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Chapter 6

A Duty of Care: Rationalising Compassion and Cruelty through Women's Experiences of War

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*"We wish to remember. But we wish to remember with a purpose –
namely to ensure that never again will evil prevail"*

(Pope John Paul II, Yad Vashem, Jerusalem), March 23, 2000

Abstract

Core ethical principles should uphold the practice of medicine, a profession in which society places considerable trust in its members. During the Second World War, however, these principles were deliberately ignored by Nazi physicians but, in the ghettos and concentration camps, they were also compromised by many Jewish doctors as they desperately attempted to minimise harm for the greater good. In this chapter, three female academics, a medical scientist, a doctor and a psychologist have each identified and then describe a woman's experiences during the Second World War. One might be considered a heroine for alleviating some of the angst of thousands of men and women travelling to an unknown fate on their way to the fighting, one a victim as a child and another a perpetrator of crimes against fellow human beings during the Holocaust. Through the lenses of their experiences and personal recollections, oral histories have led to the scrutiny of larger social issues. More specifically, through the testimonies of these women who were positioned at various junctures along the complex trajectory of war, which were considered from our multidisciplinary perspectives, allows us to continue to question and provide commentary in modern society, especially in the field of medical education.

Introduction

When Marie-Claire, a colleague and one of the editors of *Women and War: Opening Pandora's Box*, asked me to contribute to this book, I was not sure if I had a story that could be told. What experience did I have of women and war? It was only after a lengthy discussion on one of our regular Wednesday afternoon walks around the lake that the idea of this chapter was born. I had read Tessa Chelouche's 2005 and 2008 articles dealing with the medical atrocities committed during the Holocaust whilst reviewing the literature for a commissioned paper in a series entitled *Professionalism under Fire* for the journal, *Medical Teacher*, in 2014. Our contribution was to report on lapses of medical professionalism during conflict, war and epidemics (McLean, Jha & Sandars, 2015). I sent Marie-Claire Tessa's 2005 article which told first-hand of many Jewish doctors' moral and ethical dilemmas in the ghettos and concentration camps of World War II, often having to decide who lived and who died, who they had to protect and who they had to sacrifice for the greater good. Marie-Claire's response was that this was indeed a story that should be told.

I had found Tessa's papers confronting and wondered if, in the 21st century, others might still be reviled by the atrocities committed during the Second World War or whether such stories of abuse and genocide had faded in history. To provide different perspectives on the behavior and actions of German doctors which had led to the often painful death of millions of Jews, gypsies, homosexuals, lesbians and mentally and physically challenged individuals during the Holocaust, I invited two of my female colleagues, one a general medical practitioner (Anne) and the other a psychologist (Sally) to provide their perspectives on the content of Tessa's papers. I did not want to pre-empt them about the nature of the articles so I briefly explained the purpose of the book and that I had come across these two journal articles whilst preparing the *Medical Teacher* manuscript. Having raised their curiosity, both were willing to contribute. I then sent them Tessa's articles, asking them to read them chronologically (i.e. first the 2005 one, followed by the 2008 one). I requested that they write down or record their immediate reactions and thoughts as they read the papers. We then met to discuss their responses and how they thought they could contribute to the chapter. Like me, they too had found the articles confronting. For Anne, with a long-standing interest

(because of her mother's experiences during the War) in the atrocities of World War II, her immediate response had been one of anger directed at the German medical profession, individuals who were willingly complicit and even gained financially from causing harm to and exterminating several million Jews, Gypsies and other 'parasites', which is how many Germans came to view these groups of individuals. For Sally, it was her realization that while psychological theories could probably explain individual behavior, the theories fell dramatically short of adequately explaining the behavior of the German medical profession in terms of racial cleansing and eugenics.

Each of our stories identifies a woman whose life was intimately impacted by the War. In my reflections, I highlight a heroine, Perla Gibson, who, although thousands of kilometres from the action, helped to lighten the hearts of many thousands of soldiers (including three of her immediate family) who sailed into battle knowing that they may not return. Her son did not return. For Anne, contributing was an opportunity to document her mother's experiences of war, which had started as a 7 year old who had been walking happily down an English street with her best friend when they were strafed by a lone *Messerschmitt*. Memories of that event haunted Margaret until her death at 91 a few years ago. Those experiences have also had an impact on Anne's life. Finally, by trying to explain why a female Nazi doctor inflicted vicious wounds on women and children, Sally's contribution examines how psychology has attempted to explain individual behavior that is diametrically opposed to our normal actions and belief systems. More specifically, Sally's section highlights the power of social conformity and obedience to authority as she considers the testimony of Herta Oberheuser, the only female physician to be tried and convicted at the Nuremberg Trials (1945-1949).

For two of us, our 'stories' reflect how we have 'lived' the War through the experiences of our families and those of the women we have chosen. More importantly, however, all three of us have documented our personal and professional responses to Tessa's articles as we tried to rationalize what led to the brutality and to the deliberate infliction of pain and suffering on fellow humans. I then try to draw together our individual contributions by considering how events during the Holocaust can be used as a reminder to current and future generations of doctors that their role is to protect life, not to destroy it. The Holocaust should forever remain a reminder of how vulnerable we are as humans and how easy we can

stray from our values, particularly within the context of politically or religiously motivated ideologies.

Michelle's story (a biologist and now medical educator)

Born in the early 1960s in South Africa, I grew up in the 'hippie' era of *'Make love not war'* and *'Peace, Brother'*. Although World War II had long ended, it had not been forgotten by my family in South Africa. My maternal grandfather was a chef during the war and when he returned from military service, he took over the cooking at home. As a teenager, Saturday afternoons were spent with my mother and my two aunts visiting my grandparents in their retirement cottage where they often reminisced about the 'good old days' but sometimes also about the hardships endured as a result of absence and rations. Through the conversations of my mother who was only a year old when the War started, her siblings and my grandparents at our regular family gatherings that I got a sense of the impact of a War several thousands of kilometres away and on the other side of the world. With German South West Africa (now Namibia) South Africa's westerly neighbour, the War was in fact on their doorstep. My mother's siblings often spoke of the 'blackouts' when sirens sounded to let them know that a German plane was overhead. They described how they had been so frightened as young children or adolescents when the dark curtains that had to be drawn and the lights switched off.

There were also reminders of the War on my stepfather's side. Although Grandpa Mac succumbed to cancer when I was about seven or eight, after finding his war medals amongst my step-father's possessions, I learnt that he had fought in North Africa, was captured by Mussolini's troops and imprisoned in Italy. I have reminders of the time he spent in that prison: A pair of small two-tier wooden tables with intricate peacock carvings. One is now in Australia, where I reside and the other is in South Africa, with my niece, his great granddaughter. I was led to believe that the tables were carved by a prisoner-of-war with a piece of broken glass but how the tables eventually got to South Africa to become a family heirloom, remains a mystery.

As the only son, my stepfather inherited a number of Grandpa Mac's military artefacts after he passed away. One of these was his thick, green, woollen military 'great' (as we called it)

coat, designed to keep a soldier warm in the freezing desert nights. As a utility vehicle was our family's only car, I remember how my two younger brothers and I huddled under Grandpa Mac's army coat behind the driver's cab to keep out the winter nip on our way to buy take-away fish and chips on Friday evenings.

My maternal grandparents fondly reminisced about Durban's *Lady in White*, Perla Gibson, the heroine in my story. Perla was a South African soprano and artist who became internationally celebrated during the Second World War for singing to more than 5000 ships and about a quarter of a million Allied servicemen as they left Durban Harbour (Gibson & Morley, 1991). Clad in white with a red hat, she would stand at the harbour entrance and sing patriotic and sentimental songs to the troops through a megaphone from a torpedoed ship, a gift from grateful British soldiers (McWilliams, 1945; Rubin, 1992). One account of the origin for Perla's custom of singing to every warship entering or leaving the harbour arose after she was seeing off a young Irish seaman her family had entertained. As his ship departed, he was said to have called across the water for her to sing something Irish, to which she responded with a rendition of "*When Irish Eyes are Smiling*" (Jackson 2005).

Soldiers' talk led to the fame of the *Lady in White* spreading. A British army newspaper, *Parade*, dated 3 March 1945, described Gibson as a highlight of troops' visits to Durban (McWilliams, 1945):

"As the crowded ships passed into the harbour, men lining the landward rails saw a woman, dressed in white, singing powerfully through a megaphone such songs as "There'll Always be an England!" and "Land of Hope and Glory". A well-known local figure, she would drive down from her home on the Berea as soon as she could see that the ships were moving in.

She sang popular songs and classics but always ended with a moving rendition of an appropriate national theme - "*Land of Hope and Glory*" for the English, "*Waltzing Matilda*" for the Australians or "*Star Spangled Banner*" for the Americans (Barker, 2010). She sang to the ships that carried her husband, son and daughter to war. She even sang on the day she received news that her son, Roy, had been killed fighting in Italy (Jackson 2005). Reminders of Perla's tireless contribution are a statue unveiled in 1995 by Queen Elizabeth II that can be

found at the Ocean Terminal in the Durban Harbour (<http://allatsea.co.za/blog/the-lady-in-white/>) and a bronze plaque erected in her memory a year after her death in 1971 by the men of the Royal Navy on the spot where she used to sing on Durban's North Pier (Jackson, 2005).

Anne's story (a medical doctor and now a medical educator)

I am the daughter of a woman who survived the systematic bombing of Britain during the Second World War. Her story is one of a courageous woman whose life (and as a result, mine as well) was indelibly affected by war, reminding us that war affects not only those who experience it first-hand but it also impacts on the generations which follow. Aware of my mother's experiences in WWII, my interest really began as a 10-year old reading Ann Frank's diary. This interest continued into adulthood, culminating in me visiting many of the war museums in Europe and the US which remind us of the brutality inflicted by one group of humans on another.

On reflecting on the emotional recollections of Jewish doctors and prisoners in German concentration camps in Tessa Chelouche's articles, as Margaret's daughter, I wonder who my mother might have been and what her life might have been like had there been no War. It was always difficult to get my mother to talk about the War. When she did, it was only piecemeal - a puzzle that her family has pieced together over several decades. Being invited to contribute to this chapter in *Women and War* has provided me with an opportunity to not only tell my mother's story but to also grapple with my own emotions about the events that forever changed who we are as human beings.

Born prematurely in 1931 in Newcastle near the large navy docks on the river Tyne, my mother was not expected to live. She survived, with the top drawer of the family dresser being her crib for the first three months of her life. Her father, himself severely affected by the First World War, died when she was only seven, leaving her mother (my grandmother) who was confined to a wheel chair with suspected 'rheumatoid arthritis' to look after Margaret and her older sister.. When we chatted what her life was like during the War, Mum always glossed over the quandaries of where the next meal was coming from or the fact that she suffered from 'yellow jaundice' and couldn't (and didn't ever again) drink milk. In fact, her hepatitis A (contracted when ruptured sewerage pipes contaminated their water) saved

the family time, as they did not need to find or buy milk and so could use their ration stamps for other commodities.

My first memories of my mother's experiences of the War were about the air raids. Because they lived near the big navy dockyards, strategically important targets for the Germans, the air raids were incessant. Night after night, the German *Luftwaffe* rained down bombs onto their neighbourhood, with her and her sister battling to get their wheelchair-bound mother to safety. As they could not transfer my grandmother to the local air raid shelter because of the steps, the safety warden had instructed them to shelter in the cupboard beneath the staircase. The idea that my mother and her sister would leave their mother alone and take cover in the local shelter was never a consideration. Nightly, the sirens screamed their warnings as bombs hit civilian targets. Mum could mimic perfectly the whistle of a bomb as it descended, telling me that the longer the whistle, the closer was the bomb. *"Those seconds always seemed like hours"* she said. Once the whistling stopped, they would hurry outside to check on neighbours and friends. She told me that she had never forgotten the smell of the fires nor could she forget the stench of death.

My wheelchair-bound grandmother died when Mum was in her early teens. She moved in with her strict Presbyterian grandparents as her older sister (my aunt) had married. These were not happy teenage years for Mum. The strict daily rules and regimented life did not work for one so young and who was still traumatized by the War. My mother was bright and was the valedictorian at the local school. Although offered a university scholarship, her grandparents refused, sending her to work in the local post office. She struggled. My aunt told stories of her *"rebellious and driving her grandparents spare"*. It was no surprise to anyone that when she met my father, an Australian, she married him and in no time, they had boarded a ship bound for a new life in Australia. Almost immediately they moved to a tiny mining town of 40 000 people in the middle of nowhere, isolated in the hot, dry, fly-ridden northern Australian bush. So began a new chapter in her life, far from the memories of England and the War (or so she thought).

My mother was afraid of the dark. As a young child, I remember her always sleeping with the light on. Eventually, she told me the reason. During the War, following a period of intensive air raids, the all-clear had been given and she and her little friend were walking to school,

which apparently continued whenever possible. A lone *Messerschmitt* (probably lost, she thought) flew overhead, close to the rooftops. The plane was so low that when the pilot strafed them, she could see *“how young and handsome he was... his blond hair, vivid blue eyes, the brightest blue, the line of his nose but mostly the smile on his face as he pulled the trigger”*. Although Mum was not injured (but we think her friend was killed or seriously injured), that man, his face, his eyes, but mostly his smile, haunted her for the rest of her life. She had nightmares about him, never understanding why he was smiling as he prepared to kill them. On one of the peaceful few days before her death, she opened her eyes and said to me *“That bastard is still here”*. I knew who that bastard was.

My mother loved her children and was ferociously protective. She encouraged me to embrace every opportunity, supporting my passion to study medicine and later, my decision to leave Australia and live in Asia. But many times throughout my childhood and adult life, I was aware that my mother’s life, reactions and responses were the result of her war-affected childhood, teenage grief and loss of family members. It was because of these experiences that she refused to ever visit Japan, entertain any Japanese dignitaries or meet any of our Japanese friends. She felt similarly disposed about Germany and the Axis countries (except for Italy because she thought Mussolini didn’t know what he was doing!) until the day she died.

My mother’s stories and her courage and strength fostered my deep and personal interest in the events of the Second World War. I have visited Auschwitz, the Prague ghettos, churches and burial grounds and many of the Holocaust museums across the world. It is with this background knowledge, and as a doctor, medical educator, mother of three daughters and daughter of a woman inexorably affected and changed by war, that I read Tessa Chelouche’s (2005; 2008) articles on the ethical dilemmas faced by Jewish doctors during the Holocaust and the lessons Tessa offered for present and future physicians. I had expected that with my previous grounding and my medical training that I would be pragmatic and would approach the issue from a reasoned and intellectual position. I was, however, not prepared for my first response to these articles. Vivid memories of my recently passed mother resurfaced as well as a deep resurgent anger. I struggled to reconcile, as I have before, to comprehend how we (the rest of the world) allowed the systematic slaughter of almost an entire population and the murder of millions of innocent victims, many of them children. Mostly, I struggled to

understand the behavior of the German doctors, members of my own profession. It is difficult to reconcile how care-givers and keepers and protectors of life who had sworn an oath to cause no harm were not only party to exterminating millions of people, but were in fact the engineers of what has often been referred to as a '*magnificently*' efficient programme to exterminate men, women and children who had no flaw except to be Jewish, gypsies or homosexuals. For more than a brief second, I acknowledged my mother's inability to get past what had happened to her and people she knew during the War.

By 1929, German doctors, so enmeshed by the promises of Nazi-ism, had *en masse* joined the Nazi Socialist Physicians' League. This State-regulated group gave physicians unprecedented power and prestige, which they then abused (Chelouche, 2008). Put simply, the medical profession systematically medicalized, normalized and authenticated eugenics, racism and *ultimately* euthanasia for more than a decade during the 1930s and 1940s. Eugenics or racial hygiene was promoted in medical schools, research articles and in the German media. When the most prestigious medical journal in Germany published articles on eugenics and racial hygiene, this further legitimized 'racism' as a medical issue. Hitler was viewed as the great 'doctor of the people' who, through the eugenics or racial hygiene programme, would solve the economic and social crisis of German society by removing "*a gangrenous appendix from a diseased body*" (Lingens-Reiner, 1948 as cited in Chelouche, 2008, p.3), i.e. Jewish people. After all, what doctor would not remove a gangrenous appendix?

The espousal and promotion of Nazi ideology by the general medical establishment not only allowed but encouraged German doctors to quickly rise to positions of power, often with considerable personal and financial reward. Opportunities were further enhanced as their Jewish counterparts' licences were revoked. Prestigious journals with German editors excluded the voices of reason and diversity of opinion as their Jewish (now former) colleagues were excluded. What remains an enigma to me, however, is how doctors, supposedly the most intellectual members of the German population, could, contrary to their code of ethics, be systematically brainwashed to support a political ideology. That the fundamental principles of professionalism were abandoned for personal gain and national glory is difficult to comprehend considering that in 1931, Germany was one of only a few

countries to have developed strict “*Guidelines for New Therapy and Experimentation*” that protected a patient’s rights and autonomy (Chelouche, 2008).

Forsaking ethical principles did not end there. The 1933 Sterilization Laws and the 1935 Reich Physicians’ Ordinance formalized the forced sterilization of the ‘hereditary ill’ (Michalczyk, 1988). In my opinion, this would prove to be one of the most severe ethical transgressions of the German medical community, becoming the stepping-stone to the greatest collection of atrocities committed in the history of the medical profession. The fact that doctors themselves presided over ‘genetic courts’ which legalized forced sterilization contravenes the ethical principal of beneficence (first, do no harm) (Beauchamp & Childress, 2013). Patient autonomy (the right to make a choice) and the principal of informed consent (agree to treatment) (Appelbaum, 2007; Beauchamp & Childress, 2013) were also completely ignored under the guise of a legal dictate. Also, in accepting financial reward for fulfilling quotas of forcibly sterilized patients introduces not only a conflict of interest but also reeks of maleficence (doing harm or evil) (Beauchamp & Childress, 2013). While any professions can expect a few rogue members, *en masse* the German medical community came to support these measures under the guidance of a corrupt regulatory body which had in fact initiated and enacted a regulation that affirmed mandatory sterilization to be ‘good practice’. The medical community thus not only endorsed but also carried out thousands of such sterilizations.

One could extrapolate that having crossed these ethical boundaries with no repercussion (instead offering financial reward), it was then an easy and natural progression for a rogue profession to evolve the eugenic theories involving medical experimentation and euthanasia once the War started. Ethical considerations were rendered irrelevant, satisfying the socio-political ideologists. One could try to justify the profession’s actions. It was, after all a time of war. The lives and safety of the German people (and their future sons and daughters) were at stake. Perhaps the doctors had already done so much harm that there was no turning back. A corner had been turned. If they could ideologically, personally, ethically and professionally justify sterilizing against genetic diseases, was it then not a natural progression to exterminate all existing ‘biologically inferior’ individuals? In doing so, there were financial gains for the doctors as they freed up beds for German soldiers and saved food for the

healthy Germans, and, for the believers in eugenics, it would improve the German race. In the ghettos, where many German Jews were crammed for years, initially, supposedly quarantined due to typhus, thousands were exterminated under the guise of disinfection (Chelouche, 2008). Members of the medical profession had thus legitimized their position as mass murderers acting on behalf of the German people. Doctors ran the Genetic courts. They designed and implemented the euthanasia programme as the Jews became a metaphor for disease (Seidelman, 1989). They then implemented the programme efficiently, with appalling cruelty.

The rapid ethical decline into barbaric medical experimentation and the 'final solution' can only leave one horrified. No matter the depth of background knowledge, there is never immunity to the emotional reaction resulting from this greatest transgression of intrinsic medical values, morals, principles and ethics. The barbarism and sadism of the Nazi experiments was unique but not unique, however, was the power of medical science to condone victimization for the sake of science (Katz, 1994; Chelouche, 2008). Even sadder is that many of the perpetrators never apologized and few were convicted (Chelouche, 2008). While genocide has happened elsewhere, what is unique (and for me, distressing) about the Holocaust is that it was sanctioned and systematically executed by members of a profession who had sworn to 'do no harm', to maintain life at all costs. Doctors designed and supervised the 'showers' (gas chambers) and the crematoria. With the flick of a finger each day at the railway sidings, they would dispatch children and women to the gas chambers. They chose who would live and die each day and doctors administered the lethal injections. I have never understood how doctors had become so immune to the value of human life, acting in direct contradiction of the Hippocratic Oath.

Amidst the mayhem, where were the voices of reason? At that time, that 'voice' belonged to the now side-lined and imprisoned Jewish doctors. Sound scientific and medical process made way for pseudoscience as the Nuremberg Laws, which defined Germans through genetic processing and forbade marriage with Jews to prevent racially damaging diseases, were enacted. The medical profession had clearly lost its autonomy and its purpose. Practitioners became puppets of the State.

Jewish doctors too became victims. In the ghettos, they continued to practise to the best of their ability, dispensing medicine and care with minimal sanitation, food, water, heating, medical equipment and medication (Chelouche, 2005). Although an ethics committee was formed to resolve how to distribute the meager supply of medicine in the Vilna Ghetto, this committee never managed to reach a decision (Wajnryb, 1979). It was, however, in the concentration camps that Jewish doctors faced the most serious ethical dilemmas. Although they recognized that they had a responsibility to their patients to stay alive, which was at the discretion of their 'employers', the camp doctors or the Reich, their own survival often depended on them carrying out their delegated duties as assistants to the German doctors. On a daily basis, they were faced with dilemmas in terms of 'assisting' in unethical practices and depriving the desperately ill of medicine to be used for those for whom there was still some hope (Frankl 1985).

One of their main tasks was triage, tasked with listing individuals destined for forced labour camps and factories (which was often a death sentence) or the gas chamber. If they sent someone to the medical block, it too was likely to be a death sentence. As Dr Albert Haas (1984) as cited in Chelouche (2005, p.4) writes with reference to keeping a man with a contagious disease in the barracks, under fear of SS reprisal (and death for those involved), *"But if I ignored the man's condition and gave the rest of us a chance to live, he was sure to die. Where did my obligation lie – to the life of the individual before me, or to the lives of the rest of my comrades?"* Saving a life by recommending hospitalization often culminated in the patient being sent to the gas chamber anyway. Dr Gottfried Bloch (1999) as cited by Chelouche (2005, p.7) was *"overcome by deep despair and grasped for something to deny the truth"* and often caught himself nearly believing the fake words of encouragement he gave to his patients.

In some instances, the most humane approach to spare someone a more horrendous death involved the taking of life. A dose of morphine or insulin spared a child from medical experimentation or the gas chamber. Although the deliberate taking of life contravenes the Hippocratic Oath, the taking of life to protect the person from a more terrible death is the basic premise of medical euthanasia laws being debated today. The Jewish doctors in both the ghettos and the camps were faced with daily life and death moral and ethical decisions. The fact that they dispensed death on occasion to prevent the patient from an assured worse

harm – often a terrible death - stretches the discussion around medical ethics to its limit. Does this represent beneficence, an act of kindness in the patient's best interest?

After reading the two Chelouche articles, I have tried to 'put myself in the Jewish doctors' shoes'. I am left with a sense that the Jewish physicians acted within a strong moral and ethical code, the daily application of which would have been emotionally and intellectually exhausting as they had to make life and death decisions not for the individual but in the best interest of the 'community'. As medical ethics dictates that a physician shall care for all patients with equal regard, how does one decide which patients are more deserving? Their daily practice in the camps and in the ghettos encompassed the overarching code of caring for the ill be it in terms of medication, a kind word, comfort or encouragement. That, in the most stressful of circumstances, often with their own lives at risk, they continued to dispense 'care' (in whatever form that might be) is nothing short of honourable. Regardless of the German medical ethos of the time, the Jewish doctors, to the best of their ability, tried to stay true to the Oath they had sworn and to the beliefs they espoused.

Their honesty was challenged daily in the camps. With German doctors having a "*fierce fear of contagious disease*" (Chelouche, 2005, p.5), Jewish assistants lied and falsified reports and samples, often at risk to their own lives to protect patients and comrades. Considering their circumstances, this misconduct should surely be forgiven considering their overriding responsibility of preserving life at all costs? The preservation of life indeed became one of the most heart-wrenching ethical quandaries for Jewish doctors in the Second World War, manifested in the camps and ghettos daily but especially relating to the ban on Jewish births. Many Jewish doctors faced the predicament of destroying the life of the unborn to save or protect the life of the mother. The anguish of this decision is evident in these words from Dr Gisella Perl (1977) as cited in Chelouche (2005, p.5)- "*It was up to me to save the lives of the mothers, if there was no other way, then by destroying the life of their unborn children ... it was again and again my own child whom I killed to save the life of a woman*". Jewish doctors performed abortions with minimal equipment, supplies or medical support and infanticide (using cyanide or smothering) was common if the pregnancy proceeded to term. Those who could not break their Hippocratic Oath instructed the mother how to do it. A similar healing-

killing paradox also existed for those Jewish physicians forced to participate in the medical experiments. Although they often sabotaged the experiments and believed they tried to relieve suffering, their actual involvement willingly or unwillingly would have been deemed to be ethically unacceptable under normal circumstances. But, there was nothing normal about the ghettos and the concentrations camps.

As a doctor, I felt a strong emotional sense of desperation and overwhelming empathy (not that I could truly imagine what it might be like to have been in their shoes) for the Jewish doctors who faced these ethical and moral dilemmas in the ghettos and camps. Their despair at the terrible position in which they found themselves – fighting to protect life, whilst working alongside doctors who had once been their friends and colleagues but who were now the dispensers of death with no moral or ethical code, must have been devastatingly demoralizing. To uphold ethical beliefs and standards and practise beneficence in the face of such opposition and in fear for their own lives must have been mentally and physically exhausting. The impact of such decisions on these doctors is reflected in the words of Dr Ella Lingens-Reiner (1948) as cited in Chelouche (2005, p.5) - *“Once the prisoner doctors 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”*. One can understand that some Jewish internee physicians who themselves were condemned to die in the ovens towards the end of the War may have felt a sense of relief that the incredible responsibility of being the preservers of life in the face of such adversity would be over. It is also not surprising to read that many committed suicide soon after the War (Chelouche, 2008). They should be honoured for their personal strength and the perseverance with which they carried out their professional duties (often at great risk to themselves) under the most extenuating of circumstances.

I recently visited Auschwitz. What I saw confused me. The camp looked fresh and almost serene. Trees now covered the gas chambers. There was no air of despair, misery or even death. There were pretty plaques, churches, bright white walls and flowers. I later spoke to some German students about the atrocities. They were open about their feelings about what had happened but did not feel that they had to carry the responsibility and collective guilt for the actions of their forebears: *“This is in the past. We did not do it and we should not have to say sorry any more”* one told me. They were annoyed that the world wanted to keep

reminding everyone of the past. For them, *“our country needs to move forward and forget this”*. I admit being annoyed but have reflected on their words for a long time. My mother never forgot what happened to her in the War. Her experiences and the personal losses she suffered indelibly changed who she was and how she lived. There were repercussions for me, her daughter but this was nothing like the effects on German and East European Jews, who were almost exterminated. For some families, there were no future generations.

I have asked myself whether the future generations of perpetrators should share the collective responsibility and guilt for the actions of their forefathers. Probably not. The students were right in this regard. They cannot take the blame for what happened several decades ago. But, we should not forget what happened. The Holocaust should not have happened and should never happen again. We cannot afford to forget.

We should also never forget how racism and eugenics influenced one of the most intelligent and revered of professions, with members who had sworn to preserve life and to cause no harm becoming the most efficient mass murderers in history. Racism, eugenics, murder, torture and destruction were medicalized and legitimized and were thus authenticated and normalized. Rules governing professional behaviour were lost. The paradox is that their counterparts, the Jewish doctors, still managed to apply ethical principles and moral values and standards in the very worst and most challenging of circumstances. Rather than ascribe collective guilt to a nation in which the perpetrators have long passed, we need to ensure that this dark history is never repeated. We should advocate that every medical school recognise their responsibility to educate future medical doctors to be of sound ethical and moral standing and who are aware that no matter the socio-political ideology, they should not stray from their medical code of ethics (the Hippocratic Oath or its modern interpretation). These ethical guidelines must be sufficiently entrenched to withstand any future insults.

The first post-War evidence of the strengthening of human research and experimentation ethical guidelines was the development of the Nuremberg Code, drafted at the end of the Nuremberg Trials in 1947. This landmark document, generally based on the 1931 Guidelines for Human Experimentation, outlines a series of ethical principles to further and better protect the autonomy of the patient. The Declaration of Helsinki followed in 1964 (with

regular updates), further defining and building strong and clear ethical guidelines to protect the patient in research and experimentation. This Declaration remains the cornerstone of human research ethics today. As we will see later, the principles of autonomy, non-maleficence, beneficence and justice remain the mainstay of modern medical ethics. We have a duty to ensure that they are incorporated into the medical curriculum so that future generations of doctors are patient advocates, protecting their well-being both in health care and in research in our ever-changing and increasingly complex world.

Sally's perspective (a psychologist and a medical educator)

*"Unless the world learns the lesson these pictures teach,
night will fall. But by God's grace, we who live will learn".*

Night will Fall (2014)

The above quote from a documentary directed by André Singer reveals distressing 1945 footage taken by military photographers of the newly liberated Nazi concentration camps. From the sights that directly etched themselves into the memories of the Allied soldiers, through to contemporary viewers watching the small screen, these unspeakable horrors are no less shocking and incomprehensible decades after they were initially reported. But, has the world learnt? Can such misery ever be explained?

When invited to participate in writing a chapter for *Women and War*, I wondered how I might contribute. Unlike my co-authors, I have no flashbulb memories from relatives nor have I directly experienced war. As an academic psychologist, researching behavior is my practice. I thrive on what makes people - all of us – 'tick'. The aftermath of the Holocaust generated substantial social psychological research as people strove to understand how human beings could inflict such cruelty on others, especially on such a large scale. In reflecting on how I could contribute as a psychologist, I realized that seminal psychological research could, to some extent, account for this behavior and so decided to apply my knowledge in this field to the context of medical violations, including women's cruelty to other women in the Nazi concentration camps.

Despite the harrowing scale on which these atrocities occurred, it is useful to return to an individual rather than a collective focus to attempt to understand what happened. In my

contribution, I will try to align psychological theory with the brutal and barbaric actions of the only female Nazi physician, Dr Herta Oberheuser, to be tried and convicted at the Nuremberg Trials.



Oberheuser worked in Ravensbruck concentration camp in the early 1940s. Under the supervision of another doctor, she assisted with medical experiments conducted on Jewish prisoners, including a group of 86 women and children. She is mostly associated with testing the efficacy of sulphanilamide, an anti-bacterial drug patented in 1908. Oberheuser artificially created wounds on the Jewish prisoners and then rubbed the wounds with wood, rusty nails, slivers of glass, dirt or sawdust to mimic injuries sustained by German soldiers. The involuntary experimental subjects suffered agonizing pain, with some dying from severe infection. For those close to death, she administered an injection of petroleum and the barbiturate, Evipan. After the often fully conscious person died a few minutes later, she removed their limbs and vital organs to study the effects of the treatment. Oberheuser was the only female defendant at the Nuremberg Trials. She was sentenced to 20 years imprisonment but served only 10 years, being released in 1952. She returned to medical practice until 1956, when she was recognized by a Ravensbruck survivor. Her license was revoked in 1958 (Ghooi, 2011).

In many of the legal proceedings that followed the Holocaust, it was not uncommon to hear the defendants maintain that they were simply following orders. Conformity and obedience to authority are powerful social phenomena that have been extensively researched in the latter half of the 20th century. There are many reasons for individuals to conform.

Sometimes it is due to confusing or unusual situations in which we as individuals do not always know how to respond. In such situations, we may take our cues from others.

Conformity also reflects our need to be accepted. This need is emotionally driven as we do not want to be rejected – or even punished – for being different. A notable experiment conducted by Solomon Asch in the 1950s tested how people were prepared to conform with a group's behavior (Asch, 1951). Asch invited subjects to participate in what they believed to

be a test about visual perception. Individuals were placed in a group with seven other 'participants'. They were then presented with the two cards pictured below and asked to match the length of the single line with one of the three (A-C) on the second card. C is clearly the correct answer.



Unbeknown to the actual participants, however, was that the other group members were confederates – actors who had agreed to state the same but clearly incorrect response (A or B). Interestingly, about 32% of the actual participants provided the incorrect answer, presumably conforming with the group majority.

For the participants in those harmless experiments, there was little to lose save perhaps pride. Two decades earlier, however, in German society, dehumanizing a particular group of people was legitimised in a social and political climate rife with fear and hostility. It is therefore arguably feasible that anyone – German citizens, doctors, soldiers, prison guards – could have conformed to this 'norm', however unfathomable it now seems.

Herta Oberheuser's testimony at the Nuremberg Trials not only reflects this need to conform but also emphasizes the societal influence that pervaded individual ideologies and actions at the time. Below is her response to questions about preparing young girls in Ravensbruck for operations and the necessity of the procedures she carried out:

I was told by Prof. Gebhardt [Oberheuser's supervisor] as I have already said in my direct interrogation, that it had been ordered on the highest level, that the state had ordered it, and that it was legal and, in any case, that the experiments were not supposed to be dangerous, and besides, that they were Poles who had been sentenced to death. They lived in the most strictly treated block and they were not allowed to go to work outside the camp, and when they came to me they never put up any resistance, so I assumed that everything was legal (Learning from History, 2004).

The second half of her response is largely representative of her wish to conform. She was clearly aware of rules and regulations, to the point of assuming legality and not questioning her direct supervisor. The excerpt also raises the issue of obedience to authority, which was

of considerable significance to the Nazi regime and the power enforced therein. Returning to



psychology for explanatory frameworks for obedience, Stanley Milgram's famous study provides further understanding (Milgram, 1963). He devised an experiment to test the decisional conflict between obedience to authority and personal conscience.

Participants were deceived into thinking they were taking part in a learning and memory experiment. They were asked to read a set of words to a 'learner', an actor to whom they had been introduced, who had to recall matched pairs of words. Prior to the start of the experiment, however, participants witnessed the 'learner' being wired to an electric (but inactive) shock device before being led into another room. Participants were then instructed to listen to the 'learner' as he recalled words (all pre-recorded and deliberately incorrect), and, if the 'learner' provided an incorrect answer, they had to administer an electric shock. Participants were also informed that the voltage would be increased for each subsequent mistake. The 'shock generator' had 30 switches, ranging from 15 volts (slight shock) to 450 (danger – severe shock). When administering a 'shock', participants would hear the 'learner's' supposed pained response or even silence as the experiment continued.

Another actor playing the role of the 'experimenter' was in the room with the participant. If a participant expressed doubt about the procedure or refused to continue, the experimenter, wearing a laboratory coat, delivered standard responses such as "*the experiment requires that you continue*". The results were astounding. Two-thirds of the participants continued to 'shock' the 'learner' up to 450 volts (dangerous and exceeding the standard electricity voltage in most countries). All participants administered the 300-volt threshold. The interpretation of these results is that lay people are likely to follow orders from an authority figure if they perceive this person to be legitimate or morally correct. These findings can be applied to Oberheuser's testimony, in which she defends her actions because the work had been ordered by the State "*at the highest level*".

At an individual level, these experiments offer a window into understanding why Oberheuser may have been complicit in undertaking brutal medical experiments. While video footage of Milgram's participants reveals that many expressed doubt about what they were doing, questioning whether or not they should continue, in contrast, the perpetrators of the Nazi experiments did not portray such sentiments either individually or collectively. The surety in behaviour extends to making group allegiances that convey a belief that, if anything, further reinforced the notion that actions were committed for the right reasons. Oberheuser herself demonstrates this in her cross-examination:

Question: "[...] You indicated, Miss Oberheuser, that the operations were carried out by Dr Fritz Fischer, and you say: 'sometimes assisted with the operations and had the task of caring for the patients after the operations'. Now, was it or was it not your duty to care for these patients after the operations?

Answer: I understood it to be my duty and hoped to be able to help here as a woman too, because I saw a chance that the women would be pardoned, and I thought I could help here as a woman. (Learning from History 2014)

The tragedy of Oberheuser's response is her belief that she was somehow advancing the solidarity of womanhood through her work. It is a faint, small glimmer of acknowledgment that women in war were somehow united despite political, military or religious divisions. We will of course never know if she succumbed to private acceptance of her medical role within the SS in the genuine belief of what she was doing was right or if she publicly conformed whilst doubting her actions and those of her fellow officers. What is abundantly clear, however, is that she was a small part of a vast initiative, one in which destruction and death knew no limits. While psychological experiments in the laboratory with smaller groups of people may shed some light, many questions remain unanswered. Some of these questions should still be asked 70 years later.

Writing for this chapter and discussing the process with my co-authors was a rewarding but emotionally challenging process. I read documents and survivor stories that horrified me, but at the same time, I feel compelled to add to the voices that urge us to never forget these stories. During my search for material, I was reminded of one of my first experiences as an

academic in a psychology department. While marking essays about intergroup behaviour, one student made reference to the Holocaust. She correctly identified the Holocaust as the catalyst for social psychological research, but had described it as an “unfortunate event”. My initial reaction was a comment to the student that she needed to choose her words more judiciously. Now, reflecting on that incident, it is not surprising that the language she used did not befit the magnitude of what occurred during the Holocaust. Perhaps the connection between laboratory-based experiments has become so neatly packaged that emotional responses are dampened and our rhetoric downgraded. What is abundantly clear, however, is that while psychology can inform us about how we treat each other, it seems woefully inadequate in circumstances when trying to explain group behavior during the Holocaust. As a discipline, psychology may serve to account for the actions of individuals, but its relationship to the rise of large-scale social norms on such extreme levels remains arcane. After much deliberation, I am left to conclude that trying to explain these terrible events may not be the most appropriate way to continually remind ourselves to learn from that dark period in history. We should always ensure that the ‘what’ contests the ‘how’, otherwise night will indeed fall again.

Ensuring that the Holocaust never happens again, ensuring that Night does not Fall

In trying to find some common ground in terms of our stories and perspectives that have emerged as a result of our individual engagement (which transpired to be considerably emotional) with Tessa’s articles, what connects the three of us is that we are all medical educators involved in the training and education of the next generation of medical doctors. Although our students are mostly Australian permanent residents or citizens (and some New Zealanders), in terms of their historical and cultural backgrounds, they represent more than 22 countries. With many as young as 17 and perhaps born in Iran or Sri Lanka or of parents who were political refugees often from Asia, the events of WW II will probably never have been part of any conversation in their household. Although Anne, Sally and myself were born in three different countries (Australia, United Kingdom and South Africa, respectively), writing this chapter has highlighted the need for us as medical educators to remember that at the heart of medical education and medicine as a profession lies ‘professionalism’. The Royal College of Physicians of London (2005) defines professionalism as “*a set of values, behaviours, and relationships that underpins the trust that the public has in doctors*” (p.45).

Society's expectations of both individual doctors and of the medical profession are therefore based on both trust and its understanding of these values and behaviours. Professionalism is thus the medical profession's social contract. Society expects doctors as members of an almost hallowed profession to behave professionally in return for the privilege and social position assigned to them (Cruess & Cruess, 2014). Codes of professional conduct thus represent the way in which a profession defines itself to the public. In the medical profession, this code has evolved over centuries and, in Sox's (2007) view, despite considerable change, the physician's obligation to give priority to the interests of the patient has remained a fundamental principle of medical practice.

Geiderman (2002a,b), himself a physician, wrote two papers on physician complicity on the Holocaust which he dedicated to his grandparents and his uncles and the millions of innocent Holocaust victims who lost their lives or gave their lives in order to save their fellow human beings. Geiderman's (2002a) first paper identified eight moral failures of German physicians and the medical profession in carrying out the policies of the Third Reich (Table 1).

Table 1. Eight moral failures of German physicians in Nazi Germany (Geiderman, 2002a).

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1. Embracing a false science (eugenics) coupled with racism
 2. Collusion in the exclusion of Jewish physicians from medical practice
 3. Forced sterilization
 4. Implementation of the Nuremberg Race Laws
 5. Euthanasia of "lives not worth living"
 6. Participation in mass extermination
 7. Sadistic medical experiments performed without consent
 8. Post-war distortions of the truth
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Geiderman (2002a,b) and Chelouche (2005; 2008) have also described the many moral dilemmas Jewish doctors faced, the decisions they had to make under extreme duress, including saving their own lives so that they could take care of fellow prisoners. Under ordinary circumstances, some of their actions (Table 2) would be regarded as ethical transgressions. But, the Holocaust was far from normal. It is therefore not surprising that a number of these doctors who had survived the War later committed suicide (Chelouche, 2008).

Table 2. Actions taken by Jewish doctors in concentration camps.

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- Aborted pregnant women (so they would not be sent to the gas chamber)
 - Terminated the life of neonates or asked the mothers to do so (again, so the women and/or the child would not be exterminated)
 - Euthanized children who were destined for the gas chamber
 - Sent sick people to labor camps (so they would not be sent to the gas chambers)
 - Deliberately withheld medication from the dying for those who could be saved
 - Did not inform authorities of infectious diseases (to prevent the afflicted from being exterminated)
 - Sabotaged medical experiments
-

Our stories reflect our reactions and perceptions through the lenses of three women from different professional backgrounds (biologist and medical education, a medical doctor, a psychologist) and who were born in different countries. Another three women – Perla Gibson, Anne’s mother, Margaret, and Herte Oberhauser – have also provided a window into our perspectives of the complexities facing both Jewish and German doctors during the War. Our initial reactions to Tessa’s articles took us in different directions, yet we are resolute in our joint commitment as academic faculty at an Australian medical school to never let what happened to fellow humans be repeated. We are committed to educate and train the next generation of moral and ethical sound doctors who will treat patients and colleagues fairly and justly, irrespective of their religious, cultural or sexual orientation. We endeavour to do this personally by role-modelling respect for our students, our colleagues and ourselves as mothers, wives and professional women. We also do this through a curriculum that ensures that our future doctors have a firm grounding in the four principles or pillars of biomedical ethics outlined in Table 3 (beneficence, non-maleficence, autonomy, social justice) that currently frame professional medical practice (Beauchamps & Childress, 2013). To this list,

we have added informed consent (Appalbaum, 2007), something that was completely overlooked in the cruel pseudoscience of Nazi Germany.

Table 3. The four principles of biomedical ethics and their definitions (Beauchamps and Childress, 2013), plus the concept of informed consent (Appalbaum, 2007).

Principle	Definition
<i>Beneficence</i>	Balance the benefits of treatment against the risks and costs; the health care professional should act in a way that benefits that patient.
<i>Non-maleficence</i>	Do no harm. All treatment involves some harm, even if minimal but the harm should not be disproportionate to the benefits of treatment.
<i>Respect for autonomy</i>	Respect the decision-making capacity of autonomous individuals; enable individuals to make informed choices.
<i>Justice</i>	Distribute benefits, risks and costs fairly; the notion that patients in similar positions should be treated in the same manner.
<i>Informed consent</i>	Process by which the treating health care provider discloses appropriate information to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment.

The Holocaust was thus not “an unfortunate incident”. It was a genocide, carefully planned and executed by the German medical profession, with its members being rewarded for their inhumane treatment of fellow colleagues and other Germans because they happened to be Jewish, gypsies, ‘sexual deviants’ or perhaps were suffering from an inherited disease. These events must not be forgotten as this genocide should never be allowed to happen again. Night must not be allowed to fall again. Today’s medical students need to be made aware of how lapses of ethical judgement can so easily slide into moral decay (McLean et al., 2015). Engaging them in a discussion about the Holocaust might help them to think more deeply about how they as global citizens can become advocates for the many millions of refugees, some of whom have already made it to their countries, who have fled their homelands because of civil and/or religious wars. As educators, as women and as human beings, we have a duty of care.

Our chapter has woven together stories that have emanated from our ‘experiences’ of war, lived through the recollections of our families or from our research. Although we originate

from geographically distant locations, our stories have a common thread involving the impact of the War on women. Through the lenses of a perpetrator, a victim and a woman (herself a victim, losing a son) who sought to ameliorate the plight of soldiers heading to the battlefield, we hope we have made a strong case for drawing attention to why the events of World War II should be a part of our history that should never be forgotten.

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