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August 1989

The Meaning of the Holocaust for Bioethics

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Recommended Citation

Caplan, A. L. (1989). The Meaning of the Holocaust for Bioethics. Retrieved from http://repository.upenn.edu/bioethics_papers/40

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The Meaning of the Holocaust for Bioethics

Abstract

Despite the central role played by the events leading to and during the Holocaust in bioethical discourse, bioethicists have paid surprisingly little attention to examining the nature of the crimes committed in the name of medicine and science, the moral rationales used to defend these crimes, or to the specifics of history that do and do not find parallels in current public policies and moral disputes. The Center for Biomedical Ethics at the University of Minnesota convened a conference on May 17-19, 1989, to examine some of these issues. The conference focused on five major themes: What role did mainstream medicine and science play in the creation of the Nazi state; What did German scientists and physicians think about and do in the name of eugenics and euthanasia; What moral rationales were used to justify the involvement of medicine - and science with genocide, euthanasia, and racism; Should scientists and physicians make any use of information obtained from barbarous experiments conducted on innocent persons in concentration camps; and What is the appropriate use of metaphors and analogies to the Nazi era in contemporary debates in bioethics?

Comments

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Publisher URL: <http://www.thehastingscenter.org>



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The Hastings Center Report, Vol. 19, No. 4. (Jul. - Aug., 1989), pp. 2-3.

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The Meaning of the Holocaust for Bioethics

Despite the central role played by the events leading to and during the Holocaust in bioethical discourse, bioethicists have paid surprisingly little attention to examining the nature of the crimes committed in the name of medicine and science, the moral rationales used to defend these crimes, or to the specifics of history that do and do not find parallels in current public policies and moral disputes. The Center for Biomedical Ethics at the University of Minnesota convened a conference on May 17-19, 1989, to examine some of these issues. The conference focused on five major themes: What role did mainstream medicine and science play in the creation of the Nazi state; What did German scientists and physicians think about and do in the name of eugenics and euthanasia; What moral rationales were used to justify the involvement of medicine and science with genocide, euthanasia, and racism; Should scientists and physicians make any use of information obtained from barbarous experiments conducted on innocent persons in concentration camps; and What is the appropriate use of metaphors and analogies to the Nazi era in contemporary debates in bioethics?

Arthur Caplan, director of the Center for Biomedical Ethics, Robert Proctor, a historian at the New School for Social Research in New York, and Benno Muller-Hill, a geneticist at the University of Cologne, all argued that the racist underpinnings of Nazi ideology were firmly rooted in the racial hygiene theories prominent in German biology during the 1920s and 30s—long before Hitler came to power. Proctor argued, moreover, that Nazism was not a philosophy espoused on the fringes of German medicine and science. Rather, it was an ideology with roots deep in the mainstream of German biology, medicine, and public health, and German physicians enrolled in the Nazi party at a rate three times higher than any other profession.

IN BRIEF

Jay Katz, professor of law at Yale University, reviewed the atrocities perpetrated by Nazi *scientists* in the name of *scientific* research. Katz maintained that the ability to undertake murderous science was grounded in five norms: Obedience to authority; a commitment to racial superiority; a concern for the security and well-being of the state in time of war; a belief in the importance of scientific progress; and an ethos of professionalism that held that patients' interests were best served by trusting their doctors. Katz indicated that these latter two norms still linger in the contemporary scientific and medical research enterprise and threaten to erode respect for persons as subjects or patients in the interest of advancing knowledge.

Caplan reviewed the moral rationales advanced by Nazi physicians at the Nuremberg trials. He noted that the German physicians who administered the euthanasia program, supervised mass genocide, and conducted brutal experiments on Jews and other groups in concentration camps grounded their actions on utilitarian principles. The state was justified in demanding the sacrifice of the minority to advance the interests of the majority—only those “doomed to die” were selected for research involving lethal experiments. Moreover, total war demanded both complete obedience to legitimate state authority and conformity

with the requests of the state to obtain knowledge that could advance the war effort. Caplan noted that the doctrine of informed, voluntary consent that emerged in the Nuremberg Code and later in the Helsinki Declaration was a direct response to these attempts at moral justification of genocide.

Ruth Macklin, professor of bioethics at the Albert Einstein School of Medicine in New York, indicated there are important parallels between the rationales used to justify Nazi euthanasia programs and current arguments. But, she argued, conceptual caution must be exercised in seeking parallels since not all instances of termination of treatment constitute euthanasia. For the most part, Nazi policies involved active and involuntary euthanasia while contemporary debates focus on voluntary acts of either active or passive euthanasia. Moreover, the moral justifications given by Nazi doctors for active euthanasia often differed from those invoked currently. However, Macklin noted that German physicians were particularly concerned about wasteful social expenditures on persons they viewed as not “cost-worthy.” She maintained that the most dangerous basis for slipping down the slope to abuse is when economics and ethics are systematically confused.

Perhaps the most emotionally trying portion of the conference centered in the ethics of using information obtained from innocent persons in concentration camps. Robert Pozos, a physiologist at the University of Washington, argued that Nazi research on hypothermia, while cruel and often fatal, was conducted in a manner capable of producing useful, important, and potentially life-saving results. Such experiments provide the only available source of information about exposure to fatally cold temperatures. Pozos's claims provoked a heated and often passionate response. Two survivors of medical experiments at Auschwitz, Susan Seiler Vigorito and Eva Kor, argued that to use any data from Nazi experiments was to be complicit with absolute evil and lend dignity to the crimes. Others maintained that if the information could save lives, it ought

to be used, while Robert Berger, a survivor who became professor of surgery at Harvard, questioned the claim that the findings from hypothermia experiments had any scientific validity or were the sole source of information about exposure to cold temperatures.

No consensus emerged about the ethics of using Nazi findings. But it did become clear that the issue of whether Nazi science should be used or cited is misstated. Nazi data and the claims of Nazi science in areas such as genetics, physiology, pathology, anthropology, and psychiatry have in the past been studied, cited, and absorbed into mainstream science with little comment. It is important to ask why the question of using the findings of Nazi science did not surface until four decades after the collapse of the Third Reich.—**Arthur L. Caplan**



Searching for International Consensus

A group of thirty-five physicians and ethicists from ten countries has produced "The Appleton Consensus: Suggested International Guidelines for Decisions to Forgo Medical Treatment" (published in the March edition of the *Journal of the Danish Medical Association*). The guidelines apply to decisions in four different categories: (1) competent patients or patients who executed an advance directive before becoming incompetent, (2) previously competent patients, who have not issued an advance directive, (3) patients who have never been competent, (4) decisions in any of these categories significantly influenced by scarcity of medical resources.

The first section affirms that life-prolonging treatment should not be imposed on patients against their will; that advance directives by competent patients to reject treatment should be respected, that even while respecting treatment refusals, institutions have an obligation to continue to offer supportive care; and that requests, including advance directives, to continue life-prolonging treatment should also be respected except in certain specified circumstances—one of which is scarcity. In regard to requests for active euthanasia, the statement affirms in four terse sentences that there are conditions under which such requests may be justified; that this does not necessarily mean that such requests should be honored; that doctors have an obligation to "provide a peaceful, dignified, and humane death with minimal suffering"; and that at this time it would be "against the public interest" to legalize the "intentional killing of patients by physicians." This portion of the statement reveals important areas of disagreement from two directions. Three signatories dissented, claiming that active euthanasia is not only contrary to the public interest, but a violation of basic morality. Several other signatories felt that it was not clear, especially in light of several recent polls in the U.S., that legalizing euthanasia would in fact be contrary to the public interest.

For decisions about patients who were once competent but are not now competent and who have not executed an advance directive, the statement affirms the desirability of discovering in so far as possible what the patient would have wanted done. If efforts fail to reconstruct reliable substituted judgment, the statement endorses reliance on a best interest test (defined as "what would most generally be thought to advance most such patients' interests"). The examples of interest it might be presumed "most such patients" would endorse omits any reference to simple continuation of life. Indeed, the signatories specifically reject "the simple vitalist assumption that prolonging life is always in a patient's interests." They affirm that active euthanasia, "as distinguished from forgoing treatment that is deemed inappropri-

ate, has no place in the treatment of permanently incapacitated patients." On the other hand, the statement affirms (with five dissents registered) that patients in a "reliably diagnosed" persistent vegetative state (PVS) can have "no self-regarding interest," and that life-prolonging treatment in such cases may be discontinued.

The statement affirms the necessity of setting reasonable limits in providing life-prolonging treatment for patients who have never been competent, specifically endorses the "weighing of the ratio of benefits and burdens" as a tool in assessing such limits, and catalogues the interests that may conflict and may require protection in these decisions. However, decisional discretion guided by the clinical wisdom of a trustworthy doctor more than any "layers of external mandatory audit" will be most valuable in interpreting those limits and interests and resolving those conflicts.

As the signatories themselves acknowledged, the section addressing decisions influenced by scarcity is the document's weakest part. However, three very important areas of agreement appear: (1) the recognition of the inevitability of scarcity and the necessity to make choices between alternative uses of scarce resources, (2) the recognition that those choices should be open and undisguised, and (3) the endorsement of cost-effectiveness analysis as an indispensable tool in responsibly addressing problems of scarcity.—**John M. Stanley**

[Offprints of The Appleton Consensus can be obtained from John M. Stanley, Lawrence University Program in Biomedical Ethics, Box 599, Appleton, WI 54911.]

