

## Legacies of the Holocaust in Health Care

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## AMA Journal of Ethics®

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### FROM THE EDITOR

#### Why Does Medical Participation in the Holocaust Still Matter?

Tessa Chelouche, MD and Matthew K. Wynia, MD, MPH

*The past is never dead. It's not even past.*

**William Faulkner<sup>1</sup>**

As we synthesized this issue of the *AMA Journal of Ethics*, the medical profession was grappling with some of the most challenging ethical problems in generations: a viral pandemic with anticipated shortages of critical resources and, in the United States, lack of national coordination around COVID-19 testing, tracking, and prevention and treatment, all of which exacerbated and put a floodlight on underlying racial, geographic, health, and socioeconomic inequities.<sup>2</sup>

Yet, even as these problems reflect modern medical and political dynamics, they are also clearly rooted in history. In fact, these current dysfunctions are so obviously influenced by history that some bioethicists have urged that courses in bioethics take a historical perspective.<sup>3</sup> This development is to be strongly encouraged, of course, as those who can learn from the past are better equipped to address challenges in the present and future.

This special issue makes the case that any examination of medical history must look beyond medical history in the United States. Specifically, **students must learn** about the complex ramifications of a shared international legacy of racism in medicine. Indeed, students should know that American medical racism in the early 20th century became intertwined with, influenced, and supported the emergence of German medical racism,<sup>4</sup> because this shared medical racism led to some of the most horrific examples of man's inhumanity to man in recorded history. The historian Susan Lederer, PhD, states that this history is "not for the faint of heart" (email, January 13, 2020), and she is correct. It is a painful legacy we explore in this issue, one from which we must not turn away.

Medical professionals in the United States were not forced to participate in the institutions of slavery or Jim Crow segregation, but many did, and many brought "science" to bear when arguing in favor of slavery and racial segregation.<sup>5</sup> In this issue, the first author describes how **physicians in Germany** also joined the Nazi party by choice. Leading physicians in Germany, the United States, and elsewhere used arguments from scientific racism, eugenics, and "race hygiene"—buttressed by a radical new view of medical ethics—to become witting or unwitting architects of the rise of the

Nazi regime and key players in some of its most terrible, violent, and murderous abuses.<sup>6</sup> In other words, doctors in Germany were not, by and large, victims of the Nazi regime, nor were they merely complicit or even collaborators—they were leaders.

The bottom line, as Levine et al show, is that many doctors, nurses, pharmacists, and other medical scientists developed, promoted, and carried out programs ranging from forcible sterilization of individuals deemed “unfit” to reproduce, to the infant “euthanasia” program and the infamous adult T-4 “euthanasia” program, in addition to their better-known roles in heinous experiments in concentration camps and elsewhere.<sup>7</sup> In the end, even the Holocaust itself (the genocide of Jews and other marginalized communities of Europe) was described by German medical scientists as a public health program, designed to promote the creation of a so-called “master race.”<sup>8</sup> The vast majority of these medical perpetrators never expressed remorse, never were caught, and never were punished. Still, the legacy of their crimes has resonated through the ages.

This issue explores a number of ways in which this history continues to influence contemporary thought and policy. It includes essays by Arthur Caplan on [modern uses of Nazi research data](#) and Eric Juengst on the impact of this history on [modern genetics](#). Alexandra Stern explores the relations between [racism and dehumanization](#), then and now, and Susannah Sirkin describes implications of this history for law and medicine [at the US-Mexico border today](#). In sum, as the historian of medical ethics, Robert Baker argues, the ways we think about modern bioethics are essentially [framed by principles and codes](#) that arose directly in reaction to the medical crimes of the Holocaust.

Nevertheless, if it is true that one cannot fully understand modern bioethics without first learning about health professional involvement in the Holocaust, it’s also true that the historical impact or resonance of the Holocaust in bioethics has generally been at a low frequency in the United States. This painful history has largely been overlooked in American medical education, perhaps because to examine it closely one must first disturb the comfortable view of our nation and our profession as entirely heroic actors in the Second World War.

Today, looking back on the year 2020, it seems possible that the events of the past year—and particularly the exposure and exacerbation of health care disparities—will eventually be seen as a turning point in the history of medicine when it became widely recognized as problematic—and not just in the United States—to view medical professionals as purely altruistic, color-blind healers, blameless in creating and sustaining health care systems that predictably and consistently generate racial and ethnic health disparities.

Looking forward, perhaps the year 2021 will become the year in which every health professional training program awakens to the fact that health sciences students (and practitioners) must learn about and reflect upon the historical roles of health professionals in creating both the atrocities of the Second World War and the different but related atrocities of racial injustice that we witness today. After all, these legacies are deeply entwined. Our profession’s involvement in providing the pseudoscientific foundations that supported ethnic and racial violence during the Second World War cannot be disentangled from the history of scientific racism and its ongoing, powerful, and pervasive influence on the world today.

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**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should Clinicians' Involvement in the Holocaust Inform Contemporary Responsibilities to Protect Public Safety?**

Matthew K. Wynia, MD, MPH

**Abstract**

This case and commentary explore health professionals' duties to advocate for individual patients, protect their communities, and navigate conflicts between them. The perils of physicians intentionally harming individuals in misguided attempts to strengthen a community have been illuminated by the Holocaust. It is too simplistic to say, however, that public health can never outweigh individual preferences or even needs. The commentary herein articulates criteria that might justify physicians taking action to protect the public that is contrary to their individual patients' interests.

**Case**

Mr P is a 76-year-old widower who lives alone and supports himself by working as a truck driver. He needs the income from this job because he suffers from diabetes and hypertension, both of which are controlled by medications that, despite having become increasingly expensive, he must take regularly.

A few weeks ago, he accidentally drove his truck into a wall. Witnesses called an ambulance. Mr P was awake when the ambulance arrived, and he told the emergency medicine technicians that he had not lost consciousness, although he wasn't sure where he was or how he got there. When he arrived at the emergency department, he again said he had no memory of how the accident happened, and he asked where he was. Mr P was admitted to a general medicine unit for further evaluation.

Laboratory work and imaging were ordered to exclude hypoglycemia or stroke, and they were negative. Over the next several hours, Mr P's short-term memory improved and returned to normal, although he still did not remember how the accident happened. A diagnosis of transient global amnesia was made; he was released after a few days and instructed not to drive, at least until his follow-up visit with Dr D, his internist. During Mr P's postdischarge appointment with Dr D, he said he felt well and requested that he be allowed to return to driving.

Mr P's state statute on physician reporting of impaired drivers states: "Drivers should self-report medical conditions that could cause a lapse of consciousness, seizures, etc.

Physicians are encouraged to report patients who have a condition that could affect their ability to safely operate a motor vehicle.” This statute protects physicians who make such reports “in good faith.”

Dr D explains to Mr P that, although he questions the efficacy of reporting and is generally reluctant to do so, he feels obliged to report the accident to the state’s Department of Motor Vehicles, which will likely review Mr P’s case and determine whether Mr P can continue to drive his truck. Mr P is distressed at the prospect of not being able to support himself and begs Dr D not to report.

### Commentary

This case suggests the importance of considering whether and when health professionals’ duties to act as **state agents** outweigh their duties to protect interests of their individual patients. Balancing these duties is difficult, yet often oversimplified, especially when considered in light of physician participation in the Holocaust.

If we assume a diagnosis of transient global amnesia (TGA) is accurate, this case is relatively straightforward. Dr D is not legally obligated to report Mr P to the Department of Motor Vehicles, but he is protected from liability should he choose “in good faith” to do so. Since the vast majority of patients with an episode of TGA never have another one and suffer no long-term impairment,<sup>1,2,3,4</sup> there is little reason to believe Mr P poses a higher-than-average threat to others on the road than others of his general demographic group. In fact, his status as a 76-year-old man with hypertension and diabetes puts him at a greater than 50% risk of a cardiovascular event in the next 10 years,<sup>5</sup> which means that he is at much greater risk of having a heart attack or stroke while driving than having a recurrent episode of TGA.<sup>6</sup> Moreover, as Dr D notes, even if he were legally mandated to report patients who might be unsafe drivers, such reporting requirements are probably ineffective at reducing motor vehicle accidents.<sup>7</sup> Rather, encouraging patients to self-report and voluntarily stay off the road seems to be a more evidence-based approach.<sup>8</sup> Thus, it seems reasonable for Dr D to agree not to report Mr P and instead encourage him to take good care of his hypertension and diabetes and perhaps start a moderate-dose statin.<sup>5</sup>

But this case also should prompt us to wonder when, if ever, it might be ethical for health professionals to act in ways that could harm individual patients to protect a larger community. The Holocaust is not the only example of physicians having made terrible miscalculations when weighing individual harm against community benefit. US physicians, for example, were directly involved in the **torture of detainees** at Guantanamo Bay, in covering up the murder of prisoners during interrogations in Afghanistan,<sup>9</sup> and in performing an involuntary colonoscopy on a man at a New Mexico clinic whom police wrongly suspected of carrying drugs.<sup>10</sup> Presumably, like Nazi physicians, these physicians considered their actions ethically defensible, perhaps because they thought they had to obey law enforcement or military officers or because they thought that harming their patient might somehow help a larger community. Both of these reasons are wrong, however, and not because health care ethics requires physicians *never* to act against an individual patient’s interests.

### Physicians’ Duties to Communities

One might call an ethical stance that focuses exclusively on obligations to individual patients a “lawyerly version” of health care ethics,<sup>11</sup> since lawyers are ethically obligated to do the best they can for every individual client and are generally not allowed to have

conflicting duties to anyone else.<sup>12</sup> There are 2 reasons this works for lawyers. First, there is another lawyer arguing for the other side, regardless of whether the conflict is with another party or with a state. Second, there is a neutral judge and sometimes a jury charged with rendering an impartial verdict. In health care professionalism, there is neither an opposing attorney nor a judge, and neither health care professionals nor patients like it when there is. Thus, to ensure that community interests are represented in health decisions that affect a community, health care ethics must include clinicians' duties to serve individual patients *and* the community, despite the fact that this dual commitment requires clinicians to balance them<sup>11</sup> in cases like the one posed above. What is more, harms to society can result when clinicians get the balance wrong, and this is a lesson from the Holocaust.

### **Balancing Duties**

As described in professional codes of ethics, case law, and government guidance, clinician must strive to provide quality care to all, use shared clinical resources wisely, and, when one of our patients poses a significant danger, help keep communities safe.<sup>13,14,15</sup> Notably, following what state authorities tell clinicians to do is not among these duties. Furthermore, I have previously argued that there is significant social benefit to be derived from clinicians' willingness and ability—recall nurse Alex Wubbles,<sup>16</sup> for example—to **stand up to a state actor** who asks clinicians to do something contrary to core ethical values of their professions.<sup>17</sup>

But being willing or able to stand up to state authorities doesn't always help clinicians balance their duties to individual patients against their duties to communities.<sup>11</sup> Which criteria should be used to guide decisions about which duties clinicians owe to whom and when? Guidance is needed about when it might be ethically acceptable to act against an individual patient's interests to protect a community. Such guidance exists for a few specific kinds of cases, such as breaching patient confidence when reporting infectious diseases<sup>18</sup> or when **limiting individual liberties** to implement a needed quarantine.<sup>19</sup> In general, there is a stronger argument for health professionals doing something that could harm an individual patient in order to protect a community under 5 conditions, which constitute criteria for taking such action.

### **Criteria**

*Imminent danger.* When danger is imminent, urgent interventions—including interventions that might harm individual patients—are more easily justified. If potential harm to a community is in the distant future, there is time to try other interventions first, and more or stronger reasons must be offered to justify clinician action that could harm an individual patient. For Dr D, public danger is not imminent, as Mr P's risk of near-term recurrent TGA is low.

*Certainty and severity of public harm.* If harm to a community is certain and will be severe, there is a stronger argument for a clinician performing an action that could harm an individual patient. For Dr D, the severity of harm could be high if Mr P has another event, but the odds of this happening are low.

*Minimal potential harm to a patient.* If harm to a clinician's individual patient would be minimal in comparison to potential public harm generated by a clinician's failure to act, there is a stronger argument for acting. In Dr D's case, harm to Mr P from reporting would be significant.



*Identifiability.* If a potentially harmed person, place, or community is identifiable, there is a stronger argument for acting than if it is unclear who, if anyone, might be harmed. For Dr D, no identifiable person or place is at risk from Mr P's continuing to drive.

*Likelihood of harm prevention.* There is a stronger argument for doing something that might harm an individual if there is more certainty about that action's preventing harm. Dr D's patient poses a low risk to the community, so a reporting intervention is not at all certain to reduce harm to the community.

More could be said about each of these criteria, and other considerations might be important in cases other than the one above, but these criteria provide general guidance for balancing clinicians' duties to individuals and to communities. These criteria can also be used to help explain when, for example, physicians should move to isolate symptomatic patients or asymptomatic patients known to carry contagions that pose significant risk to the public.<sup>19</sup>

### Conclusion

Health professionals are primarily **bound to advocate** for their individual patients but are also bound to act to protect the public. To balance these duties is not just to follow a law or obey an authority figure, no matter what, or to declare that clinicians must always put their individual patient first. Rather, it is to ensure that, whenever challenges to core health professional values arise, they are considered in light of transparently articulated criteria and carefully deliberated upon. As the Holocaust reminds us, blind obedience to state authority is not a health professional value.

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*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should History of Physician Involvement in the Holocaust Inform How Physicians Approach Employers?**

Mark G Kuczewski, PhD and Amy Blair, MD

**Abstract**

In response to a case involving an advertisement for a physician to work in a private detention center housing asylum seekers and immigrants, this commentary considers ethical obligations of physicians responsible for detainees' health care. The commentary also suggests key points a physician should make during a job interview at a detention center and concerns a physician might articulate about caregiving practices for detainees.

**Case**

In July of 2019, with the United States in the throes of a heated debate over how the nation should manage rising numbers of immigrants and asylum seekers crossing the southern US border, a job opening was posted for a physician to care for immigrants being detained by the government. The job opening was posted by a private, for-profit company that holds government contracts to provide health care services in prisons and detention settings. The job post offered a \$400 000 annual salary for a physician with just 2 years' experience, stated that physicians must be "philosophically committed to the objectives of this facility," and listed no specific requirements related to clinical experience, training, or certifications.

Dr H is a 34-year-old native of the same state housing the detention facility who is 3 years out from completing a residency in family medicine. Dr H notices the job is for a primary care physician in a rural region, where the cost of living is relatively modest, making the proposed pay remarkably high. Dr H is generally sympathetic to the basic problem the employer faces, eager to care for detained immigrants, and personally sympathetic to the political assertion that unrestrained immigration across the southern US border poses a threat to the nation and should be stopped. Dr H is intrigued about the job but caught short by the "philosophical commitment" quotation and wonders what it could mean. Suspicious that the post could be suggesting that the employer is willing to pay a great deal to convince physicians to overcome any ethical qualms they might have about the employers' practices related to care of immigrants in an overcrowded government-funded private detention center, Dr H comes to you for advice about whether to apply and, if she were to apply, how to approach the recruitment process and the job, if offered.

## Commentary

This case of Dr H, a young, inexperienced physician who is considering applying for work in an immigrant detention center, poses a number of issues—some straightforward, others involving judgment and discernment. We explore how the physician might navigate the recruitment process and, ultimately, the job. In other words, under what conditions could this doctor claim that her work is ethical? Of great importance is identifying the ethical lines Dr H should articulate as uncrossable during job interviews.

This case is simple in its major premise. Dr H must always keep in mind what physicians do: respond with care to health-related needs of their patients. Dr H must be reasonably sure that she is taking a job that enables her to honor her **obligations as a physician**. To talk about political sympathies, political parties, or being “philosophically committed to the objectives of this facility” only creates unnecessary confusion about whether those obligations can be met. Dr H must be first and foremost philosophically committed to the obligations of being a physician.

Lessons of the Holocaust are relevant to Dr H’s concerns about the job post. The term *Nazi doctors* was an oxymoron.<sup>1</sup> By adopting the means and ends of National Socialism, Nazi doctors were no longer physicians in any normative sense. In carrying out the horrific T4 “euthanasia” program of persons with disabilities and other infirmities, Nazi physicians did not act in individuals’ interests, much less their significant health interests, or on any *prima facie* moral duty but instead abetted a eugenic state looking to exterminate these members of society.<sup>2</sup>

### Dual Loyalties?

In a detention center, a duty to an employer can come into conflict with a duty to a detainee-patient.<sup>3</sup> Some employ the language of *dual loyalties* to depict physicians’ conflicting duties to a patient and their duties to a state. **Dual or competing loyalties** can pose an ethical dilemma for physicians when a duty to keep information about a patient confidential, say, conflicts with their general duty to be truthful. Such are genuine and long-recognized dual loyalties. Similarly, physician-researchers have dual loyalties to the good of a particular patient and to generalizable knowledge that will benefit other patients. Both are legitimate ends of the health professions, and it is well chronicled that the latter duty played a significant role in atrocities committed by Nazi physicians.

An employer can expect that any employee, including a physician, will follow certain established or agreed-upon means of dealing with ethical concerns. Loyalty to one’s employer in following defined processes can strain one’s loyalty to the patient. Nevertheless, as long as those processes are somewhat responsive, a physician employee is still practicing as a physician and within the scope of a physician’s duty. However, we do not believe that physicians have dual loyalties in situations that simply pit the interests of an employer or a state in punishing a person against the medical needs of that person,<sup>4</sup> so we find it unhelpful to speak in terms of dual loyalties in this case.

Caring for detained migrants is akin to caring for patients experiencing incarceration in other environments, such as in the US penal system.<sup>5</sup> A physician’s opinion on penal code or on a patient’s guilt or innocence does not matter. At all times, physicians who care for patients experiencing incarceration have a duty to advocate for their health-related needs and basic human rights.<sup>6</sup> Physicians can, in no way, be agents of punishment, either by directly or indirectly facilitating neglect or inadequate care; to do

so is to violate defining ends of their role and recognized norms of medicine and would justify disciplinary action, including possible revocation of their licenses to practice medicine by a state medical board.

### **Prerequisites for Ethical Physician Employment**

Only 3 years out of residency, Dr H, like many physicians, might have student loan debt that makes a high salary appealing. Dr H might have sufficient experience to handle most of the medical needs she encounters among detainees, but the job could place Dr H in diagnostic and treatment situations for which her professional judgment is not sufficiently developed for her to operate in isolation. Physicians usually benefit from senior colleagues' experience and learn from each other, so it is important for any physician who takes this job to have adequate backup, referral systems, and good colleagues. For instance, Dr H must confirm that physicians at the detention facility retain full authority to send a patient to a hospital when needed and to make medical decisions subject only to review by others with medical expertise, not by company administrators who lack such expertise.<sup>7</sup> Dr H should require that patients in her care be able to access preventive and acute care that approximates a reasonable standard of care. For instance, flu shots are considered routine and possibly life-saving preventive care in the United States. To deny them to persons in custody of the federal government for an extended period is to levy a kind of *de facto*, unadjudicated punishment to detainees (for immigrating), and administering punishment of any kind is not within the scope of any clinicians' duties as a professional.

### **Requirement Not to Collaborate in Evil**

Any physician working in a detention or incarceration environment must be prepared to navigate situations in which **detainees are treated inhumanely**. For instance, denying parents' roles in consent to treatment and decision making for their children and detaining children separately from their parents and in cages without adequate supervision or hygiene is trauma inducing and violates basic human decency. There is no justification for such conditions, which obviously incur suffering and harm among these children. Because a physician may not participate in perpetrating inhumane acts, if Dr H takes this job, will she oppose these conditions or become complicit in their imposition, or do something else?

Physicians are ethically prohibited from participating in the execution of a person,<sup>8</sup> but they can attend to the health needs of patients experiencing incarceration who are convicted of capital crimes. Relieving such patients' pain and suffering and fostering quality of life should not be seen as cooperating with an eventual execution. To be clear, simply working for institutions that perpetrate inhumane acts is not necessarily contrary to a physician's vocation, as long as the physician attends to detainee-patients' well-being and does not participate in or make possible inhumane acts against them.

Health care delivery also cannot be an intrinsic part of or intended to further even a legally authorized punishment. For instance, the American Medical Association (AMA) *Code of Medical Ethics* states that a physician cannot seek to relieve a patient's psychotic episode for the purpose of maintaining that patient's mental capacity to fulfill their death sentence<sup>8</sup> because a physician in such a case would intentionally facilitate punishment. Realistically, it would seem that few things a physician would be asked to do in a detention facility would fall under the purview of the AMA *Code* opinion on execution, but one can easily imagine a physician being asked, say, to collect DNA from an asylum seeker who has not given consent. Carrying out such a request would be a

direct violation of an asylum seeker's rights and would not serve any health-related need of that detainee.<sup>9</sup> It is important for physicians applying for this job to be aware of the potential for an abundance of ethically compromising job expectations and to express adherence to basic principles of medical ethics during the job interview and course of employment. The employer should accommodate physician exemption from practices that violate duties to patients.<sup>10</sup>

Other key issues that Dr H should ask about during the job interview are these: the administrative channels available to her to register a complaint when she observes inhumane treatment of detainees and transparency in processes by which complaints are reviewed and decided upon. Since Dr H would be working for a private corporation, not the federal government, public command chains cannot be relied upon as a source of accountability.<sup>5</sup> It's not clear what a private corporation with a government contract for running detention facilities would offer in terms of transparency, so Dr H should express her general unwillingness to sign nondisclosure agreements and demand full respect for her professional autonomy and freedom of speech.

Another consideration is that employment of physicians by a company with a vague "philosophical commitment" requirement will normalize and confer legitimacy upon ethically dubious institutions or their practices, simply through physicians' membership in the medical profession. It might be useful to analyze this situation in terms of an old concept from Catholic moral theology, *scandal*,<sup>11</sup> defined as leading people to do evil by setting an example or setting up social institutions (perhaps a detention facility) in a way that can lead people to see an evil as a good. It is not hard to imagine the company or the government portraying the conditions of the detention facility in a positive light due the presence of a staff physician. The upshot here is that physicians must be able to mitigate scandal by their recognition of evil, courage to speak up against it, and ability to speak up against it.

### Dual Loyalties Revisited

A private employer might reasonably expect a physician to utilize agreed-upon channels of redress for complaints and not immediately speak to the media. The company's stipulating that Dr H may access health-related federal authorities when concerned about inhumane treatment or request independent consultation with an appropriate expert might be means by which Dr H could fulfill her obligations to her employer and her patients. If neither channel helps to rectify inhumane conditions, to avoid complicity in doing harm, Dr H might have no other ethical recourse than to resign. Nazi physicians' complicity in evil suggests the ease by which atrocities can be normalized, particularly with broader state sanctioning. In a corrupt regime, an expectation of state regard for ethical values such as accountability and transparency might be held only by the most naïve or ill-informed.

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**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should a Physician Respond to Discovering Her Patient Has Been Forcibly Sterilized?**

Rebecca Kluchin, PhD

**Abstract**

Forced sterilization has a long history in the United States. Because sterilization requires surgical skill, physicians have been the lone professionals engaging in this practice, although they were not the only experts or Americans to hold eugenic and neo-eugenic views. But physicians have also been whistleblowers who exposed sterilization abuse and led efforts to end it. The commentary on this case suggests that physicians should respond along those lines.

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**Case**

During her outpatient obstetrics clinic, Dr P saw MT. MT first came to see Dr P at age 24. At that time, she had given birth to 5 children and had normal periods and hormone levels. Now 34 years old and recently released from prison, MT explains that she delivered her most recent child via cesarean delivery at the age of 30, while she was in prison. She wishes to become pregnant again but has been unable to do so for the past 10 months and now seeks Dr P's help.

MT's recent physical examinations and lab test results were normal, so Dr P thought her inability to conceive over the last 10 months might be due to infertility in her new husband. Testing revealed, however, that his sperm's motility and numbers were normal. Dr P then ordered a hysterosalpingography, a fluoroscopic x-ray of the uterus and fallopian tubes, to see if MT had developed an obstruction, perhaps from scarring after a chlamydia infection for which she was successfully treated as a teen. Dr P is shocked to see that the hysterosalpingography reveals that MT had undergone a tubal ligation.

Dr P has no good reason to believe that MT knows that she had a tubal ligation. When Dr P tells MT that she has had a tubal ligation, she sits silently for a moment and then begins to cry. "They made me sign something right before the Caesarean section. I was drugged. That's when they did it. What can we do now?"

## Commentary

MT's story is a familiar one. Tens of thousands of Americans have been **involuntarily sterilized** since the turn of the 20th century.<sup>1</sup> MT's experience represents the most recent iteration of this practice—forced sterilization of women in prison—but it is not unique. In its earliest form, sterilization in America followed eugenics, the so-called science of racial betterment. Scientists and clinicians engaged in this field of study, and many policymakers drew on eugenic research when calling for an end to immigration in the 1910s and 1920s.<sup>2,3</sup> Eugenacists offered segregation and sterilization as solutions to the so-called problem of the unfit and the social ills they supposedly embodied and reproduced.<sup>2,3</sup> But physicians have also been whistleblowers who exposed sterilization abuse and led efforts to end it.

## Coercive Sterilization History

In 1927, the US Supreme Court upheld Virginia's eugenic sterilization law in the landmark case of *Buck v Bell*, in which Justice Oliver Wendell Holmes Jr famously declared, "Three generations of imbeciles are enough."<sup>4</sup> By 1942, 30 states had adopted similar eugenic statutes,<sup>2</sup> and sterilization rates skyrocketed. Before *Buck*, a few hundred sterilizations were performed annually, and 3233 individuals had been sterilized for eugenic reasons.<sup>2</sup> After *Buck*, between 2000 and 3000 Americans were eugenically sterilized every year.<sup>2</sup> By 1941, at least 38 087 citizens had been eugenically sterilized.<sup>2</sup> However, as historian Paul Lombardo makes clear, we do not know the actual number of eugenic sterilizations performed in the United States, because not all of them were recorded or officially counted.<sup>1</sup> Most sterilizations were performed on women because women bore children and because, before *Buck*, men who had been sterilized in prison (to make them more docile) successfully charged that their vasectomies constituted cruel and unusual punishment.<sup>2,5,6</sup>

American eugenacists, including health care professionals, positioned themselves as at the forefront of international eugenics. Worldwide, they participated in conferences, published articles, received honorary degrees, and corresponded with eugenacists in other countries—most notably, Germany.<sup>7</sup> Nazi policymakers based eugenic laws and programs on American legislation and courted support of leading American eugenacists from the 1930s through the early years of World War II.<sup>7</sup> Indeed, Nazi policymakers held up American, eugenics-informed immigration policy as a model of racial preservation.<sup>7</sup> The US immigration laws of 1921 and 1924 restricted immigration of persons with hereditary diseases and of persons from Eastern and Southern Europe, Africa, and Asia. Nazis scrutinized American eugenic research, including the infamous family studies of the Jukes and the Kallikaks that purported to prove the heritability of so-called degenerate traits. Nazi scientists and policymakers used these studies to support precursors to the Final Solution.<sup>7</sup>

Mutual admiration between German and American eugenacists led Americans drawing on Nazi propaganda to spread ideas of supposed racial betterment.<sup>7</sup> American eugenacists applauded German sterilization laws and "were the strongest foreign supporters of Nazi race policies."<sup>7</sup> California enacted more sterilization laws than any other US state and sterilized more people than any other US state,<sup>7</sup> and its eugenacists enthusiastically expressed support for sterilization laws in Germany.<sup>3,7</sup> Paul Popenoe and Eugene S. Gosney, president of the Human Betterment Foundation, the leading eugenics organization in the California, proved especially influential. Both men corresponded with German eugenacists and supported Nazi policies for years.<sup>7</sup>

### **Neo-eugenics and Family Planning**

In the 1930s, opposition from the Catholic Church, geneticists, and social scientists stressed the importance of environment rather than genetics—nurture as opposed to nature—in shaping individual behavior. This opposition weakened eugenics.<sup>1,8</sup> The number of eugenic sterilizations also declined when the US joined the allies in World War II, with surgeons now serving in the war.<sup>2</sup> Sterilization did not rebound,<sup>2</sup> but neither did it end.

*Neo-eugenics.* Ideas linking reproductive fitness to race continued to seep into clinical practice, public policy, and popular culture after World War II.<sup>9</sup> Neo-eugenics framed poverty, illegitimacy, and criminality as culturally—not genetically—reproduced by women of color and drove a new wave of forced sterilizations from the 1950s through the 1970s.<sup>9</sup> White postwar social anxiety about civil rights, overpopulation, Mexican and Puerto Rican immigration, and welfare state expansion under President Lyndon Baines Johnson's Great Society program undergirded these surgeries, which were nearly always performed by White male physicians on poor women of color.<sup>9</sup> In the 1950s, North Carolina targeted poor Black women for sterilization under its existing eugenics law<sup>10,11</sup> and "Mississippi appendectomies"—forced sterilizations of Black women who entered hospitals to undergo abdominal surgeries and, without their knowledge or informed consent, left without their uteruses—ran rampant across the South, especially in areas of intense civil rights action. Clinicians practiced White supremacy when they employed scalpels as tools of social control to demonstrate their resistance to *Brown v Board of Education* (1954) and other civil rights victories.<sup>9,12</sup>

*Family planning.* Transformation of sterilization from a eugenic procedure into a legitimate form of contraception in the late 1960s and early 1970s hid rising rates of forced sterilization among American women.<sup>9</sup> In 1960, the pill came on the market, boasting a nearly 100% success rate at preventing pregnancy.<sup>13</sup> Despite uncomfortable side effects, millions of American women rushed to have prescriptions filled. Intrauterine devices (IUDs) offered similar benefits a few years later. But the 1969 pill scare<sup>13</sup> and the 1974 Dalcon Shield IUD fiasco<sup>14</sup> revealed deadly risks associated with these methods of contraception. Unwilling to return to messy, less effective diaphragms and condoms, American women and men began requesting sterilization, which many clinicians viewed as a safe, effective method of limiting fertility, preventing unplanned pregnancy, and reducing overpopulation—a new concern in the 1960s.<sup>9</sup> Voluntary sterilization rates rose concurrently with federal family planning expansion in the late 1960s, unifying clinicians' belief in sterilization as cost-effective contraception that could alleviate effects of poverty for patients whom they saw as vulnerable—most notably, poor women of color who received state-funded health care.<sup>9</sup> When poor women were forcibly sterilized, their surgeries were included in voluntary sterilization tallies and rendered invisible.<sup>9</sup>

### **Clinician Intention and Authority**

Most clinicians acted with benevolent intentions but often crossed ethical lines when they recommended sterilization to patients, especially poor women of color who did not request them. In an era when informed consent was a topic of conversation among clinicians but not standard practice, thousands of Black, Latina, and Native American women entered public hospitals to give birth and were sterilized after delivery without their informed consent. Some clinicians deceived patients into believing tubal ligation was reversible; some pressured patients to verbally consent during labor or while under the influence of pain medication; and others **failed to use interpreters** when

communicating with patients with limited English language proficiency and pushed those patients to signify their consent on forms they did not understand.<sup>9</sup>

Occasionally, physicians were malicious, bullying pregnant and laboring women into sterilization by threatening to revoke care.<sup>15,16,17,18,19</sup> Some with malevolent intentions blamed poor women of color for a host of social problems and put their scalpels to punitive use. One North Carolina physician crudely stated: “A doctor who had just got his income tax back and realized it all went to welfare and unemployment was more likely to push it [sterilization] harder.”<sup>9</sup> Most physicians who sterilized women in the 1960s and 1970s acted within outdated standards of medical paternalism.<sup>9,20</sup> These (mostly) White men viewed reproduction as a public rather than a private issue and believed their medical license gave them the social authority to determine who should bear children and who should not. They saw themselves as uniquely qualified to create social change on an individual level; sterilization required a surgeon’s skill, after all.

By the 1950s, most physicians were no longer general practitioners making house calls among patients in their communities but specialists caring for strangers in hospitals and clinics with new lifesaving technologies and drugs.<sup>21</sup> Despite this change, many physicians continued to believe in their capacity, authority, and right to make life-changing decisions for their patients. Their patients, however, were beginning to challenge this authority and demand a greater role in the provision of their own health care.<sup>3,22,23,24</sup> This clash of values eventually caused a reassessment of the patient-clinician relationship, but it was not soon enough to end the forced surgeries.<sup>25</sup>

### **Change, but Not Enough**

In courtrooms and in the court of public opinion, victims of sterilization abuse bravely challenged the physicians who harmed them, forcing state and federal governments to confront the violence they suffered. The Department of Health, Education and Welfare (HEW) established federal guidelines in February 1974 that required informed consent and prohibited sterilization of persons under 18 years of age.<sup>9</sup> The National Welfare Rights Organization opposed the HEW guidelines in court based on their insufficiency to prevent abuse.<sup>9</sup> A subsequent court order prompted HEW to prohibit sterilization of persons unable to consent or under 21 years of age.<sup>9</sup> New York City established protections for public patients in 1975 that included a mandatory waiting period between consent and surgery.<sup>9</sup> In 1976, California adopted similar guidelines that applied to all public and private patients seeking sterilization.<sup>9</sup> State guidelines mandated waiting periods of between 14 days (California) to 30 days (New York) between consent and surgery, prohibited sterilization of minors, required consent in a patient’s native language, and provided model consent forms.<sup>9</sup> In 1978, HEW adopted rules, including a 30-day wait mandate for all patients 21 years or older whose sterilizations were federally funded; continued a moratorium on sterilization persons unable to consent; and forbade sterilization of institutionalized persons unless their informed consent could be secured and reviewed by a board, a rule that sought to prevent the practice of sterilization among persons with intellectual and **mental disabilities** that dates back to the early 20th century.<sup>9</sup>

These policy changes significantly reduced, but did not end, sterilization abuse in America.<sup>18</sup> Forced sterilization made national headlines again in the summer of 2013 when it was revealed that the California Department of Corrections had sterilized 148 female inmates between 2006 and 2010 without state approval—a significant violation because California outlawed forced sterilization in 1979 and in 1994 required clinical

officials' approval for elective sterilization of prisoners.<sup>26</sup> MT's sterilization fits the abuse profile of many women incarcerated during this period in California. It occurred in prison during a cesarean delivery and did not involve informed consent.

### **Whistleblowers and Advocates**

A small group of physicians, many of whom were active in the civil rights movement, led efforts to end sterilization abuse.<sup>22,27</sup> One year after news broke of the infamous US Public Health Service Syphilis Study at Tuskegee,<sup>9</sup> the Southern Poverty Law Center revealed that its clients in *Relf vs Weinberger*, Minnie Lee (age 12) and Mary Alice (age 14) Relf were sterilized by a Montgomery, Alabama, family planning agency whose personnel believed these young Black girls—one of whom had a disability—needed permanent pregnancy prevention.<sup>9</sup> The *Relf* case made national headlines, and Senator Edward Kennedy invited the girls' parents to testify at US Senate hearings.<sup>9</sup>

In the early 1970s, Bernard Rosenfeld, an obstetrics resident physician at the University of California, Los Angeles (UCLA), County Hospital, exposed sterilization abuse of Mexican and Mexican-American women at his institution. Rosenfeld spoke to reporters, contributed to a Health Research Group report that documented abuse, and wrote to civil rights organizations.<sup>15,16</sup> Attorneys Antonia Hernández of the Los Angeles Center for Law and Justice and Charles Nabarette took the case and filed a class action lawsuit against Edward Quilligan, chair of the UCLA Department of Obstetrics and Gynecology. Karen Benker, a UCLA medical student who also witnessed the abuse, testified on behalf of the plaintiffs. She and Rosenfeld directly and publicly challenged a leader in their field, potentially imperiling their careers.<sup>15</sup> After his first year of residency, Rosenfeld's contract was not renewed. Rosenfeld believes this was retribution for his activism, although Quilligan cited unsatisfactory job performance.<sup>28</sup> Psychiatrist Terry Kupers served as an expert witness and testified to the psychological damage that plaintiffs suffered as a consequence of their forced surgeries. When *Madrigal v Quilligan* was decided in favor of Quilligan in 1978,<sup>29</sup> Kupers published an op-ed in the *Los Angeles Times* decrying the verdict.<sup>30</sup>

New York City adopted sterilization guidelines the same year *Madrigal* was filed. Helen Rodriguez-Trías spearheaded the collaboration between the New York City Health and Hospitals Corporation and the grassroots Committee to End Sterilization Abuse that resulted in the guidelines. Rodriguez-Trías was raised and trained in Puerto Rico. She later moved to New York City, where she practiced at Lincoln Hospital, and became a leader in the women's health movement. Throughout her long career, which included serving as president of the American Public Health Association in 1993, Rodriguez-Trías promoted social change within medicine and on the streets.<sup>31,32</sup>

In the early 1970s, Constance Pinkerton-Uri, a Native American physician, raised public awareness of **sterilization abuse on Indian Reservations** after a patient requested a "womb transplant." Pinkerton-Uri discovered that this patient, believing the surgery to be reversible, had undergone a hysterectomy 6 years earlier. Suspecting a long-term epidemic of similar sterilization abuse at Indian Health Service (IHS) sites nationwide, Uri consulted US Senator James Abourezk of South Dakota, who requested a federal investigation.<sup>33,34,35</sup> The subsequent Government Accounting Office report revealed that 3000 tubal ligations had been performed between 1973 and 1976, 36 of which violated the 1974 federal prohibition against sterilization of women under age 21.<sup>36,37</sup> Keenly aware of Native American women's reluctance to seek care via the IHS because

of the risk of sterilization, Uri and 2 colleagues began to hold clinical appointments in a tepee.<sup>9</sup>

### Dr P's Response

Dr P could stay quiet and focus on helping her patient come to terms with a surgery to which she did not consent and that robbed her of her fertility. But the history just outlined suggests that MT's sterilization abuse was part of a broader nationwide pattern of systemic injustice. Dr P should inform state officials of her patient's situation and suggest a thorough review of former and current prisoners' health records in search of similar cases of abuse. Although Dr P cannot reverse MT's sterilization, she can follow in the footsteps of her socially conscious physician predecessors who helped reduce sterilization abuse in America.

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### MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

#### Teaching Health Professions Students About the Holocaust

William S. Silvers, MD, Matthew K. Wynia, MD, MPH, Mark A. Levine, MD, and Meleah Himber, MEd

##### Abstract

The legacy of health professionals' roles in the Holocaust is fundamental to understanding modern health care ethics, but teaching it is difficult. The University of Colorado Center for Bioethics and Humanities has developed a program that addresses 4 main pedagogical challenges of this content. This article identifies 3 core lessons and proposes 5 specific learning objectives related to health professionals' involvement in the Holocaust for any health professional training program.

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##### Introduction

The legacy of health professional involvement in the Holocaust is fundamental to understanding modern health care ethics, but specific teaching about this history is required in only 22 (16%) of medical schools in the United States and Canada.<sup>1</sup> This history is relevant today, as health professionals address disabilities, disparities, racism, and discrimination in carrying out their professional obligations to serve all individuals with respect and dignity, to use science responsibly, to maintain necessary professional distance while preserving compassion and intimacy, and to prevent conflicts of interest from compromising practice. At the University of Colorado Anschutz Medical Campus, despite general support from students and faculty, we have faced significant challenges in remembering, transmitting, and applying lessons of the Holocaust. This article describes these challenges and our responses to them.

##### Challenges

The Holocaust was not executed by a few proverbial bad apples or rogue clinicians but by professions synchronizing execution of state-organized crimes against humanity in the name of science and public health. Helping health professions students comprehend this history requires overcoming 4 obstacles:

1. *Complex, voluminous content.* One could easily spend a career studying health professional dimensions of Holocaust history. Adding this material deftly to

health sciences curricula requires that educators have sufficient content knowledge and carefully select educational objectives.

2. *Teaching genocide is demanding for faculty.* The Holocaust was medically driven genocide, arguably the sentinel event in modern health care ethics. Few faculty members are comfortable with teaching or pedagogically prepared to teach this content skillfully.
3. *Learning about atrocities is demanding for students.* Because Nazi doctors are frequently regarded as monstrous and evil, identifying similarities between **Nazi clinicians and clinicians today** is not intuitive for most students. Relating past atrocities to contemporary practical health care ethics problems can provoke confusion and defensiveness in students that can interfere with their reflection. What's more, the reality that more than 50% of German physicians voluntarily joined the Nazi party<sup>2</sup> and that their atrocities were executed under the banner of science and public health<sup>3</sup> is not easy for many students to accept.
4. *Competition for curricular time.* While ethics and professionalism must be included in medical education curricula, content about ethical and social implications of clinicians' roles in the Holocaust is not required. In fact, history teaching has dwindled to nonexistence in most programs.<sup>4</sup>

### **Model Program**

The University of Colorado Anschutz Medical Campus's program, Holocaust Genocide and Contemporary Bioethics (HGCB), promotes "education, scholarship and community engagement on the lessons of the Holocaust for health care and society."<sup>5</sup> With a coordinated, annual cycle of activities, including a student writing contest and multiple campus and community educational opportunities, the program delivers an annual International **Day of Remembrance** lecture for first-year health professions students. During the National Week of Remembrance for Victims of the Holocaust, nationally recognized keynote speakers participate in several days of activities, such as lectures, panel discussions, community events, art gallery exhibits, and musical performances across multiple University of Colorado campuses. Broad participation in the HGCB program is aided by stewardship of its advisory group, which includes partner organization members, academicians, community members, students, clinicians, and staff.

An evening discussion group meets regularly to consider essential lessons of the Holocaust, how to teach them, and how they relate to contemporary bioethics, particularly basic human rights protections. In the United States, other relevant historical examples include clinician participation in slavery,<sup>6</sup> researchers intentionally infecting Guatemalans with sexually transmitted diseases in the 1940s,<sup>7</sup> **coerced sterilization** of Native American<sup>8</sup> and Latina<sup>9</sup> women in the 1970s, the US Public Health Service Syphilis Study at Tuskegee,<sup>10</sup> and torture practices at Guantanamo Bay and other military detention camps.<sup>11</sup> Recent discussions were convened about public and patient trust in medicine, duties to protect vulnerable patients and communities, what constitutes the proper role of science in society, humanistic health care, and how to manage competing professional interests. The workgroup recently recommended 3 core lessons and 5 specific learning objectives for integrating this content into health professions ethics curricula.<sup>12</sup>

Since the Holocaust, in particular, demonstrates how health professionals' failure to balance competing tensions negatively affected professions, patients, and society, each

of the 3 lessons considers approaches to persistent sources of tension faced routinely by today's clinicians.

1. *Commitment to science.* One approach to balancing reason and skepticism in searches for scientific truth is aided by cultivating awareness of when ideology could motivate unproven theories or override well-proven science, such as when Nazi physicians drove eugenic ideas in the 1940s and ignored non-Aryan scientists' work or when today's clinicians ignore climate science or endorse antivaccination.
2. *Clinical detachment.* Health professionals must be able to form deep, enduring human connections with patients and maintain their ability to work while resisting inurement to suffering and death, even as individual patients suffer and die.
3. *Competing loyalties.* Health professionals must uphold their commitments to society and to individual patients while also navigating personal and professional commitments to employers, family, colleagues, the state, and others.

Health professions students' learning of these 3 lessons can be cultivated by adopting the following 5 objectives. By graduation, each student in the HGCB program should be able to:

1. Describe the theory of eugenics and its relationship to racism.
2. Describe at least 3 social, economic, or other factors that prompted many German health professionals in the 1930s to prioritize state interests over individuals' interests.
3. Describe at least one US-based forced sterilization program and its temporal and ideological relationships to Nazi programs.
4. Describe the Nazi child "euthanasia" and T4 programs and how they related to later programs of mass murder in the Holocaust.
5. Describe at least 2 rationales used by German physicians to justify experimentation on prisoners.

These 3 lessons and 5 objectives motivate students' learning of the facts of the Holocaust relevant to health professionalism today; help health professions schools meet standards for curricular content on cross-cultural awareness, health inequity, and ethics; and promote students' development of Accreditation Council for Graduate Medical Education core competencies related to patient care and professionalism.

### **Augmenting Existing Curricula**

These 3 lessons and 5 objectives can also be integrated into existing health professions curricular materials by exploring eponymous terms, such as Asperger's syndrome,<sup>13</sup> and their relation to Nazi science and discussing eugenics during genetic science lessons and when presenting content on disability, health equity, clinician bias, and racism. Integrating this content can help model humanistic caregiving practices and underscore the fundamental roles of ethics in promoting good patient outcomes and professional well-being. Each generation of health professionals must earn their patients' trust and execute their unique responsibilities as leaders, scientists, and healers, despite conflicting loyalties. Students need to learn about genocide's medicalization during the Holocaust, which is key to strengthening their impulses to protect human rights and hold sacred their relationships with patients.

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### MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

## How Should Students Learn About Contemporary Implications of Health Professionals' Roles in the Holocaust?

Robert Baker, PhD

### Abstract

Foundational documents of modern biomedical ethics, such as the Nuremberg Code, the World Medical Association's declarations of Geneva and Helsinki, and the Belmont Report, trace their origins to health care professionals' complicity in the Holocaust. Rituals of contemporary medical education, such as white coat ceremonies and oath swearing at graduations, are practices that express professional resolve to never again be complicit in genocide or human exploitation. This article considers a historical approach to teaching the Holocaust's contemporary ethical implications for clinicians and their practices.

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### History in Ethics Education

History can awaken students' imaginations to the past so that they can study its implications for the future. As one bioethicist and historian team suggested:

Good history transports those studying and practicing bioethics to an earlier time, figuratively putting them in the shoes of their predecessors and teaching them how these past individuals rationalized ... choices that now seem clearly ethically dubious. Learning how societal values, scientific zeal, ideological beliefs, and the desire for personal achievement influenced these persons reveals how similar factors can and often still remain in play, even in our supposedly more "enlightened" era.<sup>1</sup>

It is in this spirit that I routinely discuss health care professionals' roles in the Holocaust in my bioethics courses. It is important that future health care professionals recognize that in the 1930s and 1940s, their German counterparts believed they had an ethical duty to collaborate in killing children with disabilities, gay people, Roma, and—most notoriously—Jews. More to the pedagogical point, it is important for students to learn that, directly or indirectly, foundational documents of modern health care ethics—the Nuremberg Code, the World Medical Association's declarations of Helsinki and Geneva (a modern version of the Hippocratic Oath) and the Belmont Report—were written to

prevent both researchers' abuse of the people serving as human subjects and the recurrence of medical complicity in genocide.

### **The 1947 Nuremberg Code**

Earliest among these foundational documents was a code of research ethics issued by judges at the Nuremberg Doctors' Trial. Responding to revelations that German physicians subjected concentration camp inmates to experimentation, war crimes, and crimes against humanity, the court convicted 16 of the 23 accused health care professionals and Nazi administrators.<sup>2</sup> Before sentencing, justices issued a code of 10 principles to which, they claimed, all morally responsible researchers subscribed.<sup>2,3</sup> These came to be known as the Nuremberg Code.<sup>4</sup> The trial and the code have been exemplars of accountability for later generations of research ethics reformers.

### **The 1948 Declaration of Geneva**

In 1947, physicians in the allied military campaign to retake Europe from the Nazis founded the World Medical Association (WMA). The WMA's objective was to rebuild Europe's devastated health care institutions: bombed-out clinics, hospitals, laboratories, and schools. Although rumored during World War II, German health care professionals' roles in the Holocaust became fully known only after the Nuremberg Trials. What also became known was that "Nazi medical ethics" was neither a misnomer nor an oxymoron, nor was it hyperbole.<sup>5,6</sup> When Karl Brandt (1904-1948), a Nazi physician and member of Hitler's inner circle, was asked about his role in directing the Nazi Aktion T4 euthanasia initiative, a systematic program for killing children and others with disabilities, he replied:

We German physicians look upon the state as an individual to whom we owe prime obedience, and we therefore do not hesitate to destroy an aggregate of, for instance, a trillion cells in the form of a number of individual human beings if we believe they are harmful to the total organism—the state.<sup>7</sup>

When asked about traditional statements of medical ethics, such as the Hippocratic Oath, Brandt observed that, had Hippocrates been a German physician in the 1930s, he would have revised his oath.<sup>7</sup> The WMA knew that Brandt and his Nazi colleagues accepted what their teacher Alfred Hoche (1865-1943) endorsed: *euthanasie* of people with mental disabilities was ethical because it alleviated the state's burden of supporting *lebensunwertes leben* (lives unworthy of living).<sup>8</sup> Fully embraced, this racialized eugenic public health ethics, or *rassenhygiene* (**racial hygiene**),<sup>9,10</sup> justified killing "individual human beings if we [German physicians] believe they are harmful to the total organism—the state."<sup>7</sup>

Because the WMA's objective—to rebuild the health infrastructure of Europe—included occupied and postwar (West) Germany, German health care professionals' cooperation was essential. The WMA knew that effective denazification would require German health care professionals to recommit to traditional medical ethics. Accordingly, the WMA adopted a pragmatic approach: German health professional organizations' recognition would be conditional on their members' reaffirmation of traditional values of allopathic medicine. German clinicians had to publicly swear a modernized version of the Hippocratic Oath, the Declaration of Geneva. In its original 1948 formulation, the Declaration of Geneva stated:

I will consecrate my life to the service of humanity.... THE HEALTH OF MY PATIENT will be my first consideration.... I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social



standing to intervene between my duty and my patient.... I will not use my medical knowledge contrary to the laws of humanity.<sup>11</sup>

Note the declaration's explicit rejection of Nazi medical ethics—which placed the welfare of the organic state above the individual patient's health—by its emphasis on clinicians' duties to humanity, and its emphatic rejection of the relevance of a patient's race, nationality, or social class to health care service delivery. The WMA regularly updates the wording of the oath, a version of which is regularly sworn by students throughout Canada and the United States.

### **The 1964 Declaration of Helsinki**

Although inspirational, like many firsts, the Nuremberg Code was far from perfect. The judges presiding at the Doctors' Trial stipulated that “voluntary consent of the human subject is absolutely essential”<sup>12</sup> and made this the primary principle of human subjects research ethics. But some prospective research subjects lack capacity to consent, and, by overlooking the need for surrogate consent, the judges inadvertently prohibited testing interventions for sick children, unconscious patients, and other key groups. A second factor undermining the Nuremberg Code's scope of influence was the outbreak of the Cold War (1945-1990). As this conflict heated up, the code's restrictions on human subjects research came to be seen as impeding efforts to understand radiation exposure from weapons of mass destruction.<sup>13</sup>

A form of mass retrograde amnesia about professionals' roles in the Holocaust became convenient. In the United States, “Neither the horrors described at the Nuremberg Trial nor the ethical principles that emerged from it had a significant impact on the American research establishment.”<sup>13</sup> Similarly, “the Nuremberg Code ... was routinely ignored by researchers in Britain ... who believed the guidelines ... did not apply to them.”<sup>14</sup> Recognizing a need for applicable research ethics, the WMA issued a new code in 1964, the Declaration of Helsinki, which expressly recognized that surrogate consent filled a need “in case of legal incapacity” and stipulated that “consent should ... be procured from the legal guardian.”<sup>15</sup> Updated continuously since its passage, the Declaration of Helsinki's supplemental declarations (eg, the declaration on health data banks issued in 2016) continue to remain foundational for international medical and research ethics.<sup>16</sup>

### **Beecher, Pappworth, and Buxtun**

Memories of the Holocaust tended to be overshadowed by Cold War concerns in the 1970s, but they had been seared into the minds of Jews everywhere and remained in the thoughts of a handful of World War II military clinicians, including the Harvard medical researcher Henry Beecher (1904-1976). Beecher's original interest in the Nuremberg trial was that of a Cold War warrior: gleaning information from the Nazi experiments. Eventually, however, Beecher came to realize that some of his own Cold War experiments were unethical. In what could be construed as an act of contrition, he blew the proverbial whistle on content published in leading clinical journals that violated the informed consent standard in the Nuremberg Code and the Declaration of Helsinki.<sup>17,18,19,20</sup>

Beecher corresponded with a fellow World War II veteran, Maurice Pappworth (1910-1994), a British physician barred from appointments at London's teaching hospitals because, as he was once informed, such positions were reserved for gentlemen and “no Jew could ever be a gentleman.”<sup>21</sup> In 1936, Pappworth passed the Royal College of Physicians (RCP) examination, an indicator of professional achievement normally

followed about a decade later by election as a fellow to the college, but he was not elected until a few months before his death in 1994.<sup>21,22</sup> Although this unprecedented 57-year delay was unjust, Pappworth made the most of it, and to our collective benefit: unburdened by the club morality of gentlemanly RCP fellows, Pappworth informed the British medical and popular press about unethical experiments on patients in the British National Health Service and elsewhere.<sup>21</sup> In response to complaints from the British medical establishment, he replied: “Those who dirty the linen and not those who wash it should be criticised. Some do not wash dirty linen in public or private and the dirt is left to accumulate until it stinks.”<sup>23</sup>

Beecher’s and Pappworth’s whistleblowing catalyzed research ethics reforms in the United States and Britain. While working for the US Public Health Service (USPHS), Peter Buxtun (1937- ), a son of Holocaust refugees, discovered that an ongoing (1932-1972) study of untreated syphilis in African-American men deceived subjects into thinking that they were being treated for “bad blood,” a euphemism for syphilis, when in fact they were being studied for untreated syphilis.<sup>24</sup> Buxtun sent USPHS officials a report comparing the role of deception in the USPHS Syphilis Study at Tuskegee to Nazi clinicians’ atrocities condemned at Nuremberg.<sup>24</sup> Years after the USPHS rejected Buxtun’s report, Buxtun informed the *Washington Star* about the ongoing experiment.<sup>24</sup> Scandal ended the study and led to a US Congressional investigation, culminating in the 1979 Belmont Report,<sup>25</sup> which proposed the process—now encoded in the US Code of Federal Regulations—of **institutional review board** review, approval, and ongoing compliance monitoring of protocols involving human subjects that are federally funded.

### **The 1979 Belmont Report**

The ethical principles proposed in the Belmont Report—beneficence (and nonmaleficence, later) and justice—are also found in the 1947 Nuremberg Code and the 1964 Declaration of Helsinki. Autonomy or **respect for persons**, however, was new.<sup>25</sup> It transformed consent from a legal concept into a *moral* concept. Traditionally, if researchers asked their subjects to consent, it was to protect themselves against lawsuits arising from harm their subjects could suffer.<sup>27</sup> The Belmont Report reconceptualized consent as a legally enforced moral concept that asserts subjects’ rights and recognizes that, as persons, they deserve respect. The commission that authored the Belmont Report stated: “To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.”<sup>25</sup> This is precisely what the USPHS researchers had done to the African-American men in their study for 40 years. As medical historian Susan Lederer observed: “[I]nvestigators who staffed the study over four decades regarded their African American subjects neither as patients, nor as experimental subjects, but as cadavers, who had been identified while still alive”—that is, they treated them as nonpersons.<sup>26</sup> Eighteen years after the publication of the Belmont Report, the President of the United States publicly apologized to victims of the Tuskegee study.<sup>27</sup>

### **Conclusion**

As I explain to my students, the oaths they swear at white coat and graduation ceremonies<sup>28,29,30</sup> and the regulations with which they must comply when doing human subjects research originated in our responses to clinicians’ roles in the Holocaust. The founders of the WMA, Beecher, Pappworth, and descendants of Holocaust victims and survivors like Buxtun drew on the Holocaust to identify and speak out against unethical

experiments or research. Our students have **no such memories**, so it is up to us, their educators, to cultivate their professional formation and their awareness of complicity as a species of atrocity. Never forget. As Jorge (George) Santayana (1863-1952) observed: “Those who cannot remember the past are condemned to repeat it.”<sup>31</sup>

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### HEALTH LAW: PEER-REVIEWED ARTICLE

#### Health Professionals, Human Rights Violations at the US-Mexico Border, and Holocaust Legacy

Susannah Sirkin, MEd, Kathryn Hampton, MSt, and Ranit Mishori, MD, MHS

##### Abstract

Health professionals caring for asylum seekers face decisions about whether to participate in force-feeding hunger strikers, performing and reviewing unnecessary x-rays to assess detainees' ages, misusing detainees' health information, and discharging patients based on immigration officials' demands rather than patient safety. The latter action is a classic dual-loyalty dilemma reminiscent of some clinicians' actions during the Holocaust. This article investigates how professional organizations can support clinicians targeted by the state for resisting immigration officials' demands for their participation in human rights violations, opposing policies that compromise health professional values, and refusing to engage in unethical detention practices.

##### Dual Loyalty

For centuries, health professionals have pledged uncompromising devotion to patients' well-being. **Dual-loyalty conflicts** arise when clinicians' duties to public health or third parties (health care organizations, insurance companies, family members, and others) conflict with their duties to individuals, particularly patients. Failure to navigate dual loyalties well undermines the integrity of patient-clinician relationships and even entire health professions' trustworthiness. When individual clinicians succumb to pressure from states or state authorities to prioritize nonclinical factors (eg, national security, immigration enforcement, or customs policies) above the interests of patient-detainees, they compromise fidelity to vulnerable persons who have few to whom they can turn. Training clinicians to resist commission of or complicity in human rights violations is expected of health professions educators seeking to help prepare graduates of their programs to resist state-sanctioned abuse and neglect.<sup>1</sup>

Notorious examples of breaches of health professional ethics abound, from Nazi doctors' participation in "euthanasia" programs to US clinicians' participation in **state-administered torture** and executions.<sup>2,3,4,5</sup> Although international codes and professional society statements have been invoked to prevent violations and hold perpetrators accountable,<sup>6,7</sup> the possible role of medical ethics and dual loyalty has been neglected in investigations of US clinicians' involvement in asylum seekers' and migrants' traumatic custody experiences of indefinite detention, overcrowding, and squalor.

Clinicians in detention centers face dual-loyalty conflicts similar to those faced by some Nazi clinicians.<sup>8</sup> This article illuminates human rights violations that illustrate these similarities.

### **Violations Involving US Clinicians**

Physician hiring practices<sup>9</sup> for Immigration and Customs Enforcement (ICE) detention centers or their private contractors have come under scrutiny, as have challenges to clinicians' professional practice independence and lack of agency accountability.<sup>10</sup> Practices such as force-feeding hunger strikers,<sup>11</sup> withholding clinically indicated interventions,<sup>12</sup> and prescribing and administering psychotropic drugs (even to minors) without (parental) consent,<sup>13</sup> and other abuses<sup>14</sup> have happened under US health care professionals' watch in US detention centers.

*Force-feeding.* Since May 2015, at least 1600 individuals have undertaken hunger strikes at 20 US detention centers to protest their detention by ICE.<sup>15,16,17</sup> The World Medical Association (WMA) and other international and US-based organizations have expressed clear opposition to force-feeding of hunger-strikers.<sup>18,19,20</sup> The WMA's Declaration of Malta on Hunger Strikers states: "Physicians must respect the autonomy of competent individuals, even where this will predictably lead to harm."<sup>18</sup> Yet, according to civil society organizations,<sup>19</sup> some detainees have been and are being **forcibly fed**, a practice long considered to be inhumane and unjustifiable from a health care ethics standpoint, as it deprives competent individuals' rights to protest and to bodily autonomy.<sup>20,21</sup> Current and former detainees have reported not only being force-fed via nasogastric tube, but also being shackled and having intravenous (IV) lines placed by clinicians following invocation of court orders.<sup>17</sup>

*Age assessment.* Health professionals have also been implicated in administering and reviewing radiographs for purposes not clinically indicated—to determine detainees' ages.<sup>22</sup> Reports suggest that dozens, if not hundreds, of migrant children have been forced to undergo dental radiographs, which are used to determine whether they are adults who could be placed in adult detention.<sup>23</sup> This procedure has due process implications, as adults detainees are exempt from legal protections for migrant children, including protection of the right to nonadversarial asylum interview.<sup>24</sup> Many experts consider radiographic age assessments to be scientifically inaccurate and misleading because they fail to account for ethnicity, nutritional status, overall health, and development history, which are considerations especially relevant for people coming from low-resource backgrounds and environments.<sup>22</sup>

*Compromised patient safety.* Migrants' use of primary and even emergency care in community health settings has declined,<sup>25,26</sup> due to their fear of clinicians' and administrative staff members' complicity with immigration enforcement arrests and raids. Physicians for Human Rights (PHR) interviews with community health clinicians in border states have confirmed that, in some community health facilities, patients have experienced compromised access to care, compromised care quality, and racial, ethnic, and immigration status-based discrimination.<sup>27</sup> Although federal guidelines generally prohibit immigration enforcement activities at health care delivery sites,<sup>28</sup> critically ill patients have been shackled against medical advice and experienced delay in their transport by ambulance to emergency health services sites, which violates their right to nondiscriminatory emergent care and interferes with clinicians' execution of their ethical and legal duties to provide lifesaving treatment to patients.<sup>27</sup> Patients also have been denied attorney and family member visitation, have been profiled in waiting rooms, and have experienced **unauthorized disclosure** of their immigration status.<sup>27</sup>

*Unsafe discharge.* Routinization of abrupt discharge with no continuity of care plan has been reported to PHR.<sup>27</sup> Clinicians reported being intimidated by US agents to clear patients for release to detention centers or for deportation,<sup>27</sup> even though doing so would endanger patients' health or risk their death. In January 2020, an 18-month-old and her 6-year-old sibling became ill in Customs and Border Protection (CBP) detention and were hospitalized. Diagnosed with 2 infections, the toddler began receiving IV antibiotics, and an oxygen monitor was placed. Despite the lack of a plan for the toddler's continuing care, the 2 children were discharged and removed on the authority of the government and, in fewer than 12 hours, flown with their mother to Guatemala.<sup>29</sup>

*Misuse of patient information.* For the past decade, children's (allegedly confidential) therapy notes have been used as evidence against them in deportation proceedings.<sup>30</sup> One boy confided to his therapist that, under duress, he joined a gang, later refused to comply with gang demands, and then fled his country.<sup>31</sup> Without the child's or the therapist's consent, an ICE prosecutor used these notes to emphasize the child's gang membership and undermine his case for asylum. Although the extent to which this information is protected under the Health Insurance Portability and Accountability Act (HIPAA) is unclear,<sup>32</sup> violating the confidence of a vulnerable child seeking help neglects the child's dignity and undermines the therapist's capacity to execute professional caregiving duties.<sup>31</sup> Clinicians working with or for organizations such as CBP and ICE should learn about potential **misuses of information they record** about patients and perhaps even inform patients during consent processes of such potential misuses. The American Psychological Association has called for an end to government misuse of patient information and for Congress to investigate.<sup>33</sup> Clinicians should demand similar robust objections to these and other practices of health information misuse from their employers and professional organizations.

### Standing Up for Patients

The practices discussed above and the policies that support them can cause and exacerbate clinicians' moral distress. Clinicians also experience intimidation by armed agents' point-of-care interferences and by threats of demotion or dismissal for resisting or reporting state agents' actions.<sup>27</sup> Such pressure is not easy to resist. But standing up for patients and upholding ethics is a health professional requirement even when it's not easy to work within an unjust system, take legal action, blow a whistle, or resign. Responding to dual-loyalty conflicts usually means that clinicians need to clarify the nature and scope of their and their colleagues' responsibilities and then plan and execute actions to demand or promote change.<sup>1</sup> The following 10 guidelines can help (see Table).

**Table.** Guidelines to Help Clinicians Respond to Dual Loyalty Conflicts<sup>a</sup>

1. Enhance your awareness of human rights principles and "the implications of human rights for clinical practice through study and training in human rights."
2. "Develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised."
3. Always "place the protection of the patient's human rights and well-being first," especially in situations in which "there exists a conflict between the patient's human rights and the state's interests; this responsibility includes affirmatively resisting demands or requests by the state or third party interests to subordinate patient human rights to state or third party interests."



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4. “Exercise judgment independent of the interests of the state or other third party” in all clinical assessments, whether for therapeutic or evaluative purposes.

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  5. Recognize how your “professional skills can be misused by state agents to violate the human rights of individuals—especially in settings where human rights violations are pervasive—and take appropriate steps to avoid this misuse.”

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  6. “Recognize that passive participation, or acquiescence, in violations of a patient’s human rights is a breach of loyalty to the patient.”

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  7. “Only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.”

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  8. “Maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.”

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  9. “Take all possible steps to resist state demands to participation in a violation of the human rights of patients.”

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  10. Always “act with an understanding of health professionals’ collective obligation to uphold and promote the human rights and well-being of the patient.”
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<sup>a</sup>Adapted from Physicians for Human Rights.<sup>1</sup>

### Organizational Responses

Health care organizations should develop, adopt—and train clinicians and staff in how to enact— policies<sup>34</sup> that protect patients’ health rights and human rights concerning nondiscriminatory care access, interactions with state agents, not permitting searches of hospital rooms without a court-ordered warrant, and maintaining confidentiality and HIPAA compliance. Several models exist,<sup>35,36,37,38,39</sup> and they can be adapted to meet local needs.

Health professional societies can also advocate for local, state, and federal policy changes and circulate guidance about how clinicians can safeguard patients’ rights and the quality of care they deliver. If such guidance is insufficient or not followed, clinicians can **advocate for patients** through petitioning, demonstrating, registering formal complaints, launching media campaigns, documenting human rights abuses, and supporting whistleblowers. Although such actions are not without personal risk, the risk of harm to patients from an absence of advocacy by individual clinicians and health professions organizations is severe. Psychiatrist Pamela K. McPherson and internist Scott A. Allen consulted for the US Department of Homeland Security (DHS), inspected detention centers, exposed conditions that threatened detainees’ health and safety, and wrote to the US Senate Whistleblower Protection Caucus in 2018.<sup>40</sup> PHR honored these clinicians’ standing up for human rights and health professional ethics. In response, McPherson stated: “No one needs a medical degree to know that the separation of families and the detention of toddlers are wrong.... It’s clear that traumatizing children is not a political issue but one of human dignity.”<sup>41</sup> More recently, during the COVID-19 pandemic, DHS experts wrote to Congress about the “imminent risk to the health and safety of immigrant detainees” and to local communities if people are not released from detention.<sup>42</sup>

Such individual and organizational responses underscore that recognizing and responding to dual-loyalty conflicts require more than clinical skill, even for experienced clinicians. The Holocaust illuminated how easily clinicians colluded with a state in barbarism. *De jure* cruelty threatens individuals’ health rights and human rights today

and still call for clinician advocacy. Humanity relies on clinicians' individual and collective conscience, and history has a way of holding us all accountable.

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**AMA CODE SAYS**

**AMA Code of Medical Ethics' Opinions Related to the Legacies of the Holocaust in Health Care**

Scott J. Schweikart, JD, MBE and Danielle Hahn Chaet, MSB

**Abstract**

Two concerns about information from unethical experimentation are its legitimacy and trustworthiness. This article explores guidance about information use from the *AMA Code of Medical Ethics*.

**Justifiability of Using Information From Nazi Experiments**

One of the Holocaust's grim legacies is Nazi physicians' "brutal medical experiments upon helpless concentration camp inmates."<sup>1</sup> These experiments were often fatal, exceptionally cruel, and performed without subjects' consent.<sup>1</sup> The motivations for these atrocities were to gather information about the human body to enhance Nazi military survival tactics<sup>1</sup> and to apply it in service of **eugenic goals**.<sup>2</sup> The range of experiments was wide, including immersion in tanks of ice water to induce hypothermia or death, high-altitude survival, sea water poisoning, wound creation, artificial insemination, and forced sterilization.<sup>1</sup> Should information gathered from these experiments ever be used or cited?

This question asks us to consider whether and to what extent using unethically acquired information perpetuates wrong done to Holocaust victims and is separate from considering whether and how such information is or should be regarded as scientifically valid. In Stephen Post's words, "Because the Nazi experiments on human beings were so appallingly unethical, it follows, *prima facie*, that the use of their results is unethical,"<sup>3</sup> or, as Frank Swain argues, using unethically acquired information encourages unethical practice.<sup>4</sup> Some, however, suggest that unethically acquired information can still have value.

The scientific validity of information gathered from Nazi experimentation is debated, with some arguing that it is "not to be trusted at all,"<sup>5</sup> while others suggest some of it can be "useful."<sup>6</sup> A recent example of the usefulness of unethically acquired information was a noteworthy operation on a patient suffering from unbearable nerve pain.<sup>6</sup> In preparing for the operation, the surgeon "needed to consult the best anatomical maps of peripheral nerves ever created,"<sup>7</sup> which were drawn with accuracy—but from "people executed by the Nazis."<sup>7</sup> Referencing the book helped this surgeon help her patient become "pain-free for the first time in years."<sup>7</sup> Some would argue that this use of

information demonstrates the information's value and the justifiability of its use. Others would disagree.

### **American Medical Association *Code of Medical Ethics* on Unethical Research**

The American Medical Association (AMA) *Code of Medical Ethics* addresses the use of unethically acquired information. Opinion 7.2.2, "Release of Data From Unethical Experiments," states: "Research that violates the fundamental principle of respect for persons and basic standards of human dignity, such as Nazi experiments during World War II or from the US Public Health Service **Tuskegee Syphilis Study**, is unethical and of questionable scientific value" and that such data "should virtually never be published."<sup>8</sup> Although the Code emphasizes the desirability of not promoting use of such information and concern about its scientific value, Opinion 7.2.2 does permit use of unethically derived information in "rare instances when ethically tainted data have been validated by rigorous scientific analysis, are the only data of such nature available, and human lives would certainly be lost without the knowledge obtained from the data," clarifying that "it may be permissible to use or publish findings from unethical experiments."<sup>8</sup>

Opinion 7.2.2 provides further guidance about permissibility of information use in such circumstances, stating that physicians should:

- (a) Disclose that the data derive from studies that do not meet contemporary standards for the ethical conduct of research.
- (b) Clearly describe and acknowledge the unethical nature of the experiment(s) from which the data are derived.
- (c) Provide ethically compelling reasons for which the data are being released or cited, such as the need to save human lives when no other relevant data are available.
- (d) Pay respect to those who were the victims of the unethical experimentation.<sup>8</sup>

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**STATE OF THE ART AND SCIENCE: PEER-REVIEWED ARTICLE**

**“Prevention” and Human Gene Editing Governance**

Eric T. Juengst, PhD

**Abstract**

The Holocaust and the racial hygiene doctrine that helped rationalize it still overshadow contemporary debates about using gene editing for disease prevention. In part, this is because *prevention* can mean 3 different things, which are often conflated. *Phenotypic prevention* involves modifying the expression of pathogenic DNA variants to forestall their clinical effects in at-risk patients. *Genotypic prevention* involves controlling transmission of pathogenic variants between generations to avoid the birth of affected offspring. *Preventive strengthening* seeks to improve normal human traits to resist disease. These distinctions have been neglected in human gene editing governance discussions and are clarified in this article.

**Genetic Prevention and the Shadow of the Holocaust**

The scientific racism and eugenic delusions that led to the Holocaust are widely eschewed by members of human genetics and genomics communities today.<sup>1</sup> Yet the Holocaust’s long shadow is still evident in public anxiety about our growing ability to control human genes’ expression and transmission. Today, the focus of this anxiety is on the suite of **new molecular tools** for gene editing that promises to revitalize the enterprise of human gene therapy. Since the first demonstration that these tools can be used to modify genetic mechanisms in human cells more precisely and efficiently than older forms of gene transfer, global organizations charged with their oversight have produced a deluge of reports and statements proposing ethical guidelines for these tools’ use.<sup>2</sup> Most of these reports concentrate on immediate research ethics questions raised by the development of any new biomedical innovation: questions about physical risk, **informed consent**, and fair distribution of research benefits and burdens. But behind those deliberations, the memory of the Holocaust surfaces more fundamental ethical questions about where this research leads and the worry that we could repeat the mistake of creating genetic hierarchies from social prejudices and try again to remake our species against the backdrop of a fundamentally unjust vision of human health.

This background concern manifests itself in the new wave of **gene editing governance** documents that frame discussion of gene editing regulation on the presumption of 2

boundaries: (1) restricting gene editing to treating disease rather than furthering human enhancement and (2) restricting research to somatic cell rather than germline interventions.<sup>3</sup> The clinical uncertainties and risks of earlier gene therapy technologies have been sufficient to support widespread consensus on both of these boundaries within the scientific community since they were first articulated in the 1980s. But the improved safety, efficacy, and efficiency promised by the new gene editing techniques are now opening the way to renewed discussions of both conventional limits. If technical promises of gene editing technology can be realized, society will need to reconsider the conceptual and moral merits of these boundaries directly against the historical shadow of the Holocaust that inspired them. The concept of *prevention* has an underappreciated but potent role to play in these debates.

Medical applications that have been endorsed when drawing a line against genetic modification for enhancement purposes have traditionally been understood to be *treatments* for severe diseases. Many of the recent reports on human gene editing governance, however, go beyond treatment to include disease *prevention* as an ethically acceptable research goal,<sup>4</sup> which accords with precision genomic medicine efforts in genetic risk assessment and pharmacogenomics. But, in genome editing, *prevention* as a concept easily subsumes and conflates 3 interpretations of prevention goals, which I call *phenotypic prevention*,<sup>5</sup> *genotypic prevention*,<sup>5</sup> and *preventive strengthening*.<sup>3</sup> Each has ethical implications that should be disambiguated and clarified.

### **Phenotypic Prevention**

Under the banners of precision and personalized medicine, advances in human genome research are making it increasingly possible to detect pathogenic genomic variants before their problematic clinical phenotypes are expressed in specific patients. One of the hopes for human gene editing research is to use our new abilities to correct or replace those variants to forestall the clinical health problems they can cause. Phenotypic prevention of this sort is not an unusual goal for biomedical research. It reflects a goal shared by many medical interventions—from drugs to surgeries and biobehavioral interventions—that attempt to intervene early enough in the course of a patient’s malady to preempt the deleterious effects that the patient would otherwise experience. The only difference between preventive gene editing and the phenotypic prevention provided by other traditional medical means is the former’s promise to act earlier and more completely by intervening at the genomic level.

Achieving the goal of phenotypic prevention can raise a wide range of ethical questions, as the extensive literatures on ethical challenges in predictive genetic testing and somatic cell gene therapy document.<sup>6</sup> But as a translational goal for biomedical research, the close alignment of phenotypic prevention with biomedicine’s traditional ethical imperative to help specific patients avoid suffering gives it a widely endorsed *prima facie* moral authority. This acceptance is reflected in interventions ranging from newborn genetic screening programs and presymptomatic genetic testing for late onset disorders to efforts to use somatic cell gene therapy to forestall the clinical sequelae of cancer through “cancer vaccination” protocols.<sup>7</sup>

An important conceptual premise of phenotypic prevention that helps ground its medical moral authority is the assumption that its beneficiary is an identifiable individual patient whose suffering we have an obligation to address. For human gene editing protocols aimed at modifying the somatic cells of a particular patient to forestall deleterious effects of detected pathogenic variants, this criterion is easily met. But now that basic

gene editing research suggests that it might be possible to introduce the same preventive changes in *germline* cells on behalf of future patients, what does this imply?

Some would argue that gene editing interventions in early embryos that are designed to prevent diseases in later life are just as clearly examples of phenotypic prevention as newborn screening and—assuming they can be accomplished safely—should enjoy the same level of ethical acceptance. This, for example, was the line of argument that He Jiankui used to defend his effort to prevent HIV infection by editing the *CCR5* gene in human embryos.<sup>8</sup> Successfully defending embryo engineering as a form of phenotypic prevention, however, involves resolving a number of contentious philosophical questions about the identity, individuation, and moral status of early embryos as subjects of the intervention. For those who would rather leave those judgments to parents, it makes more sense to reframe the goal of such interventions as preventing the occurrence of a predictable health problem within a family rather than its manifestation within a particular patient.

### Genotypic Prevention

This understanding of the preventive goal of germline gene editing is even clearer when it is contemplated before conception, as interventions on gametes of prospective parents. The goal is to avoid the “vertical transmission” of pathogenic genotypes within families rather than the manifestation of pathological symptoms within a particular patient.<sup>9</sup> When scholars point to the availability of preimplantation screening and embryo selection to argue that embryo editing will almost always be unnecessary to prevent genetic disease, they are assuming that this form of prevention—genotypic prevention—is the goal under discussion.<sup>10</sup> But preventing transmission of particular genetic variants between generations is different than preventing the manifestation of a disease in a patient, with a much more contentious history.

Phenotypic prevention assumes the existence of a patient whose health problems might be forestalled. Thus, attempts to sort preventive interventions in genetic medicine into the traditional levels of primary, secondary, and tertiary prevention used in preventive medicine and public health usually locate examples of phenotypic prevention, such as newborn genetic screening, at the level of secondary prevention,<sup>11</sup> on the assumption that their aim is to interrupt an existing disease process in an affected patient rather than to prevent the inheritance of its causes. But the medical genetic interventions that get classified as primary prevention, such as **prenatal and carrier screening**, are not about keeping specific patients from acquiring disease-causing genes, as in infectious disease contexts. Instead, the goal of genotypic prevention is usually framed in terms of the interests of prospective parents by allowing them to avoid having children with foreseeable health problems. As disabilities scholars point out, this goal implies that one feature of genotypic prevention is always the tacit judgment that the burden of coping with new cases of genetic disease can outweigh any other value that individuals with the target genotypes might bring to a family or community.<sup>12</sup>

The tradition in modern clinical genetics has been to accept and support the reproductive decisions of prospective parents making well-informed, uncoerced decisions about their family’s welfare under the rubric of nondirective genetic counseling. If germline gene editing of gametes and preimplantation of edited embryos is ever feasible, respect for reproductive autonomy should equally extend to these technologies. However, interventions aimed at genotypic prevention are also often evaluated in social and public health terms, according to their ability to reduce the

incidence of genetic disability and disease in a population. For example, famous population-wide programs of genotypic prevention, such as Mediterranean carrier screening programs for beta-thalassemia or Tay-Sachs screening in Ashkenazi communities, are deemed success stories because they have reduced the number of community members with these conditions, not because they have enhanced parental autonomy.<sup>13,14</sup> Should this logic also apply to germline gene editing efforts?

Expanding the preventive goals of gene editing to include population interests broadens genetic medicine's responsibilities beyond the health needs of specific families to the next generation's aggregate population. This expansion makes it easy to import public health goals into gene editing and to subordinate familial decision making to population needs. Unfortunately, genotypic prevention already has an infamous track record along these lines in the excesses of 20th-century eugenic efforts to "purify and protect" idealized parts of the human gene pool from so-called contamination from immigration, interracial marriage, and the "feeble-minded."<sup>15</sup> The Holocaust remains history's grimmest warning against the idea that "racial hygiene" could mimic public health efforts against infectious disease to prevent the vertical transmission of particular genotypes in the name of health promotion. To the extent that germline editing is associated with professional allegiance to genotypic prevention at the population level, it inherits all the history, erroneous assumptions, and moral liabilities of this past, which dims the prospects for well-reasoned public assessments of its merits.

### **Preventive Strengthening**

Since the inception of human gene transfer research in the 1980s, public policy and professional opinion has discouraged researchers from pursuing interventions aimed at human enhancement because of the value judgments such pursuits would entail and the questions of justice they provoke.<sup>16</sup> Indeed, current proposals for governing human gene editing research largely stand by 1980s research restrictions on enhancement applications.<sup>2</sup> But current studies of genetic variants that are benign, functional, or even beneficial suggest another way in which gene editing might approach prevention: by enhancing normal traits to build resistance to disease. Should this vision of preventive strengthening trigger worries about human enhancement or be embraced as a legitimate translational goal for gene editing research?

Under the banner of "wellness genomics," scientists are already identifying natural genomic variants they see as helping their carriers resist disease, tolerate environmental extremes, and rebound from injuries more quickly.<sup>17</sup> When gene editors use these variants to try to upgrade such traits in nonhuman animals, they do so in the name of preserving health and draw analogies to vaccines as human immune system upgrades that help us combat infection by certain pathogens.<sup>3</sup> A recent human gene editing governance report suggests that research justified in terms of preventive strengthening of humans could also be used to justify translational goals of gene editing research.<sup>4</sup>

But preventive strengthening interventions can also raise the same concerns about equity and human nature that haunt nonclinical conceptions of human enhancement. Some preventive strengthening interventions, such as those promising to build resistance to anticipated injury or boost the ability to better tolerate sleep deprivation,<sup>18</sup> might confer serendipitous social advantages to those with such physical enhancements. A preventive strengthening intervention to increase muscle mass in muscular dystrophy patients, for example, could be used "off label" to enhance healthy

people who want more muscle mass for social purposes.<sup>19</sup> The result is an interesting challenge for gene editing governance that has yet to be addressed: if the same interventions can serve legitimate preventive goals in some patients and be used by others for enhancement purposes, how should their development and use be managed?

### In Common

To anticipate the ethical challenges that can attend the 3 senses of prevention distinguished here—phenotypic prevention, genotypic prevention, and preventive strengthening—the policies that govern human gene editing must appreciate their differences and implications. Each form of prevention sends us in a different direction for guidance: phenotypic prevention, to our emerging experience with preemptive genetic medicine; genotypic prevention, to our history of efforts to control gene flow; and preventive strengthening, to the translational pipelines of beneficial genomic variant research. What should integrate and ground these efforts is a renewed resolve to never again allow invidious genetic value judgments to undermine our commitment to our common human moral equality in the face of our biological diversity.

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**STATE OF THE ART AND SCIENCE: PEER-REVIEWED ARTICLE**

**How Should We Regard Information Gathered in Nazi Experiments?**

Arthur L. Caplan, PhD

**Abstract**

Immorally acquired information from Nazi experimentation or other sources infects the body of scientific and biomedical knowledge. Responding to this reality ethically means insisting on good teaching about the horrific history of such information's sources and careful deliberation about how it is referenced and described.

**Ethically Fraught Information**

I first confronted the issue of the morality of using information obtained from heinous experiments when I was teaching medical ethics at the University of Minnesota, Twin Cities in 1988. I received an email from Robert Pozos, then a physiologist at the University of Minnesota at Duluth and a nationally known expert on hypothermia. Pozos wanted to know my opinion on using information from experiments conducted at the Dachau concentration camp. Nazi scientists had, he told me, used 300 to 400 inmates of the camp as human guinea pigs to determine how people survive or die in extreme cold. They killed about 80 prisoners investigating brutal exposure.<sup>1</sup> Inmates, mostly Poles and Russians, were held for hours in tanks of bitterly cold water or left standing naked in freezing weather. Some were frozen to death in attempts to learn how much cold a human could endure. Others were brought near death, then subjected to warming techniques (ie, hot baths or body heat transference from “cuddling” female prisoners) to assess the possibility of recovery.<sup>1</sup>

Pozos told me that his own studies of cold exposure in human subjects, funded by the United States Armed Forces and private companies with operations in cold environments, had been conducted over many years with institutions' review and approval and subjects' consent. Responses to hypothermia available in the 1980s included out-of-body heart bypass to warm the blood, hot humidified air, and warm blankets.<sup>2</sup> But Pozos' studies of hypothermia got nowhere near temperatures that would kill or nearly kill his subjects. Only the Nazis had gone that far, summarizing their findings in reports published in various places, including in the Nuremberg War Trials proceedings.

Pozos thought information gathered in Nazi experiments had value and deserved conversation, so we agreed to hold a conference at the University of Minnesota to

consider whether and how to use hypothermia information gathered at Dachau and to review the roles of medicine in the Holocaust. At the time, I was unaware of a seminal article, published years earlier by a journalist, which addressed many questions that interested us.<sup>3</sup> Nevertheless, that conference was important: it was one of the first to examine Nazi experiments and a key factor in my researching and publishing my book, *When Medicine Went Mad: Bioethics and the Holocaust*.<sup>4</sup>

### **Distinguishing Applications' Justifiability**

During the conference, we considered a discovery I made that information gathered at Dachau about human beings' responses to hypothermia had been used by many military organizations in many nations,<sup>5</sup> including the United States. It was cited in military circles right after World War II, during a national obsession with the perceived threat from the Soviet Union and preparations for a Cold War that might turn hot (ie, what became the Korean War). Although it was not evident to me when Pozos reached out to me, I later appreciated that information believed by some to aid pursuit of war or national security or to aid responding to perceived terrorist threats presumably was deemed ethically justifiable to use. This rationale was offered by German scientists and physicians at the Nuremberg trials<sup>4</sup> and by many others. But not by me.

Invoking national security as a reason to use information gathered from immoral research is naïve. National security seemingly justified using information gathered by **military psychologists** who participated in interrogations using torture in Guantánamo Bay, Cuba, and in the US prison in Abu Ghraib, Iraq.<sup>6</sup> But neither national security nor war justify torture or use of information gathered from torturous interrogation. Nor do they either justify suspension of internationally agreed-upon **human subjects research protections**. However, some—including me 30 years ago<sup>4</sup>—argue that if there is no other way to save a life or lives, prevent disability, or prevent intense suffering, using immorally acquired information, such as that gathered about hypothermia in Dachau, is justifiable.

### **Lessons**

*Knowledge.* As I learned from studying the hypothermia experiments at Dachau, questions about using information gathered from grossly immoral experiments can easily morph into a debate about justifying past use or continued use but not about that information's wider effects on knowledge or how we should orient ourselves to knowledge arising from empirically or ethically flawed sources. Tainted information—gathered by Nazis at Dachau, US Public Health Service researchers at Tuskegee, or others—tends to be used if it has practical application. But tainted information infects the body of scientific and biomedical knowledge, silently becoming a part of that body. This *silent becoming*, however, should be regarded as ethically and epistemically problematic when the immorality of that information's source or means of acquisition is subsumed—rendered invisible—by the general legitimacy of that broader body of knowledge. Managing this reality responsibly and ethically requires insistence upon good teaching about the horrific history of this information's creation and careful deliberation about how it is referenced and cited in journals, books, exhibitions, clinical practice guidelines, award presentations, talks, and other sources.<sup>3,4,7</sup>

*Application value.* If information from the Dachau hypothermia experiments was useless, then the need to debate when, how, and where it should be referenced would evaporate. Like Pozos, many believed that information gathered at Dachau had value.<sup>1</sup> But others have argued that information gathered from sick, starving, and stressed



subjects is of little, if any, scientific value.<sup>1</sup> Reliance on better or alternative sources of information deemed useful has also informed discussion about using the *Atlas of Topographical and Applied Human Anatomy*, which depicts dissection studies on victims of Nazi atrocities, as an anatomical reference.<sup>8,9,10</sup> But alternatives to **immorally sourced information** do not always exist, as is the case for information gathered at Dachau from freezing (emaciated) persons to death. Yet even when legitimate scientists argue persuasively that immorally sourced information has scientific value, ethical questions about that information's use persist.<sup>8</sup>

*Moral standing.* Some survivors of Nazi concentration camps who were alive in 1989 attended the conference we organized in Minnesota. Some were subjects in experiments other than the hypothermia experiments, some were in concentration camps as children but were not experimental subjects, and some were children of Holocaust victims.<sup>4</sup> Although not all victims of Nazi experimentation were Jewish,<sup>4</sup> Jewish religious authorities shared their views during the conference, as did research ethics scholars, American physicians, British physicians, and members of the media. I even sought the opinion of my father who, as a medic in the 45th Infantry Division of the 2nd Chemical Mortar Battalion, was among the troops who liberated the Dachau camp.<sup>11</sup> In 1989, the views of Holocaust survivors were seen as carrying substantial, if not extra, moral heft. As the survivors and witnesses died, their opinions seemed to be less often invoked, which suggests the importance of their written or recorded opinions about what they experienced and believed.

*Description.* Questions about how to characterize information or its means of acquisition in Nazi camps had little influence on early debates about this information's use, but examples of important neglected questions that deserve consideration are these: Should observations of how people froze to death, for example, be described as *information* (as I've used the term in this article), *findings*, *data*, *torture*, *facts*, or something else? Should Nazi experiments, as I've been calling them in this article, be called *experiments*, *protocols*, *research*, *trials*, *barbaric exposure*, or something else? Should the camp personnel who administered or designed the experiments be called *scientists*, *German scientists*, *Nazi scientists*, *perpetrators*, *quacks*, *monsters*, or something else?<sup>7</sup> The language we use to represent what happened is ethically important for many reasons, including whether we place these nouns linguistically within or outside the scope of what we're willing to call *biomedicine*. If that enterprise is described as biomedical, its social and cultural authority and legitimacy are conferred upon what is described within its scope, so the normative significance of our descriptors underscores the importance of our obligation to be thoughtful, careful, and respectful in our word choices in this debate.

My own view is that the hypothermia experiments were conducted by expert German scientists who intended to create valid data for military application. So-called experiments in camps other than Dachau were carried out by inept sadists to maim and torture and do not merit description as *science* even when carried out by physicians. The history of medicine reveals innumerable instances of mainstream clinicians and scientists doing horrific things with the best techniques of their time to do what they believed to be important science, to generate what they intended to be data, and to produce what they hoped would be useful applications.<sup>10</sup> This history must be acknowledged if we are to grapple, as we should, with biomedicine's ethically fraught past.<sup>7</sup>

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### MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

#### Teaching Hard Truths About Medicine and the Holocaust

Tessa Chelouche, MD

##### Abstract

The Holocaust differs from other instances of mass murder in that it was medically sanctioned genocide. Modern health care ethics was born of the Holocaust, and this article describes numerous misconceptions about medicine's key roles in several events prior to and during the Holocaust. This article also illuminates lessons that should be formally integrated into all health professions ethics curricula.

##### Birth of Modern Health Care Ethics

Health care ethics is often taught using cases of health professionals' ethical transgressions in research and has been said to originate in the 1960s, in response to unethical experimentation.<sup>1</sup> Specifically, some have argued that health care ethics was born of Nazi experimentation abuses and the subsequent Nuremberg Code.<sup>2</sup> But these views reflect fundamental misconceptions, because health care ethics did not arise exclusively from Nazi crimes in human experimentation. Rather, modern health care ethics has its roots in what transpired prior to and during the Holocaust—the murder of 6 million Jews.

Unlike other instances of genocide, the Holocaust was unique because of Nazi health professionals' leadership in the conceptualization, design, and implementation of several murderous programs that led directly to extermination and torture of millions of people. As such, the Holocaust has been called the seminal event of the 20th century in the historiography of bioethics.<sup>3</sup> Medicine, of course, was not alone in supporting National Socialism, but it differed from the other professions by virtue of its explicit commitment to preventing human suffering. Medicine was abused to the extreme before and during the Holocaust, and today nearly every health care ethics issue (eg, value of human life, **dual loyalties**, power and authority, professionalism and ethics education) can be better understood by considering the Holocaust's legacies.

##### Lessons for Health Professions Education

*Eugenics.* As a scientifically and politically motivated attempt to improve humankind, eugenics existed in the first half of the 20th century in many countries, led by the United States.<sup>4</sup> In Germany, eugenics was called *racial hygiene* and modeled on the American eugenics movement.<sup>5</sup> When negative eugenics merged with German National Socialism, racism was medicalized to rid society of chronically ill people and others whose lives were considered unworthy, burdensome, and threatening to Aryan

“hereditary health.” The first German eugenic initiative was legal **coercive sterilization**, which progressed to the notorious “euthanasia” (medically sanctioned murder) program that was a next step on the path to the systematic murder of millions of people.<sup>6</sup> Students should learn this history, which informs current debates about care of the dying, the disabled, and people with minoritized **racial and ethnic identities** and about **genetics and reproductive health care**.

*Complicity.* It is a misconception that physicians were forced to comply with Nazi demands. It’s true that Nazi politicians needed physicians to implement eugenic programs, but physicians didn’t join reluctantly. Most joined eagerly, earlier, and in much greater numbers than other professionals.<sup>7</sup> Diagnoses by Nazi physicians were ascribed to those social and racial minorities perceived as “sick elements” threatening to “hereditary public health.”<sup>6</sup> Health professions students should explore possible reasons for physicians’ avid involvement in the Holocaust: obedience to state authority, group identity, abuse of professional power, and hierarchy placement.<sup>8,9</sup> Reflection on and discussion of these and other reasons can help prompt students’ considerations about maintaining integrity and balancing their obligations to individuals and communities.

*Evil was mainstream.* It’s also a misconception that physicians who joined the Nazi party were fringe elements of medicine. Despite German medicine being advanced and sophisticated, professionals from internationally revered institutions led and executed Nazi eugenic programs, including mass extermination.<sup>10</sup> Academic physicians practicing and teaching mainstream medicine made Nazi crimes against humanity possible and efficient. Students should reflect on the roles of professional pride, or hubris, in relation to appropriate applications of medicine’s social, political, and technological power.

*Nazi medical ethics.* Another crucial misconception is that German physicians “abandoned” medical ethics to execute Nazi goals. In fact, Nazi physicians had strict, detailed ethical codes that prioritized their obligations to the state over their obligations to individuals. This conception of ethics was rigorously taught, with Germany being the first country in the world to mandate ethics classes in every medical school. Although Nazi medical ethics allowed patients to choose their physicians and labeled billing for unnecessary procedures unethical, these traditional conceptions of ethical values applied only to Aryan, able-bodied patients. Individuals perceived as threatening to the “racial purity” of the state were excluded from protection according to Nazi medical ethics. Furthermore, Nazi medical ethics lectures were delivered in medical schools by practicing physicians, some of whom were active participants in the eugenic programs. Teachers were carefully chosen from within Nazi party ranks and students provided with a textbook detailing the key ethical obligations of Nazi physicians: (1) physicians are “health leaders” with authoritarian, paternalistic roles; (2) physicians should rid society of Jews, disabled persons, and others deemed unfit contributors to the state; (3) physicians must denounce care for “hereditarily inferior” people; and (4) physicians must sterilize, abort, and “mercy kill” to secure “racial purity and hereditary health.”<sup>11</sup> Reflection on these truths of Nazi medical ethics can illuminate how even ethics education can be undermined by state influence and other powers external to a profession.

*Limited scope of Nuremberg Trial.* The Doctor’s Trial at Nuremberg (1946-1947) and the ensuing Nuremberg Code have been regarded as epochal in health care and research ethics.<sup>12</sup> The trial was concerned mainly with human experimentation abuses and not with the broader range of Nazi medical crimes,<sup>13</sup> such as labeling some individuals’

“lives not worthy of living,” forced sterilization of 400 000 Germans with disabilities, and “euthanasia” of about 200 000 Germans.<sup>14</sup> One reason for the trials’ limited scope was because Germany was the first nation to have uniform human subjects research guidelines, which Nazi physicians flagrantly ignored. A 1900 Prussian law, which specified that vulnerable subjects should not be exploited, among other traditional research ethics principles, was the model for the Reich Health Council Circular in 1931.<sup>15</sup> Since victims of the Nazi’s infamously cruel experiments were perceived as subhuman, they were seen as outside their own research ethics’ applicability.<sup>11</sup>

*Nuremberg Code and human experimentation.* It has been argued that the Nuremberg Code applied only to Nazi physicians and not to modern medical researchers,<sup>16</sup> but this is false. Another misconception is that Nazi experiments were pseudoexperiments committed by crazed physicians; this is also false, as many of the Nazi experiments were accepted forms of science at the time, conducted not only in concentration camps but also in hospitals and clinics across Germany.<sup>17</sup> The physicians involved in Nazi experiments never apologized but defended their actions using reasons such as these: subjects had volunteered, war made individuals’ expendable to promote the good of the state, and subjects were doomed to die anyway.<sup>16</sup> Discussions with present-day health professions students should be held on the Doctor’s Trial and the ensuing Nuremberg Code and modern codes governing research, and students should reflect on the fragility of these codes under certain circumstances.

### **Medicine and the Holocaust Pedagogy**

Misconceptions about the breadth and depth of Nazi physicians’ involvement in the Holocaust might help some avoid confronting the acute horror of medicine’s complicity in crimes against humanity during the Holocaust. But these misconceptions must be corrected, as they contribute to neglect of the ramifications of the Holocaust’s legacies today. Failure to teach Holocaust history has also exacerbated almost universal ignorance of its relevance to health care and political life today.<sup>18,19</sup> Additionally, while modern health care ethics values, principles, codes, and regulations are based on lessons learned from the Holocaust, they do not explicitly state this indebtedness. The lessons of the Holocaust are complex and emotionally and cognitively challenging for teachers and learners, but discomfort does not justify their distancing themselves from the history of the worst human and professional impulses that the Holocaust illuminated. Medicine was powerful in the era of National Socialism in Germany, and it is powerful today. Professional power and hubris enabled collusion with a racist political regime,<sup>20</sup> and present-day clinicians are not immune to corruption, racism, anti-Semitism, genetic bias, and disrespect for human dignity.<sup>21</sup> Teachers and learners of health professions should become familiar with this legacy of the Holocaust, which offers great opportunities for growth.

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### MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

#### Cautions About Medicalized Dehumanization

Alexandra Minna Stern, PhD

##### Abstract

Critical lessons can be gleaned by examining 2 of the most salient relationships between racism and medicine during the Holocaust: (1) connections between racism and dehumanization that have immediate, lethal, deleterious, longer-term consequences and (2) intersections of racism and other forms of hatred and bigotry, including discrimination against people with disabilities; lesbian, gay, bisexual, transgender, and queer people; and social and religious minorities. When considered in the US context, these lessons amplify need for reflection about the history of eugenics and human experimentation and about the persistence of racism and ableism in health care.

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##### Racism, Medicine, and Dehumanization During the Third Reich

The murder of 6 million Jews and millions of other people in Nazi Germany was made possible by dehumanization on a pervasive and catastrophic scale. In her classic book, *The Origins of Totalitarianism*, Hannah Arendt analyzes historical conditions that gave rise to Nazism, arguing that an overriding impulse of Nazi ideology was to deprive its victims initially of their juridical and civil rights and next of their existential rights, ultimately denying perceived enemies of “the right to have rights.”<sup>1</sup> This process turned social and human beings into “bare life,” naked and exposed to the regime’s brutalities.<sup>2,3</sup> Nazi Germany, of course, was not the first dehumanizing regime. Archives of [colonialism](#), slavery, and war abound with examples of dominant powers using religious, moral, and scientific rationales and stereotypes to disparage and treat minorities as subhuman. Yet, during the Holocaust, health professionals and the awful ideologies they operationalized played an outsized role in dehumanizing and depraved medical practices.<sup>4</sup>

Health professionals’ complicity in the Third Reich has garnered significant scholarly attention and served as a negative example that can be—and has been—used in the development of bioethics and health justice.<sup>5</sup> One defining aspect of medicine during the Holocaust was its exhaustive infiltration and distortion by racism and racist



ideologies. During the Third Reich, dehumanization was on grotesque display in ubiquitous portrayals of Jews as parasites and vermin that required extirpation from the body politic.<sup>6</sup> Animalization worked in tandem with anti-Semitic presumptions that Jews were genetically inferior, incapable of full human essence. Family trees produced by Nazi geneticists often were accompanied by sinister and macabre representations of Jewish physiognomy and Jewish-Aryan intermixing.<sup>7</sup> This kind of dehumanization fueled passage of anti-Jewish laws starting in 1933—notably, the Nuremberg Laws of 1935 that stripped German Jews of citizenship and outlawed unions between Jews and those of “Aryan” blood.<sup>4</sup>

Nazi dehumanization pivoted around medicine and science. Nazi scientists devoted their careers to measuring Jews’ physiology and mapping their heredity, producing studies that displayed and intensified **underlying racist biases**. For example, Otmar von Verschuer, the director of the Division of Human Heredity at the Kaiser Wilhelm Institute for Anthropology, conducted research on twins in a quest to determine the heritability of conditions such as criminality, schizophrenia, and epilepsy.<sup>4</sup> To confirm Jews’ inherent defectiveness, he presented distorted results of these experiments in a professional journal and incorporated them into training for state physicians at the Kaiser Wilhelm Institute.<sup>8</sup> Verschuer’s eugenic studies were taken to the harrowing extremes of maiming and murder at Auschwitz by his student, Josef Mengele, who conducted lethal experiments on Jewish and Roma (Gypsy) twins, most of whom were children, to study heterochromia and to test how different “races” withstood infectious disease.<sup>9</sup>

### **Long Arm of Dehumanization**

*Nazi Germany.* The horrors of Mengele’s experiments at Auschwitz are a focal point for understanding how medicine and racism converged in Nazi Germany. Nazi clinicians enacted dehumanization on a wide scale during the entire Third Reich, infusing racist theories of genetic inferiority and superiority into daily health practices. As laws were promulgated to restrict Jews from social and political life in Germany, Nazi physicians were founding clinics where thousands of **people with disabilities** would be sterilized. The 1933 Law for the Prevention of Hereditarily Diseased Offspring authorized genetic health courts to sterilize women, children, and men “afflicted” with ostensibly inherited conditions, such as “feeble-mindedness,” schizophrenia, epilepsy, and alcoholism.<sup>10</sup> Over the next decade, an estimated 400 000 people were sterilized under this law.<sup>4</sup> Strikingly, sterilization led to euthanasia, performed initially in clinics—on children and later on adults—and ultimately on millions corralled into gas and kill chambers.<sup>9</sup>

Medicalized dehumanization evolved in large part out of disdain for people with disabilities and was interlinked with and fueled by anti-Semitism and racism. As such, Nazi logic was applied to a range of groups and intersecting identities, always denigrating those who fell outside the bounds of so-called Aryan purity. Jewish women “experienced dehumanization in distinct ways from men that specifically targeted their bodily integrity.”<sup>11</sup> Women were vilified as breeders of undesirables, as threats to Aryanism.<sup>11</sup> Gay men, and to a lesser degree lesbian women, were treated as vectors of sexual depravity, criminality, and illness; they were persecuted by law, unwittingly subjected to psychiatric experimentation, and assigned to brutalizing hard labor.<sup>12</sup> Medicalized dehumanization also affected the Roma (Gypsies), Jehovah’s witnesses, and political dissidents seen as traitors.<sup>9</sup>

*Limitations of the Nuremberg Code.* After the war ended, the Nuremberg Doctors’ Trial (1946-1947) held high-profile perpetrators such as Karl Brandt (Adolf Hitler’s personal

physician) accountable for the war crimes of human experimentation and genocide through mass euthanasia. Of the 23 defendants brought before the court, 20 were physicians; most were found guilty, including 7 who received death sentences and 9 sentenced to prison for terms ranging from 10 years to life.<sup>13</sup> The trial served as the impetus for the drafting of the Nuremberg Code, a postwar blueprint of bioethical principles intended to guide human subjects research ethics.<sup>14,15</sup> Although the drafting of the code was a pivotal moment in bioethics' history, its heavy emphasis on ghastly experimentation and euthanasia underplayed "the nonmilitary ideological and occupational motivations" of clinicians and scientists that permeated the discourse on racial hygiene in less dramatic yet insidious ways.<sup>16</sup>

*Postwar human subjects research.* The partial scope of the Nuremberg Code helps explain why coercive studies involving vulnerable human subjects proceeded unchecked in the United States even after World War II. Henry Beecher's game-changing 1966 article in the *New England Journal of Medicine* described the purpose, funding, and moral dubiousness of 22 ongoing "unethical or questionably ethical studies."<sup>17</sup> Yet neither awareness of the Nuremberg Code nor alarms raised by Beecher disrupted business as usual. The US Public Health Service Syphilis Study at Tuskegee, launched in 1932, tracked the course of untreated syphilis on Black men in rural Alabama while deceptively promising them free treatment.<sup>18</sup> This blatantly racist study continued for 40 years until a reporter broke the story as front-page scandal in 1972. Similarly, physicians carried out hepatitis experiments on children with disabilities at the Willowbrook State School in Staten Island, New York.<sup>19</sup> From 1955 to the early 1970s, a team of physicians intentionally infected minors with hepatitis to study the course of infection and evaluate the efficacy of gamma globulin injections to confer immunity. The perfunctory, vague consent forms that Willowbrook physicians asked parents to sign exemplified maleficence and coercion.<sup>19</sup>

*Mandatory sterilization.* Eugenic **sterilization**, which paved the way for the Final Solution in Nazi Germany, continued in the United States long after 1950. Between 1907 and 1937, 32 states and Puerto Rico authorized state health officials to sterilize those labeled defective and "unfit."<sup>20</sup> By the time these laws began to be repealed in the 1970s, more than 60 000 Americans had been sterilized.<sup>20</sup> Akin to Germany's sterilization laws (informed by California legislation), US laws were couched in terms of protecting the nation from unwanted disability and defectiveness and identified putatively hereditary conditions as sufficient indicators for reproductive surgery.<sup>21</sup>

Although no US laws were aimed at specific racial or ethnic groups, racism was refracted through the prism of mental disability, such that African Americans were sterilized disproportionately in North Carolina—most notably in the final decade of that program (1958-1968), when Black women, many of them single mothers, made up approximately 60% of those sterilized even though Blacks were roughly 23% of the population.<sup>22</sup> At the height of California's eugenics program—from 1920 to 1950—Latin men were 23% more likely than other men to be sterilized, and Latin women were 59% more likely than other women to be sterilized.<sup>23</sup>

### **COVID-19 and the Recalcitrance of Medicalized Dehumanization**

It is worth dwelling on the juggernaut of dehumanization, which enabled US health professionals in diverse settings to treat particular populations as subjects undeserving of autonomy or rights. In the United States, deep-seated racism, xenophobia, and homophobia facilitated clinicians' perpetration of dehumanization in the 20th century in

mental institutions, hospitals, prisons, and reformatories. But with the civil rights movements of the 1960s came questioning of authority and interrogation of medical paternalism, and the status quo began to fracture. By the 1970s, class-action lawsuits and congressional hearings held unscrupulous health professionals to account, and more robust bioethical policies, frameworks, and organizations emerged and solidified. In the United States, following the formulation and release of the Belmont Report in 1979,<sup>24</sup> the Nuremberg Code became less a guide than a relic.

Despite such strides in the field of bioethics, dehumanization is still expressed in bigotry and cruelty against Jews,<sup>9</sup> people with disabilities,<sup>10</sup> gays and lesbians,<sup>12</sup> and many with minoritized identities. Acknowledging the intersectional dimensions of discrimination and how biases amplify one another can shed light on contemporary incidents of medical malfeasance, such as the unauthorized sterilization of more than 140 women—the majority of them women of color—in 2 California women’s prisons from 2006 to 2010.<sup>25</sup> Many of these women were sterilized by a physician who opined that the money spent sterilizing inmates was negligible “compared to what you save in welfare paying for these unwanted children—as they procreated more.”<sup>25</sup> From 1989 to 2014, people with mental illnesses in many states saw restrictions on their civil rights, especially related to marriage and parenting,<sup>26</sup> underscoring the recalcitrance of eugenic stereotype of some as “unfit” to couple or parent.

The COVID-19 pandemic has laid bare not only the devastating **racial health inequity** that characterizes American society, but also the human costs of systemic racism, long-standing disinvestment in public health and infrastructure, and implicit racial bias in health care.<sup>27,28,29</sup> African Americans, Latin Americans, and Native Americans all have been infected and died of COVID-19 at disproportionately higher rates than Whites.<sup>29</sup> In Michigan, one of the states hit hardest during the early months of the 2020 pandemic, African Americans, who make up 14% of the population, constituted 40% of the fatalities as of May 2020.<sup>30</sup> The planning for health care rationing in intensive care units during projected COVID-19 hospitalization surges illustrates a persistent eugenic assumption that the lives of younger—presumably healthier—people are more worth saving than those of older people or people with disabilities or chronic illnesses.<sup>31</sup> Uprooting racism, ableism, and other forms of discrimination in health care will require a commitment to systemic transformation and constant reminders that complacency about dehumanization is not ethically or clinically acceptable.<sup>32</sup>

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## ART OF MEDICINE

### What Art Museums Can Teach Today's Clinicians About How to Orient Themselves to Their Professions' Roles in the Holocaust

Martina Lentino

#### Abstract

As products of the Enlightenment and Western European civilization, museums must acknowledge their ties to colonialism, empire, White supremacy, and structural exclusion. Museum practices that facilitate visitors' reflection on legacies of oppression encourage social and cultural growth and express organizational commitment to ethics and justice. This article discusses how the Art Institute of Chicago has reckoned with its own colonial legacies to begin dismantling them. Practices of diversity, equity, and antiracism in the museum field can inform how health professionals orient themselves to their professions' roles in the Holocaust.

#### Interiors of the 17th to the 20th Centuries

Millions of visitors to the Art Institute of Chicago (AIC) have experienced the **Thorne Miniature Rooms**, nestled in a custom-built gallery just off the grand staircase, which offer some of the AIC's most iconic and popular works of art. Every day, this gallery's narrow halls are packed with visitors of all ages who look carefully, curiously, and cautiously at the collection's 68 intricately crafted dioramas. Conceived by Mrs James Ward Thorne (né Narcissa Niblack Thorne), the Miniature Rooms were intended to serve as educational models, demonstrating period-specific interior decor and design.<sup>1</sup> Mrs Thorne had expertise in the decorative arts and collected miniatures for years throughout Europe and the United States. She directed a team of master craftspeople, artists, and architects to create European and American interiors from the 17th to the 20th centuries, a traditional **Japanese interior**, and a traditional **Chinese interior**.<sup>1</sup> They were exhibited globally prior to being gifted to the AIC by Mrs Thorne in 1941.<sup>1</sup>

One source of visitors' delight and curiosity is likely the rooms' unique capacity to inspire storytelling: the way the rooms are placed and illuminated makes them feel like tiny stage sets, poised for action. Take the **Virginia Kitchen, 18th Century**. The door is flung wide open, sunlight streaming in as though the house's inhabitants left the scene just as we come upon it. A little doll and a ball at the far right on the floor suggest a small child had just been playing with them. A fresh pie (maybe cherry?), waiting to be eaten, sits on the table by a plate and knife. The family's simple, perhaps joyful, life is easy for a viewer to imagine.

Upon closer inspection, however, something becomes more apparent, even uncomfortable: the rooms predominantly tell stories from homes where White people are protagonists. The *Georgia Double Parlor, c 1850*—with its beautifully upholstered chairs, lavish curtains, chandelier, and crown molding—models decorative schemes from the 1939 film adaptation of *Gone With the Wind*.<sup>2</sup> Viewers might imagine ladies and gentlemen taking tea and discussing pleasantries, and they might also envision Black people serving them, since the diorama invites us to picture a US southern plantation manor home. Although Mrs Thorne’s intention was to catalog taste, style, and design through impeccable craftsmanship, we must also consider how the rooms represent legacies of injustice, racism, and colonization. The Thorne Miniature Rooms, though beautiful and imaginative, are not neutral, empty scenes—they come with predetermined, period-specific histories, showing us a past that benefitted some and deeply wronged others.

**Figure. A30:** *Georgia Double Parlor, c 1850, 1937-1940, designed by Mrs James Ward Thorne*



The Art Institute of Chicago®. Gift of Mrs James Ward Thorne.

### **Tiny Rooms, Entire Museums**

In their seeming neutrality and telling of exclusionary histories, the Thorne Miniature Rooms can be regarded as microcosms of museums proper, for Western museums are tied to legacies of colonialism and White supremacy. Many major art and natural history museums in Europe and the United States were founded in the late 19th and early 20th centuries, mostly by White men.<sup>3,4,5,6</sup> Museums were established with the presumably generous aim of educating the public while collecting and exhibiting “the best of the best.”<sup>7</sup> For art museums, this meant acquiring works by established White men from Europe. This commitment, of course, led to a structural, institutionalized exclusion. Additionally, many museums were built in the neoclassical architectural style reminiscent of ancient Greece and Rome to resemble these so-called pinnacles of Western civilization.<sup>8</sup> Museums, as such, were not only founded by the powerful and

privileged, but also meant to occupy higher intellectual ground by seeking to educate the masses on relevance and beauty.

As a world-renowned home to a dazzling collection in all media from all over the world, the AIC is not exempt from these legacies. Founded in 1879, the museum moved to its current home in downtown Chicago in 1893.<sup>8</sup> The iconic Michigan Avenue building, designed by Shepley, Rutenfranz, and Coolidge in the Beaux Arts style (named for the École des Beaux-Arts in France) combined architectural styles from the Italian Renaissance with Greek and Roman decorative motifs.<sup>8,9</sup> Many European museums, cultural centers, and administrative buildings erected during this period were designed in this style.<sup>9</sup> The building is one of the only surviving structures from the World's Columbian Exhibition of 1893, which similarly utilized the Beaux Arts style to create a civic vision and celebrate the arrival of Christopher Columbus to the Americas in 1492 and to establish Chicago as a world-class city.<sup>8</sup> As such, the AIC's presence was inextricably tied to the celebration of empire building and colonization. Recognizing these ties to exclusionary histories, the AIC has taken important steps to acknowledge them and embrace an inclusive and equitable future as a civic and global institution.

### **Looking Back to Move Forward**

The AIC has made clear that it understands its obligation not only to the public it serves but also to the museum field at large. In June 2020, for example, in response to domestic and international Black Lives Matter activism, James Rondeau, president and Eloise W. Martin Director of the AIC, articulated a vision of the museum's future:

As we reflect on our past, we are accountable for our museum's legacy of white privilege and exclusion, not only in the representation of artists of color in our collection but also of those in our community who have historically felt unwelcome in our spaces. That legacy is antithetical to the museum we aspire to be. We have been investing resources, and will extend those commitments, to create meaningful change.<sup>10</sup>

These commitments have extended—and must necessarily extend—to all areas and all levels of leadership and not just to the work displayed or collected. In undertaking a massive overhaul of the museum's internal workings and external initiatives, the AIC is attempting to create a pervasive attitude and culture of equity, so that antiracism dialogues and decolonizing attitudes will be consistent, expected, and encouraged.

Additionally, in 2019, the AIC made an official acknowledgement to recognize that the museum occupies Indigenous lands:

The Art Institute of Chicago is located on the traditional homelands of the Council of the Three Fires: the Ojibwe, Odawa, and Potawatomi Nations. Many other tribes such as the Miami, Ho-Chunk, Menominee, Sac, and Fox also called this area home. The region has long been a center for Indigenous people to gather, trade, and maintain kinship ties. Today, one of the largest urban American Indian communities in the United States resides in Chicago. Members of this community continue to contribute to the life of this city and to celebrate their heritage, practice traditions, and care for the land and waterways.<sup>11</sup>

This statement has been followed up by AIC leadership's commitment to work actively with Indigenous populations that reside in the Chicagoland area—in particular, through a partnership with the American Indian Center of Chicago and through open dialogues with the Department of the Arts of the Americas, the curatorial department that displays Native American art at the AIC.

With respect to daily museum practice, the AIC's Learning and Public Engagement (LPE) Department works to develop learning strategies and enact practices that motivate and



promote access, inclusivity, and equity. Because this department interacts the most with the public and concerns itself with visitor experience, its goal is to create spaces in the museum where visitors will feel safe, engaged, and welcome. It is also LPE's prerogative to advocate for all visitors to the museum regardless of ability, race, ethnicity, or personal background. LPE aims to enact these values not only through tours and talks within the galleries, but also through large-scale programs, civic-minded initiatives, and exhibition planning.

Although a lot of work, learning, and unlearning remain to be done, the AIC continues to take powerful steps toward achieving equity in the museum profession, aspiring to the "highest ethical standards and practices" across the board.<sup>12</sup>

### From Museums to Health Care

Museums and museum holdings help frame historical and cultural narratives that visitors draw upon during their encounters with art—miniature and monumental—and in their everyday lives, perhaps to help make sense of their or their ancestors' roles in perpetrating or experiencing oppression. Museum professionals are obliged to model and advocate for antiracist thinking and decolonization of museum spaces and practices, just as health care professionals must find ways to orient themselves to their professions' earlier mistakes or atrocities or their own complicity in them. During the Holocaust, for example, eugenicists, particularly Nazi clinicians, wrought damage that ramifies and persists today. Like museums, health professions must reckon with their pasts in perpetuating injustice. Also like museums, health care organizations occupy positions of power and authority and are widely regarded as keepers of collective knowledge and histories. Our professional and organizational roles as social and cultural stewards of public and common goods of humanity and **advocates for equity** in the present and future demand reconciliation with our pasts.

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#### Editor's Note:

Visit the Art Institute of Chicago [website](#) or contact Sam Ramos at [sramos@artic.edu](mailto:sramos@artic.edu) to learn more about the museum's medicine and art programming. Browse the *AMA Journal of Ethics* [Art Gallery](#) for more Art of Medicine content and for more about the *AMA Journal of Ethics'* partnership with the Art Institute of Chicago.

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## AMA Journal of Ethics®

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### VIEWPOINT

#### A Call to Commemorate International Holocaust Remembrance Day, January 27, in All Health Science Schools

Matthew K. Wynia, MD, MPH and William S. Silvers, MD

##### Abstract

This viewpoint proposes why and how Holocaust Remembrance Day, January 27, should be honored in all health professions schools. A public letter, from which this viewpoint is adapted, has been endorsed by over 50 teachers of medicine, ethics, and history.

Learning about the **role of health professionals** in the Holocaust is critical to understanding contemporary bioethics. Yet, in recent years, only 22 of 140 North American medical schools (16%) required any teaching of this history.<sup>1</sup>

There are several reasons for this omission, but we believe the barriers can be overcome by an international initiative encouraging every health science school to commemorate the tragic legacy of health professionals' involvement in the Holocaust on the date of the liberation of Auschwitz, January 27, International Holocaust Remembrance Day. First, accreditors do not require that health sciences schools teach about the history of health professional involvement in the Holocaust, and health science curricula are already very tight. But an annual commemorative event is a nominal request and would reduce conflicts about appropriating existing curricular time. Second, the Holocaust was a uniquely medically driven genocide and its lessons are sensitive, complex, and **difficult to teach**; as a result, few faculty members are proficient teachers of this history and its lessons for today. But a once-a-year commemorative event means that schools would need to find just a single speaker per year capable of addressing this subject matter. Third, although lectures in health sciences training programs have given way to case-based discussions, the core historical facts about health professional involvement in the Holocaust require some didactic content delivery. Fortunately, guest lectures as special events remain popular, and a further pragmatic consideration is that an annual commemoration lecture of this type has the potential benefit of drawing the interest of donors who might not otherwise contribute to health sciences programs.

Of course, there are drawbacks to this idea, including that an annual commemorative event does not comprise a full curriculum on this complex and important history and its contemporary implications. Ideally, a commemorative event would spark additional opportunities for learning and reflection. There is also a possibility, if every school were

to adopt the idea immediately, that there might be an excess demand for the limited supply of effective lecturers all on the same day. But the experiences of several schools in developing commemorative programs for International Holocaust Remembrance Day suggest that an annual event can be supported through philanthropic gifts and is an effective starting point for teaching, reflecting on, and instilling lessons from this critical history for health professionals today.<sup>2,3,4</sup>

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**VIEWPOINT**

**The Nazi Analogy Muddles Our Thinking About Physician Aid-in-Dying in the US**

Holland M. Kaplan, MD

**Abstract**

What has become known in bioethics as “the Nazi analogy” likens a change’s potential to precipitate moral deterioration to Nazi atrocities of the mid-20th century. This analogy has been applied in physician aid-in-dying (PAD) deliberations by those fearful that a physician’s role in enabling a patient’s death is too similar to Nazi physicians’ roles in systematic murders during the Holocaust. This article suggests the importance of carefully distinguishing between when the Nazi analogy is aptly applied and when its use is limited to urging great caution about abuse or inequity.

**Slipping to the Bottom of a Slope?**

Physician aid-in-dying (PAD) is currently legal in 8 US states and the District of Columbia<sup>1</sup> and seems likely to become legal in other states. Thus, it is important to address concerns about PAD as subject to erosion of professional ethics like those espoused by executioners of Nazi state-sanctioned, physician-led genocide campaigns and protocols that were deftly propagandized as euthanasia.<sup>2,3</sup> Thoughtful, thorough, and sensitive comparison between PAD and Holocaust killing means considering tensions between collectivism and individualism in historical context. Questioning health professionalism, cultural and educational hierarchies, and social tendencies to represent *others* as socially and fiscally burdensome do indeed require that we interrogate present or future policies and practices in light of past policies and practices.

History suggests that clinicians can succumb as easily as anyone to what Hannah Arendt describes as “the banality of evil,” a kind of hyper-focus on one’s self or one’s work that normalizes commission of evil if it has become so routinized as to be unrecognizable as wrong.<sup>4</sup> In his testimony in the Nuremberg Doctors’ Trial, defendant Karl Brandt, a high-ranking Nazi physician, was asked whether the ultimate responsibility for the medical crimes that took place in the Nazi concentration camps should fall on the state or on the physicians. Brandt responded: “In my view, this responsibility is taken away from the physician because ... the physician is merely an instrument.... [T]he feeling of a special professional, ethical obligation has to subordinate itself to the totalitarian nature of the war.”<sup>5</sup> Today’s clinical trainees might also identify with the ease of responsibility abdication and **empathy erosion** when distracted or exhausted by long hours of study

and work.<sup>6</sup> We are right to worry about the social and cultural threat of clinicians' roles in patients' dying becoming banal or unworthy of close ethical scrutiny. Thus, we must deliberate on PAD only with apt analogies and carefully drawn distinctions.

### Relevant Changes

Regulation of US medicine and human subjects research has developed significantly since World War II, starting with the Nuremberg Code,<sup>7</sup> which led to national and international policy innovations that have enabled professional self-regulation and responded to ethical conflict and questions arising in health care service delivery and human subjects research. We have also cultivated awareness of how **hierarchy** and hyper-obedience undermine patient safety and patient care.<sup>8</sup> Such measures help reign in authority abuses in health care practice. In current practice in the United States, PAD takes place after careful discussion with a physician and patient. The trend to problematize hierarchy in medicine makes it more likely that clinicians and trainees would feel free to speak up if asked to perform PAD in a way that expresses exploitation.

### Equity Cautions

We must also be cautious about scapegoating if PAD becomes more widely legalized, particularly in US states with more diverse populations. Although studies of PAD's influence on vulnerable populations have not revealed disproportionately negative impact on these groups, they are based on small populations sampled over a limited period of time and might have only limited applicability in states considering PAD legalization.<sup>9</sup> Inequity in access to and quality of health care in the United States has potential negative implications for PAD, especially since patients with inequitable access to medical care are also likely to have subpar access to proper palliative care. Legalizing PAD in states where many do not have equitable access to palliative care could mean some members of marginalized populations seek out PAD prematurely. While this phenomenon would not approach Nazi-level atrocities, the analogy helps us remain vigilant and cautious about exacerbating inequity in good end-of-life care.

In the United States, elders are also commonly marginalized. Arguments in favor of discrimination in health care based on age are often justice based and focus on health care as a limited resource.<sup>10</sup> For example, Ezekiel Emanuel<sup>11</sup> describes elders as "faltering and declining." He notes that they do not "contribute to work, society, the world" and describes them as "feeble, ineffectual, even pathetic." The caution here is that **ageism** in health care certainly exists<sup>12,13</sup> and can negatively influence the quality of elders' care, so educational initiatives to eliminate ageism and other species of discrimination should be integrated into health professions training to prevent PAD's use in abetting inequity.

In sum, the Nazi analogy does not aptly apply to PAD in the United States today. But it does draw upon historically situated sources of fear that should inform how PAD legalization and implementation efforts account for health equity and social determinants of patients' vulnerabilities to discrimination.

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