



Tammes, P. (2019). Medical sabotage by Jewish doctors in Nazi-occupied Netherlands and Holocaust survival. *Medicine, Conflict & Survival*, 35(1), 4-11.
<https://doi.org/10.1080/13623699.2019.1589688>

Peer reviewed version

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[10.1080/13623699.2019.1589688](https://doi.org/10.1080/13623699.2019.1589688)

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Medical sabotage of Jewish doctors in Nazi-occupied Netherlands and Holocaust survival: a commentary

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Despite the erection of a Monument to Jewish Resistance in Amsterdam in 1988, Jewish resistance is rather a neglected subject in Dutch historiography on WWII. Some attention is given to Jewish participation in general resistance and to spiritual resistance, however, historians and the general public have not paid much interest in this matter.¹ One of the reasons given is that as Jews were regarded mainly as passive victims after WWII, there was less interest in their resistance.² Lately, there is some renewed interest in Jewish resistance.^{1,3,4} Van den Ende's study⁵ on medical sabotage - as a form of resistance - by Jewish doctors in the Netherlands during the Nazi-occupation 1940-45 might be placed in this context. However, she does not explicitly present her well-written book as such. Van den Ende, a doctor herself and a lecturer in public health, is interested in medical ethical norms under extreme circumstances. Her study focuses on shifting medical ethical norms and doctors' medical sabotage to avoid or delay patients being deported, while doctors themselves - because of their profession, were in a better position to survive the Holocaust. My commentary will describe and reflect on medical sabotage and its impact on medical ethical norms. Thereafter, I will reflect on the effect of medical sabotage on survival rates and discuss doctors' survival chances.

Van den Ende counted 534 doctors being classified as Jewish according to the Nazi-definition, which is having at least three Jewish grandparents or having two Jewish grandparents and married to a Jew or belonged to an Israelite congregation. This figure doesn't include about 125 German Jewish doctors who fled to the Netherlands during the 1930s, and still lived there in 1940. As their doctor's degree wasn't recognized and therefore most weren't allowed to work as a doctor in the Netherlands, these refugee doctors aren't part of her case study. The book title's imperative 'Don't forget you are a doctor', though, originates from a conversation between a young Jewish German doctor and his father suggesting a doctor should always obey the profession's ethical norms. To what extent doctors obeyed traditional medical ethical norms and how these norms were transformed during the occupation years is a key theme of the study.

Based on archival material and ego documents such as diaries, Van den Ende describes the change in medical ethics among doctors during the Nazi-occupation from a deontological approach (the intrinsic value of the medical activity) to a teleological or utilitarian approach (goal directed medical activity). However, the paternalistic view among doctors hardly changed, resulting in doctors being reluctant to go into hiding or to commit suicide as in that case they would leave their patients in medical hands of someone they might not know or trust. Their patient list could only contain Jews from May 1941, as Jewish doctors were not allowed anymore to treat Gentile patients.

After Jewish doctors were restricted in their practice, and those working as civil servants were dismissed in 1941, a medical ethical issue arose in early 1942. Jewish doctors were asked to examine 'unemployed' Jewish men aged 18-45 for employment in Dutch labour camps. As in the 1930s unemployed men had to work in camps to be entitled to benefits, this Nazi-regulation was purely aimed at Jewish men of whom most had lost their job because of other Nazi-regulations. If Jewish doctors refused, national-socialist minded doctors would do these examinations. Therefore, the Jewish Council was of the opinion it would be better to keep these examinations in one's control. Although, the general opinion among Jewish doctors was to refuse to conduct these examinations,

some of them were willing to do as they agreed with the Jewish Council's view. The Jewish doctors conducting these examinations were able to declare more than half of the men unfit, an unusually high proportion; soon national-socialist minded doctors took over the examinations. As declaring people unfit for work or military service when they weren't happened in other conflicts as well, during the Nazi-occupation it was a clear move away from medical ethical norms such as to provide truthful medical reports requested by a third party.

From July 1942 onward, regular deportation of Jews from Westerbork transit camp to Nazi camps started. Jews could be exempted for several reasons including medical certificates or illness statements [*attests*]. Some doctors produced many of these statements for their patients. As one doctor wrote in his diary: " ... the doctor stopped being a physician: patients just ask him: how can I be sick?" This same doctor coined the term 'attest factory' which conflicted with the medical norm at that time to be reluctant in providing such's statements.

After a while these illness statements weren't enough anymore to be exempted from deportation. Only those who couldn't be transported on medical grounds or were '*Transportunfähig*' could be exempted. The medical department of the Jewish Council encouraged doctors in writing such statements and thereby institutionalised medical sabotage. Medical reports needed to be attached to illness statements and patients had to send these to the *Zentralstelle für jüdische Auswanderung* in Amsterdam [The Central Office for Jewish Emigration], a Nazi institution regulating deportation of Jews, resulting in breaching the professional confidentiality of a doctor. Many doctors, both Jewish and Gentile, providing these medical reports didn't mind this breach as long as this procedure prevented patients from deportation. Some doctors provided support to patients who wanted to commit suicide or undergo abortion, departing from the general norm at that time that doctors should be pro-life guardians (differing from today's views on assisted dying and abortion).

As other options were limited, Jews continued to explore medical opportunities to postpone or escape deportation. The focus shifted from primary care to secondary care. As being admitted and staying in a hospital or other (mental) health institutions was regarded as being safe from deportation, a few doctors took a next step: damaging or cutting healthy patients and using other medical tricks to simulate sicknesses or medical conditions, violating the 'primum-non-nocere'-principle [first, to do no harm]. However, sterilisation of intermarried Jews – a eugenic Nazi-regulation allowing them to stay, was a bridge too far; only two Jewish doctors were willing to do these operations. A rise in hospital admissions was the result and to keep patients in hospitals patients became, for example, medical assistants blurring the boundary between patients and medical staff. However, in early 1943 nearly all Jews staying in and working for medical and care institutions were transported to Westerbork. In this transit camp medical sabotage continued as it had its own hospital.

A German Jewish ophthalmologist already breached medical ethical norms in 1940 after Germany occupied the Netherlands by purposely misdiagnosing German soldiers who were then sent home. As Van den Ende didn't include these refugee doctors in her study, it remains unclear how German Jewish doctors were connected through networks or memberships to the Dutch Jewish doctors and to what extent these doctors, who experienced Nazi-persecution in Germany, influenced Dutch doctors to conduct medical sabotage.

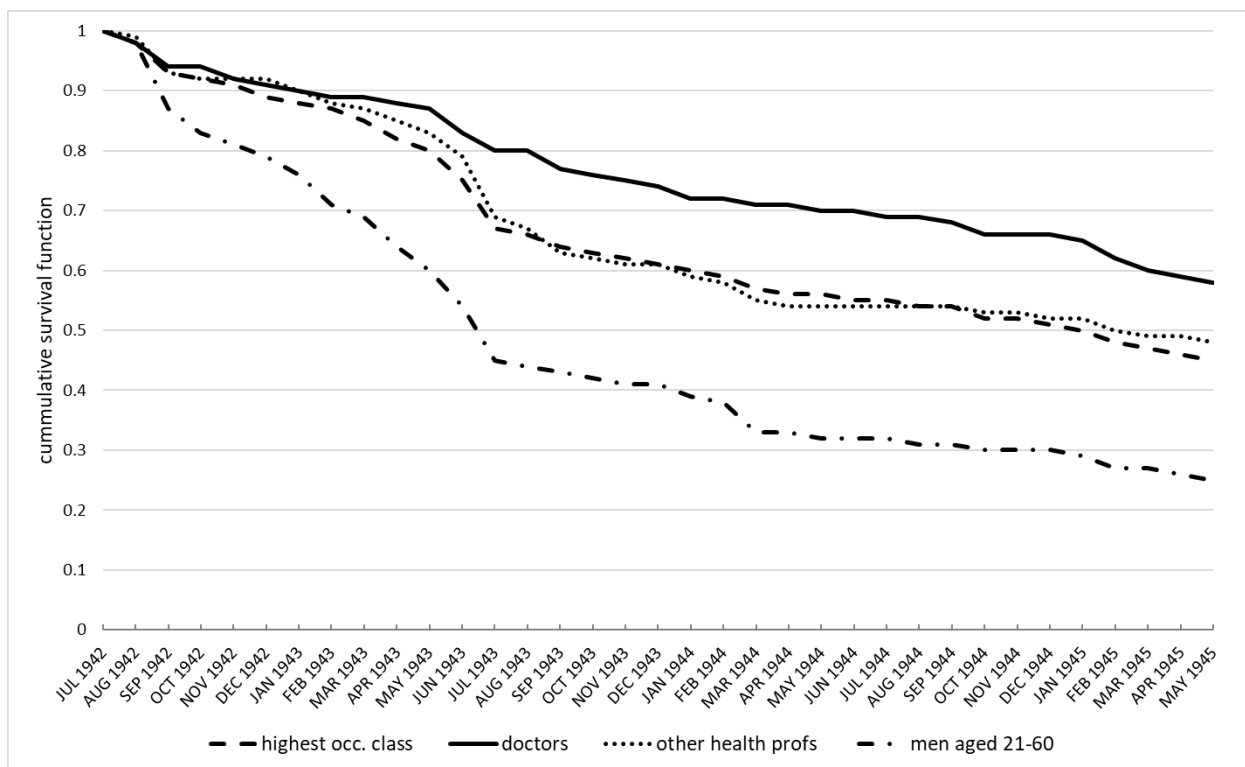
The question arises how many Jewish lives medical sabotage saved. Van den Ende states in her conclusion that doctors holding on to traditional medical ethical norms might not have gotten the best outcome, referring to Jewish doctors refusing medical examinations of Jewish men in the first half of 1942. However, it is unclear whether medical sabotage resulted in reduced risk of being killed. We don't know, for example, whether men declared unfit for work in Dutch labour camps may in fact have been better off in the end than those who were selected. What is clear from Van den Ende's study is that doctors could delay or postpone deportation of patients. We might assume that some of these patients had higher chances of surviving the Holocaust or at least reduced risk of death because they managed to find a hiding place or were deported later to less deadly camps such as Bergen-Belsen and Theresienstadt compared to, for example, Auschwitz. Medical sabotage might have then reduced risk of death for individuals, but likely not reduced the overall victimization rate as deportation trains needed to be filled and 'sick' persons were replaced by others.

Van den Ende provides more statistical details about the survival chances of doctors themselves. Based on the data she has collected, she arrives at 211 Jewish doctors who did not survive the Nazi-occupation [p. 324]. Throughout her book she mentions numbers of deportees, returnees, locally killed and suicides, though they do not total 211 victims; the inclusion of a table including numbers by 'type of victim' would have helped the reader. Likewise, when she mentioned a total of 86 returnees, the numbers she gives for Auschwitz (14), Bergen-Belsen (15), and Theresienstadt (41) total 70 [p. 324]. Historian Presser mentioned Jewish doctors trying to save a Jew being wounded after a failed execution in Westerbork in September 1944⁶; this raises the question how many doctors were liberated in Westerbork. Earlier on in her book, she estimated about 150 Jewish doctors had been in hiding (p. 272), claiming that relatively more doctors hid than estimated for the Jewish population as a whole (28% vs 17%). It is unclear how she arrived at this number to support her claim, while an explanation for the higher hiding rate among doctors is lacking. Possibly, Jewish doctors were given more time to find hiding places as many were given (temporary) exemptions from deportations because of their occupation, position or intermarriage status while connection with (pre-war) non-Jewish patients might have given them better opportunities to find a hiding place, though this latter point is not addressed by Van den Ende. These factors together with a relatively higher number of re-classified Jewish doctors – that is not being defined as a 'full' Jew anymore, and a relatively high number of returnees contributed to a substantial lower victimization rate among doctors (211 or 40% of 534) compared to the overall Dutch national of Jews murdered, 73%⁷. However, it's unclear whether victimization rate among doctors differed between regions, as local victimization rates vary hugely.⁸

Furthermore, Van den Ende argues that doctors had a lower victimization rate than lawyers, another elite group. She could have made other and better comparisons when having used the municipal Nazi-registrations of Jews including sociodemographic characteristics using occupation, nationality, marital status, and gender. Based on the Amsterdam Nazi-registration list of May 1941 linked to post-war victimization lists⁹, I calculated victimization rates for A) 229 Dutch doctors [Van den Ende counted 261], B) 267 other Dutch health professionals such as dentists, pharmacists, nurses etc., C) 1136 Dutch Jews with occupations in highest social class, D) 19616 Dutch Jewish men aged 21-60 as most doctors were males in that age range, respectively 42%, 52%, 55%, and 75%; included in these rates are Jews killed by Nazis in- and outside Nazi camps and suicides, though excluded are Jews who died of natural causes, such as 8 doctors. Besides, of the 26 German doctors 16 were killed (62%), suggesting being a doctor was less protective for German refugees.

Calculated survival functions for these groups presented in Figure 1 suggest that risk of death was lowest for doctors from March 1943 onwards. Between March and July 1943 deportation trains from the Netherlands went to Sobibor, a death camp only. The decrease of the survival function for doctors is less steep around that time, indicating that doctors were relatively less often deported. Jews occupying other health professions show a similar survival function as Jews with occupations in the highest social class. These results support Van den Ende's explanations for Jewish doctors' better survival by being deported later, being deportation to less deadly camps, and the role they could play within camps. Besides, the data for Amsterdam show the relative number of mixed-married Jews was higher among married Dutch Jewish doctors (19%) than for other married Dutch Jews (15%), as signified by Van den Ende, resulting in relatively more of them (initially) being exempted from deportation. These data also show that 26% of all Jewish doctors in Amsterdam compared to 8% of Dutch adult Jews in Amsterdam had abandoned Judaism, i.e. were no longer a member of an Israelite congregation, suggesting Jewish doctors had more connections with non-Jewish communities and thereby better opportunities to survive the Holocaust. These findings suggest that next to being a doctor other sociodemographic factors were of importance in surviving the Holocaust, such as the degree of assimilation.

Figure 1: Survival function of Dutch Jews in highest occupational class, Jewish doctors, other health professionals, and men aged 21 to 60 living in Amsterdam in 1941.



Van den Ende's book might go beyond a historical case study as it provides potential ethical lessons for current doctors and medical students. A general moral lesson is that ethical norms are not fixed but can (and perhaps should) be adapted to circumstances or events people face. This is what happened regarding several ethical norms within the Dutch health profession during the Nazi-

persecution of Jews, in an attempt to save lives, such as producing reports declaring patients 'unfit' while fit. Doctors still face this dilemma today.¹⁰ The generally accepted paternalistic view among doctors in those days, however, didn't change and resulted in doctors staying with or helping patients under very difficult and life-threatening circumstances. According to Van den Ende, paternalism among doctors resulted in altruistic behaviour, labelling it 'paternalistic altruism'. Relating this type of altruism to other types of altruistic rescuers¹¹ or the altruistic personality¹² could have put Jewish doctors' altruistic behaviour in perspective and broadened the discussion on altruistic motives of helping Jews to survive the Holocaust. The move towards patient agency and shared decision making and the negative connotations of paternalism for medical health professionals today might result in ignoring some of its positive elements. There is still evidence of paternalistic altruism among general practitioners (family physician) practicing, for example, in deprived areas¹³. As a doctor, Van den Ende should have elaborated on this in her chapter on 'History offers moral lesson'.

Acknowledgement: I like to thank Gene Feder for commenting on an early draft.

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