed to have hastily stuffed all of his "research reports" in a suitcase never seen again.

What happened to the exhibits Mengele had preserved from the organs and skeletons of his victims' bodies and dispatched to the KWI-A and other institutions has been hushed up. They disappeared immediately after the war and their whereabouts are still unknown. In the postwar period, the KWI, originally founded in 1911, was revamped and had its name changed to the Max Planck Institute to disassociate itself from its murdeous past during the Nazi period.

However, there is a considerable amount of evidence that shortly before the Red Army took Berlin and entered the premises of the Kaiser Wilhelm Institute, which today is the property of the Free University of Berlin, some of the "exhibits" were hastily incinerated. Decades later, in 2014, workmen on the building site for the university's new campus stumbled on human remains, presumably from this collection. The university's authorities had these bones cremated without conducting an investigation to determine their exact origin.[18] So much for Germany's widely flaunted coming to terms with its past.

18 Aly, Götz. "Knochenfunde auf dem FU-Gelände: Alle Spuren weisen nach Auschwitz," Berliner Zeitung, June 6,3021; https://www.berliner-zeitung.de/mensch-metropole/knochenfunde-auf-dem-fu-gelaende-alle-spuren-weisen-nach-auschwitz-li.162699 [Accessed June 7,2021]; Reitzstein, Julien. "Das Grauen von Dahlem." *Die Welt am* 10.06.2021; https://www.welt.de/kultur/plus231687045/Knochenfunde-an-der-FU-Berlin-Das-Grauen-von-Dahlem.html [Accessed June 12,2021].

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What can be learned from Holocaust survivors' adaptation to hunger and the long-term effects of anorexia/bulimia on the cardiovascular system

Marie Judille van Beurden Cahn

Jacques D. Barth

It is not new knowledge that a lengthy period of hunger can affect an individual's health. We now know a great deal about what a quantitative and qualitative shortage of food can do to the bodies of victims. This article draws a link between the health of the victims' descendants (second generation, or 2G) because

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of their parents' hunger and stress during the Holocaust. It recounts what we know about hunger, zooms in on its harmful effects on the cardiovascular system, discusses the descendants' responses to food and describes the diseases they contract.

Our article summarizes the most recent findings of the TreeGenes study that has been conducted in the Netherlands since 2015.[1] Its aim is to record the physical and psychological condition of Jewish survivors and their descendants. The population studied consists of descendants, all of whom are children of at least one Holocaust survivor. There were 220 respondents and a random selection of 67 were studied. They related their life stories via the Fortunoff Video Archive method,[2] and during a follow-up appointment their medical history was registered and a physical examination was conducted.

Holocaust Survivors' Adaptation to Hunger and Long-Term Effects on Their Descendants' Cardiovascular System: An Observational Study describes results measured in a wider context of hunger as a means of repression and control over a population. Instances of this phenomenon occurred in the 20th century and under circumstances such the *Holodomor*,[3] the Communist man-made famine in the Soviet republic of Ukraine from 1932 to 1933.

Of course, this immoral policy is outlawed by international conventions,[4] though it is still being practiced. So as not to lose sight of the Dutch Jewish second generation which is the target group of the TreeGenes study, this article includes a historical context.

It will not be an expansive overview of the use of hunger politics, but a simple and linear outline going from the hunger policy used by the British on Germany from 1914 up to the Weimar Republic in 1923; and in Hitler's Third Reich, where an active Hunger Plan, drawn up and designed for use after the invasion of the Soviet Union (22 June 1941), ultimately shaped the food regime in Nazi concentration camps.[5]

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1 "TreeGenes" https:// www.treegenes.nl/en [Accessed June 5, 2022].

2 "Fortunoff Video Archive for Holocaust Testimonies" https://fortunoff.library.yale.edu/ [Accessed June 5, 2022].

3 https://www.oorlogsbronnen.nl/thema/Holodomor [Accessed June 1, 2022].

4 "1907-10-18 Conventie van Den Haag" https://www.belgiumwwii.be/nl/belgie-in-oorlog/artikels/1907-10-18-conventie-van-den-haag.html [Accessed May 31, 2022].

5 "Food and Genocide: Nazi Agrarian Politics in the Occupied Territories of the Soviet Union" https://www.jstor.org/stable/40542587 [Accessed May 1, 2022].

We would like to express our gratitude to Dr Janina Kowalczykowa (1907–1970). Her description of the hunger regime at Auschwitz with its somatic and psychosocial effects on the lives of the prisoners[6] is one of the earliest scientific surveys of the phenomenon and has helped us to arrive at a better understanding and interpretation of the results of the Hunger Winter study and the effects of hunger on a fetus. If pregnant women have to go without essential nutrition, this affects their progeny, and we now know this can be scientifically proven. It is striking that no general research has been conducted on the physical condition of Jewish survivors after World War Two, since they were the ones who suffered the most from the hunger policy followed by Nazi Germany. Hunger was also an important part of the Nazi practice of persecution and homicidal strategy.

In 1972, H. Mauritz, Director of Information and Coordination of Services at ICODO, the Dutch National Institute for Victims of War,[7] wrote that it is self-evident that "not only should the moment of birth be taken into consideration but also the nature of the problem. The question is whether the second generation should not be viewed as war victims." He was saying something that was plausible over a century earlier but had not yet been researched. Nowadays we are getting more and more evidence to show that later generations also suffer from the effects of hunger and persecution, and not only in a psychosocial sense but also in a demonstrably physical manner. Although we still have a great deal to discover, the connection is clear. In 2008, physicians and medical researchers Elizur Hazani and Shaul Shasha wrote:

> 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 regarding behavioral and mental aspects. However, very little is known about their physical health . . . to the best of our knowledge the effect of the Holocaust on the physical health of the offspring of the survivors has never been studied. It is high time this issue was dealt with.[8]

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6 Kowalczykowa, 2019.

7 Stichting, ICODO, 1972.

8 Hazani and Shasha, 2008: 251, 254.

TreeGenes is globally the first study to address the physical condition of the (Dutch) second generation and speak to the respondents. This is done not via psychosocial questionnaires but using non-invasive cardiovascular measurements supplemented by interviews and medical histories to get a clear picture of the somatic suffering of this cohort of Jews after World War Two. These TreeGenes measurements and calculations on physical aspects have been added in an easy access framework and are referred to in the text.

THE HISTORICAL CONTEXT: FROM WORLD WAR ONE AND THE INTERBELLUM TO HITLER'S GERMANY

When Britain and its Allies blocked food shipments to Germany from 1915 to 1919, this had serious ramifications for the German population's food situation. In *The Politics of Hunger: The Allied Blockade of Germany, 1915–1919,* the American historian Paul Vincent called the hunger blockade a crime that belongs in the "category of forgotten state atrocities of the twentieth century."[9] He wrote that in 1918 the National Health Office in Berlin calculated that 763 thousand people died of starvation. Their daily caloric intake was so low (1,000 kcal for adults) that the mortality level in 1918 was 38% higher than in 1913. The appalling result was a rampant tuberculosis epidemic, and the vitamin C and D deficiencies led to brittle bones and scurvy. Victims' bones were warped, they suffered from dramatic weight loss, and wounds failed to heal. They developed black and blue spots and their weakened immunity led to infections that could often be fatal. In his book, Vincent quoted a British journalist who wrote with more than a hint of hostility that "tens of thousands of Germans now in the wombs of famished mothers are destined for a life of physical inferiority."[10] This unadulterated malice was obviously a product of the political relations at the time and describes the extreme hunger the German population was faced with until 1923.

9 Vincent, 1985.

10 Vincent, 1985.

The promotion of starvation to the status of an official policy was cruel and a violation of human rights, so the Hunger Plan launched by Herbert Backe (1896–1947), Reichsminister of Food and Agriculture in Hitler's Germany, was not a new idea to the Germans. Starvation was a central strategy in the Nazi genocide program against the Jews. Hitler had long been aware of the power inherent in being able to control what people ate. Operation Hunger[11] envisioned death by starvation for millions of Slavic and Jewish "useless eaters" following Operation Barbarossa, June 22, 1941, when Germany invaded the Soviet Union. Food was to be rationed and distributed as follows: Germans were to get 100% of the "standard" calorie intake, the Dutch were to get 90%, Poles 70%, Greeks 30% and Jews 20%; although by that time "standard calorie intake" meant the daily minimum for human survival.

Deliberately induced starvation also played a key role in the Holocaust. In the Jewish ghettos access to food was tightly controlled. It was up to the Nazis to decide who would eat meat or bread, and the Jewish shops had a very small assortment of food. "It is hard to say how many Jews died from hunger," writes Anette Homlong Storeide, who is a researcher at the Falstad Centre, a museum, memorial and human rights institution in Norway.[12] "Many of those who died in the gas chambers or during transport to the concentration camps were already emaciated."[13]

In 1961, the Polish physician Dr Janina Kowalczykowa (1907–1970), an anatomical pathologist, wrote a paper on starvation in Auschwitz. She was a prisoner herself there for a lengthy period and tried to record her observations as a witness in a scientific manner.

> The detailed assessment of individual aspects of hunger disease was not always easy. I was able to understand some specifics that I had observed during my stay in the camp only after I was released and read the appropriate medical literature. . . . Moreover, hunger disease did not always take the same course with everyone and depended on the specific set of circumstances. It was frequently accompanied by complications such as typhus,

11 Kay, 2006: 685–700.

12 "Hitler's Hunger Plan" https://www.nobelpeacecenter.org/en/news/hitler-s-hungerplan [Accessed May 3, 2022].

13 "Torture—a perspective on the past." https://doi.org/10.1136/jme.17.suppl.9 [Accessed March 1, 2022].

purulent infections, or injury. Nonetheless, the typical syndrome displayed some very characteristic changes. . . .[14]

In short, the stages of starvation can be summarized as follows: In the first stage, hunger leads to dry mouth, frequent urination, rapid weight loss and an irrepressible craving for food. In the second stage, the craving for food becomes less compelling and is replaced by apathy and an overall sense of weakness. The hungry person prefers to curl up into a fetal position and is always cold. Fluid accumulates in the cells, starting with the face, feet, and legs as hunger edema sets in. Premature aging occurs in the third stage, and a young woman's face looks like an old, shrivelled berry. The skin becomes pale, dry and flaky, parchment-like. Brown pigmentation appears, the hair falls out, movements become slower and clumsier. The fourth stage is often fatal. The shadow of a person trips over their own feet. The heartbeat is slower, the blood pressure and body temperature are low and the voice becomes hoarse. Death of prolonged hunger is like a slowly extinguishing candle.

It is important to note that in all four stages there are "distortions in the nervous system . . . both mental and neurological."[15] Hunger is well tolerated in the first week. In the beginning there are hunger pains and stomach cramps, but they disappear after a few days, making the victim feel quite well. The blood sugar level drops from 0.8 to 0.6 mmol/l, but then remains stable. If the individual gets a sufficient intake of fluids, there is still not much of a risk. They can even do physical exercise.

After the first week, the victim's weight has already decreased significantly. There are also several other obvious changes. Orthostatic hypotension (low blood pressure) and bradycardia (slow heart rate) cause dizziness and headaches. Fatigue and muscular pain—even after the slightest exertion—reduce mobility. There are concentration problems, which make reading impossible. Body temperature drops due to the reduced metabolism. Abdominal pain and sometimes hiccups may occur. Communicating becomes difficult because talking is tiring, so people whisper in short sentences.

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14 Kowalczykowa, 2019.

15 Strøm, Refsum, Eitinger, et al., 1962: 43–62.

After about a month, the hungry person falls ill. The turning point is around day 40. A general feeling of illness may be accompanied by loss of hearing, double vision, nausea, vomiting, poorer vision or bleeding from the digestive tract. There is no mental decline, just concentration problems, apathy, and psychological instability, but in the terminal stage a hungry person can become euphoric. After that, there is confusion and a stage of coma, and death can occur within hours. The medical literature covers a period of 42–79 days prior to death. Victims can stay alive longer if there are no complications and they are in a normal condition. Overweight and obese people have an advantage over lean people because they can use their resources of fat when all the glucose in the liver has been released.

However, there are also other diseases like dysentery, beriberi, pellagra, typhoid and marasmus in children, which frequently attend severe forms of hunger and malnutrition.

The Norwegian scholar A. Homlong Storeide writes that

> All the prisoners at the camps were starving. But the Jews starved the most. . . . Non-Jewish prisoners were allowed to receive food from the Red Cross, as well as from friends and family—a privilege not afforded to the Jewish inmates. In the Nazi worldview, they were at the bottom of the hierarchy. Jews who starved to death were not seen as a problem. On the contrary—it was welcomed.[16]

HUNGER IN GENERAL

How much do we know? Everyone knows what a stomachache feels like. If you miss a single meal, you feel the effect on your mood and ability to concentrate and sometimes even your ability to think straight. So you try to avoid this feeling as much as possible, but what if you have no choice?

Although hunger is normally associated with the stomach, it can also affect the brain in several ways. Due to a shortfall in essential nutrients, vitamins, proteins and minerals, severe and continuous hunger can stop the brain from develop-

16 Bruaas, 2021.

ing cognitively, socially, and emotionally, all of which affect an individual's ability to read, concentrate, memorize, and even speak. Other key organs are also directly affected by hunger. Impaired vision and other eyesight issues result from a lack of vitamin A, and the gums and teeth can be damaged by calcium deficiency. What is perhaps even worse is the effect extreme hunger can have on the immune system. If the immune system lacks basic vitamins, nutrients, and minerals, it cannot defend the body properly against disease, which is why people in developing countries are constantly battling against a variety of illness.

All children should have access to nourishment, and it is crucial for newborns and infants to receive the necessary nutrients. It is well known that 70% of the brain develops in the first two years of life. If young children are malnourished, especially at that age, the brain can be damaged permanently. Not only are the effects of hunger and malnutrition damaging, but they can also be irreparable.

HUNGER WINTER RESEARCH[17]

Aside from discomfort, hunger causes serious health issues. A famine suddenly induced by the Nazis in the Netherlands was the Hunger Winter (*Hongerwinter*) in the fall and winter of 1944 and the winter and spring of 1945. After railroad workers went on strike against the orders issued by the occupying authorities to transport more Dutchmen to work in German factories, hardly any food could be transported to 4.4 million hungry people. The Germans blocked all the incoming food, and calorie intake in the western part of the Netherlands dropped to 400–600 calories a day. As a result, 25 to 50 thousand Dutch people died of hunger. The situation became so severe that Sweden and the Allies organized an airlift to drop bread over Holland.

Even in such chaotic times, women did get pregnant and carried their babies to term. Many of them were admitted to the Wilhelmina Clinic in Amsterdam. The government and public services continued to function throughout the winter, and accurate records of demographic and medical data were kept by Dutch officials.

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17 Eskes, 2001: 245.

About 750 babies were born in the Hunger Winter. They had the following physical irregularities: Their glucose and lipid levels were disturbed. They were usually born very small, but as adults had higher rates of obesity, cancer, and premature death. The effect of hunger on the fetus depended on the trimester when it occurred. Undernourishment in the first trimester of pregnancy had the greatest impact, resulting in the mothers' increased weight toward the end of their pregnancy and in children with a high birth weight who were overweight in adult life. Hunger in the first trimester led to diabetes mellitus, cardiovascular diseases, obesity, breast cancer, depression, hypercholesterolemia, and schizophrenia in the offspring. Starvation in the second and third trimester led to kidney and lung diseases, diabetes and susceptibly to stress. Hunger in the third trimester led to diabetes and other endocrine diseases. Hunger could lead to smaller children with a lower birth weight, a decreased head circumference, and a small placental surface. Pregnancy during the siege was accompanied by an average weight loss of 4.3%. After the war, with food more abundant again, a weight gain of 10.5% was observed.[18]

Babies born during the acute and severe famine of the Hunger Winter in the western part of the Netherlands (October 1944–April 1945) not only had health trouble, but they also had psychosocial problems. The cohort studied in the Hunger Winter research was followed up for many years. A third generation, the grandchildren of the victims, are still being followed up by Leiden University. It is a unique and unequaled research project that has made it possible for us to examine the immediate and long-term effects of food shortage on the health of the population.

18 Prenatal hunger, particularly in the first trimester, resulted in significantly higher cardiovascular morbidity in later life, regardless of the weight at birth. The lipid profile was atherogenic, with a low-density/high-density lipoprotein ratio as high as 14 (the desired ratio is <3, and 11 is considered high risk), lower than normal apolipoprotein A, and higher apolipoprotein B levels (although statistically non-significant). The weight of the mother before delivery did not affect the lipid profile.

THE TREEGENES PROCEDURE

Leo Eitinger, a medical doctor, psychiatrist, and Holocaust survivor, wrote about the suffering of camp survivors. He dedicated his life to studying the psychological effects of traumatic stress and laid the foundation for the definition of post-traumatic stress disorder (PTSD) and post-concentration camp syndrome, thus facilitating the recognition of the survivors' post-war condition.[19] Currently, Natan Kellermann is giving the best psychosocial overview of child survivors.[20] But to our knowledge, no other study except for TreeGenes has been conducted on the impact of psychosomatic problems and diseases due to hunger and prolonged stress in the Dutch 2G.

Since this is a study in an area where no data were available before, we interviewed 32 respondents, the number usually considered adequate for an academic medical study. Originally no fewer than 220 Dutch 2G respondents were willing to participate in the study. The number was reduced to 67 after the first phase of the study, when the interviews were conducted. The third stage of the study was done in March–July 2018 to prevent method variation and time differences. Everything was done within a relatively short period to prevent too much talk about the study and guarantee the same historical setting. This was good in retrospect, because the number of anti-Semitic incidents increased in the Netherlands after July 2018.[21] The interviewer was always the same person, so the tone, atmosphere, and angle remained the same.

The 67 respondents were invited to tell their extensive life stories with no reservations and no interruptions. Of course, there were short breaks. The interviews were done in the safe setting of their own homes, and the respondents chose where they would be most comfortable—on the couch, at the table—to tell their story. The interviews were registered audiovisually and took 60–240 minutes. The interviewer remained off-screen and spoke as little as possible. In es-

19 Chelouche, 2014: 208–211.

20 Kellermann, 2001: 256–267.

21 "Tweede Kamer" https://www.tweedekamer.nl/kamerstukken?clustername=Tweedekamer.nl&fld_prl_voortouwcommissie=vaste+commissie+voor+Binnenlandse+Zaken&fld_tk_categorie=Kamerstukken&srt=date%3Adesc%Adate&todate=18%2F2018&search_str=antisemitisme [Accessed June 7, 2022].

sence, the method for the tapes resembled the one for recording the tapes in the Fortunoff Video Archive, where 4,400 testimonies given by Holocaust survivors are kept. The interviewers were clearly present, and more questions were posed. In the TreeGenes interviews, the interviewer notes the date of the interview off-screen, asks the respondent's name and year of birth, the names of the parents and members of the family, and asks for permission to use the interview for the TreeGenes study. Although there was a format of fixed questions available about the respondent's background, position in the family, ideas about Dutch society, international relations and more specifically Israel, the interviews were generally very spontaneous. The respondents took the initiative to tell their own life stories and determined the pace and contents. As in the interviews in the Fortunoff archives, "the witness is an expert on the life story" and the interviewer is only there to listen, learn, and clarify.[22] Hence, we would like to make a few comments. The overwhelming majority, 96% of the respondents, were not professional speakers. The percentage of professional social workers or therapists was 4%. All of the respondents were speaking for the first time as members of the second generation. None of them had taken part before in a large research project on the topic, and their (now deceased) parents were not invited but very emphatically present. The interviewer was very cordially received, and usually there was delicious food on the table. From about half of the interviews, the interviewer went home with a kind of Jewish Care (Yiddish Care) package.

Box 1. | Baseline characteristics of the respondents

- Number of respondents: 66 (aged 55–73 years, 38 women and 28 men)
- All respondents were second generation survivors (2G) with at least one Holocaust survivor parent
- Volunteered for the study in outpatient setting
- Born in the Netherlands after May 5, 1945
- Speakers of Dutch

How to further process the information in the interviews is something we are just learning to do. The intention is to draw up a transcription for each interview which includes the pauses, moments of silence, and repetitions.

22 "Fortunoff Video Archive for Holocaust Testimonies" https://fortunoff.library.yale.edu/ [Accessed 5 June 2022].

RESULTS OF THE TREEGENES STUDY

The following can be stated from an assessment of the data of the Holocaust survivors and their offspring:

This study showed that the offspring are experiencing psycho-social problems. Compared to our earlier studies, we took a more comprehensive approach. The interviews and questionnaires were recorded. A more detailed report was made, given the fact that an extensive diagnosis was to be done. The offspring showed extensive anxiety and clinical depression as well as eating disorders.

Another interesting fact concerns the usage of psychotherapy and psychotropic medication. It is not uncommon for both factors to have been present for a long time. One woman had been in psychotherapy for 49 years. Another woman had been on benzodiazepine for many years and taking another drug every 2 hours. At the same time, most offspring downplayed the seriousness of their psychosocial problems. Remarkably, most of the offspring were divorced.

We did an assessment of the psychosomatic aspects of the study. Our larger investigation group confirms earlier published findings regarding cardiovascular health. In addition, we were able to establish other psychosomatic findings like gastrointestinal trouble and lung function.

Table 1. | Results of psychosocial examination of Holocaust survivors and their offspring participating in the study (part one)

	Holocaust survivors	**Offspring**
Number of persons	82	67
Chronic anxiety	78 (97%)	63 (94%)
Depression	70 (86%)	25 (37%)
Obsessive-compulsive disorder	32 (40%)	12 (18%)
Dementia	5 (26%)	0
Eating disorders	8 (10%)	23 (34%)
History of suicide in the family	Not applicable	7 (10%)

Table 2. Results of psychosocial examination of Holocaust survivors and their offspring participating in the study (part two)

	Holocaust survivors	Offspring
Number of persons	82	67
Neurological conditions	11 (14%)	7 (10%)
Addiction	15 (19%)	8 (11%)
Admitted to psychiatric ward	14 (17%)	6 (9%)
Divorce	54 (66%)	63 (94%)
No children	Not applicable	7 (10%)
Mean Body Mass Index	21	26
Mean systolic and diastolic blood pressure (mmHg)	162/91	159/83
Mean heart rate (bpm)	76	82
Male to female (%)	45/55	41/59
Mean age in years	84	66

Table 3. Psychosomatic anamnestic conditions upon physical examination in Holocaust survivors and their offspring participating in the study

	Holocaust survivors	Offspring
Number of persons	82	67
Cardiovascular diseases	21 (26%)	33 (50%)
Diabetes mellitus	33 (40%)	17 (26%)
Hypertension	79 (96%)	63 (95%)
Gastrointestinal disorders	34 (41%)	43 (53%)
Chronic autoimmune disorders	10 (13%)	13 (19%)
Chronic obstructive pulmonary disease	4 (5%)	13 (19%)
Osteoporosis	19 (23%)	13 (19%)
Cancer	25 (30%)	15 (22%)
Number of regularly visited medical specialists >3	78 (95%)	51 (76%)

The rate of diabetes was significantly lower than in their parents. A unique finding in the offspring was the determination that they did not want to have children.

Both hypertension and chronic cardiovascular disease were observed in a larger number of the offspring. We should not forget that most offspring born in the Netherlands spoke Dutch. However, most of them have traveled to many countries like Israel or the United States. Another finding that is worth mentioning is that the great majority of the offspring have seen numerous medical doctors and used many drugs. An overwhelming problem seemed to be the fact that they had a limited family circle in the Netherlands, which resulted in a kind of social isolation. Our participants came from all over the Netherlands, not just the big cities.

Let's now turn to the Holocaust survivors. The offspring said who their parents were and how they managed to survive the Holocaust. Unfortunately, many parents are now deceased. We were able to double-check the history (medical and psychosocial) by doing an investigation on 23 parents. The parents—that is, the Holocaust survivors themselves—were less open than their children. Initially, they were wary about participating in the TreeGenes study. Their level of depression was much higher and we recorded a high frequency of admission to a psychiatric ward for them. In addition, there was a very high frequency of obsessive and compulsive behavior. On the other hand, the rate of eating disorders was relatively low in the parents. There was a high rate of occurrence of psychosomatic diseases, notably diabetes mellitus and chronic cardiovascular diseases. There was also a very high rate of occurrence of osteoporosis in the women survivors.

DISCUSSION

For centuries the use of starvation and induced famine in a war situation has been a deplorably common practice.

With the recent military invasion of Ukraine (February 24, 2022), famine and induced starvation are again making their presence felt in the general population of certain countries.

Currently no other study is being done to look at the impact of psychosomatic problems and diseases on second-generation Dutch Holocaust victims. That is why we launched the TreeGenes study of the offspring born in the Netherlands between 1945–1960.

Moreover, the trauma-related psychopathology of those directly exposed to violence and war may also have intergenerational consequences. The term "transmission of trauma" has been used to describe these consequences, defined as thoughts, feelings, and behaviors generated from the survivors' experiences and transmitted to their offspring.

Much research has also been done on the impact of the psychosocial challenges to Holocaust offspring, and fairly recent work by Yehuda et al. points to an epigenetic change in child survivors.[23] They found a problem with the level of cortisol metabolism. The situation they observed was similar to that of a fetus having great difficulty adjusting *in utero* to an increased level of stress and cortisol by downgrading cortisol metabolism. The results obtained by Yehuda and her colleagues showed for the first time that epigenetic changes in humans caused by exposure to trauma can be passed on to children born after the event—in this case, Holocaust survivors and their adult children. Epigenetic processes alter the expression of genes without producing changes in the DNA sequence and can be transmitted to the next generation. The researchers focused on *FKBP5*, a stress gene linked to PTSD, depression, and mood and anxiety disorders. The results suggest that Holocaust exposure had an effect on *FKBP5* methylation—a mechanism that controls gene expression—which was observed in parents exposed to the horrors of the concentration camps as well as their offspring, many of whom showed signs of depression and anxiety. Therefore, this may demonstrate and explain why trauma can be transferred to offspring.

There are a lot of questions that should be answered by other studies. For instance, how is it possible that Holocaust survivors have the diseases we observe them to have, and what about their offspring? Or does transmission occur in the third generation, and to what extent, if at all?

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23 Yehuda et al., 2007.

As an observational study, the TreeGenes study focused on the purely psychosomatic and psychosocial aspects of the trauma in Holocaust survivors and their offspring.

The following are the highlights of this study, in addition to previously reported data.

The focus on the second generation had some special aspects where little attention has been given:

1. Food
2. Parentification
3. *La belle indifférence*[24]

1. Food: The incredible preoccupation with food is indeed striking. During the interviews, our interviewees spoiled us with food, forgetting the Dutch custom of "a cup of coffee with only *one* cookie." The amount of food in the freezers in their kitchen was overwhelming. Food has a special meaning for Jews, like fasting on different fast days in the year and extensive eating on Friday evenings at the beginning of the Shabbat. People need not be observant to see this tradition continue. We must think of the people who refused to eat on Yom Kippur, the holiest day in the Jewish calendar, while standing in a camp roll call.[25] The fear of being without food is omnipresent. Food can be kosher and that may not be enough, it needs to be *milchig* (milk-like), *parve* (neutral) or *fleishig* (meat-like). We think we have established the special role food plays in this Jewish cohort. The combination of losing and gaining many kilogrammes in conjunction with their rampant chronic cardiovascular diseases was certainly something to note. A related interesting observation was the high percentage of Holocaust survivors suffering from diabetes mellitus, which cannot be explained by weight gain. The percentage of 2G with diabetes was half the number for the Holocaust survivors, but it was still very high.

The key inference is that food plays a much more essential role in a situation associated with war. This should be explored much more in today's unstable and chaotic world.

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24 *La belle indifférence* is a paradoxical absence of psychological distress despite a patient's serious medical illness or symptoms related to their health condition.

25 Roll calls were held on the *Appelplatz*. This German word was generally used for the roll calls, regularly held twice a day, in Nazi German concentration camps.

2. The term "parentification" refers to situations where the roles of child and parent are exchanged, where the child assumes parental responsibility over a "child-like" parent. For example, a 44-year-old mother needed an 8-year-old son to comfort her whenever she was having a period of anxiety. In another case, a daughter of 12 comforted her mother of 35; whenever the mother had a spontaneous tantrum, the daughter took over the household. In addition to psychological support, the 44-year-old mother sometimes wanted a physical form of consolation, for instance, a gentle pat. The opposite was also observed to occur with the mother of 35, who had moments of rejection of her 12-year-old daughter. Kellermann refers to this in an observation that the specific psychological profile for the offspring includes "a predisposition to PTSD, difficulties in separation-individualization and a mix of resilience and vulnerability when coping with stress."[26] Parentification is a type of distorted division of roles and responsibilities in the family where the roles of parent and child are reversed. It is a situation that goes beyond the child's capabilities and exhausts their resources, usually leading to numerous negative consequences. Nevertheless, in some circumstances parentification may be beneficial by shaping resiliency. Hans Keilson made a point by naming a similar phase "secondary traumatization," where war was the first level of traumatization and the relationship between parents and children was the secondary traumatization.[27]

We confirmed this in our study.

Parentification is not an easy concept to understand fully. It means that two generations switch roles. In a situation of stress, the parent wants to be supported by the child. The child accepts the responsibility of a parent but it is a demand that the child cannot bear. The result is the child's feeling of guilt toward the parent. A positive aspect of this phenomenon is the child's readiness to function well in an adult situation.

An interesting point that has been made before concerning Holocaust survivors is that sometimes keeping the victim and the stories to oneself deprives the child of access to the Holocaust stories. If the Holocaust survivor has passed away, it is very difficult to continue to share in their ideas and feelings.

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26 Kellermann, 2013: 33–39.

27 Keilson, 1980. Original German edition: Keilson and Sarphatie, 1978.

Another fascinating phenomenon we observed in a large number of the offspring is the tendency to behave in a way that expresses a sense of jealousy and parentification toward a sibling or another fellow offspring.

It is as if I were a child entrusted with a great deal of responsibility, therefore I will take others to task to prevent them from interfering with what I can do best! This is a tangled web behavior and can also be put under the parentification label.

3. The term *la belle indifférence* may be used in situations when Holocaust survivors or offspring appear to be out of touch with reality when talking about their diseases to the outside world. As we have said above, *la belle indifférence* is defined as a paradoxical absence of psychological distress despite having a serious medical illness or symptoms related to a health condition. This condition is most commonly associated with conversion disorder (CD).

Example: a 61-year-old offspring who had metastasized melanoma and breast cancer told me she was planning to make an extensive trip in the near future, as if the diseases she was suffering from could not touch her.

The gravity of being a Holocaust survivor has brought these individuals recognition for their suffering. However, Holocaust survivors have great difficulty sharing their information with their offspring. Certainly, it is important for the message about the horror to be shared with the next generation. This is very tough to do, as some Holocaust survivors think that being recognized as a sufferer of something terrible is a blot on their escutcheon and feel that even their kids cannot recount their story to others. Unfortunately, the result will be that those memories will be lost.

Life is even more difficult when there is a clash between two different approaches to the Holocaust. One group does not want to talk about the war, but the other group only wants to talk about the Holocaust. Nevertheless, Holocaust survivors want to shun illness, as during the war being ill meant almost certain death. Curiously, sometimes their children behave in a similar fashion.

There were also some Holocaust survivors who reproduced certain aspects of the German aggression against them in their behavior toward their children. Unfortunately, sometimes this may have an effect on the children, as their loyalty to their disturbed parents is limitless. An older child committed suicide as he could not please his mother and "satisfy her needs." The Holocaust offspring born short-

ly after the war are now retired or approaching retirement age, while those born later have reached mature adulthood. Some are caring for their elderly parents, but many have already lost them. When they become parents and grandparents themselves, their focus of attention shifts to their own children and grandchildren. Numerous offspring have made "successful careers" and seem to have transformed the legacy of the Holocaust into post-traumatic growth. For them, the impact of the Holocaust has become less important in their lives, and they seem no longer to be "lost in transmission."[28] The scientific debate about whether the offspring suffer more from psychopathology than comparable populations has been resolved more or less. It is now widely acknowledged that parental trauma does not have a universal detrimental effect on offspring in general. Only 25% of offspring meet the criteria for mental disorders and require mental health treatment from time to time. Many more are preoccupied with disorganizing experiences, according to Kellermann,[29] and have Holocaust associations from time to time.[30] Some also struggle with stress-related problems and a lack of emotional resources when faced with adversity.

SUMMARY

The TreeGenes study is a project conducted in the Netherlands to assesses both the psychological and somatic well-being of Holocaust survivors and their offspring.

The study started in 2015 with 67 volunteers as second generation and 82 Holocaust survivors. The research results are preserved in a safe environment. Our extensive interviews were conducted on the basis of the guidelines recommended by the Fortunoff Video Archive. The functional tests were performed with the use of standardized operational procedures.

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28 Fromm, 2012. Also: Fromm, 2014: 90–92.

29 Kellermann, 2013: 33–39.

30 Scharf and Mayseless, 2011: 1539–1553.

While Holocaust survivors tend to have more diabetes or gastrointestinal problems than their offspring, the Holocaust offspring observed in the TreeGenes study suffer more from cardiovascular diseases, chronic lung disease, and medications. Both groups suffer more from hypertension and cancer and have been using the services of various medical practitioners (>3).[31]

We are continuing the study. As transmission of trauma is very likely, we expect the TreeGenes study of the 2G will demonstrate this. The epigenetic part is still open. We believe that famine is not something of lesser importance; its consequences are long-term and severe.

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The Sino-Japanese War in which Dr Mitsuo Kaneda served: the collapse of Japanese military ethics and the medical crimes of Unit 731

Giichiro Ohno

INTRODUCTION

I have already told the story[1] of Dr Mitsuo Kaneda, who translated papers from *Przegląd Lekarski – Oświęcim* into Japanese [during the 3rd international conference Medical Review Auschwitz: Medicine Behind the Barbed Wire—Editor's note]. He gave the following messages:

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1 See Ohno, Giichiro. (2021). "Mitsuo Kaneda: the first doctor to translate *Przegląd Lekarski – Oświęcim* into Japanese." In: Ciesielska, Maria, Gajewski, Piotr, Antosz-Rekucki, Jakub (Eds.), *Medical Review Auschwitz: Medicine Behind the Barbed Wire Conference Proceedings 2021*. Kraków: Polish Institute for Evidence Based Medicine, 133–140. Online at https://www.mp.pl/auschwitz/other-publications/show.html?id=287204.

1. It is impossible to provide humanitarian medical care in wartime conditions if murder is justified.
2. War transforms medicine and doctors, who are supposed to save human lives, into life-threatening implementers of cruelty.
3. Risks to morality in medical research could happen not only in Auschwitz but also today.

I think Dr Kaneda found parallels between Auschwitz and the Japanese imperial army in China during the Second World War. I will describe the moral dangers to medicine in the Japanese imperial army in China, discussing especially Unit 731.

UNEARTHED MEDICAL RECORDS FROM KONODAI HOSPITAL

After the Second World War, a drum containing 8 thousand patients' medical records was unearthed at Konodai Hospital in Chiba near Tokyo, Japan. This facility was a former military psychiatric hospital. Soldiers diagnosed with a psychiatric disorder on the battlefield were brought in and taken care of by 50 psychiatrists here. At the end of the war, the staff were ordered to incinerate the medical records. Dr Toshiomi Asai, a psychiatrist at the hospital, considered these documents an invaluable resource on war and mental illness, and had them buried in a drum, in defiance of the order.

According to an analysis of these records, the breakdown of the cases was 41% for schizophrenia, 12% for "hysteria," 10% for head injuries and traumatic epilepsy, as well as for other forms of nervous breakdown, mental retardation, malaria, and reactive psychosis. The number of patients from China was larger than from other areas. There were fewer patients from the Pacific front, where Japan fought against the USA; 80% of the soldiers on that front were killed, so it was difficult to send psychiatric patients back to Japan.

In China, many young soldiers were considered to suffer from "hysteria." It was believed that the army recruited soldiers from rural areas and they were so affable that they could not keep their mental condition normal in the face of cruelty.

All Japanese soldiers in the first year of their military service in China were gathered in a precinct and made to watch officers decapitating Chinese prisoners, to harden the recruits.

Dr Ken Yuasa, with whom I worked at a clinic in Tokyo, talked about his experience of live human vivisections. He was born in Tokyo in 1916, graduated from Jikei University, and became a surgeon. Forty days after his arrival, the first surgical procedure of this kind was performed on a live Chinese prisoner. Training by vivisection finishing with the victim's death was ordered by a senior military doctor as part of the education of inexperienced military physicians. Sometimes doctors shot at Chinese prisoners as part of their surgical practice and then left without administering treatment for the gunshot wounds. In two years of service, Dr Yuasa witnessed 18 live vivisections. As there were over a thousand military doctors in the northern Chinese area, the number of Chinese victims is estimated to have run into tens of thousands.

UNIT 731

Dr Yuasa used to isolate typhoid bacteria and submitted samples to the epidemic water supply department. He later learned that this material was used in a program for biological warfare. Dr Yuasa was in the 1st Army of North China. Its chief military physician was Dr Shirō Ishii, who was the founder of Unit 731.

In 1932, Dr Ishii set up a laboratory for epidemic research at the Army Medical School in Tokyo. In 1936, he established the Kanto Military Disaster Prevention and Water Supply Department in China located 20 km outside Harbin, north-east China. This facility was called Unit 731.

Unit 731 consisted of 2 thousand staff, including over 100 medical scientists, with an annual budget of 9 million yen. It was an exceptional unit compared to the Institute of Physics and Chemistry, which was conducting research on the atomic bomb and had a staff of 1,800 members and a budget of 3 million yen. Unit 731 was one of the largest scientific institutes in Japan at that time. But its operations were top secret for two reasons. First, the purpose of Unit 731 was research on biological weapons, and second, it performed experiments on humans on a routine basis.

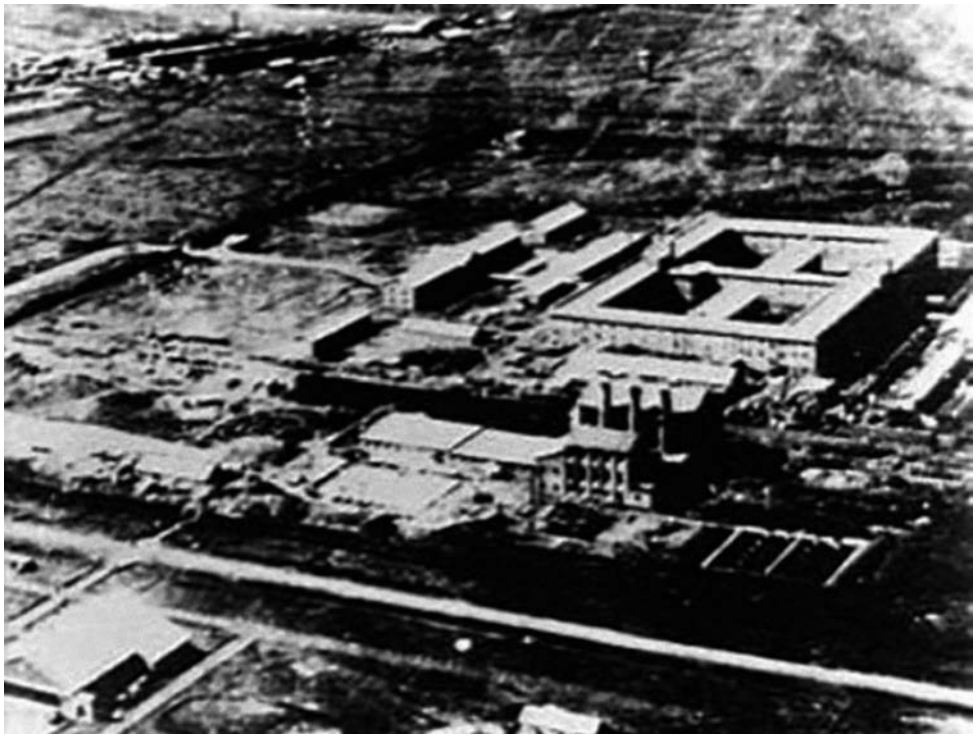

Photo 1. | The Kanto Military Disaster Prevention and Water Supply Department in northeast China, 20 km outside Harbin (Unit 731), a wartime photo by an unknown author. Source: Wikimedia Commons

RESEARCH AND DEVELOPMENT OF BIOLOGICAL WEAPONS

As chemical weapons had caused enormous damage in World War I, they were banned internationally by the Geneva Protocol of 1925. At the same congress, biological warfare was also banned in accordance with a proposal put forward by a Polish member. Japan did not ratify the bans. Dr Ishii claimed that biologial weapons were cost-effective given the poor resources of Japan and that research for defense purposes was acceptable. He advised the military to make bacteriological warfare one of the imperial army's tactics.

The Japanese army had used biological weapons twelve times. Typhoid bacteria were scattered in a river during the Nomonhan incident with the Soviet Union

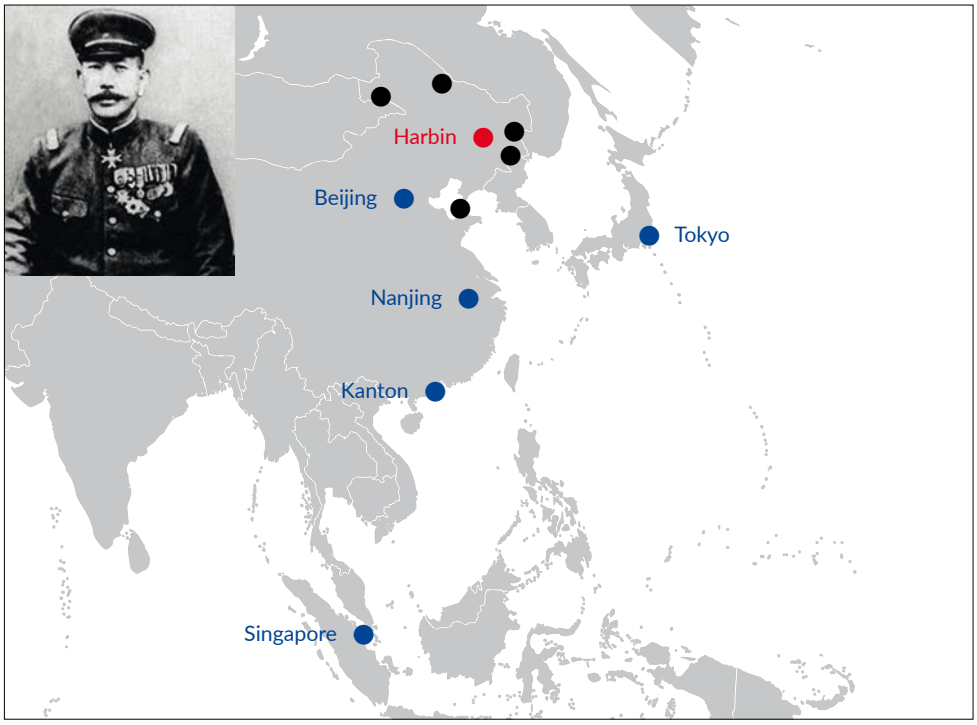

Photo 2. | Ishii Agency: Unit 731 in Harbin established four branches in preparation. Dr Ishii oversaw the Department of Epidemics in Beijing, Nanjing, Guangzhou, and Singapore to work on biological warfare. This networks established in East Asia was collectively called "the Ishii Agency." Figure provided by the Author. Dr Shirō Ishii's photo from the archives of the Unit 731 Museum in Harbin, China

in 1939. Six attacks targeting Chinese troops and civilians were carried out with the use of *Yersinia pestis* (plague) and cholera.

When the USA entered the war in the Pacific area in 1941, Dr Ishii instructed the Departments of Epidemics in Beijing, Nanjing, Guangzhou, and Singapore to work on biological warfare. These networks established an institution in East Asia later collectively called the "Ishii Agency." The Saipan Island Operation effectively started when a ship sank while loading. The Japanese army designed and produced balloon bombs made of paper and *konnyaku* paste. Nine thousand and three hundred balloons were released and about a thousand of them reached the USA, setting off fires. There were several casualties.

The effects of the biological attacks were unreliable and a good deal of damage was done to Japan's own troops. Opinions on the practicability of biological weapons were divided.

HUMAN EXPERIMENTATION

The aim of the research carried out by Unit 731 was to look for hyperpathogenic bacteria strains, develop massive supplies of them, and regularly dispatch them.

The medical researchers in the Unit injected live bacteria into prisoners, who were dissected before they died of infection to avoid the infectious changes that develop with the passage of time. Many bacteria strains were injected into each individual to compare the clinical course of of the disease. A person who developed the most aggressive clinical course was killed at an early stage before they died of the disease taking its "natural course." This was done to extract blood without the various bacilli that develop *post mortem*. The strain cultured from the blood of such individuals was highly pathogenic. Unit 731 also bred and weaponized fleas to spread *Yersinia pestis* (plague).

Dr Ishii was so familiar with bacteria as a weapon that he explained in a post-war interrogation that

> Anthrax is the most effective bacterium . . . it can be mass-produced, retains high toxicity, and has a fatality rate of 80–90%. . . . The most effective infectious disease was plague, and the most effective disease from fleas was epidemic encephalitis.

The doctors were working in groups on plague, dysentery, spleen gangrene, viral infections, typhoid, tuberculosis, and rickettsia. They used *maruta* [Japanese for "logs;" the counterpart term in English is "guinea pig," and in Polish it is *królik* ("rabbit")—Editor's note] as experimental subjects instead of laboratory animals.

Human prisoners were the *maruta*. They were Chinese, Koreans, Mongolians, Americans, Russians, etc., including women and children. The Japanese authorities arrested them on suspicion of anti-Japanese resistance and sent them to Unit 731 without trial.

A prison was set up in the middle of the building so that it could not be seen from the surrounding area. The prisoners had their heads shaved and became nameless except for an Arabic numeral marked on their chest. They were used as experimental material for research until they died. Over 3 thousand *maruta* are estimated to have been killed in the Unit, and none survived.

On August 9, 1945, the Soviet Union invaded Manchuria. Unit 731's experimental facilities were destroyed completely and all the prisoners were murdered to hide the evidence of human experimentation and bacteriological weapons.

HOW WERE MEDICAL DOCTORS RECRUITED?

The inhumane medical research in Unit 731 was led by talented medical scientists from the best research institutions in Japan. Why did they join the criminal human experiments and research on bacteriological weapons that went beyond medicine and was a violation of medical ethics?

During the war, research funds available to universities and medical schools were reduced. All staff other than professors were called up to serve as military physicians and could not conduct research. The only research the army permitted was for military purposes. Dr Sueo Akimoto said that his professor suggested to him, "You can continue your research at the Pasteur Institute in Bandung or at Harpin Kanto Army Unit 731." The facilities and equipment of Unit 731 were excellent, it had many researchers, and the annual budget was 30 billion yen. They were treated as officers and their pay was much better than their university salary. Outstanding medical scientists chose to join Unit 731 of their own accord.

Some professors encouraged other researchers to join Unit 731. Their university received more research funding in return for sending researchers there.

The Sino-Japanese War broke out in 1937. The Japanese military called the Chinese who rebelled against them "bandits" and conducted a sweeping operation. China's fierce resistance increased the casualties of the Japanese military, and both the government and the media emphasized Japan's sacrifice. Public opinion grew more and more hostile to the "bandits" and Japanese citizens approved of military reprisals. The medical milieu was no exception. Bandits "deserved to die," and could be killed in human experiments because they were death row prisoners.

POSTWAR TRIALS

With the defeat of Japan in 1945, the withdrawal of Unit 731 was quick. Its associates were ordered to keep the two things they had done confidential: the research on bacteriological warfare and the experiments on humans. Within a few weeks in August, Dr Ishii and 1,300 people formerly working at the facility returned home on a special train.

The United States exempted researchers from Unit 731 from liability in exchange for the data collected in the human experiments. Most of the doctors from the Unit did not stand trial.

Dr Ishii opened a clinic in Tokyo and worked as a doctor until the end of his life. Shozo Toda, a professor of Kyoto University, became president of Kanazawa University. Kazu Tabei, who developed the typhoid bomb, became a professor of bacteriology at Kyoto University. Hisato Yoshimura, a frostbite researcher, also became a professor. Unit 731 was the biggest and only medical research institute during the war, and other medical personnel from Unit 731 were also selected to work on the atomic bomb, infectious disease control, medical school reform, restoration of medicine, medical industry and business, and in the bacteriological warfare units of the United States, including Unit 406.

After the war, Japan passed the Eugenic Protection Act of 1948. This law contravened Article 25 of the Japanese Constitution, which guaranteed a "minimum healthy and cultural life." The aim was to "prevent the birth of bad offspring" in order to limit the population due to the shortage of food and other basic necessities after the war. Forced sterilization was performed on people with genetic disorders, leprosy, and mental conditions. By the time the law was abolished in 1996, it had been enforced on 16,500 people nationwide, with the largest number (2,500) in Hokkaido. Shozo Toda, a former Unit 731 associate, was one of the strongest proponents of this law. One of its staunchest supporters in Hokkaido was Naoto Nagatomo, Deputy Governor and Chief of Health of the Hokkaido Government, a doctor who had worked on plague research in Unit 731.

DR MITSUO KANEDA'S MESSAGE

The history of Unit 731 was kept secret and members of the Unit remained a part of the Japanese medical milieu. This makes it difficult to research the violations of medical ethics the Japanese committed in China.

In that respect, there is a lot to learn from the experience of Auschwitz and from the Medical Review Auschwitz conference. Dr Kaneda paid tribute to the original medical journal *Przegląd Lekarski – Oświęcim* for publishing a record of the history of Auschwitz based on evidence and for continuing a worldwide commitment to physicians for the protection of their ethical standards.

And to conclude my journey with Dr Kaneda, by looking into his life and work, I was lucky enough to be able to come to this conference and now I can say I feel about these things the same way he did.

What are the basic historical facts that every medical student should know about the history of health professional involvement in the Holocaust?

Matthew K. Wynia

INTRODUCTION

The last time we met for this conference in person, in 2019, I reviewed a number of challenges facing those of us who hope to bring learning about the role of medicine in the Holocaust into health professional training programs.[1] Some of these challenges were pragmatic—such as finding time in an already overcrowded curriculum and finding teachers qualified to teach this complex and difficult material—while others were conceptual problems, many of which affect all aspects

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1 Wynia, 2019.

of Holocaust history. Among these, most notably, is the problem that anyone attempting to draw lessons from the Nazi past and apply them directly to a contemporary issue risks being accused of "playing the Nazi card," or *Reductio ad Hitlerum*.[2] In other words, Nazi doctors have become caricatures of absolute evil and, with perhaps some rare exceptions, if you tell someone today that they are behaving in some way like a Nazi, it's unlikely to prompt them to pause and thoughtfully reflect on their actions or attitudes. Instead, they are more likely to angrily tell you that you are wrong, or that you are disrespecting the victims of Nazi atrocities by making the comparison, or even that *you* are the one acting like a Nazi for making such a heinous and unfounded accusation.[3] In short, it is difficult to draw contemporary lessons from such extreme examples of bad behavior and toxic ethical values.

These pragmatic and conceptual challenges to teaching about and learning from this history each deserve focused attention, but today I propose that another challenge needs to be addressed first, and this challenge lies at the intersection of pragmatic and conceptual concerns. Namely, the history is enormously complex and deep, with a huge potential body of knowledge for students to learn. Moreover, some of this knowledge is contentious and much of it is prone to the integration of opinions and speculation; all of which makes it difficult to teach this history because each teacher has to choose which topics deserve attention.

This is problematic because the lack of standards could be perceived as a tangible demonstration that there is no core factual curriculum for this subject matter—rather, what is taught might seem merely to reflect the interests and opinions of each teacher. In reality, I expect there is much more in common than there is different across the many different curricula on the history and implications of medical involvement in the Holocaust, but this perception of lack of standards matters because, to be blunt, it seems unlikely that accreditation organizations will support the implementation of mandatory coursework in a health sciences training program if there are no agreed core fact–based curricular learning objectives. Passion for the importance of this history on the part of those who teach it will not be enough—we will need to show that learning the core facts about this history is both important and achievable.

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2 Strauss, 1953.

3 Curtis, undated.

A PRAGMATIC AND CONCEPTUAL CHALLENGE

In one sense, setting out a group of core facts for students to learn about this history seems to be merely a pragmatic challenge, solvable by examining the body of historical knowledge on this topic and selecting which pieces are most important to learn. There will be hard choices involved, of course, but this problem is no different than the pragmatic problem facing teachers of many aspects of health and medicine that are complex and that have become the subjects of specialization, whether it's renal pathophysiology or cardiac electrophysiology or my own field of infectious diseases. None of us get to teach students everything we know, we have to select the "high value" material from our field that we think every student should learn. Fortunately, for most aspects of health professional training there are long-standing consensus–based guidelines, often quite detailed, describing which facts (and often even which controversies) should be in the core curriculum.

The problem for teachers of Holocaust history is that there are as yet no such consensus guidelines, and the reason for this, I believe, is that there is no consensus on how one should assess the "value" of learning about any given part of this complex history. To answer the question, "What parts of this history are 'high value' for students to learn?" we must first address the potential value for students, the profession, and society in learning about this history.

"HIGH VALUE" FACTS

When teaching about clinical issues, we tend to define high-value materials as, first, topics that have applications across a wide range of common conditions. This is why acid-base disorders are always taught, for example, and often they are revisited repeatedly across the curriculum, because they arise frequently and intersect with multiple organ systems and disease processes. Relatedly, we tend to think about how likely it is that the student might encounter the issue in clinical practice. Hence, common conditions and their common presentations are obligatory in the curriculum. Among infectious diseases, for example, every student will learn about community-acquired pneumonia, urinary tract infections, hepatitis, cellulitis, and so on. Finally, we tend

to emphasize learning about rare or esoteric conditions that would be especially dangerous to miss. Many physicians will see just one or two cases of necrotizing fasciitis in their careers, but it would be a tragedy to miss it—so it's in the curriculum.

Are there comparable considerations for making decisions about which facts about the legacy of medical involvement in the Holocaust ought to be in the core curriculum for medical schools? That is, are there facts about this history that (1) have wide applicability across health care, (2) are commonly faced in practice, or (3) are especially dangerous to miss?

EXAMPLE: TO TEACH OR NOT TO TEACH ABOUT DR MENGELE?

Criterion 1, broad application across multiple domains of health care, is useful because it can help us narrow the scope of teaching somewhat. For instance, I believe it should preclude spending much time on some of the most infamous aspects of this history, such as the heinous medical experiments carried out on prisoners.[4] Of course, every student should know something about the responsible conduct of research and, in this context, it is likely that the legacy of Nazi medical experiments, the Nuremberg Medical Trial and the "Nuremberg Code" will be mentioned.[5] But on balance, I would not include much about these experiments if I only had an hour, or even an afternoon, to talk about the legacy of health professional involvement in the Holocaust and its contemporary implications for students and practitioners.

Why is this, given the incredible disrespect for human life and dignity demonstrated by Drs Mengele, Rascher, and the like? After all, a core lesson to be explored through reflection on this history should be that health professionals must never lose sight of the dignity and value of every individual patient. But while this should be a core lesson (and not only because it has broad applicability but also because physicians in practice commonly face challenges to treating every patient with dignity and respect—from time pressure, to professional distancing, to inevitable feelings of

4 US Holocaust Memorial Museum, 2006.

5 US Holocaust Memorial Museum, undated.

revulsion from olfactory or visual triggers, to socio-political differences and more), if this history is to be used to help students learn about this common challenge facing health professionals, then historical facts should be presented that will best support student reflection on this core lesson. The question is, *which facts about this history are best to prompt student reflection on the common temptation to dehumanize our patients?* Is it the story of Dr Mengele? I don't think so. Instead, one might more productively focus on historical facts about how many Nazi medical professionals used medicalized discrimination and racism to dehumanize and then harm people with disabilities and other disfavored groups, like Jews and other so-called "biological enemies" of the state.[6] Such examples were much more common than medical research in the camps, they have clear applicability outside the issue of research ethics, and they are closer to the everyday dilemmas facing medical practitioners today.

COMMON CHALLENGES THAT THIS HISTORY CAN ILLUMINATE

The foregoing example also raises an important question: before asking "What are the high-value historical facts every student should learn?" we should ask, "What lessons about health care ethics can—and arguably should—be learned at least in part through learning about and reflecting on the history of medical involvement in the Holocaust?" If there are ethical issues or challenges across care settings that can and should be taught using this history, then we can use these to work backwards and develop a set of core historical facts that ought to be taught, because they will best support reflection on important challenges that health professionals today must manage frequently.

Box 1 provides an initial set of three common if not ubiquitous challenges to professional ethics that can be explored through learning about the history of medical involvement in the Holocaust. These are derived from earlier work with our "Lessons Learned Working Group" in Colorado.[7] With just three entries, this is

6 Stern, 2021.

7 Levine et al, 2019.

obviously not an exhaustive list of issues that can be illuminated by reflection on this history, and I expect others might come up with additional issues or even a completely different list. The point here is not to finish the task, but to get started.

Box 1. 3 challenges facing health professionals on a daily basis across multiple disciplines and work settings

1. Upholding human dignity: never lose sight of the inherent worth of every human being we serve
2. Managing competing obligations: use care when forced to balance responsibilities to individual patients with societal or other responsibilities
3. Retaining scientific humility: be cautious in assessing medical theories, and especially so when they are intuitively appealing

Note also that each of these lessons could be taught through other historical or contemporary examples; they are not specific to the Holocaust. This is to be expected. After all, we hope to never experience another Holocaust, and it cannot be called a common event. Yet, health professional involvement in the Holocaust vividly and often horrifically (and therefore memorably) illustrates and can prompt deep reflection on each of these perennial threats to the ethics of health care.

The list starts with the example provided above, health professionals must never lose sight of the inherent dignity and worth of every human being we serve. At the individual level, this means avoiding becoming inured to the suffering we will witness in our work and seeing the humanity in each person under our care. At a larger level, it also means understanding concepts of fundamental human rights and the unique roles of medical professionals in protecting and upholding human rights.

Second, health professionals must use great care when we are required to balance obligations to individual patients, other patients, and our communities. This type of challenge encompasses dramatic examples like those of the Nazis, or of a government asking health professionals to participate in torturing prisoners,[8] but importantly, it also relates to daily choices we all must make around time management, balancing the needs of one patient against those of other patients, or in making decisions about whether to allow a patient to continue driving after a neurological event, or in developing policies for priority setting when managing scarce resources.[9]

8 Mirzaei and Wenzel, 2019.

9 Wynia, 2021.

Third, health professionals must be cautious in assessing scientific theories (like eugenics and theories of racial inferiority, which turned out to be incorrect),[10] and this is especially important when a theory is intuitively appealing. Theories that are intuitively appealing may create a dynamic whereby an initial desire to believe the theory can cause the health professional to seek out confirmatory evidence and discount contrary evidence.[11] There should be even higher levels of skepticism when medical theories and interventions are proposed as technical solutions to complex societal challenges.

HISTORICAL FACTS SHOULD HELP LEARNERS EXPLORE COMMON CHALLENGES

These three perennial challenges can be directly illustrated and explored by examining the ways in which health professionals in the Nazi era initially saw some human beings as less worthy of care and respect, and eventually came to believe that they posed such a threat to the community that it was ethically acceptable (or even required) to kill them. This progression is presented as a set of three fact-based learning objectives in Box 2.

While much in the complex history of medical involvement in the Holocaust is disputed, these

Box 2. | Core fact–based learning objectives for health professional students about medicine, Nazism and the Holocaust

By the end of training, every student should know:

1. Nazi health professionals explicitly altered their ethical and regulatory standards to place the perceived needs of the German nation (including the "racial purity" of its people) over the needs and lives of patients from devalued groups.
2. Nazi Germans were not alone in their racism, nor in implementing policies based on contested scientific theories of eugenics and racial hygiene, including forcible sterilization programs.
3. Leading medical professionals were willing participants in the Nazi child "euthanasia" and *Aktion T4* programs, and these programs are related in several ways to subsequent Nazi programs of mass murder and genocide by medical means.

10 National Human Genome Research Project, 2021.

11 Nickerson, 1998.

three core learning objectives are based on undisputed facts. Each is incomplete, of course, as these are merely learning objectives; each points to a set of facts to be presented but does not detail the underlying fact base. The latter task is beyond the scope of this paper, but suffice to say that a robust fact base exists to support each learning objective.

Also, learning about these facts will undoubtedly raise and should be supplemented by reflection and discussions that should include the opportunity for students to explore opinions and theories, such as about the extent to which medical personnel had room to maneuver in certain circumstances, questions about *why* the German medical profession changed its ethics, or *why* it progressed to a program of mass murder of people with disabilities after the start of war. Such conversations can help students explore their own values, discuss the core values of their chosen profession, and learn that—like individuals—professions and professional organizations are not static. This history can help students understand how we came to have the ethical values we aspire to uphold today, but there is also great value in understanding how changes happen in medical ethics, policy, and practice, including the possibility of making explicit some of the warning signals that can indicate when an individual professional or a professional organization is going off-track, as well as clues for how to steer oneself and one's profession to a better future through creative change.

NUANCE AND ROOM TO MANEUVER

Conversations about these core facts will also provide opportunities to explore nuances in this history. For instance, the progression from healers to killers and participation in genocide is sometimes portrayed as having been linear and inevitable, but students will learn from facts in this history that it was not. Of course, theories of eugenics and medical racism in Germany, as well as in the US and several other countries, did in fact lead to the implementation of forcible sterilization programs justified on the basis of protecting public health—but in many other countries such programs did not arise despite active eugenics movements and proponents, proving the progression to forcible sterilization programs was not inevitable. Similarly,

while the US pioneered programs of eugenic forcible sterilization that were eventually adopted by the German medical profession during the Nazi era, and America was certainly suffused with medical racism and antisemitism, the US did not progress to programs of mass killing of people with disabilities or to an attempted genocide of Jewish people.[12] Learning about this can lead to a factually-informed but inevitably theory-based conversation about risk or protective factors in professional groups. Historians understandably tend to balk at speculating on alternative histories (e.g., what might have happened if German medical professional associations had refused to oust Jews from organizational leadership positions in 1935—denouncing the proposal as anti-scientific and harmful to the profession as a whole?), but facts can be presented to students that will demonstrate that each step on the terrible path taken by Nazi health professionals had real alternatives that were not taken.

CONCLUSION

In most medical, nursing, pharmacy, or other health science training programs, if there is an opportunity to teach about the history of medical involvement in the Holocaust it will often be brief and therefore should be focused on "high value" history for health professional learners. High value topics are those that can inform contemporary responses to common ethical challenges arising across multiple health care disciplines. Ideally, a session or sessions on this history should not merely present key facts about what happened in the years around the Nazi era, it should provide opportunities for students to explore how this terrible history can illuminate some of the common challenges and temptations health professionals face today. More generally, it should also help learners become more aware of how contemporary professional ethics arose, how it can change, and the potential impacts of those changes for bad and for good. In this way, a successful session or course on this history should leave students better prepared to manage daily

12 Note that I am using examples from the US, but educators in other countries should focus on using examples from their own country—both positive and negative—to help make this history more salient to students.

ethical challenges, better armed to help protect the core values of their profession when they are under threat, and better positioned to serve as enlightened change agents and effective advocates when changes are needed.

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Can art be soulless?

Karol Gąsienica Szostak

According to the definition of art I heard Professor Stefan Świeżawski present during a television programme, there are three components that go to make up art—first, the material used to create a work of art, such as the paint and the stretcher bars used to make a picture, the stone or the bronze used for a statue, or the words of a work of literature recorded on paper or delivered by an actor during a recital. Then there is the content which we can read from the work of art, even if it is an abstract work but still decipherable because it is abstract with respect to a concrete reality. And finally there is that inscrutable and mysterious component which we call "metaphysics" (to use Aristotle's term), or alternatively "the spiritual element of art." "What Socrates had in mind when he said that 'to know the good is to do good' was that a man of integrity who had lived a virtuous life for many years, standing up against evil and thereby learning what is good, could not do anything contrary to his knowledge, just as someone who had ascended a high mountain could not suddenly take just one step to reach the bottom of the mountain. A man of virtue would need to submit to evil for a long time before he would be able to commit evil."[1] I think that by analogy you

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1 Dzielski, Mirosław, 7.

could never get to that mountain top in just one step, especially if you left the path of goodness because you didn't know of it or did not want to do good or search for goodness, or for pecuniary or ideological reasons. Staying in limbo leaves a permanent effect and gives rise to a bad emanation. Maybe you can develop your spiritual identity on a foundation of negative emotions. After all, we speak of "the dark side of the soul." However, perhaps it's worth considering whether that kind of spirituality can be brought into the spiritual side of the world of the Mediterranean civilisation, which is grounded on concepts like truth, goodness, and beauty. Let's put aside all that is connected with the ethical and religious dimension, eschatology, and the question of the existence of evil, and try to define the criterion which determines whether the activities an artist chooses to engage in belong or do not belong to the realm of art.

We expect art to exert an impact on the senses and evoke emotions which we call artistic experiences. Sometimes—and let this sound like an accusation—if we are out for an instant effect and have learned from experience that scandalising promotes a rapid career in the world of the sensationalist media, we may resort to desperate measures and trespass into domains considered taboo, locking our conscience up in a cage at the prospect of earning fame, celebrity, and money. That's why it's good to be able to tell emotions evoked by dramatic events from experiences which emerge from encounters with art. To be able to accomplish this, just as with the ability to recognise what's right and what's wrong, it's good if we know, or are ready to search for the right knowledge how to do this. This essay is too short for me to address the question of criteria in the arts, so let me just recall that apart from the simple standard of "I like it" or "I don't like it," at an elementary level we can consider and examine the quality of proportions as it has evolved in the European civilisation over the millennia. The principles governing proportion have established themselves in our everyday life—from the golden ratio, through musical harmony, down to knowing the right size of paper to use. The European way of seeing things has become the predominant model for visual perception and has given rise to the principles of perspective, in other words the mapping of spatial relations onto a two-dimensional surface, allowing the imagination to develop its ability to read a map or discern the illusion of space behind a flat picture. And that includes the TV screen and computer monitor. Right down to the deconstruction of space and understanding it as spacetime or quantum space.

Now I shall return to the question in the title of my paper and ask you to consider whether a road accident which is presented in an art gallery arouses artistic or non-artistic emotions. Does the fascination evoked by the notorious atmosphere of the scene of a crime emanate the values proper to art when a talented artist presents it on canvas? A special instance of this kind of premeditated act occurs when an artist accedes to the line in creative activity tasked with the dissemination of propaganda. Art created on commission is not reprehensible in itself; for centuries works of art have come into being not only as a labour of love, and after all, the recipient is an indispensable element determining the very existence of art: they make its subjects come to life in their mind, aspire to exerting an influence on the creation of art and want art to commemorate events or immortalise persons. The recipient would like to make use of the power that lies dormant in art to send its message straight to the minds of other people. But more importantly, one of the key points in this dialogue are the limits to freedom. Creative freedom is the salt of art. The number of ways in which artists can express themselves is as infinite as the multiplicity of their characters, the only bounds are

Photo 1. Arno Breker was Hitler's court sculptor and architect, a representative of the *Blut und Boden* branch of Nazi propaganda, and a member of the Nazi Party. The Nazis acclaimed his *Prometheus*, which was erected in front of the Third Reich's Ministry for Public Enlightenment and Propaganda, as the embodiment of the ideal of "Aryan racial purity." The naturalistic and schematic look characteristic of practically all the works in the service of dictatorships contributes no creative features (except for faultless craftsmanship) to the world of art; their only impact comes from their link with the criminals and ideology of the party they portray. This photograph comes from *Grosse Deutsche Kunstausstellung*, a special edition of the monthly magazine *Kunst dem Volk* (August–September 1941). When the Germans fled Zakopane, Karol Gąsienica Szostak's grandfather, himself a sculptor, found a copy in a dustbin and kept it out of curiosity and as a memento and a warning.

set by the magnitude of their talent. As the distinguished artist Antoni Kenar, who educated several generations of students at Zakopane's art school, put it succinctly, "The more personal art is, the more human it becomes."[2] And here we come to the essence of art, which began the moment humanity sparked its self-awareness and is one of our greatest inventions, serving us no less than culture or civilisation. Art has been serving us by upholding the values of humanism. The laying down of limits that are too narrow leads to dehumanisation. Curtailment caused by commissions prompted by ideology bind the artist in the fetters of content and form, depriving them of room to express their personality, preventing them from exercising the right to manifold expression. Instead, it prescribes a schematic agenda supplanting the study of reality with a schedule of formal tricks and sidesteps learned off pat. Its contents revolve around a series of monotonously reiterated banalities. Its structures emanate an ultimately soulless, impersonal void, which may still be as mesmerising as the insalubrious emotions triggered by visions of bestiality. Yet the question remains whether the emotions spawned by soulless form, contrary, well-nigh hostile to the ideals of humanism—whether they are still emotions proper to art.

We are not accustomed to reject things a priori without proof that they are bad. Common decency requires us to give the benefit of the doubt and apply the principle of tolerance even to things that look suspicious. We are restrained by a paradox which is a trap: can we debar debarment? Perhaps it would be a good idea not to call every single creative experiment a work of art merely because it meets the first two of the criteria I enumerated at the beginning of this essay. It may be an artefact that has been sculpted, painted, or written, and it may carry a message yet still not have a spiritual, humanist component. Do the artefacts created by Nazi or Socialist Realist propaganda still belong to the realm of art? Perhaps we should give up our mental clichés and pluck up the courage to reinstate Art in the domain usurped by evil emanation. Casting aside the forms and shapes many a time treated ineptly and superficially, material testimonials to their times serving as a warning, not letting them shock their way into the award of an undeserved membership of the world of true values. Especially as the activities intentionally pursued by creative agents who enter a pact with Evil have most definitely had

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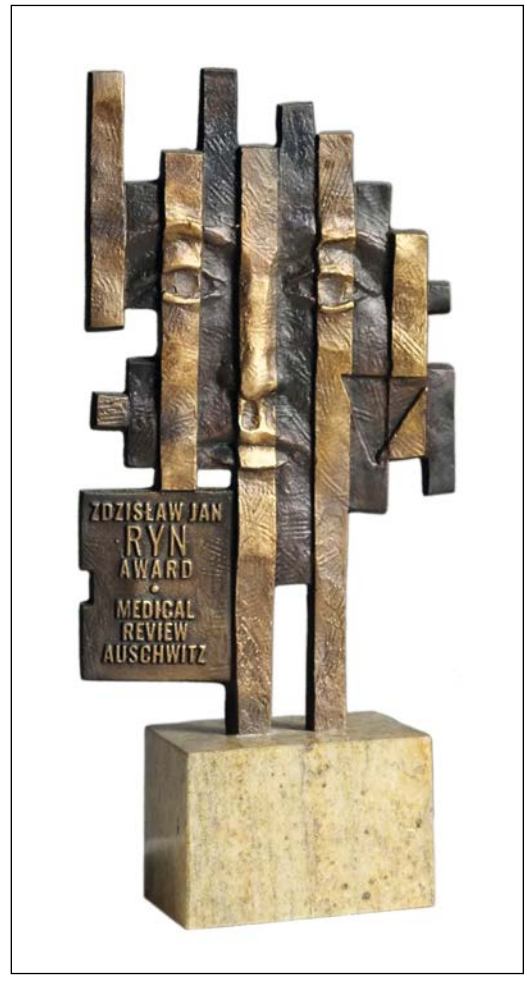
a part in the emergence of all the outrages, but have been indulged in from the safe distance of the ostensibly innocent, sterile interiors of exhibition halls, central squares and public buildings. Ultimately, all definitions whatsoever are nothing but words, words, words... and personally I am convinced that deep down in their soul every sensitive individual knows the answer to the question whether soulless works deserve the ennobling reputation of being considered works of art.

POSTSCRIPT

The striped prison gear once worn by concentration camp inmates provided the inspiration for my sculpture in memory of Professor Zdzisław Jan Ryn, who initiated the Medical Review Auschwitz project dedicated to research on human beings in extreme situations and focused on the criminal medical experiments carried out in the concentration camps. The stripes hit you in the eye whenever you see the documentary films and photographic records of the camps, and they also appear in works of art showing concentration camps. The deconstruction of the human face done by dissecting it with these stripes makes use of one of the fundamental tools in the visual arts, the contrast between hard and soft matter, and it is also a metaphor for mechani-



cal interference in the living body, symbolising the organic mutual penetration of the human individual and the traumatic fate that befell them. The sculpture has an open composition, suggesting that each of our experiences is individualised, that the arrangement of its components may represent an individual's personal experience.

While I was making this sculpture, I had another, recurrent reflection: we might think that the question of the limits to freedom has already been answered. All we need to do is to keep our activities from harming others. Yet experience, including the experience of today, bespeaks a completely different state of interpersonal relations. Do we really have to be put in an extreme situation to test the limits to our potential when subjected to inhuman pressure? I trust we have the integrity and faculty to make sacrifices, to probe and make discoveries in all the aspects of our lives of our own free will. That is what countless examples of those who stand on the side of the good show. I would like to see sculptures carrying a message of warning become redundant in the future.

Editor's note: *Karol Gąsienica Szostak's sculpture is the prize awarded for unique contribution to the Medical Review Auschwitz project (see www.mp.pl/auschwitz), and for the best lecture at the international conference Medical Review Auschwitz: Medicine Behind the Barbed Wire, which is held annually within the framework of the project.*

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