

Confronting Medicine during the Nazi Period: Autobiographical Reflections

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Abstract

This essay describes why, having started my professional life as a physician, I chose to make research and teaching on medicine during the Nazi period the focus of my work, and why I am now leaving this field. Confronting medicine during this period has been a transformative experience for me. This confrontation did not occur in a single, circumscribed event, but rather in a continuous process related to my personal life as a German and a number of experiences during my medical education and career as a physician in German medical institutions. The result for me was a profoundly changed image of medicine and professional medical organizations. This essay highlights some of the formative experiences and describes the associated questions and changes in my evaluation of modern medicine in general.

This essay is an unusual one for me, completely different from all others I have written as a physician and medical historian. For the last twenty years, medicine during the National Socialist period has been one of the main focuses of my professional work. I have done detailed research on eugenics and racial hygiene, on the emergence of the modern understanding of euthanasia and programs of systematic patient killing, as well as on human subjects research in concentrations camps and psychiatric institutions. In addition to my specific community of medical historians, I have addressed physicians, historians, medical students, and other audiences, and I've been invited to lecture internationally on the related issues. Although the topic was (and is) a strong personal concern for me, I have now decided

to turn to other topics in medical history without, however, completely abandoning the questions related to medicine during the National Socialist period. During this transition, Shelly Rubinfeld asked me to explain why, having started my professional life as a physician, I chose to make medicine during the Nazi period the focus of my professional work, and why I am leaving the field.

To put it in a nutshell: Confronting medicine during the Nazi period has been a transformative experience for me not only as a physician, but also as a citizen. This confrontation did not occur in a single, circumscribed event, but rather in a continuous process related both to my personal life as a German and to a number of experiences during my medical education and career as a physician. In spite of some doubts about if and how I could meet Shelly Rubinfeld's expectations, I accepted his challenge and responded with this brief biographical account highlighting some formative experiences and the associated changing images and evaluations of medicine that may explain why this particular period in the history of medicine was (and is) so important to me.

Medicine appealed to me as a highly interesting and rewarding field when I left high school at age 18. I remember explaining my choice of medical school in an application letter for a grant, listing three reasons for this decision: I could help suffering patients and do "good" work; I could systematically look into the universe of the human body and study the structures and processes constituting man as a living organism; and I would have legitimate and privileged access to the broadest imaginable range of people and social contexts that otherwise would be out of reach for a "normal" middle class person. When I made this choice in the second half of the 1970s, the medical profession had a thoroughly positive image, and what I saw, read, and heard of medicine suggested that there was an even brighter future to come, both for the field of medicine itself, and—with medicine's help—for humanity.

Because my father was a physician who specialized in laboratory medicine, I had very early experiences with the everyday life of a medical doctor. He had his own practice in

Heidelberg, offering diagnostic services to medical practitioners and hospitals of all kinds in a wide region of southwest Germany, including university departments that required special tests. Before we reached our teens, my two brothers and I accompanied our father in the evenings or weekends to his practice. We were fascinated by the laboratories with their technical equipment and strange smells. Not only could we look at a drop of our own blood or an autumn leaf under the microscope, but we could also observe our father doing some laboratory work, like checking the growth of bacterial cultures after defined intervals or reviewing preliminary diagnoses of stained pathological tissue specimens prepared by his assistants. We also stood beside him when he signed outgoing reports in the evenings, eagerly listening to his comments on the “cases” or on his physician-colleagues. Long before leaving high school, I knew at least a dozen types of bacteria, their growth patterns in special culture plates, and their susceptibilities to antimicrobial drugs, and I was able to do a differential blood count.

For me, however, the most intriguing aspect of my father’s profession was his contact with people. For example, a shepherd outside the town looked after a wether and some sheep that belonged to my father, and every now and then, he collected blood from the animals that he needed for certain specific investigations. This blood collection was always an occasion for coffee and a chat with the shepherd, and I loved it when I had a chance to accompany my father on these visits. He also had patients with chronic illnesses like diabetes who could come to his practice for regular blood or urine checks, but he preferred to visit them in their homes, including those in the poor areas of Heidelberg’s old town center. I looked forward to school holidays because then I could come with him to the exotic worlds of people that otherwise neither I nor my friends would ever have access to. My father also talked to people on these visits, learning about their living conditions and debating public affairs and politics. The patients and their families appeared to like him, invited him for coffee, and occasionally

gave him presents like a freshly baked loaf of bread or cake or a big basket of just harvested cherries or apples. What a wonderful job!

Soon after commencing medical training, however, I became more and more disillusioned. Apart from an obligatory short course in medical psychology, the first two years of medical school were filled with laboratory work and accompanying lectures on material that we could readily read about in textbooks. Our professors expected, apparently, that we students learn the natural sciences as *the* relevant grounding of any medical work. But where was the sick human being in this kind of medical education, the suffering patient with his perceptions and interpretations of his body and his symptoms, with his biography and social relations?

Two big exceptions to the focus on the natural sciences were the facultative seminars on medicine and literature and on ethics in medicine, organized by the medical historian Dietrich von Engelhardt. Using novels and other literature, he addressed a broad spectrum of views, perceptions, and interpretations of human life, body and mind, birth and death, and normality and deviance. The implications of potential attitudes and behaviors of both patients and physicians concerning these issues were probed and fully discussed.

After the experiences in my father's laboratory, and the recognition of the priorities in the medical curriculum, I decided early during my studies to "really" learn about science in medicine. Therefore, I began research for a doctoral dissertation in my third year of medical school. I did not want to work with animals for ethical reasons or with statistics because of a concern about reaching inadequate conclusions from amalgamated numbers representing some aspect of the reality of human existence or suffering. I chose an immunological topic: to search for specific antigens or antigen patterns to differentiate in the laboratory among the various clinical forms of acute leukemia, which involved testing blood samples from leukemic patients with a range of naturally occurring human monoclonal antibodies.

Developing laboratory methods was tricky and, at times, intellectually challenging. I also found the long hours in the laboratory tedious, boring, and sometimes annoying—the antigens and the instruments appeared to have a life of their own and did not behave as I wanted or expected. I realized that generating scientific knowledge in the laboratory was not as direct and rational as I had assumed; instead it often involved tinkering, improvisation, contingencies, and impactful social dynamics among the laboratory personnel. I began reading about the processes of bricolage analyzed in the laboratory fieldwork of the anthropologist Bruno Latour in the Jonas Salk Institute for Biological Studies (Latour & Woolgar, 1979).

After these disillusioning experiences with experimental laboratory work, I searched for another kind of academic medicine, one that systematically takes account of the patient as a unique human being living in a specific network of social relations that influenced the way he or she encountered his or her suffering. I had read that general practice was a distinct and obligatory subject at British medical schools. Hoping that this discipline might offer a different approach to patients than in the body- and laboratory-centered medicine we were taught at Heidelberg Medical School, I decided to spend a year at Glasgow University Medical School.

Another reason for my decision to go abroad was personal: My father, who was responsible for my positive image of medicine, increasingly gave me cause for questions and doubts. We had been taught in school about National Socialism, the persecution of the Jews, and the atrocities committed during World War II. I realized that my father, born in 1907, had been in his mid-20s when the Nazi party was elected to power in 1933 and that he had been an ambitious young doctor in his early 30s when World War II started. During the early 1940s, my father was the deputy director of Heidelberg University's Institute of Hygiene. He told us that in the absence of its director, Professor Ernst Rodenwaldt, *Generalarzt* and chief physician of the German army who served in North Africa under General Erwin Rommel, he

was responsible for surveying the hygienic conditions in the Heidelberg region. My father also told us that Rodenwaldt had been a great scientist whom he much admired. Now I found out that Rodenwaldt had not only been a renowned bacteriologist and specialist in tropical medicine, but also one of the most prominent German racial anthropologists and a fervent supporter of racial separation and the sterilization laws (Eckart, 1998). After the war, the American occupational officers dismissed Rodenwaldt and my father from their academic positions (Eckart & Gradmann, 2006).

This dismissal raised irritating questions: What was my father's attitude toward the Nazi party and its politics? Had he been involved in the eugenically motivated Nazi "hereditary health policy" that included the identification and sterilization of those supposedly suffering from hereditary disorders? Had he been involved in anti-Semitic activities? What had he known at that time about the Holocaust, and what did he think about it after the war? And why was he forced to end his promising academic career immediately after the war and begin a private practice?

I turned to my father for answers in the early and mid-1970s. My father evaded any clear responses, pretended not to remember, and occasionally became verbally aggressive—a behavior I had never seen before—and finally withdrew more and more, refusing any coherent reply. He developed increasing apathy, difficulty with concentration, forgetfulness, and mood changes, and we slowly realized that he had a progressive illness that psychiatrists ultimately diagnosed as dementia.

In the beginning, my father's evasive reactions to my and my brothers' questions made me furious. Later, when we realized that his behavior was part of a disease process, we were very frustrated but abstained from further direct questioning, and I chose to find other ways to explore my father's past. But on a deeper level, I experienced a profound unsettledness: The personal knowledge that I had of my father as a cultivated and intelligent physician, interested in other peoples' lives and well versed in history, music, and philosophy,

completely contradicted the possibility that he was involved in medical atrocities or, more generally, in ideological activities infringing on the rights and well-being of other people. How could I reconcile these two fundamentally different images of my father?

I gathered more disquieting information. After Rodenwaldt's dismissal by the American occupational forces in 1945, he was initially classified in the denazification process as "involved [in Nazi activities] to a minor degree" [*Minderbelasteter*]. Following an appeal in 1948, the judgment was changed to "not guilty," and he was reinstated as provisional director of the Institute of Hygiene, retiring in 1951 with all the rights and pensions of a full professor.¹ On the occasion of his death in 1967, the university and the Heidelberg Academy of Sciences honored Rodenwaldt in spite of his activities in racial anthropology and racial hygiene. Until 1998 a large institute of military medicine and hygiene of the German army in Koblenz was named after him. How, then, were the quite different post-war developments regarding my father to be understood?

After a 32-month military internment by the American occupational forces, my father was also classified as "involved to a minor degree," but this judgment was not altered any more. Although Rodenwaldt supported my father's attempt to regain his former position at the university in 1948, it was not successful (Eckart & Gradmann, 2006, p. 717). Did that mean that my father had done more "wrong" (whatever that might have been) than Rodenwaldt himself? This question caused me considerable irritation and led to the decision to look more thoroughly into what had happened.

For me, both Rodenwaldt's and my father's biographies illustrated that physicians who had successfully acted in congruence with Nazi health and population policies were not one-dimensional monsters, but were appreciated and honored by their patients and colleagues in the post-war period. This was a deeply disconcerting thought. Rodenwaldt and my father

¹ On the de-Nazification procedures at Heidelberg University, including longer passages on Rodenwaldt, see Remy (2002).

also had apparently practiced scientifically sound medicine (in their view) during and after the war. Did that not imply—at least to them—that the principles and rationalities of medicine during the Nazi period had not been fundamentally different from the post-war period? Was it possible that scientifically coherent medicine was compatible with inhumane, indeed, atrocious effects?

At that stage, however, I was not able to find answers to these questions; I needed more distance, spatially and emotionally, but I was determined to research these issues later. During my year at Glasgow University, my father died. Although other concerns, including the completion of my medical studies and the dissertation project, moved into the foreground, I was now gripped by an interest in the history of medicine. In the 1980s, triggered by the German television-series *Holocaust* (1978–79) and the film *Shoah* by Claude Lanzman (1985), a rapidly growing public interest in the exact circumstances and the developments leading to Nazi atrocities and the Holocaust coincided with my personal motivation to learn more about the role of medicine during this period.

In Glasgow, I was fortunate to get to know another kind of medicine. Stimulated by the teaching of Hamish Barber and David Hannay in the department of general practice and primary care, I decided to compete in a student research project in general practice. I did two extensive electives, one with a Glasgow general practitioner working in poor areas with unemployment rates up to 20 percent and one with the only medical practitioner on the Isle of Tiree, the most remote island of the Inner Hebrides off the west coast of the Scottish mainland. The project involved the study of the impact of life events on the well-being of individuals and on the occurrence of minor psychiatric illness in the general population using semi-structured interviews with a representative sample of probands in the local communities. The fascinating experiences in this project strengthened my feelings about the impact of social and cultural factors on the development and course of diseases, on the prevention of diseases, on illness behavior, and on the care of patients.

Back in Heidelberg, while completing my medical degree and the dissertation, I made further irritating discoveries at my medical school. Rumors implied that Hans-Joachim Rauch, a long-retired professor of forensic psychiatry, had been involved in unethical research on psychiatric patients during the Nazi time, but apparently, he had never been prosecuted for these activities. Some of my fellow students and I, therefore, were surprised to see the university and the medical school organize festivities to celebrate this distinguished medical scholar—as they saw it—on his 75th and then, in 1989, his 80th birthday. Rauch had not only been a much appreciated academic teacher and researcher after the war, but also one of the most prominent expert witnesses in forensic psychiatry in southern Germany's courts. It was, however, also clear that in the beginning of his career during the war, he had been a resident and junior lecturer at the Heidelberg University Department of Psychiatry under the notorious Professor Carl Schneider. It was already known by the late 1940s that Schneider had played a key role in the program of patient killings both as an expert advisor for the initial central *Aktion T4* “euthanasia” program and as the coordinator of human subjects research on euthanasia victims (e.g., Platen-Hallermund, 1948; Mitscherlich & Mielke, 1947/1949). Schneider had been arrested by the Americans in the immediate post-war period and then committed suicide in prison. Now it dawned on me that after his death, Schneider may have been a welcomed scapegoat both in post-war narratives on Nazi psychiatry in general and in the Heidelberg psychiatry department in particular, diverting attention from broader contexts and colleagues.

Rauch maintained that he had had nothing to do with the atrocious activities of Schneider. But had Schneider really acted in complete isolation within his department? What kind of research had actually been done there? What had Rauch and other faculty in the psychiatry department and the Heidelberg medical school before and after 1945 known about these research activities and Schneider's role in the broader programs of patient killing? After all, my father had been a member of the faculty until 1945. Even if Rauch or my father had

not been directly involved in any barbarities, had they tried after the war to find out exactly what had happened in their immediate institutional surroundings? Had they addressed the responsibilities for and implications of the atrocities committed in their medical school in any relevant way?

Although I was looking for indications of self-reflection in the post-war period by either Rauch or my father, I found none. Nor were there any indications that the Heidelberg Medical School had undertaken any systematic investigations. As a consequence, the positive image I originally had of my father as an engaged, cultivated, and patient-friendly physician and the positive image that existed of Rauch in the public sphere as a medical scientist and legal expert advisor were profoundly put into question for me. I also saw that the implications of such questions were much broader than the behavior and culpability of individual doctors: If physicians, university medical schools, and professional medical organizations in Germany in the post-war era had not confronted the origins and the full range of atrocities committed by their colleagues prior to 1945, then something was deeply flawed with the ability or willingness for self-reflection by the medical profession. This reluctance to confront the Nazi past of medicine was not necessarily limited to Germany. For example, in later visits in Britain or in Switzerland where one of my brothers worked as a medical resident, I observed a “shortcut” response when the topic came up, usually a quick explanation that only a few fringe and fanatic Nazi physicians had been actively involved and that the rest of the profession had suffered from outside pressure by the regime. I knew that the behavior of Rauch, Rodenwaldt, and my father did not fit into this simple picture, and I had the impression that nobody really wanted to look into the relevant history in more detail, perhaps from fear of the unflattering, broader implications for medicine.

After graduation from medical school and completion of the doctoral project, I began studies in cultural and medical anthropology. This decision was not only a result of my interest in the social and cultural contexts of medical thought and practice, but also a chance

to get some distance from medicine proper in order to rethink what I really wanted to do as a physician. After completing a master's degree, I looked for a clinical discipline in which the biographical and social contexts of an individual's illness would be taken into account in a systematic way and found psychosomatics and psychotherapy. I took a position as lecturer and resident in the Department of Psychosomatic Medicine and Psychotherapy of Heidelberg Medical School, a department founded in 1950 by Alexander Mitscherlich, the official observer delegated by the West German Chamber of Physicians to the Nuremberg Doctors' Trial. His great awareness of both the subjectivity of the patient and the political dimension of medicine was a guiding legacy for some of us working there, including Waltraud Kruschitz, a psychoanalyst and consultant in charge of the outpatient services of the department.

In September 1989, on the occasion of the 50th anniversary of the German attack on Poland and thus the beginning of WW II, Waltraud, Sophinette Becker (a Frankfurt psychologist and former member of the department), and I organized a public conference to discuss the conditions leading to the war and, in particular, the post-war implications for German society using a kind of socio-psychoanalytic perspective. The reactions both in the department itself and in the medical school were overwhelmingly critical. For example, the newly appointed professor and chair of the department was very uncomfortable with our "political" activities, and he explicitly distanced himself from any broader social application of psychoanalytic theory and the legacy of Mitscherlich. We were urged to declare that the conference was our private initiative and that, while the event took place in departmental rooms, the department had nothing else to do with it. I was telephoned at home by a number of mostly elderly professors, acquaintances of either my father or my half-brother (also a member of the faculty) whom I did not personally know, to warn me about inconsiderate and imprudent political activities.

All this again illustrated that the Nazi period and its aftermath were particularly sensitive but not quite clear dimensions of medicine in the late 1980s. I wondered to what

degree these dimensions affected not only the recollections and self-images of individual physicians and institutions, but also the content of medical knowledge and practices or the structure of medical institutions. Waltraud and I looked into the history of our department and the findings were eye-opening. It turned out that the founding of the department was closely related to the Nazi past of Heidelberg University and its medical school, its closure in 1945 and comparatively early re-opening (in contrast to other universities) by the American military government. Mitscherlich, one of only few politically “untainted” members of the medical faculty and short-term minister in the government of the American-occupied zone, was needed by representatives of the university for its re-opening. The university and medical school were, therefore, reluctantly prepared to yield to Mitscherlich’s requests for a psychoanalytically inspired psychotherapy department separate from psychiatry, which he argued was both too biologically oriented and also discredited by its involvement with the patient killings. The new discipline would differ from the other somatic disciplines by systematically looking into the psychological and social dimension of organic diseases. With external support from the Rockefeller Foundation, the new Department of Psychosomatic Medicine and Psychotherapy, the first academic unit of its kind, created a therapeutic approach radically different from either psychiatry or internal medicine, and it became a model for the institutionalization of similar departments, also separate from psychiatry, at almost all medical schools in West Germany.²

While researching the history of my department, I joined an already existing group of (then) medical students who looked into the history of the Heidelberg psychiatry department during the Nazi period, particularly the psychiatric research in the context of patient killings and the roles of psychiatrists Schneider and Rauch. After overcoming obstacles to gaining access to various archives, another disquieting picture emerged. Using patient files and

² A considerably revised and extended English version of an original German publication (1991) on this department may be found in Roelcke (2004).

physicians' correspondence for our analysis, we demonstrated that the psychiatric research practice was not the work of a few fanatic and irrational Nazi doctors: The research question posed by Schneider and his group, namely the differential diagnosis between genetic and acquired forms of clinically identical psychiatric conditions, was completely rational and in tune with scientific debates of the time. What is more, judged by the scientific standards of the time, their methods were up-to date, if not innovative (Roelcke, Hohendorf, & Rotzoll, 1994). However, the subjectivity and the suffering of the patients was completely neglected in the first phase of the investigations on living probands, and the killing of the patients for immediate correlation of clinical with postmortem findings was an obligatory part of the research. We also documented that Rauch had played a crucial role in the research process, as had three other psychiatrists with remarkable post-war careers either in academic contexts or in the German army (Hohendorf, Roelcke, & Rotzoll, 1997; Roelcke, Hohendorf, & Rotzoll, 1998).

We also discovered an institutional link between the deadly research at the Heidelberg psychiatric department and the elite German Psychiatric Research Institute in Munich, an institute of the prestigious Kaiser-Wilhelm-Society, which had been a model for the Institute of Psychiatry in London in the 1920s. Further investigations elucidated broader issues. The director of this Munich institute, Ernst Rüdin, who was the president of the German Association of Neurologists and Psychiatrists until 1945, had been a fervent eugenicist and expert advisor for the Nazi sterilization policy (this had been known before), but, at the same time, he was considered an internationally leading figure in the field of psychiatric genetics and epidemiology. For example, as late as the eve of WWII in 1939, he was invited to be a plenary speaker to the World Congress of Genetics in Edinburgh. What is more, scientists who today are considered founding fathers of psychiatric genetics in the United States (Franz Kallmann), Britain (Eliot Slater), and Scandinavia (Eric Essen-Möller) were all post-doctoral

researchers at Rüdin's institute during the Nazi period.³ After Kallmann emigrated from Germany in 1936 (due to his Jewish origins) and Slater and Essen-Möller returned to their native countries, they had slightly modified, but not given up the eugenic motivations for their medical genetic research.⁴ Finally, it turned out that Rüdin himself had supported the deadly genetic research on children in Heidelberg from the budget of the German Research Institute, and had himself situated this research within the broader measures aimed at the killing of handicapped children (Roelcke et al., 1998; Roelcke, 2000).

All this (and similar historical research by colleagues) implied that the dominant post-war images and narratives of the atrocities of Nazi medicine were quite inadequate. In fact, I found that the issues involved were not specific for medicine during the Nazi period but had much earlier origins and broader implications: Backward scientists and fervent Nazis were not the only ones propagating and practicing eugenics (or racial hygiene, the term commonly used in Germany and Scandinavia).⁵ Rather, up until the 1940s, many, if not most of scientifically up-to-date medical geneticists in Germany, Scandinavia, Britain, and the United States were motivated by eugenic/racial hygienic concerns. The rationale for their genetic endeavors was a scientifically grounded biological improvement of the population.

Similarly, the programs of systematic patient killing were not the result of an ideological craze invented by Nazi politicians, and imposed on physicians. Rather, these

³ For the Munich institute as an international "Mecca" for young researchers in psychiatric genetics and epidemiology, see Roelcke (2006, 2013).

⁴ For example, Kallmann (1938b) talked of the "danger of the development of new schizophrenic cases" arising from the "unions" of heterozygous carriers of the supposed genes: "From a eugenic point of view, it is particularly disastrous that these patients not only continue to crowd mental hospitals all over the world, but also afford, to society as a whole, an unceasing source of maladjusted cranks, asocial eccentrics and the lowest types of criminal offenders. Even the faithful believer in the predominance of individual liberty will admit that mankind would be much happier without those numerous adventurers, fanatics and pseudo-saviours of the world who are found again and again to come from the schizophrenic genotype" (p. 105). He concluded that "there should be legal power to intervene, in addition to the general eugenic program of the biological education of all adolescents, marriage counsel, obligatory health certificates for all couples applying for a marriage license, and the employment of birth control measures" (page 113). See also Kallmann (1938a); Slater (1948); Roelcke (2013a).

⁵ In the understanding of the time, racial hygiene (or eugenics) was focused on scientifically based studies of and interventions in one's own population to protect or enhance the biological-genetic quality of that population/folk body/"race," whereas—in contrast—racial anthropology looked into the (supposedly biological) differences between distinct populations ("races") in order to protect a particular race by prohibiting the mixing with other races.

programs had been initiated by leading psychiatrists and pediatricians, and they were a logical and radical extension of ideas propagated widely by German and American physicians beginning in the late nineteenth century. These physicians argued that certain groups of people, such as chronic psychiatric patients or severely handicapped newborns, were not fully human. Supposedly, due to their mental incapacities, they were not able to suffer, and they constituted a burden to their families and communities. Physicians further argued that medical experts were able to judge the “value” of such “life” and, after a thorough evaluation by a state committee, these experts should be mandated to recommend and implement the termination of lives of low value. These pre-existing ideas were put into practice in the “Third Reich”: Physicians in close cooperation with Nazi institutions pursued a radical and efficient “deliverance” of the collective *Volkskörper*, or German people’s body.

Furthermore, the cases of atrocious human subject research were not, at closer look, the activities of a few fanatic and sadistic doctors acting beyond any standards of science. Rather, the research questions pursued in most cases were up-to-date and, in part, related to military questions during wartime. Scientists of international reputation, including Nobel prize winners such as Adolf Butenandt and Richard Kuhn as well as representatives of prestigious research institutions, were directly or indirectly involved in this research.⁶ As a matter of fact, rational and brilliant medical scientists searched for research settings with the least regulations or where research subjects had no rights. In these contexts, scientists could pursue the answers to their research questions without regard for the well-being or even the lives of their probands.⁷ Research subjects were treated exactly like animals, as is illustrated in an exemplary way by the term *Versuchskaninchen* (experimental rabbits) used by physicians in the Ravensbrück concentration camp to describe their objectified

⁶ For a short overview of the core findings and implications, as well as further reading, see Roelcke (2010). On Butenandt and Kuhn, as well as the involvement of many other distinguished scientists of the elite Kaiser-Wilhelm-Society, see Heimet al. (2010).

⁷ The search for deregulated places for research and a value hierarchy that prioritizes the production of new knowledge over the well-being of research subjects may be found internationally throughout the twentieth and early twenty-first century. For recent examples, see Angell (1997) and Rothman (2000b).

prisoners/human subjects (Weindling, 2004; see also Chapter 4 in this book). This kind of research not only completely neglected the probands' well-being, but it also systematically excluded the impact of the subjectivity, the quality of social relations, and the biography of a patient on the origin, symptomatology, and course of the suffering individual's disorder, a tendency apparently inherent in a body-centered medicine that had created considerable discomfort for me as a medical student.

A further irritating point for me was the behavior of physicians towards the “new state,” as the “Third Reich” was called in contemporary terminology. More than 50 percent of German physicians became members of the Nazi party or one of its affiliated organizations, such as the SS (*Schutzstaffel*) or SA (*Sturmabteilung*) (Forsbach, 2006, pp. 39–40). This is a much higher percentage than found in other, comparable academic professions such as lawyers or teachers, and points to a particular affinity of the medical profession for the regime. Conversely, this percentage is a clear indication that physicians were not forced to join—more than 40 percent of physicians were not party members. In fact, historical research has documented the existence of a range of possible behaviors in all fields of medicine. For example, although the “Law for the Prevention of Hereditarily Ill Offspring” made the reporting of patients with potential genetic disorders to the regional health offices mandatory, an exemplary study illustrated that only a small percentage of physicians in private practice followed this law, in contrast to physicians in public service or academic medicine who were much more willing to comply. Physicians who did not comply with the law did not experience any negative consequences (Ley, 2004). Similarly, as far as we know, individual physicians were never coerced to participate in human subject research⁸—rather, physicians themselves provided the initiative for almost all such research. Taken together, these findings imply that physicians acted much less in response to direct outside pressure than broadly assumed, and much more out of a tendency to adapt to the expectations of those in power or in possession

⁸ The only known exceptions were prisoner physicians who were forced to assist in atrocious research.

of career resources. Thus, there was some degree of leeway for individual physicians to choose how to act (Roelcke, 2006). Again, this pattern of adaptive or opportunistic behavior toward those in power is not at all specific for the Nazi context, but may be ubiquitously found in many other medical contexts.

Armed with this knowledge, I realized that medicine during the Nazi period was a particularly radical manifestation of problematic potentials in modern medicine in general. Thus, looking at Nazi medicine, it appears to me, we are not seeing something peculiar and specific to National Socialism. We are instead presented with an opportunity to study in microscopic detail the central features and dynamics of such problematic thinking, practices, and attitudes that are less visible but always present in medicine.

This growing insight, developing over time from my confrontation with Nazi medicine, led me to devote twenty years of my professional life to explore related questions. I also sought to bring the findings and conclusions to the attention of colleagues and medical students and to encourage (together with other colleagues) medical institutions and professional organizations to confront their Nazi past (e.g. Kolb, Weindling, Roelcke, & Seithe, 2012). I found that the decades of refusal by both individual physicians and medical organizations to confront this past, to acknowledge extreme forms of wrongdoing, and to investigate their origins, were an extreme expression of a broader tendency in the profession not to admit mistakes and not to investigate the genesis and mechanisms of malpractice as described, for example, by David Rothman (2000a).

In sum, for me, confronting medicine during the Nazi period became a process of deep and continuous irritation with powerful repercussions and implications. At the core of this process was an emerging awareness of the persistently problematic potentials present in modern medicine, potentials that may become manifest in adverse economic, social, or political contexts, such as severe recessions or war. I had assumed that a systematic study of medicine and the Holocaust might “vaccinate” contemporary medicine against the temptation

to behave badly: Exposing medical students and professionals to the choices made by Nazi physicians might help develop mechanisms for the early detection of similar moral hazards and the avoidance of unethical decisions, and thereby safeguard the physical integrity and well-being of the weak and suffering.

Why then, one might ask, have I decided to turn away from these topics in my professional work? As I now see it, several factors contributed to this decision: First, the continuous occupation with medical atrocities, the responsible physicians, their motivations and rationalities, and the suffering of victims did not lead, as one might assume, to habituation and inurement toward the dehumanizing and often brutal facts. On the contrary, my feelings of shock and shame have increased over time, especially at historic sites. For example, every semester for the last eight years, I have gone with medical students to the psychiatric asylum and euthanasia memorial in Hadamar. My feelings about the “banalities of evil” embedded in the everyday life of this small German town—the provisions for the arrival of the patients earmarked for euthanasia, their final walk to the gas chamber disguised as a shower room, and the crematorium—have intensified and become more terrifying as I detect additional details with each visit.

Simultaneously, while the emotions evoked by the atrocities have intensified, talking about the historical events and their implications has become more and more repetitive and even tedious. I realize that in spite of a continuously growing number of well-researched publications on the topic, many physicians, medical students, and the broader public still cling to the simple explanations that have dominated so many decades of post-war narratives about medicine and the Nazi period, narratives that place blame and responsibility on political forces and a few ideological Nazi physicians. Persistent adherence to these false narratives allows us to characterize Nazi medicine as a perversion of inherently “good” medicine, the kind of medicine that physicians learn and practice today. In contrast, history shows the inherent ambiguity of medicine itself, and the moral frailty of physicians and medical

organizations. Therefore, physicians, medical organizations, and all other individuals and groups involved need to continuously strive to practice medicine in a way that is first and foremost orientated to the well-being of the suffering individual. I realize that it is becoming tiring and even frustrating for me to argue against this naïve, idealistic view of medicine. I have come to the conclusion that it is time for a younger generation of medical historians to develop their own analytical approaches to and narratives of Nazi medicine as well as to create new ways of communicating their insights.

Finally, I find that the core concerns that have motivated my historical work can be articulated and illustrated in ways other than focusing on this specific period in the history of medicine. The Nazi period is a particularly extreme case study in medicine that illustrates core concerns, but it is certainly not the only example suited to these purposes. The history of medical professionalism, the emergence and trajectory of the concept of the “animal model” to study human illness—a model that brackets out the psychological and social dimension of suffering⁹—and the history of the changing dynamics in the physician-patient relationship are but a few topics that have the potential to generate similar considerations and conclusions.

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References

Angell, M. (1997). The ethics of clinical research in the Third World. *New England Journal of Medicine*, 337, 847–849.

⁹ On the origins and implications of the concept of the “animal model” to study human disease and to gain knowledge of potential interventions, see Roelcke (2013b).

- Arendt, H. (1963). *Eichmann in Jerusalem: A Report on the Banality of Evil*. New York: Viking Press
- Eckart, W. U. (1998). Generalarzt Ernst Rodenwaldt. In G. Ueberschär (Ed.), *Hitlers militärische Elite*, (Vol. 1, pp. 210–222). Darmstadt: Primus Verlag.
- Eckart, W. U. & Gradmann, Ch. (2006). Hygiene. In W. U. Eckart, V. Sellin, & E. Wolgast (Eds.), *Die Universität Heidelberg im Nationalsozialismus* (pp. 697–718). Heidelberg: Springer Medizin Verlag.
- Forsbach, R. (2006). *Die Medizinische Fakultät der Universität Bonn im "Dritten Reich"*, Munich: Oldenbourg.
- Heim, S., Sachse, C., & Walker, M. (Eds.). (2010). *The Kaiser-Wilhelm-Society under National Socialism*. Cambridge: Cambridge University Press.
- Hohendorf, G., Roelcke, V. & Rotzoll, M. (1997). Von der Ethik des wissenschaftlichen Zugriffs auf den Menschen: Die Verknüpfung von psychiatrischer Forschung und "Euthanasie" im Nationalsozialismus und einige Implikationen für die aktuelle medizinische Ethik. *Beiträge zur nationalsozialistischen Gesundheits- und Sozialpolitik*, 13, 81–106.
- Kallmann, F. (1938a). Eugenic birth control in schizophrenic families. *Journal of Contraception*, 3, 195–199.
- Kallmann, F. (1938b). Heredity, reproduction, and eugenic procedure in the field of schizophrenia. *Eugenical News*, 23, 105–113.
- Kolb, S., Weindling, P., Roelcke, V., & Seithe, H. (2012). Apologising for Nazi medicine: A constructive starting point. *The Lancet*, 380, 722–723.
- Latour, B. & Woolgar, S. (1979). *Laboratory life. The social construction of scientific facts*. London: Sage Publications.
- Ley, A. (2004). *Zwangsterilisation und Ärzteschaft: Hintergründe und Ziele ärztlichen Handelns 1934-1945*. Frankfurt: Campus.

- Mitscherlich, A. & Mielke F. (Eds.) (1947). *Das Diktat der Menschenverachtung*, Heidelberg: Lambert Schneider. English edition: Mitscherlich, A. & Mielke, F. (Eds.). (1949). *Doctors of infamy: The story of the Nazi medical crimes* (trans: Norden, H.). New York: Schuman.
- Platen-Hallermund, A. (1948), *Die Tötung Geisteskranker in Deutschland*. Frankfurt: Verlag der Frankfurter Hefte.
- Remy, S. (2002). *The Heidelberg myth. The Nazification and de-Nazification of a German university*. Cambridge, MA: Harvard University Press.
- Roelcke, V. (1991). Die Zählung der Psychoanalyse durch öffentliche Institutionen: Zur Gründungsgeschichte der Heidelberger Psychosomatischen Klinik. *Psychoanalyse im Widerspruch*, 6, 13-26.
- Roelcke, V. (2000). Psychiatrische Wissenschaft im Kontext nationalsozialistischer Politik und "Euthanasie": Zur Rolle von Ernst Rüdin und der Deutschen Forschungsanstalt/Kaiser-Wilhelm-Institut für Psychiatrie. In D. Kaufmann (Ed.), *Die Kaiser-Wilhelm-Gesellschaft im Nationalsozialismus* (pp. 112–150). Göttingen: Wallstein.
- Roelcke V. (2004). Psychotherapy between medicine, psychoanalysis, and politics: Concepts, practices, and institutions in Germany, c. 1945–1992. *Medical History*, 48, 473–492.
- Roelcke, V. (2006). Funding the scientific foundations of race policies: Ernst Rüdin and the impact of career resources on psychiatric genetics, ca. 1910-1945. In W. U. Eckart (Ed.), *Man, medicine, and the state: The human body as an object of government sponsored medical research in the 20th century* (pp. 73–89). Stuttgart: Franz Steiner.
- Roelcke, V. (2010). Medicine during the Nazi period: Historical facts and some implications for teaching medical ethics and professionalism. In S. Rubenfeld (Ed.), *Medicine after the Holocaust. From the master race to the human genome and beyond* (pp. 17–28). New York: Palgrave Macmillan.

- Roelcke, V. (2013a). Eugenic concerns, scientific practices: International relations and national adaptations in the establishment of psychiatric genetics in Germany, Britain, the US and Scandinavia, 1910-1960. In B. Felder & P. J. Weindling (Eds.), *Baltic eugenics: Bio-politics, race and nation in interwar Estonia, Latvia and Lithuania 1918-1940* (pp. 301–333). Amsterdam/New York: Rodopi.
- Roelcke, V. (2013b). Repräsentation – Reduktion – Standardisierung: Zur Formierung des „Tiermodells“ menschlicher Krankheit in der experimentellen Medizin des 19. Jahrhunderts. In R. Borgards & N. Pethes (Eds.), *Tier – Experiment – Literatur, 1880-2010* (pp. 15–36). Würzburg: Königshausen & Neumann.
- Roelcke, V., Hohendorf, G., & Rotzoll, M. (1994). Psychiatric research and “euthanasia”: The case of the psychiatric department at the University of Heidelberg, 1941-1945. *History of Psychiatry*, 5, 517–532.
- Roelcke, V., Hohendorf, G., & Rotzoll, M. (1998). Erbpsychologische Forschung im Kontext der "Euthanasie": Neue Dokumente und Aspekte zu Carl Schneider, Julius Deussen und Ernst Rüdin. *Fortschritte der Neurologie und Psychiatrie*, 66, 331–336.
- Rothman, D. (2000a). Medical professionalism – Focusing on the real issues. *New England Journal of Medicine*, 342, 1284–1286.
- Rothman, D. (2000b). The shame of medical research. *New York Review of Books*, 47 (19), 60–64.
- Slater, E. (1948). Genetics, medicine, and practical “eugenics.” *Eugenics Review*, 40, 62–69.
- Weindling, P. J. (2004). *Nazi medicine and the Nuremberg Trials: From medical war crimes to informed consent*. Houndmills/Basingstoke: Palgrave Macmillan.