



Moral erosion: how can medical professionals safeguard against the slippery slope?

Jason Liebowitz

Correspondence to

Jason Liebowitz, Johns Hopkins School of Medicine, 690 N. Calvert St. Baltimore, MD 21202, USA; jliebow3@jhmi.edu

Accepted 1 April 2011
Published Online First
20 April 2011

ABSTRACT

The extensive participation of German physicians in the atrocities of the Holocaust raises many questions concerning the potential for moral erosion in medicine. What circumstances and methods of rationalisation allowed doctors to turn from healers into accomplices of genocide? Are physicians still vulnerable to corruption of their guiding principles and, if so, what can be done to prevent this process from occurring? With these thoughts in mind, the author reflects on his experiences participating in the Fellowships at Auschwitz for the Study of Professional Ethics program and offers a medical student's perspective on the ethical issues encountered in clinical training and the practice of medicine.

The indelible photographic image is seared into my mind: the physician, with his hand nonchalantly held out to the right, pointing a grey-haired, cane-wielding older man in the direction of the gas chambers and certain death. It all seems so simple, so routine—just another day at the office for this doctor—yet I cannot think of a more disgusting or horrific perversion of the medical profession. What was going through the physician's mind at that moment in time? What was this doctor's path in medicine, beginning in medical school and ultimately leading to his role as a perpetrator of genocide? And, most importantly, at what point could this physician's course in life have been changed so that he would be a protestor against injustice rather than a facilitator of evil?

This past summer I participated in the Fellowships at Auschwitz for the Study of Professional Ethics (FASPE) program, in which medical students and professors from across the USA and Canada come together to explore issues in contemporary medical ethics through the lens of physician participation in the Holocaust. Throughout the course of the FASPE program, I found myself constantly contemplating the reality of moral erosion in the practice of medicine. I use the word reality because, for the vast majority of physicians, the ethical ideals with which they enter their medical training will be challenged and, in some way, tarnished by a system that often promotes efficiency, detachment and accountability to the professional team at the cost of infringement on patient comfort and dignity. This does not mean that most doctors will go on to involve themselves in murder and genocide, as so many German physicians did in the Holocaust, but it does mean that any physician, myself included (in futuro), has the *potential* to do so. Not only is this capability to harm or cause discomfort to patients an ongoing

threat, but it is also an insidious one, making it that much harder to safeguard against the slippery slope of abuses against patient rights and autonomy.

As I will soon be entering the clinical rotations portion of my medical education, these thoughts and fears weigh heavily on me. Will my ethical principles remain intact throughout the course of my training, or will the practice of medicine change my opinions in permanent and unpredictable ways? Will such a transformation affect the way in which I interact with patients and, if so, will it be for the better? If confronted with dark humour on the wards, would my participation or inaction represent a betrayal of my patients' trust and a possible first step in the course of moral erosion? These are not easy questions to answer, yet the history of physician participation in the Holocaust necessitates contemplation of these issues, especially with regard to the doctor–patient relationship and the responsibility of physicians to act in the best interests of their patients under all circumstances.

It is this last tenet of medicine—the physician's primary obligation to the patient—that, when obscured or disregarded, poses the greatest threat to the well-being of patients. In the Third Reich, German physicians began to perceive themselves as more beholden to the wants and needs of the state rather than to those of the individual patient. Many factors contributed to this evolving definition of professional responsibility, namely the development of hereditary science, the growing influence of ethnic and racial hierarchies, and the reduction of social issues to a medical model, as exemplified by German public health programs to curb tobacco use. With these changes in mind, scores of physicians volunteered to assist the Nazi party in forced sterilisation and euthanasia programs against individuals with mental and physical disabilities, and it would not be long before doctors began experimenting on and sentencing to death millions of Jews, Poles, Roma and other prisoners in concentration camps.¹

One would hope that these atrocious acts by Nazi physicians were made possible solely by a disregard for their patients' best interests, which in today's world of modern medicine are held in high esteem. Yet defining what constitutes the patient's best interests is not always so clear and can, in fact, still lead to abuses of human rights. The prominent German jurist Karl Binding, in writing on the subject of 'life unworthy of living', claimed that the mentally ill and those with severe disabilities were nothing more than a burden on society and on their families, and that the only just action was to euthanise these individuals. Doing so,

Binding explained, was actually in the best interests of the patient, for it would end a life full of suffering while allowing these individuals to do the one thing within their power to contribute to society: discontinue their existence as drains on the state. Such rationalisation was used to justify the T-4 Euthanasia Program, in which Nazi doctors oversaw the systematic extermination of tens of thousands of patients with mental and physical disabilities.²

I would like to believe that this paternalistic view of the doctor–patient relationship—that is, the physician assuming they are acting in the patient’s best interests without consulting the patient or seeking to understand their perspective—was restricted to German doctors in the Nazi regime, but this is clearly not the case. Just a few decades ago in the USA it was common practice for physicians to not inform their patients that they had cancer. Physicians argued that withholding the diagnosis was justified by the utter lack of effective treatments for the disease and by the psychological toll such news would take on the patient, yet this mode of thinking ignores the practical concerns of patients (eg, choosing their own course of care, allowing time to speak with family and friends, writing last wills and testaments), as well as the fundamental right that patients have to know the truth about their own treatment. Although medicine has progressed in its understanding and regard for patient autonomy, the dynamics of the doctor–patient relationship within the hospital setting often challenge the physician’s commitment to protecting the dignity, comfort and general well-being of patients.

At the core of my fears concerning erosion of my own moral principles is this potential conflict between acting as the patient advocate I want to be and functioning as the physician-in-training that I have to be. The ethical quandaries I will encounter in the practice of medicine will not, by and large, be black and white or as categorically egregious as genocide; rather, they will be the day-to-day situations that will force me to decide whether or not someone, including myself, has crossed the moral line. The decision to withhold pain medications due to suspected drug-seeking behaviour, a judgemental comment made behind a patient’s back—these are often the realities of medicine, and I will not only be responsible for determining if such actions are ethical, but I will also have to choose whether or not to speak out against these potential breaches of professional conduct.

As a medical student, many factors affect my ability to perform such deliberations and act accordingly. Since I am early in the course of my training, I rely on more experienced physicians to model how a doctor should act, yet not every physician is the perfect role model, nor does each ethical question have just one ‘correct’ answer. Speaking out against every possible infraction may not be entirely realistic, especially given the fast-paced and oftentimes confusing nature of the medical system. I must also admit that personal considerations may affect my decisions concerning dissent; confidence in my own judgement, level of fatigue, evaluation by attending physicians and awareness of my role as part of a medical team relying on cohesion, will all influence how I act on the wards.

Thus, I am left in a bind: I am not sure where to draw the proverbial line in the sand with regards to ethical conduct, yet the implications of my actions will be of tremendous consequence to me and to my future patients. It is not just that each potential breach of ethics is intrinsically detrimental, but also that the cumulative effect of allowing for many small infractions is the loss of safeguards against harming patients. As each instance of passivity begets another, I worry that what was once

the outlier will become the norm, and the moral principles I originally found to be self-evident and instrumental will be left in the dust. From our readings and discussions in the FASPE program, I believe this is very much what happened to many German physicians; whether by means of scientific rationalisation, ambitious careerism or personal prejudice, Nazi doctors allowed themselves to justify progressively greater and greater breaches of professional conduct until there was no turning back—they had already transformed themselves from healers into murderers.

One such example of this phenomenon can be found in the story of Sigmund Rascher, the son of a doctor and a physician himself who would ultimately be responsible for killing hundreds of prisoners through experiments at Dachau concentration camp. Towards the start of his medical career in 1939, Rascher was an assistant physician in a hospital in Munich, toiling in relative obscurity as he conducted cancer research on mice. When Rascher’s wife put him in contact with Heinrich Himmler, Commanding General of the SS, Rascher saw this as his opportunity to move from animal to human experiments and achieve greater personal and professional success.³ However, it was not long before Rascher switched his research from the fields of oncology and cancer therapeutics to the subjects of altitude sickness and hypothermia, both of which were of considerable importance to the German military. With Himmler’s enthusiastic approval, Rascher began conducting high-altitude depressurisation experiments on camp prisoners who were placed in vacuum chambers, deprived of oxygen and observed by physicians as they convulsed, foamed at the mouth, went blind, and, more often than not, died. In studies of hypothermia, Rascher exposed hundreds of prisoners to sub-zero temperatures in water tanks and recorded whether or not they ever regained consciousness when allowed to huddle together with other naked inmates. Through these brutal and horrific means, Rascher distinguished himself among Nazi physicians and, for a time, incurred the favour of Himmler and other prominent military and political leaders in Germany.⁴

Though the history of torture and genocide committed by Nazi doctors is certainly a cautionary tale for American physicians, many may be disbelieving of their own capacity to harm patients. After all, today’s doctors may wonder, don’t we now have many more safeguards against abuses of patients’ rights and well-being? While it is true that modern medicine holds patient autonomy in much higher esteem than in years past, it is undeniable that many of the same factors that drove Rascher and others to perpetrate such heinous acts still exist today. The desire to have a successful medical career, the willingness to appease professional superiors, the ability to rationalise nearly any human research in the name of advancing knowledge—these explicit motives behind the actions of Rascher and countless Nazi physicians represent potential traps for modern medicine in the struggle to uphold beneficence and non-maleficence even when self-interest comes into play.

The most difficult aspect of balancing the patient’s interests with those of the physician is that the two are sometimes complementary but, in many cases, are so different as to indicate entirely separate courses of action. For instance, a patient of sound mind may refuse a life-saving blood transfusion on religious or moral grounds, but, even having acted in accordance with ethics and the law, the physician may still believe that they have failed to fulfil their fiduciary responsibility. Conversely, a doctor may feel compelled to order what could be considered a superfluous diagnostic test in order to protect themselves from potential malpractice litigation, knowing full well that doing so

exposes the patient to additional risks and costs. At the heart of these conflicts is the physician's ability to weigh matters of optimal care for patients—that is, acting altruistically, demonstrating empathy and compassion, reducing harms and maximising benefits—with matters of his or her own well-being—that is, fatigue, personal preferences, legal and fiscal matters, etc. I know I will be faced with such challenging situations in just a few weeks when I begin on the wards—after all, it is imperative that I learn how to perform a lumbar puncture, but at what cost to the patient in terms of pain caused by my inexperience and novice's technique?

With these realities in mind, I am left to wonder: how can I prevent my own ethical values from being degraded or forgotten? How can I strike a balance between meeting the challenges of medical training and living with the moral consequences of my actions? While realising that some mistakes will be made and that I cannot let perfection be the enemy of the good, I can begin by both following the Golden Rule and recognising its limitations. By this I mean I can seek to treat patients as I would want to be treated—by protecting their dignity and autonomy, by resisting dark humour on the wards, and by providing education and guidance without coercion—but I will not assume I know what is in their best interests; rather, I will speak with the patient and their families to better understand their goals and desires. Part of this process of dialogue will involve finding mentors to model for me how best to provide care in a compassionate and professional manner. Not only will I seek out professors and clinicians who combine competence with thoughtfulness, but I will also look for fellow students who can provide reflection on their own experiences and writers (in the medical field and beyond) who inspire me to do good in this world.

I must also recognise that many of the atrocities committed by German physicians were born out of hatred and fear of those who were different—the belief that Jews were an inferior species and not worthy of the rights and protections guaranteed to all human beings. Although I do not harbour such putrid animosity towards others, it is important that I work to understand, rather than ignore, any cultural differences I encounter in treating patients. I want and need to see patients as people with families, jobs and lives outside the hospital, and I look forward to discussing with patients how their health and illnesses have affected them in more than just the medical sense. In this vein, I hope to pursue new, sometimes uncomfortable, experiences to expand my own conceptual horizons and prevent myself from seeing the patient as 'the other'. By exploring the surrounding community, especially in an urban area like Baltimore with stark contrasts between the wealthy and the impoverished, and talking with people, I hope to ensure that issues of race, religion,

drug use, socioeconomic status and life experiences play no role in my ability to connect with and earn the trust of my patients.

As issues of self-interest in the field of medicine are often hidden within the complexities of our healthcare system, I believe it is particularly important that I seek to understand my own motivations and potential conflicts of interests when caring for patients. The fee-for-service payment method that exists in the USA is designed to provide financial rewards for greater and more costly procedures, but this does not always translate to better care for the patient. Perhaps the best way to determine the optimal course of treatment for patients is to continually ask the following question: disregarding all extraneous considerations—including monetary reimbursement and career aspirations—is the plan I have created for my patient designed to maximally promote their well-being, protect their wishes and deliver the best possible outcome? If I can answer this question in the affirmative throughout the course of my practice, then I can in good conscience say I am doing right by my patients.

Finally, as medicine is a truly wonderful and dynamic field that requires constant self-improvement and learning on the part of physicians, I will continually seek opportunities for reflection and personal growth in order to mature as a doctor and as a human being. I have started to keep a diary of my experiences in medical school, with my thoughts, my feelings and my memories poured out on paper through poetry and prose. I will speak with other students, physicians and patients about their ideas on these subjects, and I will take the time to marvel at the privilege I have been given to practice medicine. Lastly, but certainly not least, I will continue to participate in profoundly moving and meaningful experiences like the FASPE program. I sincerely believe this fellowship has and will continue to change me as a student, as a budding physician and as a person; I am eternally grateful for this opportunity and I am confident that my ongoing friendships with the people I have come to know through this program will set me on the course to becoming the physician I aspire to be.

Funding This work was supported by the Fellowships at Auschwitz for the Study of Professional Ethics program.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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