Revisiting psychiatric support for the National Socialist Agenda in Germany: Implications for medical and residency training

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Introduction

There is continued relevance of historic events and the roles physicians played in the National Socialist German Workers' Party (Nazi) regime, catalogued at the Nuremberg trials over 76 years ago.[1] Psychiatrist Leo Alexander, advisor during these trials, described the physicians' roles in policy progression from sterilization and euthanasia to exterminations at Chelmno, Belzec, Sobibor, Treblinka, Maidanek, and Auschwitz. While current ethical norms make these events less likely to happen, the ideas and sentiments in Nazi Germany persist in some form today. The roles psychiatrists played in these events are a timely reminder of the slippery slope that led these physicians to participate in such practices.

Post-First World War (WWI) and The Weimar Republic

The Weimar Republic (1918–33) was a constitutional republic established after the defeat of the German empire in World War I. At that time, Germany's achievements included claiming half of all Nobel Prizes awarded,[2] medicine that combined care of the ill individual (*Fursorge*) with preventive care (*Vorsorge*),[3] and state social services that provided resources and information on sex, birth control, child guidance, and family healthcare for its citizens.[4]

Despite these achievements in health care, the post-war era witnessed a significant rise in patients with psychosis and schizophrenia, creating massive overcrowding of psychiatric hospitals, an economy crippled by war reparation payments and the Great Depression, and the consequent reduction in social and public spending.[5,6] The increasing public discontent became the ideal setting for the Nazis' rise to power in January, 1933. In this historical context, it is also important to understand the foundational theories of Nazi policies.

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Mendelian inheritance, Social Darwinism, racial hygiene, and antisemitism

By the late 19th century, physicians applied the biological basis of heredity to mental illnesses. Psychiatry professor Emil Kraepelin was a proponent of the hereditary nature of schizophrenia, while psychiatrist-anatomist Auguste Forel viewed alcohol use disorders as hereditary degeneracy.[4] These theories progressed toward genealogical research among affected individuals in the interest of promoting health of future generations. Psychiatrist Ernst Rudin proposed a Mendelian pattern of inheritance for schizophrenia transmitted through a recessive gene.[5] Franz Kallman, the eponym of the congenital endocrine syndrome, was a pioneer in using twin studies for the genetic basis of psychiatric disorders.

The theory of Social Darwinism brought the tenets of Darwin's theory of evolution to a larger, geopolitical scale.[7] Fitness, in the context of Social Darwinism, was characterized as genetic purity.

Racial hygiene theory, rooted in the writings of Social Darwinist physician Alfred Ploetz, asserted the primacy of biological determinism over environmental factors for human development.[8] It was taught at German universities with the aim of determining optimal conditions for the maintenance and betterment of the Aryan race. Genetic pathology with racial undertones was taught at medical institutes throughout the country.[9] Sciences that were considered Jewish, from psychoanalysis to quantum physics, were under attack at universities in the 1920s.[10] Racially

motivated pamphlets were handed out on campuses. The underlying antisemitism was codified in the 1933 Law of Restoration of Professional Civil Service that removed civil servants of non-Aryan descent from their posts.[10]

Racial hygiene theories and eugenic practices were not unique to Germany at the time. Courses and research on eugenics and racial hygiene were common in medical schools around the world,[11] and sterilization was legal in the U.S. and Canada.[3]

Medical profession, eugenics, euthanasia and extermination camps

In their 1920 book, *Permitting the Destruction of Life Unworthy of Life,* authors Karl Binding and psychiatrist Alfred Hoche argued that the mentally ill or disabled have naught or negative value to society based on a cost versus productivity analysis, and as such were a financial burden to the government.[3] They were categorized as "useless eaters" who have "lives unworthy of life."[5] German propaganda had a significant role in turning public opinion to these viewpoints.[12] Films and textbooks referenced a cost-benefit analysis of high government spending on feeding and care of the chronically sick and disabled who have no work potential. Eugenicists argued for the necessity of sterilization and euthanasia due to the economic hardships at the time.

Based on Rudin's theories, the Law for Prevention of Hereditary Diseases of Descent was passed in 1933 permitting involuntary sterilization of people with hereditary diseases, who were selected by a committee of two physicians and a judge.[13] The most common reasons for sterilization were "hereditary feeblemindedness" and schizophrenia.[4] Franz Kallman further proposed sterilization of healthy relatives, usually children, of people with mental disabilities.[3] These programs resulted in an estimated 360,000 people sterilized from 1934 to 1945.[4]

In September 1939, the first direct order for euthanasia created *Aktion T4*, a program through which physicians selected chronically ill patients for what was euphemistically called "mercy death."[5] Mercy death was done by starvation, exposure, poisons, carbon monoxide gas and/or a cyanide-based pesticide (*Zyklon B*). This program was the prototype of future extermination campaigns. The killings took place in five psychiatric hospitals and in an abandoned prison in Brandenburg.[14] This program began with euthanizing children with developmental or physical disabilities, and was later extended to killing adults in mental hospitals. Adolf Hitler also secured passage of a law allowing "mercy death" for children with incurable medical conditions who were selected by two pediatricians and a psychiatrist.[13] *Aktion T4* systematized the transfer and medically supervised killing of institutionalized patients.

By 1941, *Aktion T4* had eliminated more than 70,000 psychiatric patients.[14] Due to public backlash, Hitler ordered the program halted the same year. Unofficially, the killing continued by "wild euthanasia" (death by exposure and starvation) at various hospitals.[3]

Euthanasia continued in German concentration camps, under the Code Name *14fl3*, as a method of eliminating sick or mentally ill prisoners in these camps.[15] Many *Aktion T4* program personnel transferred to work in concentration camps with strategies learned from previous euthanasia centers. Imfried Eberl, an Austrian psychiatrist who ran the euthanasia programs at Brandenburg and Bernburg, transferred to Chelmno and later became the first commandant of the Treblinka extermination camp.[16]

Medical profession during the Nazi era

At its peak, 45% of physicians in Germany were part of the Nazi party, with psychiatrists having the largest representation.[17,18] Physician representation in the Nazi paramilitary organization, *Schutzstaffel* (SS), was seven times higher compared to the employed population.[13] Career posts as selectors in euthanasia programs and concentration camps were offered by the Nazi government in a time of widespread unemployment.

Prior to the Nazi era, nearly 60% of all physicians in Berlin were Jewish.[13] Jewish physicians had their professional roles diminished and were allowed to practice medicine only on other Jews.[15] By 1938, all

Jewish physicians' licenses were revoked, and many sought exile abroad to escape persecution.

Non-Jewish physicians largely participated in these sterilization/euthanasia programs and later obfuscated their roles to resume their careers in medicine after the war. In 2010, Frank Schneider, in his address as head of the German Association for Psychiatry, Psychotherapy and Neurology (DGPPN), formally acknowledged the role of some of its members in these events.[19]

Discussion

These events raise several themes with implications for how physicians train to ensure awareness of the context in which they learn, reflect, and practice.

Impact of political, economic and social factors on social determinants of health care

Economic hardships in the immediate post-WWI years promoted a pivot to utilitarian concepts and eugenics. Crowded mental institutions were seen as a strain on limited resources that disposed the government to favor sterilization and euthanasia.[20] The prevailing theories that addressed these socioeconomic problems, namely Social Darwinism, Aryan racial superiority, and racial hygiene, were significant factors facilitating psychiatrists' engagement in sterilization and euthanasia as counterselection to inferior procreation.[18]

There were social pressures to subscribe to theories and ideology and loyalty to one's ethnic group. The Nazi regime imposed a system of coordination (*gleichschaltung*) of all sectors in society using fear of punishment and ostracism for non-compliance.[21] Physicians participated in these programs to avoid suspicion of communist sympathies or disagreement with Nazi politics. The SS called this method of forced group cohesion "blood-cement" (*Blutkitt*).[12] Resistance was difficult in hospitals in which SS members occupied high-ranking positions, and many professional bodies were dissolved.[7] Those who chose not to participate became victims of these policies themselves.[22,23] Many physicians absolved themselves of their complicity by claiming they were merely following orders. Career posts with rank and financial rewards provided a strong incentive to conform. Collaborators rationalized their compliance with the fear of losing their practice.

Despite the focus on mostly psychiatric patients, there was no significant resistance to these programs from psychiatrists, suggesting some denial or dissociation from these horrific acts based on a somatic conceptualization of psychiatric illnesses as brain diseases that were incurable, progressively worsening, and hereditary. Some physicians who participated in these programs may have come to believe that it was the right thing to do or that they were ending the patients' suffering.[24]

Hence, how social determinants of health care were defined ultimately had a significant role in these events. Current approaches addressing social determinants of healthcare are notably different and more humane, but the impact of social, economic and political factors on healthcare remains relevant to discussions on issues such as healthcare disparities, the Affordable Care Act, medication costs, and substance abuse. As noted by Berwick,[25] the moral determinants of healthcare, which advocates for the vulnerable, disadvantaged, and minority individuals in populations, must have an integral role in these discussions, and in doing so carry a weight that is no less than that of the other factors.

Service versus utilitarian ethics

Recent healthcare trends have included privatization of public programs, increasing costs of care, reduced choice in and access to care, and compromised quality of care.[26] Healthcare systems tread the balance between service and business ethics. A healthcare system driven by increasing healthcare costs and profit margins can be susceptible to extreme utilitarian, impersonal, cost-benefit analyses that were employed in Nazi medicine and ultimately resulted in policies of eliminating people considered worthless due to chronic illnesses or disabilities. These considerations impact public discussion on assisted suicide, with projected costs of care often overriding

traditional beliefs on suffering and illness. It remains an ethical dilemma because treatment response and prognosis can vary individually. Differential access to insurance and healthcare resources, often determined by employment status, should be considered in this light as well. Deinstitutionalization of state psychiatric hospitals since the 1950s and 60s is a further example of this dilemma. While current practices regarding this patient population differ markedly from the sterilization and euthanasia of the Nazi period, as the number of beds of state hospital beds has declined, the number of individuals with psychiatric illness who are homeless or in jails, prisons, or nursing homes has dramatically increased, thus providing further dilemmas in the care of this population.

The individual versus the population

The Nazi emphasis on the health of a nation superseding that of the individual was fostered by its ideology on racial hygiene. The shift in focus of care from the ill individual (*Fursorge*) to preventive care (*Vorsorge*) for the population culminated in eugenics by sterilization and extermination of individuals with disabilities, psychiatric conditions, substance use disorders, and chronic illnesses. Patients came to be regarded as objects for study; many were regarded as deviants to be neutralized, or economic burdens to be reduced in service of a higher purpose.[18] The importance of addressing population health without sacrificing care of the individual patient is a lesson that is increasingly relevant. Today, the care of the individual is challenged by increasingly bureaucratic healthcare systems, whether corporate, venture capital, or government owned. Such systems, increasingly driven by rising costs and profitability, can make it more and more difficult for individualized and/or timely care without excessive cost to the individual.

Academia and research

Psychiatrists in academia and professional associations took an active part in the execution and evolution of these Nazi policies from eugenics by sterilization and euthanasia to the killings of the *final solution.*[27] The focus of medical research changed from the patient's benefit to that of the state.[28] Collaboration between euthanasia programs and neuropsychiatric research reveal bodies of euthanasia victims being given to medical researchers for postmortem studies. Neuropathologist Julius Hallervorden collected 697 brains from euthanasia victims.[29] The collection of brains amassed from victims of Nazi crimes remained in research institutes, e.g., Kaiser Wilhelm Institute in Munich and Berlin, decades after the war and the trial at Nuremberg.[30] These events show that neither exceptional brilliance nor professional dedication provide immunity from being influenced, whether by ethical indifference, or by personal or professional gain, to take active part in atrocities.

Relevance for medical education, training and self-reflection

Medical ethics was taught in German medical schools at the beginning of the last century.[31] With the rise of the Nazi regime, the curriculum became mandatory and was overhauled to focus on Nazi political agendas like racial hygiene, the obligations of physicians to the state, the subordination of individual patient care to public health, and the authoritarian role of a physician. Present ethical codes that emphasize autonomy, beneficence, nonmaleficence and justice have been broadly implemented to protect the care of the individual patient. However, a focus on justice in the name of the population's health can result in conflicts with autonomy, beneficence, and nonmaleficence in the name of individual health. Accordingly, particularly in the light of such ethical dilemmas, the stability of ethical norms can be continuously challenged by increasing complexity in medicine and external pressures from society; thus, a need for continued monitoring of their application is warranted.

The compartmentalization and efficiency of Nazi medicine and research and the extensive documentation thereof allowed for programs to be completely unknown to others working in a different site of the same institution. While many may have been truly unaware of these practices at their own hospitals, compartmentalization also provided physicians with deniability and a pretext to remain silent.[14] This serves as a precaution in the current increasing specialization

and compartmentalization in medicine. Further, rising partisanship along ideological lines has seeped into nearly all aspects of our culture, including universities and institutions where open, public discourse is necessary for learning and science to thrive. The trend of physicians being increasingly employed by hospitals, insurance companies, and venture capital organizations, along with the need for clinician time to be more and more devoted to documentation in the electronic health record to satisfy reimbursement criteria, can further decrease the focus on care of the person. Taken together, such factors further emphasize the importance of incorporation into the training of medical and healthcare professionals information about relevant historical events and conflicts of interest that can influence the ethical care of patients.[32]

Conclusion

Educating physicians today about the distortions of scientific theory and ideology, the inhumane use of technology, the ethical failures in Nazi era medicine, and how similar sentiments may continue to linger in current society is an essential undertaking. Medicine and psychiatry in particular may promote the best interests of the population at large, but the cost is high and the damage is severe if regard for the individual and humane, ethical treatment are lost in the process. Physicians must keep in mind the need to examine biases and prejudices which, under circumstances of societal, economic, cultural, and political pressures can result in deviation from ethical norms of patient care. Periodic self-reflection on adherence to the standards of care and ethical norms is important. The timeless maxim that failure to learn from the past increases the likelihood of its repetition is particularly applicable today with regard to clinical training and practice. The durability of this maxim over time is a testimony to its inherent truth and relevance, particularly in educating and training future physicians.

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Keywords: National Socialist German Workers' Party, Nazi, psychiatry, Social Darwinism, racial hygiene

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