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The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?

Ashley K. Fernandes[1] and DiAnn Ecret[2]

[1]*The Ohio State University College of Medicine/Nationwide Children's Hospital, USA*
E-mail address: ashley.fernandes@osumc.edu
ORCID ID: http://orcid.org/0000-0002-8376-0544

[2]*Jefferson College of Nursing, USA*
E-mail address: diann.ecret@jefferson.edu
ORCID ID: https://orcid.org/0000-0001-8145-0203

Abstract

Physicians, nurses, and healthcare professional students openly (and in many cases, eagerly) participated in the medical atrocities of the Shoah. In this paper, a physician-bioethicist and nurse-bioethicist examine the role of hierarchical power imbalances in medical education, which often occur because trainees are instructed 'to do so' by their superiors during medical education and clinical care. We will first examine the nature of medical and nursing education under National Socialism: were there cultural, educational, moral and legal pressures which entrenched professional hierarchies and thereby commanded obedience in the face of an ever-diminishing individual and collective conscience? We will then outline relevant parallel features in modern medical education, including the effects of hierarchy in shaping ethical decision making and conscience formation. We then propose several solutions for the prevention of the negative effects of hierarchical power imbalances in medical education: (1) universal Holocaust education in medical and nursing schools; (2) formative and experiential ethics instruction, which teaches students to 'speak up' when ethical issues arise; (3) acceptance of, and adherence to, a personalistic philosophical anthropology in healthcare; (4) support for rigorous conscience protection laws for minority ethical views that respect the role of integrity without compromising patient care.

Key-words: *Holocaust; medical education; hierarchy; power imbalance; conscience formation; conscientious objection; bioethics education*

I. Hierarchy in the dark days of medicine

In early 2019, Dr. William Husel, an intensive care physician, was accused of the murder of at least 25 patients in Columbus, Ohio (USA) over a period of five years. Dr. Husel trained at one of the most prominent hospitals in the world and yet, according to the criminal complaint, gave his gravely ill patients excessive doses of pain medication in order to hasten their deaths, without the consent of the patients or families.[1] No one forced Dr. Husel to do this, and in order to do it, he needed the cooperation of nurses and pharmacists, some of whom obeyed his orders without question. Years after it began, the killing ended when an employee spoke up and made an anonymous report. What was Husel's true motivation? Why did other health professionals follow his clearly dangerous orders? Why did no one else speak up? What will be the long-term impact on the medical profession, both in the city of Columbus and in the United States?

The horror of this contemporary malfeasance pales in comparison to the destruction wrought by physicians and nurses during the Holocaust, and demonstrates that – despite the clear lessons to be learned from that tragic time in history – certain members of the health professions continue to make irrevocable mistakes; hence all of us need to reexamine the reasons why.

The role of physicians in planning and implementing medical abuses of human persons during the *Shoah* has been well documented – most notably by Robert J. Lifton[2] and Robert N. Proctor[3] – shattering the myth that health care professionals were coerced citizens "forced" to utilize knowledge and skill against those considered unfit for existence. By 1945, half the physicians in Germany had joined the Nazi party and 7% had joined the *Schutzstaffel* (SS), much higher rates than other professions.[4] The Nazi physician played a critical role in organizing and implementing efficient, medicalizing killing by garnering public support using the profession's prestige and status and justifying (to themselves and an eager society) practices such as eugenic sterilization and euthanasia by labeling them with the omnipotent moniker, "science."[5] It is important to realize that the role of medicine in the organization

[1] Bennet Haeberle, "Former Mount Carmel Doctor Pleads Not Guilty to 25 Counts of Murder; Bond Set at $1 Million," *Columbus Dispatch*, https://www.10tv.com/article/former-mount-carmel-doctor-pleads-not-guilty-25-counts-murder-bond-set-1-million-2019-jul.

[2] Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 2000).

[3] Robert N. Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge, Massachusetts: Harvard University Press, 1988).

[4] Proctor, 62-66.

[5] Alessandra Colaianni, "A Long Shadow: Nazi Doctors, Moral Vulnerability and Contemporary Medical Culture," *Journal of Medical Ethics* 38, no. 7 (2012): 435-438.

and implementation of discriminatory public health practices continues to this day.

Paralleling much of modern medicine and academic scholarship, the critical role of (primarily female) nurses in the Holocaust has been understated. Scholars in the field have shown without question, however, that the active participation of nurses (whose party affiliation was as high as 30%)[6] in medical research abuse, eugenic sterilization (especially, but not exclusively, at Auschwitz),[7] and nonvoluntary euthanasia was extensive.[8] The murder of six million Jewish persons, and nine million non-Jewish persons at the hands of the Nazis simply could not have occurred without the active participation of physicians and nurses.

In teaching a course on *Medical Ethics after the Holocaust* for the last eight years, the first author is struck by the most common sentiment among final year medical students at the start: "This simply could not happen here." The egregious human rights violations, torture and medicalized murder that occurred during the Holocaust, as barbaric as they were, are inconceivable to comfortable American students in a democratic republic. Initially, the students fail to recognize that the educational and cultural climate in which they exist – a climate permeated by hierarchy – is not completely dissimilar from that of Germany in the early to mid 1900s. Our hypothesis is that the hierarchical nature of medicine, so ingrained in both clinical education and practice, yet often unnoticed, had a role in shaping the moral actions of healthcare professionals during the Holocaust.

Why stay silent in the face of such evil? According to Colaianni, fear of punishment is not an answer:

> [...] many studies have concluded that, 'after almost 50 years of postwar proceedings, proof has not been provided in a single case that someone who refused to participate in killing operations was shot, incarcerated, or penalised in any way.' Furthermore, a few doctors did refuse to participate and far from being killed for their actions, they were tolerated and even, in some cases, respected for their decisions.[9]

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[6] Mary Deane Lagerwey, "The Third Reich, Nursing, and *AJN*," *American Journal of Nursing* 109, no. 8 (2009): 45-48.

[7] Susan Benedict, and Jane M. Georges, "Nurses and the Sterilization Experiments of Auschwitz: A Postmodernist Perspective," *Nursing Inquiry* 13, no. 4 (2006): 277-288.

[8] Linda Shields, and Thomas Foth, "Setting the Scene," in *Nurses and Midwives in Nazi Germany: The "Euthanasia Programs,"* eds. Susan Benedict, and Linda Shields, 1-12 (New York: Routledge, 2014).

[9] Colaianni, 435.

We are humble in our ambitions and do not intend to provide a complete account of the reasons for complicity in the murder of innocent persons, nor to suggest that hierarchy is the sole or even main culprit. Our view, however, is that the reexamination of the role of physicians and nurses in the Holocaust from the point of view of education is vital; the suffering and death of our brothers and sisters in the camps, at our professions' hands, is an inexhaustible, perpetually renewable source of deep ethical reflection *in every age*. In this paper, we hope to highlight the role of hierarchy in medical education and in medicine broadly, and how reflecting on its effect may help us to avoid profound ethical pitfalls that begin with merely staying silent, yet end tragically with, in Primo Levi's words, "the demolition of a man."[10]

II. What is hierarchy and why is it so important?

i. Hierarchy in healthcare

Those who practice clinical medicine often speak colloquially (and sometimes jokingly) of "hierarchy" as a reality of medical and nursing school, with little further reflection on its effects. While in some respects one could argue for a place for hierarchy in both medical education (e.g., the teacher and student do not – and should not – occupy the same roles) and clinical medicine (e.g., in a cardiac arrest and subsequent code, not every member of the team should be simultaneously giving orders), here we will focus on the potential negative effects that hierarchy can have, both on medical outcomes and moral formation.

Hierarchy in medicine, nursing and other health care structures can be conceptualized by describing unequal power gradients between doctors, nurses, professionals and patients that are common within organizational healthcare system structures; doctors and nurses in training depend upon the supervisory role or oversight of training mentors or preceptors during their educational training and clinical experiences.[11] The supervisory role of the mentor or preceptor builds relationships based upon evaluation processes that determine successful demonstration of competencies through subjective assessment evaluations, or based upon perceived adherence to professional standards of clinical practice. Poor communication, decreased supervision, poor role modeling, human error made in clinical judgments, blaming those with less experience, or the infliction of apprehension or fear for those who

[10] Primo Levi, *Survival in Auschwitz: The Nazi Assault on Humanity*, trans. Stuart Woolf (New York, New York: First Collier Books, 1993), 26.

[11] Bill Runciman, Merry Allen, and Merrilyn Walton, *Safety and Ethics in Healthcare: A Guide to Getting it Right* (Burlington, VT: Ashgate Publishing, 2007), 72.

are in positions of lower authority can contribute to factors that increase harms to those who are being cared for in health care systems.[12] [13]

However, the hierarchical power imbalances do not begin or end with the training of inexperienced nurses and doctors by their immediate supervisors or with the hierarchical imbalances that occur between prescribing physicians and professions that carry out orders in clinical practice; in fact, the entire organizational structure is dominated by hierarchy.[14] The dominance of organizational structures today requires professionals to increase patient outcomes, decrease patient length of stay, and decrease cost of care, all of which becomes a daunting task for professionals in response to the complexities of patient health conditions.[15]

In the time of National Socialism, organizational structures might have been legal and regulatory forces, including the bureaucracy charged with medical education, health care delivery (and discrimination), employment, and the execution and implementation of the racial hygiene and anti-Semitic exclusionary laws, which further stigmatized Jewish professionals and citizens.

Perhaps the heightened hierarchical imbalance today is best displayed through the vulnerability of a patient who seeks the care of trained professionals during moments of intense human vulnerability and illness. During a physiological and psychological stressed state, the patient encounter with the health care provider and health care system remains a relationship of particular or special vulnerability; despite initiatives to diminish this vulnerability for patients through patient centered care initiatives, those with the authority, resources, and knowledge to manage such illness and disease continue to function within a hierarchical authority gradient that places the care of those with the least authority, education, and support at risk for harms.[16] This relationship highlights the "downward slope" of hierarchy – if physicians occupy the higher positions, and then the nurses, the influence of the power differential becomes exaggerated as one considers the patient and family.

ii. Hierarchy's effects on patient care

The hierarchical relationship between physicians and nurses and supervisors and trainees is known to have negative effects on interprofessional commu-

[12] Ibid., 72-79

[13] Robert M. Wachter, *Understanding Patient Safety* (New York: McGraw Hill Medical, 2012), 149-157, 260-262.

[14] Ibid., 149.

[15] Ibid., 149-150.

[16] Henk ten Have, *Vulnerability: Challenging Bioethics* (New York: Routledge, 2016), 126

nication and relationships – effects that can directly affect patient care.[17] [18] Often, the silencing of nurses (voluntarily or involuntarily), can increase the risk of medical errors, as one nurse writes:

> This isn't about hurt feelings or bruised egos. Modern health care is complex, highly technical and dangerous, and the lack of flexible, dynamic protocols to facilitate communication along the medical hierarchy can be deadly. Indeed, preventable medical errors kill 100,000 patients a year, or a million people a decade [...] Because successful health care needs to be interdependent, the silencing of nurses inevitably creates more opportunities for error. In a system that is already error-prone and enormously complicated, where health care workers are responsible not just for people's well-being, but their lives, behavior that in any way increases dangers to patients is intolerable. When I became a nurse, that's not the kind of harm I signed on for.[19]

Silence has an effect on conscience, and the hierarchy of the Nazi establishment attempted to suppress conscience and ensure absolute silence amongst their nurses by requiring written nondisclosure agreements that prohibited interactions with the inmates or discussion of the daily activities within the concentration camps.[20] Maria Stramberger, a nurse of the resistance, signed the nondisclosure statement without intention of keeping silent, but rather with the conviction to help those in need, despite the risk to her own life.[21] The more a human person is reticent to speak out (whatever the reason), the less they are able to discern *when* to speak out the next time. We note, however, that medical error today (in which both physician and nurse are truly looking out for the patient's best interests) is vastly different in kind than the deliberate harm of Nazi physicians and nurses. The point we are trying to make is that there is a *moral lapse* when an error is *deliberately* not disclosed or a potential harm not stopped because of reticence; the moral lapse is much worse if the harm is intentional (as in the Nazi healthcare profession-

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[17] Erika Gergerich, Daubney Boland, and Mary Alice Scott, "Hierarchies in Interprofessional Training," *Journal of Interprofessional Care* 33, no. 5 (2019): 528-535.

[18] Carolyn DiPalma, "Power at Work: Navigating Hierarchies, Teamwork and Webs," *Journal of Medical Humanities* 25, no. 4 (2004): 291-308.

[19] Teresa Brown, "Healing the Hospital Hierarchy," *New York Times*, March 16, 2013, https://opinionator.blogs.nytimes.com/2013/03/16/healing-the-hospital-hierarchy/.

[20] Susan Benedict, "Maria Stromberger: A Nurse in the Resistance in Auschwitz," *Nursing History Review* 14, no. 1 (2006): 189-202.

[21] Ibid.

als and the story of Dr. Husel at the beginning of this paper). All of these stories relate to how the hierarchy of medicine, without proper controls, can encourage silence and moral apathy, which harms patients.

iii. Hierarchy's effect on moral conscience

It is not difficult to imagine how deference to authority might lead to the erosion of one's conscience through not "speaking up" when unprofessional or unethical behavior occurs. Numerous studies confirm this phenomenon,[22] [23] including the disturbing notion that medical trainees are introduced to the "hierarchy" through processes of humiliation and fear.[24] In one Irish study focusing on emotional responses to hierarchy, the responses of two trainees are quite telling: a female trainee commented, "There's very much the patriarchal thing of the consultant [senior physician], you never question them and you're there to do exactly what they say' (Participant 40, female);" another said, "You're dealing with people who've been there for 10 years, 20 years, 30 years [...] You can't really say anything because it's so poorly received' (Participant 10, male)."[25]

In addition, little incentive is given to alter the structure of the hierarchy, nor are such mechanisms accessible – especially to trainees. Medical professionals have not only become accustomed to unprofessional behavior toward themselves and others within the hierarchy, but the fear of retaliation and the lack of institutional incentives to change (e.g., accreditation) have further eroded students' empathy.[26]

"Empathy erosion," like the hierarchy, is a well-documented phenomenon in medical and clinical education, and the two are clearly interrelated. Melanie Neumann and colleagues systematically reviewed reasons for medical trainees' empathetic erosion and discovered that not only does hierar-

[22] Catherine V. Caldicott, and Kathy Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal: Lessons in Ethics from Third-Year Medical Students," *Academic Medicine* 80, no. 9 (2005): 866-873.

[23] William Martinez, Sigall K. Bell, Jason M. Etchegaray, and Lisa S. Lehmann, "Measuring Moral Courage for Interns and Residents: Scale Development and Initial Psychometrics," *Academic Medicine* 91, no. 10 (2016): 1431-1438.

[24] Heidi Lempp, and Clive Seale, "The Hidden Curriculum in Undergraduate Medical Education: Qualitative Study of Medical Students' Perceptions of Teaching," *British Medical Journal* 329 (2004): 770-773.

[25] Sophie Crowe, Nicholas Clarke, and Ruairi Brugha, "'You do not Cross Them:' Hierarchy and Emotion in Doctors' Narratives of Power Relations in Specialist Training," *Social Science & Medicine* 186 (2017): 70-77.

[26] Edison Vidal, et. al., "Why Medical Schools are Tolerant of Unethical Behavior," *Annals of Family Medicine* 13 no. 2 (2005): 176-180.

chical mistreatment play a significant role, but over time, empathy erosion can have a negative impact both on patient outcomes and on what one study called "moral judgment competence" – "the capacity to make decisions and judgments which are moral (i.e., based on internal principles) and to *act* in accordance with such judgments."[27] This is, essentially, the definition of conscience.[28] Simon Baron-Cohen takes the erosion of empathy to be the root of evil behavior and makes the direct connection between a loss of empathy, the dulling of the human conscience, the "turning of people into objects," and the ability to inflict the unimaginable cruelty of the Holocaust.[29]

III. The entrenchment of hierarchy under National Socialism

In a recent paper, Shmuel Reis and his colleagues, in reflecting on lessons learned from the Second International Scholars Workshop on Medicine during the Holocaust and Beyond (2017) affirmed the crucial role of the hierarchy in the corruption of the medical profession:

> Medicine is a hierarchical profession, with senior clinicians issuing orders to be carried out by junior ones, and where physicians often direct or command allied health personnel. While these features of medicine are applied with the noble goal of healing and administering best practices within humanistic care, the combination of elements of hierarchy, obedience, and power constitutes a risk factor for abuse of power.[30]

What factors led to the entrenchment of a malignant hierarchy in medicine under National Socialism? We wish to highlight three: educational/cultural; moral/philosophical; and legal. These three overlapping factors all profoundly influenced ethical decision making for both physicians and nurses during this time period and are instructive to revisit.

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[27] Melanie Neumann, et al. "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," *Academic Medicine* 86, no. 8 (2011): 996-1009.

[28] Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 135-149.

[29] Simon Baron-Cohen, *The Science of Evil* (New York: Basic Books, 2017): 1-17.

[30] Shmuel Reis, Hedy Wald, and Paul Weindling, "The Holocaust, Medicine and Becoming a Physician: The Crucial Role of Education," *Israel Journal of Health Policy Research* 8, no. 1 (2019): 1-5.

i. Educational/cultural factors

All persons are moral beings, and any act is a moral act if it is performed with both intellect and will. Hence moral acts by moral beings do not occur in a vacuum, and the cultural milieu in which the "actor" lives will affect the decisions she makes. Likewise, persons and their ethical acts will also affect the culture at large. In particular, because of the high esteem the medical profession held in Nazi Germany with the general populace, Nazi leadership prioritized the active participation of the medical profession. Martin Bormann, the secretary to Adolf Hitler, famously said, "The Führer holds the cleansing of the medical profession far more important than that of the bureaucracy, since in his opinion the duty of the physician is or should be one of racial leadership."[31] Edmund Pellegrino noted that

> What the Nazi doctors illustrate is that ethical teaching has to be sustained by the ethical values of the larger community. In Germany, this support system was weakened well before the Holocaust and the experiments at Auschwitz. German academies, especially psychiatrists, were leaders in theories of racial superiority, social Darwinism, and the genetic transmissibility of mental illness before Hitler came to power.[32]

In short, like a firestorm whose own heat and energy continues to sustain it in a swirling, diabolical fashion, culture and medical ideology continuously circle back to one another.

Thinking of how cultural education might influence medical education, we must again reflect on the structure of hierarchy. The "sage on stage," so common in our medical education, has the medical or nursing professor as the disseminator of true wisdom, of objectivity, and of the knowledge and power of science – the latter being perhaps the most coveted of the three. Even today, medical and nursing students in both the classroom and clinic are reluctant to question a "superior." Sometimes this may be out of fear, but often - though rarely mentioned – it is simply because the nature of education in a hierarchy is to simply *believe* one's teacher. Medical and nursing students living in the time of National Socialism would have no reason to disbelieve their professor or mentor – particularly in a larger culture of anti-Semitism, where the "strongman" will-to-power rules and the individual's duty is to subjugate

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[31] Naomi Baumslag, *Murderous Medicine: Nazi Doctors, Human Experimentation, and Typhus* (Westport CT: Greenwood Publishing, 2005), 47.

[32] Edmund D. Pellegrino, "The Nazi Doctors and Nuremberg: Some Moral Lessons Revisited," *Annals of Internal Medicine*, 127, no. 4 (1997): 307-308.

their own desires to the broad interests of the state. Florian Bruns has documented that the teaching of medical ethics in Nazi-era medical schools (a new course in a revised curriculum in 1939) was done solely by party loyalists as lecturers. They used a textbook authored by Rudolph Ramm that praised the cleansing of the medical professions from those foreign to the Aryan race, openly advocated for the killing of disabled persons, and supported eugenic sterilization laws. Ramm

> [...] believed in the authoritarian paternalistic role of the physician as a 'health leader' and blatantly defined the Nazi physician's ethical obligation as being responsible for ridding society of certain groups: Jewish persons, disabled persons, and any others who were deemed unable to contribute to society.[33]

German physicians and the Nazi leadership over time thus created a powerful biological metaphor, easily understood by the common man or woman: *Germany is a body*. To keep the body healthy, it was the duty of each citizen to preserve those things in the racial state that led to "health," and to destroy or cut out those things that could lead to the death of the Reich. Hence, Jews were a "disease" that must not merely be suppressed, but rooted out. This is a powerful, easily understood metaphor by lay people, people willing to put physicians and nurses in charge of eradication. A "biological organism" is one that is predictable, empirical, material. There is no mystery that we cannot discover or manipulate for our ends. While we cannot own the metaphysical or mysterious, we can own, control, and dominate the material body – including those of others, for the sake of the state.

The cultural and educational environment of nursing is understandably different, and, given the diminished power and autonomy of nurses (and in particular, female nurses) during this time, the ethical pressure and influence on them from those higher in the power structure would have been tremendous, and the prominence and profiles of male Nazi "physicians and scientists" would have, no doubt, been higher. Susan Benedict and Jane Georges point out that "the very nature of nursing as a female-dominated profession, with its historical commitment to the relief of suffering, has rendered its involvement in the Holocaust unthinkable, and therefore, invisible." Yet, the fact remains that nurses were active, willing participants in the horrors of Auschwitz and other death camps.[34]

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[33] Florian Bruns, and Tessa Chelouche, "Lectures on Inhumanity: Teaching Medical Ethics in German Medical Schools Under Nazism," *Annals of Internal Medicine* 166, no. 8 (2017): 591-596.

[34] Benedict and Georges, 286-287.

ii. Moral factors

Duty was another critical concept in understanding the moral culture of nursing at the time. According to Andrew McKie, nurses were able to justify doing horrific, unpleasant things because it was their duty to do so – they did not have to "like it" to do it. Furthermore, important and necessary principles of past and current nursing practice – executing orders, precision, and confidentiality all took on a new meaning when applied to participation in the killing of others.[35] It should be noted that moral actions for the sake of duty still involve an active will – nurses, whatever the justification – were committing and cooperating with moral evil, albeit in an extreme of the hierarchical environment.

Thus, while Stanley Milgram's "agentic state" theory of moral agency – the notion that a perpetrator sees himself as an *instrument* of another (person, state) and therefore ceases to feel personal responsibility – has often been associated with health professionals in the Holocaust, this association has more recently come under scrutiny. In large part, this is due to the fact that most physicians and nurses (unlike the participants in Milgram's experiments) felt no regret while committing medical atrocities, nor did they actively seek a way out.[36, 37] Instead, the agentic state should be seen as a moral choice,[38] rather than a psychological state. That is to say, especially within the hierarchy of medicine, it would be easy for a person (e.g., a medical resident or nurse) to make a moral choice at the direction (but not compulsion) of another and then choose to transfer responsibility to the person responsible for training them.

Michael von Cranach has commented on the effect the medical hierarchy had on the individual's conscience within Nazi psychiatry, a negative effect leading to the abuse and murder of some of the most vulnerable patients in medicine. He estimates that 200,000 such persons were killed with the aid of the "elite" of the psychiatric profession. Von Cranach concludes that hierarchies tend to "blur" the concepts of responsibility and conscience, allowing a person to transfer responsibility for an individual action to the authority over them. Hence, "openness, transparency, and civil dialogue" – *not* typically compatible with hierarchy – are sacrificed.[39]

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[35] Andrew McKie, "'The Demolition of A Man:' Lessons From Holocaust Literature For The Teaching Of Nursing Ethics," *Nursing Ethics* 11, no. 2 (2004): 138-149.

[36] Allan Fenigstein, "Milgram's Shock Experiments and the Nazi Perpetrators: A Contrarian Perspective on the Role of Obedience Pressures during the Holocaust," *Theory and Psychology* 25, no. 5 (2015): 581-598.

[37] Allan Fenigstein, "Were Obedience Pressures A Factor in the Holocaust?" *Analyse & Kritik* 20, no. 1 (1998): 54-73.

[38] Nestar Russell, and Robert Gregory, "Making the Undoable Doable: Milgram, the Holocaust, and Modern Government," *The American Review of Public Administration* 35 no. 4 (2005): 327-349.

[39] Michael von Cranach, "Ethics in Psychiatry: The Lessons we Learn from Nazi Psychiatry," *European Archives of Psychiatry and Clinical Neuroscience* 260, no. S2 (2010): 152-156.

iii. Legal factors

Hierarchies – medical or otherwise – are also not very compatible with change or upward mobility: there is a natural resistance to it. The Nuremberg Laws of 1935 codified racism and banned marriages and other sexual activity between Jews and non-Jews, purportedly to prevent "mixing of blood."[40] Such laws no doubt created a tremendous stigma in a culture already primed for anti-Semitism by centuries of scapegoating; but, by being embraced by physicians, researchers, and the major medical and scientific journals throughout Germany, the Nuremberg Laws tied legal regulation to "science." Now physicians or nurses in training had a consistency of messaging.

Prior to Hitler's rise to power in 1933, Jewish doctors had risen to prominence in many of the large cities in Germany and Austria, and the national health system's rules meant that physicians had to wait for vacancies before they could rise within the ranks.[41] When the Nazis came to power, they systematically banned Jews from medical teaching positions, stripped them of academic rank and title, removed the ability to have pensions or insurance, and did not allow them to practice medicine on non-Jews. Jews permitted to practice medicine as an exception (in part, to not overburden non-Jewish physicians with patients) were not allowed to call themselves "physicians," but had to be referred to as "attendants." The ban on Jews treating non-Jews was even incorporated into Ramm's medical ethics textbook in 1942.[42] Even Dr. Otto Loewi, the Jewish Nobel Prize winner in Medicine (1936) was forced to leave Germany in 1938, but only after transferring his award money to a Nazi-affiliated bank.[43] Because of their absence, Nazi-affiliated physicians and other non-Jews could now occupy ranks of the hierarchy hitherto out of reach. By 1940s, as Proctor notes, Ramm had declared that "no man of German blood is treated by a Jewish doctor."[44] Once Jews were excluded, non-Jewish physicians filled the open spaces; indeed, as a result of the Nuremberg Laws and the purging of Jews from medicine, the numbers of physicians in Germany actually *increased*.

Why is this important? The legal exclusion of Jewish health care professionals created a powerful conflict of interest for physicians and nurses; even

[40] Proctor, 131-176.

[41] Alexa R. Shipman, "The German Experiment: Health Care without Female or Jewish Doctors," *International Journal of Women's Dermatology* 3, no. 1 (2015): 108-110.

[42] Proctor, 138-155.

[43] The Nobel Prize, "Otto Loewi: Biographical," https://www.nobelprize.org/prizes/medicine/1936/loewi/biographical/.

[44] Proctor, 154.

if they did not support Nazi racial policy, the laws provided them a financial incentive to stay silent, and in doing so, to improve their economic and social position. Once ensconced in the hierarchy of medicine – then as now – it is extremely difficult to withdraw from it, to have the courage to do the right thing in a culture where the laws not only stigmatized Jewish physicians and health care workers, but their very blood as well.

IV. The dangers of modern medicine and possible answers

i. Cultural/educational dangers and possible solutions

We believe the involvement of nurses and doctors in the Holocaust can teach us perpetual lessons that deserve revisiting. It is well known that medical students face the ethical and professional dilemmas of "speaking up,"[45, 46] and that, as practicing physicians, the moral courage to do so becomes even higher stakes when patient safety is at risk.[47] David Malloy and colleagues, in a comparison study across four different countries, describe the phenomenon so present in nursing culture, of the "silenced voice:" "Despite their belief that they were aware of patients' needs and wishes, and capable of acting and/or recommending treatment, their voices were often silenced by the system, physicians, and patients and their families, albeit sometimes voluntarily."[48] These are dangerous developments for the moral health of the profession. Will the health care professionals of today have the courage to speak up, especially when the vulnerable human person is at risk? Will they be willing to challenge the existing hierarchy when they think someone is wrong *morally*, and if so, how?

In medical education, several reforms should be undertaken in practical ethics. First, we believe that "Medicine and the Holocaust" courses can be very successful and should be mandatory in every medical and nursing school in the United States. M.K. Wynia and his colleagues reported the results of a Liaison Committee for Medical Education (LCME) survey of 140 medical schools in the USA and Canada that showed only 22/140 (16%) "have any

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[45] James Dwyer, "*Primum Non Tacere*: An Ethics of Speaking Up," *Hastings Center Report* 24, no. 1 (1994): 13-18.

[46] Dimitri A. Christakis, and Christopher Feudtner, "Ethics in a Short White Coat: The Ethical Dilemmas that Medical Students Confront," *Academic Medicine* 68, no. 4 (1993): 249-254.

[47] William Martinez, et al., "Speaking Up about Traditional and Professionalism-related Patient Safety Threats: A National Survey of Interns and Residents," *British Medical Journal Quality and Safety* 26, no. 11 (2017): 869-880.

[48] David Malloy, et al., "Culture and Organizational Climate: Nurses' Insights into their Relationship with Physicians," *Nursing Ethics* 16, no. 6 (2009): 719-733.

required curricular elements on the roles of physicians in the Holocaust, and half of these (11/22) teach this material using a lecture format only."[49] In recent years, important first steps have been made, both in the US and internationally, and demonstrate the success of both online and in-person teaching modalities.[50] The first author of this paper has shared a model for teaching medical ethics and the Holocaust that is flexible, low-cost, and generates a high level of student satisfaction; he has continued to teach this course in online and in-person formats for medical students and graduate students in bioethics.[51] The Galilee Declaration, signed by scores of physicians, bioethicists, historians, and medical educators, calls for the universal adoption of Holocaust education for the health professions.[52]

Second, ethical education that focuses on vital concepts such as improving empathy through faculty development in modelling and small group interactive cases,[53] defining virtues such as moral courage,[54] and, above all, *practice* and simulation in speaking up during ethical encounters,[55, 56] will provide preventative measures to slow the pattern of moral erosion and loss of empathy we have already alluded to.

Finally, interprofessional education and collaboration that encourages teamwork, transparency, and the ability for physicians, nurses, and trainees to practice "speaking up" is critical. This important work is already being done in a number of medical contexts,[57, 58] and needs to be expanded to empower

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[49] M. K. Wynia, W. S. Silvers, and J. A. Lazarus, "How Do U.S. and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust?" *Academic Medicine* 9, no. 6 (2015): 699-700.

[50] Reis, Wald, and Weindling, 3-5.

[51] Ashley K. Fernandes, "Nazi Medicine and the Holocaust: Implications for Bioethics Education and Professionalism," in *Nazi Law: From Nuremberg to Nuremberg*, ed. John J. Michalczyk (London: Bloomsbury Press, 2017): 149-153.

[52] Western Galilee College, "The Galilee Declaration," http://english.wgalil.ac.il/category/Declaration.

[53] William T. Branch, "Supporting the Moral Development of Medical Students," *Journal of General Internal Medicine* 15, no. 7 (2000): 503-508.

[54] Olivia Numminen, Hanna Repo, and Helena Leino-Kilpi, "Moral Courage in Nursing: A Concept Analysis," *Nursing Ethics* 24, no. 8 (2016): 878-891.

[55] James Dwyer, and Kathy Faber-Langendoen, "Speaking Up: An Ethical Action Exercise," *Academic Medicine* 93, no. 4 (2018): 602-605.

[56] Ashley K. Fernandes, et. al., "Integrating Simulated Patients in TBL: A Strategy for Success in Medical Education," *Medical Science Educator* 29, no. 2 (2019): 383-387.

[57] Liane Ginsburg, and Lorna Bain, "The Evaluation of a Multifaceted Intervention to Promote 'Speaking Up' and Strengthen Interprofessional Teamwork Climate Perceptions," *Journal of Interprofessional Care* 31, no 2 (2017): 207-217.

[58] Nancy Berlinger, and Elizabeth Dietz, "Time-out: The Professional and Organizational Ethics of Speaking Up in the OR," *American Medical Association Journal of Ethics* 18, no. 9 (2016):

those "lower" on the hierarchy to utilize their conscience without fear or apathy setting in.

ii. Moral dangers and possible solutions

While in the US and Europe, the political forces of the "will-to-power" that made fascism possible seem remote, philosophical threats to the human person remain ever acute and urgent. Physicians, nurses, and those who work in the health care field will never be able to safeguard the dignity of human persons from society's threats, and – perhaps especially – from our own corruption, unless we can adopt, first and foremost, a *philosophical solution*.

The philosophical anthropology of personalism was beautifully articulated by French philosopher Jacques Maritain in *The Person and the Common Good*, where he advanced a *relational aspect* of personhood that is critical for our discussion.[59] In National Socialism, Maritain lived through the danger of having a concept of "person" which is not absolute, one in which other "goods" (race, state, profit) obscured the good of the individual human person. Nazi physicians had, in fact, a robust concept of person – but only if one contributed to the race. The elimination of the vulnerable made perfect sense, for society was merely a collection of individuals who live together out of convenience or self-interest. Personalism, by contrast, posits the ultimate unit of value is the individual person herself. Society is and ought to be built around this value. No contingent factor – race, religion, economic status, disability, or actions of the past, present or future – can rob a person of the dignity she is owed. Integrating this kind of rigorous, universal philosophical anthropology is an antidote to the corruption of medicine, and vital for the prevention of future genocides.

Today, we seem to be caught in a medical and educational culture of radical individualism, where we cannot "impose" *any beliefs* about right or wrong on others, and where the value of persons seems to be exclusively up to oneself (whether in error or not). We are often taught in training (within the "hidden curriculum") to prioritize "population-based medicine" over the individual patient. The medical profession proposes, permits, or participates in euthanasia and assisted suicide for persons with severe dementia,[60] depres-

925-932.

[59] Jacques Maritain, *The Person and The Common Good*, trans. John J. Fitzgerald (South Bend: University of Notre Dame Press, 1985).

[60] Tony Sheldon, "Dutch Approve Euthanasia for Patient with Alzheimer's Disease," *British Medical Journal* 330, no. 7499 (2005): 1041.

sion and schizophrenia,[61] autism,[62] addiction,[63] and even transgenderism.[64] Tours of Auschwitz have been given as a "learning experience" for supporters of euthanasia.[65] Abortion has been touted as a form of good eugenics that reduces crime[66] and disability.[67]

But, if a person is the fundamental unit of value of our society, then no "other good" can eclipse her. Practically, this must mean an expansive definition of person, and the end of physician and nurse involvement in killing of any kind – in state-sponsored torture, capital punishment, euthanasia, and eugenically motivated sterilization and artificial reproductive technologies. Then, as now, the consequences of a disordered philosophical anthropology necessarily have an impact on relationships to others, and to society.

iii. Legal Dangers and Possible Solutions

We have discussed the connection between hierarchy and the dulling of one's moral conscience. It should be obvious, then, that the protection and right use of conscience in medicine is an essential virtue, both for speaking up as individuals when wrongdoing occurs – and collectively as a profession of nurses and physicians, for the safeguarding of our shared values. Now, however, the right of conscientious protection for health care professionals who oppose the prevailing moral view on issues such as abortion, sterilization, or euthanasia is under siege. Julian Salvulescu and Udo Schuklenk, for example, recently made this startling claim which seeks to exclude physicians from practice who refuse to perform (legal) procedures they deem (medically or morally) harmful to their patient:

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[61] J. Scott, Y. H. Kim, Raymond De Vries, and John R. Peteet, "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014," *Journal of the American Medical Association Psychiatry* 73, no. 4 (2016): 362-368.

[62] Maria Cheng, "Belgium Investigates Doctors Who Euthanized Autistic Woman," *Associated Press News*, November 27, 2018, https://www.apnews.com/249a8067af6740d2af22ed66fc9e1a90.

[63] Wayne Hall, and Malcom Parker, "The Need to Exercise Caution in Accepting Addiction as a Reason for Performing Euthanasia," *Addiction* 113, no. 7 (2017): 1178-1180.

[64] G. Heylens, et. al., "Transgender Persons Applying for Euthanasia in Belgium: A Case Report and Implications for Assessment and Treatment," *Journal of Psychiatry* 19, no. 1 (2016): 347-348.

[65] K. Kuntz, "Euthanasia Doctors Seek Existential Answers at Auschwitz," *Spiegel Online*, November 21, 2014, http://www.spiegel.de/international/zeitgeist/belgian-euthanasia-doctors-seek-answers-at-auschwitz-a-1003441.html.

[66] J. J. Donohue, and S. D. Levitt, "The Impact of Legalized Abortion on Crime," *The Quarterly Journal of Economics* 116, no. 2 (2001): 379-420.

[67] D. P. Dixon, "Informed Consent or Institutionalized Eugenics? How the Medical Profession Encourages Abortion of Fetuses with Down Syndrome," *Issues in Law and Medicine* 24, no. 1 (2008): 3-59.

> Doctors must put patients' interests *ahead of their own integrity* [...] If this leads to feelings of guilty remorse or them dropping out of the profession, so be it [...] There is an oversupply of people wishing to be doctors. The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside, once these procedures are legal and a part of medical practice.[68]

What the deafening silence from medical professionals in the Holocaust has taught us, however, is that conscience is everything – and, even if we do not agree with the minority view, the default position should be tolerance, if we are to empower those who would protect medicine's values from (present and) future corruption. We must therefore have rigorous conscience protection for physicians, nurses and other health care providers. While contemporary literature in bioethics favors the removal of conscience protection laws, particularly on "hot button issues" such as abortion, contraception, sterilization, and now euthanasia, some have made powerful defenses of it.[69] We side with this "minority" view – a physician or nurse's oath to her patient is only as strong as her conscience; allow (or even force) her to break it, and we have forgotten that conscience is an active, driving force that is part of who we are as persons.

Ronit Stahl and Ezekiel Emmanuel[70] have also argued for the end of conscience protection laws, citing (in part) the fact that physicians are bound by duties set by the regulatory agencies that license them. Therefore, if something is both legal and permitted by a medical licensing body, a physician (and, in our view this applies *a fortiori* to nurses) should not be permitted to refuse. They even call for the (voluntary) exclusion of conscientious objectors from the profession. While not strictly statutory in nature, it should be noted that regulatory bodies and licensing agencies still exert the force of law on health care professionals and exert tremendous social and economic pressure on practitioners. This pressure can be nefarious when ethical reform is actually needed – and indeed might silence it, if physicians or nurses are

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[68] Julian Savulescu, and Udo Schuklenk, "Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception," *Bioethics* 31, no. 3 (2017): 162-170, 164 [italics by the authors].

[69] Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 135-149.

[70] Ronit Y. Stahl, and Ezekiel J. Emmanuel, "Physicians, Not Conscripts – Conscientious Objection in Healthcare," *New England Journal of Medicine* 376, no. 14 (2017): 1380-1385.

worried that speaking out, or refusing to act, might result in not being able to practice.

Calls for exclusion and ostracization[71] of physicians with minority ethical views should alarm us, regardless of our own political or religious affiliation. The exclusion of Jewish physicians under National Socialism had a tremendous moral cost as an inherently unjust act, but it also had a medical and economic cost, since it oppressed some of the brightest, most capable physicians Germany had – simply because as persons their existence went against the prevailing medical ideology. Christopher M. Radlicz and Ashley K. Fernandes note that there is also a potential cost to the suppression of conscience today that will hurt medicine in the long run:

> Medical training is naturally hierarchical and inherently tends to encourage a culture of subordination. During training, there are incentives not to speak up, even when there is explicit evidence of wrongdoing. Since residents and attending physicians often complete evaluations in places of authority, students will readily subjugate everything from bodily needs to their conscience in order to appease their attending physicians [...] The weakness of conscience leads to a chipping away of one's moral compass, which changes the person herself. Inaction can occur when there is worry about repercussions from conscience expression. For the physicians and students who try to do right, this may lead to a deep resentment or apathy, which may prompt an exit of the medical field of those we need the most, certainly to the patients' detriment. So, while opponents of conscientious objection define the problem as a simple one – get rid of the "problematic, religious physician" and the problem is solved – in fact doing so weakens the moral nature of the profession as a whole, by removing those very persons who are most committed to integrity.[72]

In order to stop the cycle of empathetic erosion, conscience dulling, silence, and moral apathy, persons need to be free to decide the right, and empowered to act on that right within the medical system. Had physicians and

[71] Christian Fiala, and Joyce H. Arthur, "'Dishonourable Disobedience' – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection," *Woman - Psychosomatic Gynaecology and Obstetrics* 1 (2014): 12-23.

[72] Christopher M. Radlicz, and Ashley K. Fernandes, "Physician Conscience and Patient Autonomy: Are They Competing Interests?" *Linacre Quarterly* 86, no. 1 (2019): 139-141, quote from 140-141.

nurses in the Holocaust done more of precisely this, many of the medicalized horrors might have been prevented.

V. Conclusions

Physicians and nurses during the time of the *Shoah* committed moral acts of omission and commission that were reprehensible and sacrificed the lives of millions of innocent patients. The hierarchy of medicine contributed to the silence of health care professionals, the suppression of moral courage and the individual and collective conscience. In this paper, we have tried to suggest that cultural, educational, moral, and legal factors all played a role in strengthening the power of the hierarchy and exerting negative moral influences and pressures on people sworn to protect the vulnerable patients. There are significant warning signs for the ethical character of contemporary medicine. We call for universal medical and nursing education in Holocaust studies that incorporate empathy-building exercises, which emphasize universal practices in the art of "speaking up." We also suggest a rigorous adherence to a personalist philosophical anthropology that reaffirms legal commitments to conscience protection for doctors and nurses. Such acts will demonstrate that the lessons learned from the Holocaust have not been forgotten and that initiatives to speak up against hierarchy will build resilience and ethical character within an environment that actively seeks to protect the vulnerability of the patients we serve.

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