Six Values Never to Silence: Jewish Perspectives on Nazi Medical Professionalism

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ABSTRACT
An ideological case study based on medical profession norms during the Third Reich will be used to exemplify the importance of diversity in the manifestations of professional ethics. The German professional medical community banned their Jewish colleagues from treating German citizens. This included legally mandated employment discrimination and outright censure which led to a professional ethic devoid of diverse voices. While the escalation to the T-4 program and medicalized genocide was influenced by many causes, the intentional, ethnocentric-based exclusion of voices was an important contributing element to the chronicled degradation of societal mores. For illustration, six core Jewish values—life, peace, justice, mercy, scholarship, and sincerity of intention—will be detailed for their potential to inspire health-care professionals to defend and protect minorities and for readers to think critically about the role of medical professionalism in Third Reich society. The Jewish teachings highlight the inherent professional obligations physicians have toward their patients in contrast to the Third Reich’s corruption of patient-centered professionalism. More fundamentally, juxtaposing Jewish and Nazi teachings exposes the loss of perspective when a profession’s identity spurns diversity. To ensure respect for persons in all vulnerable minorities, the first step is addressing professional inclusion of minority voices.

KEY WORDS: History of medicine, Holocaust, Jewish ethics, medical ethics, medical professionalism, principle-based ethics

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INTRODUCTION

With the recent rise of divisive rhetoric in the US and Europe, it is important to remember how ignoring diverse voices can contribute to the ethical deterioration within a culture. For instance, several core Jewish values apply to medicine, including an emphasis on the preservation of life; however, by mid-1933, the professional medical community of Germany banished Jews from their ranks through employment discrimination followed by outright censure, preceding relevant Nazi legal decrees.1 Professionals and institutions relinquished their duties to the individual patient in favor of a societal emphasis on economic worth and eugenic hygiene, which, as recent scholarship has shown, even became codified into professional ethics curricula for German medical students.2 This obsession with racial-national identity purity escalated into a distinctly medical form of genocide. While the escalation was due to many complex factors beyond the scope of a single paper, the initial ethnocentric-based exclusion of voices from powerful professional institutions contributed to the degradation of social mores. We posit that professional discrimination served not only as a step in the growing persecution of Jews specifically, but also as a means of ignoring cultural teachings which would have resisted professional entanglements in Nazi priorities more generally.

We contrast Jewish teachings with a historical review of Third Reich medicine, in particular the development of the T-4 euthanasia program, as an ideological case study in divergent teachings. This historical example serves to illustrate how the medical profession can fail to serve and protect marginalized groups, in part by whether the profession has chosen to include those oppressed voices within itself as a means of self-critique. We will discuss six carefully selected core Jewish values—life, peace, justice, mercy, scholarship, and sincerity of intention—which could have inspired health-care professionals to defend minorities had these core values not been ignored or distorted by the architects of Third Reich medicine. These principles draw on the Jewish canon of Written and Oral Torah, as well as later influential Jewish works addressed specifically to physicians as professionals. Taken together, these teachings repeatedly emphasize the inherent professional responsibility of physicians toward their patients in making decisions about life, health, and ultimately death. These moral errors and ultimate failures of the Third Reich are based on this fundamental disruption of the patient–physician relationship and the corruption of patient-centered medical professionalism.

HISTORICAL BACKGROUND

Modern-day physicians may not comprehend the extensive role physicians performed during the societal escalation of genocide under the Third Reich. Although the Nuremberg Doctors’ Trial illuminated a subset of the most egregious behaviors,3(pp17–18) the medicalization and sustainability of the sterilization and genocidal practices required the systemic support of the medical community. The “why” and “how” of these historical behaviors were based, in part, on professional socialization which converted the physician’s fiduciary responsibility, obligations, and accountability away from patients to the politicized goals of society. Drawing from a broader, existing scholarship on the rise of Third Reich medicine, only a few key events, ideas, and persons will be summarized here as particularly illustrative of the contrasting values discussed below.

The concept of beneficence was applied toward the health of the general population (Volk) rather than the individual, gaining prevalence at least two years before Adolf Hitler’s ascension to power; early talk of euthanizing the incurable to prevent a “financial burden” within the economically destabilized post-WWI Germany had begun but was not yet embraced professionally.2(p591) After the fall of the Weimar Republic, the scientific theory of eugenics was used to justify the concept of racial-biological hygiene, both legally and ethically. The Nuremberg Law for the Prevention of Progeny of Hereditary Diseases4 led to the creation of the Hereditary Health Courts (Erbgesundheitsgericht), an infrastructure utilizing physicians and judges to provide scientific justification for decisions which were intended to improve the genetic health and racial purity of the German population,3(pp25,5(pp299–300), 6(pp29–30) Practices such as involuntary sterilization and mixed heritage abortions helped ensure racial purity by weeding out undesirable members of the gene pool.3(pp21–29,42) The subsequent sterilizations were portrayed as a necessary medical procedure, based on the model compulsory sterilization law proposed by Harry H. Laughlin in the United States.5(p312) Beyond legalization, this policy was later reinforced through the Medical Law and Professional Studies (MLPS) medical ethics curriculum, implemented by 1939 and featuring lectures by euthanasia thought-leader Eugen Stähle, and through a key textbook by Rudolf Ramm which redefined the...
physician’s role as “responsible for ridding society of certain groups ... unable to contribute to society ... in order to heal the organism of the German people.” Though relatively late in institutional dissemination, this curriculum reinforced what was already professionally accepted. Between 1937 and 1939, concerns were raised that sterilization had become over-applied by zealous physicians caught up in the new industry, and the Nazi party stepped in to systematize the process, which led to the T-4 program, “improving” (among other things) cost efficiency and economic performance.1

Although the earlier German sterilization processes resulted in more than 400,000 involuntary sterilizations,1,5(p299),6(p30) this program was not considered robust enough to address the perceived threat posed by the unfit. Hence, an escalation of harm progressed to purportedly objective determinations of lives that were considered unworthy of a social safety net and by default, “unworthy of life.”3(p40),cf.7 Within an additional context of rationing war time resources, the Third Reich in August 1939 required the registration of children with defined medical conditions for “special treatment” based on the 1920 writings of Karl Binding, a jurist, and Alfred Hoche, a psychiatrist.8(pp182–188) Binding and Hoche argued the law should permit the killing of “incurable ... feebleminded” individuals and suggested the definition of a worthy life was determined by an individual’s social contribution.3(p46) Hoche described the economic burdens to society from individuals he described as “human ballast.”3(p47) Hoche was a member of Brandt’s board of examiners9(pp33,38) and served an instrumental role in teaching Karl Brandt (a key personal physician of Hitler’s)3(pp51,64),8(p186),9(p37) that “euthanasia” was a “humane” therapeutic goal for the “damaged, useless or harmful.”6(p36) Hoche’s teachings “provided the intellectual and moral basis from which Brandt would later argue his case, after Hitler had asked him to implement” the T-4 program.6(p37) Both Brandt and Hoche felt “the life of one human being could be sacrificed for the greater good of society or the advancement of medical science,”6(p37) thus providing a medical rationale for eugenically based euthanasia programs. The economic burdens of Hitler’s new war also supplemented the earlier (post-WWI) economic justifications, that “the continued existence of those classed defective could no longer be justified in Hitler’s war-strapped Reich.”5(p317)

Discomfort with T-4, however reasoned away, remained implicit in its lack of transparency and euphemistic means of operation. The central administrative structure for the program was secretly authorized by Hitler in October 1939, and a bureaucratic program was created to camouflage the deaths as natural, and not intentionally caused by the hands of the physicians.8(pp186–191),9(pp124–129) Research was performed to determine the most humane way to shorten individual and group lives, and the lessons learned were later applied in the concentration camps. Euphemisms, such as “merciful act,”8(p388) “putting to sleep,”3(p57) or “special treatment,”8(p208) provided psychological distance for the Nazi physicians to accept these murders as legitimate medical practice and indeed even as a form of mercy. While the bureaucracy diffused individual responsibility, Brandt emphasized that “only doctors were meant to perform the gassing operations,”9(p340) echoed also in the motto of T-4 operational head Victor Brack, “the needle belongs in the hand of the physician,”6(p33),10(p708) providing a medical rationale for the next stages of extermination. When faced with opposition, Brandt asserted this professional sovereignty as authoritarian—“doctors could not violate medical ethics, not because they were unable to inflict harm on humans, but because they were doctors. Their professional status freed them from any kind of moral and ethical responsibility towards their patients ...”9(p256) As Proctor notes, “Doctors were never ordered to murder psychiatric patients and handicapped children. They were empowered to do so, and fulfilled their task without protest, often on their own initiative,” and those “who did object, complained primarily that the operation was not, strictly speaking, legal.”8(p193) A euthanasia law was never formally created beyond the draft stage.3(pp56,64),10(p706)

Although Hitler promised the administrators of the T-4 program that “he would bear full responsibility” for physicians’ actions,6(p194) both the words of his physician thought-leaders and the relative legal silence regarding T-4 suggest the governmental powers played a secondary role (protecting against liability, first by court rule and then by obfuscating the more extreme activities from public eye) to the central role of the physician, whose values must dictate the destruction of life for economic and racial reasons in order for that destruction to occur.

As other scholars have implied,1,2,3(p93),3(p40) a key facilitator in this drastic professional re-evaluation was isolation from any contrary values. In keeping with the nationalist and racial focus toward the supreme German Volk, it was against policy for Ger-

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man doctors to accept the international Nobel Prize (though spreading Nazi medical ideas via hosted conferences was allowed). The expulsion of Jews from the medical profession proceeded with alarming speed, first locally, then nationally, then by legal decree, all within March and April of 1933. Through circulation in the prestigious professional publication, Deutsches Arzteblatt, and by the directive of Karl Haedenkamp, Jews were first to be replaced so that employment preference could be given to Aryans doctors; they were then barred from practicing on non-Jewish patients; then from treating any insured patients (as a matter of professional enforcement by lobbying with the insurance companies); then legally from such practice as well as from re-licensure. Propaganda was also utilized, including cartoons and caricatures of Jewish physicians as “anti-healers,” accusing them of rape, abortions, and differential treatment against Aryans, and of treating “sicknesses and not sick people” (the irony and hypocrisy of which is not lost on commentators, who note that Nazis would inflict exactly these wrongs onto the Jewish people). All such efforts were successful, and “by 1936, all German Jewish physicians were professionally decertified.” Some exceptional licenses were allowed for the treatment of non-Aryans only, but that still left only an estimated 285 “non-Aryan” physicians in 1938, versus 9,000 “non-Aryan” practitioners in 1933.

It would be a mistake to attribute this forceful exclusion solely to the idea that Jews were convenient targets for Nazis’ racism or nationalism during a period of economic hardship. Physician-educator Rudolf Ramm rejoiced in particular that “the profession had been extensively cleansed of politically unreliable elements foreign to our race.” A Jewish presence within German medicine would not only be seen as a racial impurity in general, but as a source of “unreliable” ideology contrary to Nazi medical ethics. In order to reinvent the medical profession as one which values individual life by economic and eugenic parameters, discards life for the sake of a monolithic national culture, and furthermore considers doing so to be a justified professional duty, voices had to be silenced first.

JEWISH VALUES

Six values receive special emphasis within Judaism and have been applied directly to medical practice: life, peace, justice, mercy, scholarship, and sincerity of intention. These values are showcased based on the first author’s own immersive experience learning among multiple Jewish denominations. We do not assert this list as exhaustive, but only as especially prominent and well-attested among the applicable values in Jewish religion and overall culture. These select values will be considered within the structural context of Jewish practical ethics, or halakhah from the Hebrew word “to walk” (as in, to walk the ethical path; see Table 1), as well as two direct codes, the Oath of Asaph (a Jewish cousin to the Hippocratic Oath, circa third–seventh century CE) and the Prayer for Physicians (eighteenth century; though often called the Prayer of Maimonides, and inspired by the twelfth-century rabbi-philosopher-physician, it is notably of much later German origin). A glossary of Jewish/Hebrew terms is also provided in Box A.

Life (Chayim)

Life is sacred in Judaism, as expressed by the halakhic principle of pikuach nefesh (saving a life)—actions which save a life from danger, or prevent such danger, override other Commandments. Halakhah has a legalistic style, allowing nuanced exceptions, case rulings, and circumstantial sub-clauses to carefully qualify what might otherwise be taken as absolute obligations. Obligatory mitzvot (Commandments) therefore become sinful (prohibited rather than obligatory) if performed contrary to pikuach nefesh. Sabbath laws against work must be violated to save a life. Fasting on Yom Kippur (Day of Atonement, the holiest of High Holy Days) is forbidden if it would seriously endanger health (e.g. for uncontrolled diabetics). Only the most serious prohibitions (idolatry, adultery, and murder) stand in exception to this rule (i.e. religious martyrs are allowed this self-sacrifice since the alternative would have been forced idolatry). Pikuach nefesh thus prioritizes sanctity of life while also permitting resistance against violent tyrants, even in the face of personal danger.

On the more homiletic side (the less formalistic counterpart of halakhah, called aggadah), the story of Genesis reinforces this value. Adam is portrayed as the single progenitor of all humanity in order to affirm that the life of each individual human is connected with the inherent worth of all—“anyone who destroys a life ... destroy[s] the world; and anyone who saves a life is as if he saved an entire world.”

Because life is so infinitely holy by these teachings, an ironic quandary for professional medicine arises. One is not supposed to profit from the per-
In some interpretations, this charge for medical services is not even characterized as direct fee-for-service, but as compensation for the many hours of study required of the physician to make practice possible.\textsuperscript{19}

The contrast to the economic rationales of Third Reich medicine speaks for itself. Judaism fears turning away patients unable to pay, whereas T-4 charged the patient’s insurance for involuntary euthanasia, which itself was performed to rid the state of the economic burdens posed by societally defined patient populations.\textsuperscript{1} The German-Jewish philosopher Moses Mendelssohn forecast an opinion on this concept of “public health” in 1842:

\begin{quote}
“People expendable to the State; useless to the State,” these are statements unworthy of a statesman ... No country can dispense with even the humblest and seemingly most useless of its inhabitants without seriously harming itself. To a wise government not even a pauper is one too many; not even a cripple is altogether useless.\textsuperscript{20(p175)}
\end{quote}

\textbf{Peace (Shalom)}

Shalom can also be translated as wholeness or harmony, and prayers for it constitute the bulk of Jewish liturgy. This value encompasses not only an internal sense of cohesion within and among the Jewish people; it explicitly includes respect for foreigners. Regardless of differences in religious belief or tribe, non-Jews who demonstrate a basic level of morality are considered righteous under a separate covenant with God (defined by seven Noahide Commandments). An act religiously required of a Jew might even \textit{defile} the Name of God (“chillul Hashem” in halakhic terms) if its performance would threaten peace between Jewish and righteous Gentile communities. There is a second

\begin{table}
\centering
\begin{tabular}{|c|c|c|}
\hline
Tier & Sources & Contents \\
\hline
Written Torah & Five Books of Moses & Traditionally parsed to contain 613 mitzvot (Commandments) \\
Oral Torah & Mishnah, Babylonian Talmud (TB)*, Jerusalem Talmud (TY) & Ancient commentaries and interpretations (Talmud codified 6th century CE), including: Derived rules, Legislated rules, Informal homiletics \\
Responsa & Later case-based responses extending to the present day & \\
Minhag (Local Custom) & Responsa, Later codifications & Aspects of Judaism that differ by region, arising from Rabbinic authorship or gradual popular adoption \\
Lexical Codifications & Mishneh Torah (12th century), Shulchan Aruch (16th century) & Influential collections of prior rulings, including responsa and minhag, organized topically \\
Progressive Judaism & Alternate responses and commentaries by non-Orthodox movements & More emphasis on individual liberty in decision-making and/or evolving interpretations of canon; traditional halakhah may serve in an adaptive or advisory capacity \\
\hline
\end{tabular}
\caption{Categories of Halakhic Sources in Rabbinic Judaism.}
\end{table}

\textsuperscript{*Standard Babylonian Talmud citations are given as “TB [tractate] [pg. #] [a/b for page side],” as in “TB Bava Metzia 59b.” The Mishnah and Jerusalem Talmud are divided into tractates, chapter #, and verse # (“Pirkei Avot 1:2” or “TY Pe’ah 1:1”). See \url{www.sefaria.org} or \url{www.sacred-texts.org} for public domain translations.
and third part to the exegesis about Adam cited above, that the Genesis story is also told “to promote peace among the creations, that no man would say to his friend, ‘my ancestors are greater than yours’” as well as to link human diversity to divine grandeur:

A man strikes many coins from the same die, and all the coins are alike. But [God] strikes every man from the die of the First Man, and yet no man is quite like his friend. Therefore, every person must say, “For my sake the world was created” [and we might add, for the sake of every other as well].

Hence the sanctity of life and multicultural peace are not easily separated in Judaism.

The Prayer for Physicians also interweaves chayim and shalom (life and inclusive peace) by expressing to physicians the value for all human life. Its preface praises God for creating the human body
“with infinite wisdom,” describing the intricate harmony of “ten thousand times ten thousand organs” working in concert;12 disease is likewise portrayed as purposeful, to warn the patient of the dangers to be averted through medical knowledge, rather than as a punishment to be accepted blindly or as a test to be healed through unassisted faith. Learning to identify and combat illness is necessary for patients “to succeed” not only in their healing process, but in life generally.12 The prayer makes no distinction between patients based on background, since all human beings experience suffering.12 This endorses the opinion of the historical Maimonides, that medicine—particularly through preventive and holistic care—is instrumental to healing, spiritual growth, and worship.21 Maimonides treated all patients in his multicultural environment in accommodating terms. For example, in a letter to a Muslim patient, Maimonides quotes the Koran instead of the Torah.22 Another patient famously praised Maimonides above the Greeks: “Galen’s art heals only the body, but [Maimonides’] art heals body and soul,” because the patient is valued in body, mind, and soul.22(p550)

As the Prayer for Physicians and Maimonidean practice in general suggest, Jewish ethics would not support eugenics as a premise for practicing medicine. While it would be consistent with Maimonides to consider cases of medical futility, the reference point for this determination must be the patient’s own good, not the patient’s social “worth” based on eugenic evaluations of ethnic difference. No concern for “public health” or community beneficence has encroached on even the most permissive rabbinic opinions regarding cessation of care or euthanasia.23,24 In fact, the emphasis is toward restoration of health or a reduction in suffering.

Shalom shows up in remarkably subtle and diverse ways in medical responsa as well. For instance, Rabbi Jakobowitz argues that observant Jewish patients have no right to refuse physician advice (by pikuach nefesh above, to protect life), but he also asserts Jewish doctors should acknowledge the right for Gentiles to refuse treatment.25 It is not the doctor’s place to impose religious rules on those of other faiths, not even out of beneficence, as doing so could drive a wedge between communities, and thus be regarded even as blasphemy (chillul Hashem noted above, or, in more secular terms, a violation of the public trust in a health-care system that serves their needs). Thus, a physician promotes shalom between people by the same route as promoting shalom within the person, through a respectful, holistic, and patient-centered approach.

By way of caveat, there is no perfect faith or ideology immune from cultivating in-group biases, and Judaism is no exception, though such ambivalent counterpoints fall far short of the Nazis’ picture of the Jew as anti-healer. The same tribal thinking which entails that a Jewish doctor should not impose Judaism on Gentiles also entails, in several
places, that protective measures which apply to Jews would not apply to Gentiles. In particular, rules referring to “your brother” customarily meant only a fellow Jew (e.g. the return of lost persons). In more extreme cases, commentaries imply Jewish lives are more valuable, as in the Talmudic reading which paradoxically interjects “a life from Israel” into the Mishnaic discussion which derived “anyone who saves a life is as if he saved an entire world” from the Adam story. Disturbing structural parallels come to mind—such as Rudolf Ramm’s emphasis that general ethical precepts in his textbook only apply to Aryan patients, or the proactive Nazi policies of supporting employment and medical care for Germans and amputee veterans even while initially discriminating against and eventually exterminating Jews. However, it is notable that both Maimonidean medical ethics and the later German-authored Prayer for Physicians follow the majority readings (in both the Mishnah and Jerusalem Talmud) which lack “from Israel” and instead apply value to life in an unambiguously universal manner. This choice can be explained two ways. One way is descriptive: the Maimonidean version simply follows the more attested trend both in terms of ancient sources, and in post-Enlightenment Germany—in sermons of universal brotherhood by the early reformer Israel Jacobson and neo-Orthodoxy founder Samson Raphael Hirsch (both early nineteenth century). To portray racially supremacist views as a matter of canonical Jewish Law (as Nazis in fact did) would misread not only the tradition in its full retrospect, but these German-born movements in particular. The second way is normative: an inclusive stance was simply seen as more fitting for a physician to encourage, in order to serve all patients without discrimination. Again in comparison to Ramm and the case of Nazi medical curricula, the shift between inclusion and exclusion may be gradual, but not passive—it was the physician faculty (not solely or even primarily appointed party ideologues) who explicitly chose which norms to endorse and which to condemn when training the next generation of German doctors.

Justice (Tzedek) and Mercy (Chesed)

In Judaism, distributive justice (tzedakah, righteous giving) and acts of loving kindness (g’mitul chasadim) are expressed through social action (tikkun olam, “fixing the world”), based both conceptually and grammatically on the balance of the two general values, justice and mercy. The Torah and prophetic writings stress the needs of vulnerable populations in particular—the poor, orphans, widows, and “strangers” (Table 2). The Talmud finds so many Torah verses protecting the stranger, in fact, that any mistreatment involves double jeopardy: verbal abuse counts as three sins, plus two for more material harms.

Tzedakah can refer to any charitable donation, but in medicine it requires that poor and marginalized groups receive treatment as a matter of social justice, essentially corresponding to modern post-WWII secular principles of justice, universal healthcare systems, and global health improvement initiatives.

G’milut chasadim are acts of loving kindness which relate directly to caring for the sick on an individual level. This concept is linked to the early origins of Jewish nursing professionals. Mercy as “loving kindness” is both patient-centered and life-centered when used in the medical context. The Prayer for Physicians states: “May I never see in the patient anything but a fellow creature in pain ... In the sufferer let me see only the human being.” The ancient physician Asaph exhorts: “do not harden your heart against the poor and the needy; rather have compassion upon them and heal them.” A doctor’s fiduciary duty is to heal the patient burdened by society, not to heal society burdened by the patient (still less to heal society burdened by a vulnerable population of patients, in violation not only of the value of life but also of justice). This contrasts with Brandt’s misapplication of the concept of mercy in the T-4 program, wherein “the essential question was not whether the programme was ... in itself humane, but whether the method of killing was humane.” or with Ramm, who had relocated the physician’s mercy towards the body of the German Volk, seeing patients as potential pathogens to that reified collective.

Scholarship (Limmud)

Scholarship, as a virtue, is encouraged both culturally and in explicit homilies. For instance, study is described as the greatest Commandment, in the sense that it leads to knowing how to perform all the others. Intensive study and intellectual curiosity support one’s efforts in leading a moral life, and scientific observation can become a basis for illuminating truth.

Scholarship is obviously relevant to medicine. Explicit codes such as the Prayer of the Physician emphasize life-long learning, intellectual humility
regarding the scope of one’s knowledge, and scientif-ic objectivity; in that same spirit, Maimonides practiced critical appraisal of all medical teachings, whether from Jewish, Greek, or Islamic authors. His appreciation of diverse sources of knowledge stands in marked contrast to the Nazi ethnocentric science, which banished Jewish scholarship from sight (literally and figuratively).

Objective scholarship requires careful avoidance, or at least identification and management, of conflicts of interest. Asaph denounces bribery twice: once in reference to doing harm for a bribe and again for becoming an accomplice to sexual misdemeanors, suggesting that he appreciated conflict of interest not as an abstract idea to be spoken of in generalities, but in terms of the specifically lucrative transgressions and erosions of commitment which deserved direct address. “Do not lust” and “do not shed blood” go without saying to a commitment which deserved direct address. “Do not specifically lucrative transgressions and erosions of speech of in generalities, but in terms of the conflict of interest not as an abstract idea to be spoken of in generalities, but in terms of the specifically lucrative transgressions and erosions of commitment which deserved direct address. “Do not lust” and “do not shed blood” go without saying to a commitment which deserved direct address. “Do not lust” and “do not shed blood” go without saying to a pious audience, but do not lust after a patient or “shed blood by ... dangerous experiment in the exercise of medical skill” are specifically medical temptations.

According to some interpreters, the Talmud directly addresses physician objectivity with the provocative line, “The best doctors go to hell.” The line stands in stark contrast to an otherwise pro-medical tradition, so the commentaries read “best” with some nuance. The sort of ideological doctors who seek the “best” for themselves over the patient, or who forget intellectual humility and fail to place their “best” practices under scrutiny, are the more sensible culprits for this verse, rather than physicians who are truly effective at saving lives. On a historical reading, however, “best doctors” likely refers not to biased or compromised doctors but to literal witch-doctors, because the Talmud pre-dates any modern distinction between medicine and magic. Asaph’s Oath (which is contemporary or near-contemporary to the Talmud) also dwells on the illicit use of idols in medicine. Maimonides enjoyed the emerging proto-science of medieval Islamic medicine and could therefore apply at least some common empirical standards across medical authors of different faiths. Aside from some medieval apologetics against heresy, Maimonides associated the practice of good, scholarly medicine with careful methodology, whereas bad medicine was marked by superstition or dogmatic metaphysical speculation, better resembling a modern epistemic distinction.

By the Enlightenment context of the Prayer of the Physician, quackery completely replaces sorcery or heresy as the noteworthy intellectual concern. The prayer condemns both political and financial ambitions as “strange thoughts” far removed from wise scholarship and sound practice—a phrase which, though perhaps evocative of the Biblical idea of “strange gods,” limits itself entirely to mundane examples of financial, social, or intellectual pressures to accept the advice of the less knowledgeable instead of responsibly seeking what is right for the patient. The physician must distinguish legitimately wise mentors from “conceited fools,” though the prayer does understate the challenge of choosing mentors, evidence, and research programs wisely—the modern distinction between science done well and science done poorly (or completely as a “pseudo”—science). Philosophers of science consider this difficulty under a special heading dubbed “the problem of demarcation.” Historical examples often show a “know it when we see it” basis, but more precise methodological or evidential standards tend, upon philosophical scrutiny, to include something absurd within the definition of proper science (i.e. flat-Earth model), or exclude cases too broadly (e.g. failing to account for epidemiology or germ theory as scientific).

The philosopher’s struggle is no mere theoretical concern, but impacts concrete and life-altering choices facing the professional physician. As already noted above, Brandt chose Hoche with confidence, and eugenics (however flaw-ridden in hindsight) was as promising and mainstream a research paradigm then as genomics potentially is now. The “best doctors” of Nazi Germany studied eugenics and systematically applied it as a social policy, learning their medical ethics from lecturers like Eugen Stähle. During the Third Reich, physicians did not separate their racial identities, academic ambitions, and ideology from a self-reflective and independent consideration of their generation’s dominant scientific paradigm. These doctors first became morally and intellectually compromised, and, in consequence, murderers, yet contemporaneously speaking—it is disturbing to admit—they followed (what had become) mainstream curricula and research agendas. Any voices that might have spoken contrary to that agenda were already “cleansed” from professional ranks.

It may seem fanciful today to compare the intellectual challenges of medical scholarship to idolatry,
as our references to the Talmud and Asaph imply. However, no matter how much the diction may change over time, the result of error remains the same: death. The practice most frequently associated with idolatry in Scripture (whether to Moloch, Baal, or unnamed deities of Canaan) is child sacrifice, typically through fire. Indeed these paradigm cases of idolatry mark the difference between those faiths respected by Judaism (under shalom above) and those condemned—i.e. whose beliefs harm children to protect theoretical effigies. One-and-a-half million children died in the Holocaust for the effigy of Nazi science. For a more recent medical example, children in the developed world have been placed at risk of measles due to a single case of research misconduct (involving, among other things, psychosocial information used to provide medical care). The Nazis defined life through definition, allowing physicians to deviate from patient-centered mercy to an amoral justification for ethnic extermination. Rule of law cannot suffice to restrain these retreats—Nazis could legislate around inconvenientation. Rule of law cannot suffice to restrain these retreats—Nazis could legislate around inconveniently protective regulations and even disregard them. Even values such as life (for whom?), peace (with whom?), or mercy (toward whom?) are vulnerable to misapplication or misappropriation.

Martin Buber portrayed the difference between defining and relating with the objective term “It” and subjective term “Thou.” Clinicians may also see the parallel to the dual medical stances: seeing the patient as a clinical “It” of biological lab results, a diagnostic puzzle to be solved, a research subject/guinea pig, or a pharmacologic equation to be balanced, versus recalling the mortal, vulnerable humanity of each patient as a “Thou.” Both stances are necessary—one to treat the illness, but the other to care for the patient.

Contemporary philosopher Hilary Putnam attempts to illustrate the depth of this approach for the lay reader, notably invoking the Holocaust itself in his description:

> The danger in grounding ethics in the idea that we are all “fundamentally the same” is that a door is opened for the Holocaust. One only has to believe that some people are not...
“really” the same, to destroy all force of such a grounding. Nor is there only the danger of a denial of our common humanity (the Nazis claimed that Jews were vermin in superficially human form!). [sic] Every good novelist rubs our noses in the extent of human dissimilarity, and many novels pose the question: “If you really knew what some other people were like, could you feel sympathy with them at all?” But Kantians will point out that Kant saw this too. That is why Kant grounds ethics not in “sympathy” but in our common rationality. But then what becomes of our obligations to those whose rationality we can more or less plausibly deny? These are ethical reasons for refusing to base ethics on either a metaphysical or a psychological “because.”46(p71) (emphasis added)

This approach does not deny the many obvious similarities between members of the moral community (or between those who ought to be considered equal members of the community). Rather it denies that building a theory on that similarity would ever provide a foolproof grounding for ethics. Putnam’s choice of Kant (instead of, say, utilitarianism, with its known problems of including respect and justice among its values)53 illustrates the challenge of capturing good intention through theory. Ostensibly, Kant speaks strongly of human dignity, but his criteria have been criticized for being thoroughly ableist (basing moral dignity entirely in rationality and thereby failing to situate the cognitively impaired within the moral community).52–54 Thus the Nazis did (“more or less plausibly” from a Kantian perspective) deny rationality and thereby personhood to the disabled and (implausibly) from a philosophical perspective) deny rationality and thereby personhood to the disabled and (implausibly) but nevertheless effectively) to ethnic and political targets. From the stance of Buber and Levinas, there are no rules to abuse or to dodge by crafting exceptions—the reality of another person is basic, preceding all understanding. As long as we believe we can totally understand the Other, we can become unaccountable fiat of a dictator). In contrast to an unchecked principle of authoritative autonomy, Judaism has two principles of halakhah in response.

Lo bashamayim hi (“the teaching is not in heaven”) is based on the following story in which two sages refuse to change their official ruling in a case of halakhah, even when miracles and Heavenly voices are conjured against them by a third sage:

... After failing to convince the Rabbis logically, Rabbi Eliezer said to them: If the halakha is in accordance with my opinion,
willing collaborator (or even an intellectual contrib-
from the sway of a dictator, but not necessarily for a
would already insulate a professional’s judgment
This alternative concept of professional autonomy
with reason and procedural justice matter as well.
authority merely for authority’s sake; consistency
professionals should eschew uncritical obedience to
wisdom is
particular sort of oven). The real story implies that
rather insignificant (it regards the kosher status of a
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accountability, and how the consequences of their
Thischapterdescribesthatofa
value-laden sense of
responsibility. Mishnat chasadim describes proph-
ets, sages, and legendary rabbis who have enhanced
accountability, and how the consequences of their
failure affect the entire community. Excellence does
not mean that great men are great because they
exceed their obligations, but that “a great man has
higher obligations than other people” at baseline,
precisely because he is great.62(p203)

One story recounts a Talmudic sage whose clay
trees were broken by day laborers. It is normally
within the law to charge workers for damage by neg-
ligence, but in this case the sage was required to pay
them normal wages and take the damages himself,
having the greater privilege and wisdom. Mishnat
chasidim also applies to utilitarian dilemma cases
(e.g. whether to give up a fugitive seeking sanctuary
if the authority threatens violence to the community
for non-compliance; whether to split scarce water
that could save one life to provide insufficient hydra-
tion for many lives). In each of these cases, the
common person’s answer is the one which maxi-
mizes benefits or adheres to a stringent concept of
justice (charge the workers; give up the fugitive;
hoard the water), while the sage’s obligation leans
towards “mercy and self-renunciation,” even when
such unyielding principles lead to worse out-
comes.62(p200)

Even professional ethics have limits, however.
Dilemmas can make any decision impossible to
justify. After studying cases of Jewish prisoner-
physicians in concentration camps, Tessa Chelouche
finds several instances in which the physician was
forced into “unethical” behavior, including lying,
stealing, falsifying patient records, and abortions.10
Ironically, some of these examples are actually
defensible from a halakhic perspective, as “the usual
code among prisoner doctors was that they would
try to do everything to save lives,”10(p710) and
compared to that, other obligations are forfeit (by
pikuach nefesh); abortion is a complex case but
arguably also falls under halakhic precedent to favor
the life of the mother over unborn life.69(p535–58,139–43)
Other cases were impossible to adjudicate by any
rule or principle, as not even pikuach nefesh allows
the sacrifice of one life for another. These cases
included rationing life-saving drugs, infanticide
(both to spare children the gas chamber and to avoid
daughter casualties, whom the Nazis would put to death
for procreating), euthanasia, and collaboration in
inhumane experiments (and in the system in gener-
al). Choosing the path of mishnat chasadim, allow-
wronger outcomes for the sake of principle as the
Talmudic case studies suggest, and even martyring
oneself rather than collaborating, would also con-
demn the doctor’s patients to worse fates. Thus, in
extremis, the real difference between professionals’ behavior is still kavannah – as Chelouche’s assessment similarly implies:

The juxtaposition of the Nazis’ use of medicine to inflict pain and suffering on innocent victims with the Jewish doctors’ attempts, in the absence of even the most basic tools, to alleviate suffering and preserve life demonstrates the diametrically opposed purposes to which medical skills could be put.\textsuperscript{10(p715)}

The cost of true professional intention is also high. Whether ethical principles were available as rationales or not, they would bring the prisoner-physicians little comfort. Their decisions (including the decision to recount them to historians later) are described as “tortured ... excruciatingly painful,”\textsuperscript{10(p714)} and that “once [they] realized that the decision of life and death was in their hands, the responsibility crushed them. They had to justify their actions before their consciences,”\textsuperscript{10(p711)} Doctors in Nazi Germany’s academia were being taught, in the words of Eugen Stähle, “The fifth commandment ‘you shall not kill’ is not a commandment of God but a Jewish fiction.”\textsuperscript{2(p593)} The prison doctors, conversely, did what was necessary in the system, without fooling themselves into thinking the system itself was right, or even that what was necessary was right. In the example of abortion, one analyst puts halakhic decisions in context: “... the landscape of the Holocaust bore no parallel to any other experience, such that rabbinc rulings from within that world cannot be seen, in any way, as creating precedents for halakhic rulings in ‘normal’ times.”\textsuperscript{63(p129)} Rather than allow a theoretical basis of ethics (“a because,” as Putnam calls it) to normalize an atmosphere of death, the prison doctors considered only the lives in front of them, as best as they could.

CONCLUSION

Even for individuals who are non-observant followers of specific faith traditions, the ethical values presented here can provide guidance in modern-day decisions. By exploring the bioethical premises and motivations of Jewish teachings, a physician can recognize (1) life is truly sacred, and neither naturally occurring genetics nor socially occurring diversity in culture should be discounted as “inferior” forms of life (chayim); (2) co-existence should be strived for (shalom); and (3) social justice and compassion (tzedek v’chesed) entail accommodating the sufferer as sufferer in spite of disability. Whether based on eugenics, genomics, or transactional economics, any scientific program (limmud) which can suggest the violation of these principles must face constraints from professional ethics. The locus of responsibility for this determination is on the physician as professional, and the focus can only ever be on the patient. This emphasis bars any Brandt-like notions of “mercy” toward the “unworthy.” Totalitarian medicine was able to operate outside of these values, in part, by silencing the voices that might say “this is not right,” and then normalizing the behavior of killing behind false intentions (a failure of kavannah). Nazi doctors considered (and trained their students to consider) their behaviors ethical, but political ideology and incentives which emphasize the interests of society over caring for individuals dislodge the righteous foundations of medicine, and such dislocations should be resisted whenever and wherever they occur.

As society continues to explore the complex politics of health-care systems, so too its relevant professionals must take part in a self-reflective and diversified professional community to minimize moral errors. Complacency about even the slightest in-house discriminatory practice(s) or barrier(s) to representation hampers a profession’s ability to engage in such reflection. Our current world tests moral intuitions on an increasing number of issues: the rise and renewed popularization of genetic testing, privacy in a digital age of big data research, learning health-care systems which blur the boundaries between research and practice, end-of-life care economics, access to reproduction options, gender and identity politics, RVU-based (relative value unit) compensation, and disparity-based access to health care, to name a few. Before crafting advocacy responses to these issues, professionals must consider whom they represent and for whom they are responding, in terms of individual and societal motivators.

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