Chapter 16
Medicine, the Holocaust, and Human Dignity: Lessons from Human Rights

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Abstract The development of bioethics in the late Twentieth Century parallels the development of human rights discourses. Both intellectual movements have ideological roots in a reckoning with the tragedy of the Holocaust and both invoke conceptions of human dignity that have sometimes been accused of being vague or empty and therefore useless. However, despite its ambiguity, human dignity plays an important role in both discourses. In particular, we argue that bioethics scholars can learn from how advocates of human rights have balanced their idealized and abstract conceptions of dignity (and other values) with a focus on how real-world personal and institutional moral failures can inform efforts to promote human rights. We argue that a reengagement with the horrors of the Holocaust can supplement and motivate a critical, real-world bioethics, one that is responsive to the personal and institutional failures of our time and which provides practical guidance under *non-ideal* conditions.

16.1 Introduction

The Holocaust gave birth to an international human rights agenda and, later and somewhat circuitously, to the bioethics revolution. These are distinct movements: The former expresses the idea that individual persons have fundamental interests that ought to be protected by the state and which are also a matter of international concern and potential intervention. The latter expresses the idea that patients and research subjects are entitled to special protections and that clinicians and researchers need

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S. Gallin and I. Bedzow (eds.), *Bioethics and the Holocaust*, The International Library of Bioethics 96, https://doi.org/10.1007/978-3-031-01987-6_16

to better incorporate the values and preferences of patients and subjects. However, human rights and bioethics movements are similar kinds of *philosophical* projects. They both introduce new moral vocabularies that attempt to build a consensus about what people are owed among diverse peoples within and between societies (Andorno 2009).

In light of the structural similarity between human rights and bioethics discourses, bioethics may have something to learn from critical philosophical work about human rights. In particular, bioethics can benefit from insights about the role that human dignity plays in explaining and justifying human rights claims. We argue that one such insight is that bioethics needs to balance the idealization and abstraction of its theories (e.g., about the basis of ‘respect for persons’ or what ‘autonomy’ means) with a focus on real-world personal and institutional moral failures. In the Twentieth Century, experiences of the Holocaust helped the creators of human rights and bioethics to identify *ideals* towards which their theories directed people. In the Twenty-First century, a reengagement with the details of the Holocaust can teach us how to respond to the *nonideal* complex moral challenges and messy contingencies of real life.

In this chapter, we argue that bioethics faces similar philosophical challenges as those that face human rights discourses and that these challenges can be met in a similar way. Appeals to human dignity are prevalent in bioethics, but that concept is just as under-developed in bioethics as it is in the human rights literature. Also, bioethics similarly turns to autonomy as a core value, but it supplements it with other values, including beneficence, justice, and non-maleficence. Yet, these concepts are often too abstract or too idealized to give the kinds of guidance that real-world bioethics requires. What we need is a non-ideal theory of bioethics. The bioethical lessons wrought from the Holocaust about human dignity itself and the challenges involved in specifying that construct can contribute to such a theory.

This chapter explores what the Holocaust can teach medicine and bioethics about human dignity, particularly as a concept that signals more about the moral worth of persons than simply their ability to make choices (autonomy), avoid pain (nonmaleficence), and pursue interests (beneficence). We acknowledge the substantive emptiness of the concept of human dignity, but the combination of its universal appeal and its philosophical ambiguity can generate immediate consensus and motivate ongoing moral investigation. Indeed, the dominant bioethics discourse surrounding ‘autonomy’ is an example of such an investigation. ‘Autonomy’, such as it is in bioethics, has been informed by appeals to human dignity, with roots tracing back to the Holocaust and the Doctors’ Trials at Nuremberg.[1] Thus, while the notion of autonomy conceives of what it means to be a person in only a partial way, it is nonetheless illustrative as a product of a collective methodology. We will argue that many of the shortcomings of the principles of bioethics can be supplemented by

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[1] As we discuss below, the relationship of the Holocaust to bioethics was not formally engaged to any significant degree until the later advent of bioethics as a professional discipline following additional travesties in research ethics such as Tuskegee.

engaging in similar ongoing discourses, and, in particular, by reorienting to a non-ideal bioethics grounded in the Holocaust. That is, appeals to human dignity, even as a substantively impoverished construct, can generate new moral tools for the kinds of bioethics problems that the principles of bioethics cannot sufficiently address.

16.2 Making Sense of Human Dignity

From its beginning, there has been substantial criticism about the philosophical foundations of human rights and, in particular, the central role played by the idea of human dignity. On one hand, human rights discourse aims to be a universal moral vocabulary, so it should not be expressed in terms of parochial religious or philosophical ideas. On the other hand, there must be some set of moral reasons to care about human rights, or else it is an empty placeholder (Schulman 2008). Depending on how one attempts to resolve this dilemma, they can end up with conceptions of human rights that seem hopelessly vague, inevitably religious, western-centric, or that represent indefensible forms of human exceptionalism (Jacobson 2006; Schmidt 2007).

Many people have attempted to provide more fully theorized accounts of human dignity (Gilaber 2018; Kateb 2011; Rosen 2018), but these efforts consistently meet with skepticism or irresolvable disagreement (Macklin 2003; Sangiovanni 2017). Some suggest that human dignity can be operationalized as autonomy. In turn, the practical work of protecting dignity entails protecting people from coercion and ensuring their ability to make choices (Griffin 2008). Others reply that autonomy does not capture everything that human rights aim to protect or that it does not accord with the variety of justifications people provide for human rights (Beitz 2009). Ultimately, the fundamental problem may concern excessive abstraction and idealization in our theorizing (Farelly 2007; Mills 2005; Sen 2011). What we need, perhaps, is a theory of human rights—and of political philosophy, more generally—that offers guidance in the real, highly imperfect worlds we actually inhabit, and not a perfect abstract philosophical theory. On such a view, we need moral concepts that offer guidance when other people are acting immorally, when the institutions we work within are faltering, and when we aim to *resist* particular injustices, rather than when we are merely *aspiring* for a utopian ideal.

We do not answer these critiques, nor do we provide a robust philosophical defense of human dignity. Instead, we provide a modest defense of dignity, but one which paves the way for future discourse and richer analysis. We agree that the current conception of human dignity ultimately serves as a placeholder for our intuitions about the value of human persons and the duties that are grounded by that value. By itself, ‘dignity’ tells us little about *what* we ought to do, or *why* we ought to do it. Nonetheless, this concept can serve as a touchstone that directs us to answer questions about our moral sentiments, to refine and better articulate a fuller notion of our ethical obligations.

We cannot avoid the centrality of human dignity for the normative foundations of international human rights documents. It is invoked at the beginning of the UN

Charter and of the Universal Declaration of 1948. According to the two major human rights covenants—International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social, and Cultural Rights (ICESCR)—human rights "derive from the inherent dignity of the human person" (International Covenant on Civil and Political Rights 1976; International Covenant on Economic, Social and Cultural Rights 1976). The 1975 Helsinki Final Act states that "all" human rights, including "civil, political, economic, social, cultural and other," "derive from the inherent dignity of the human person" (Conference on Security and Co-Operation in Europe 1975; quoted in Beitz 2013, p. 259). The horrors of the Holocaust, having been put on display at Nuremburg, help explain such rhetoric. However, the correct operationalization of dignity in political action, in establishing exactly what kinds of restrictions particular sovereign states could place on citizens and which could be subject to international condemnation, requires further evidence and argument.

The numerous competing interpretations of the concept render ambiguities pervasive when it comes to elaborating the duties that follow from a commitment to human dignity (Chapman 2010). It is clear to the point of obvious that genocide violates dignity, whatever the details of any theory of dignity. But it is less clear that it violates someone's dignity to fail to provide them with access to the "enjoyment of the highest attainable standard of physical and mental health," as article 12.1 of the ICESCR states. Does dignity require that all people have the best possible medical care, or should this statement be struck from the ICESCR as inappropriate for inclusion in a list of *true* human rights? To answer these kinds of questions we need a robust theory of what 'dignity' requires. We also need a theory underlying the philosophical foundations of human rights, something that international human rights documents currently do not provide (Gostin 2001).

Correspondingly, in the area of medical ethics, we can ask what it means for health care professions to protect and promote the dignity of patients. Here, too, some transgressions are clearly prohibited (e.g., causing harm or unduly undermining patients' choices about their treatments), but many questions are left unanswered. Thus, while rhetorical appeals to respect for persons and dignity are common, what they mean for how we ought to treat patients is often unclear. On this point, Ruth Macklin argues that we should abandon the idea of "dignity" in bioethics and, instead, rely on more substantive moral ideas, like autonomy and nonmaleficence (Macklin 2003). She writes:

> Possibly the most prominent references to dignity appear in the many international human rights instruments, such as the United Nations' universal declaration of human rights. With few exceptions, these conventions do not address medical treatment or research. A leading exception is the Council of Europe's convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine. In this and other documents "dignity" seems to have no meaning beyond what is implied by the principle of medical ethics, respect for persons: the need to obtain voluntary, informed consent; the requirement to protect confidentiality; and the need to avoid discrimination and abusive practices. (Macklin 2003, p. 1419)

Macklin continues, noting the perhaps inevitably religious foundations of human dignity:

> Why, then, do so many articles and reports appeal to human dignity, as if it means something over and above respect for persons or for their autonomy? A possible explanation is the many religious sources that refer to human dignity, especially but not exclusively in Roman Catholic writings. However, this religious source cannot explain how and why dignity has crept into the secular literature in medical ethics. (Macklin 2003, p. 1420)

Noted critic of bioethics, Stephen Pinker, agrees with Macklin:

> Reductions in dignity may harden the perceiver's heart and loosen his inhibitions against mistreating the person. When people are degraded and humiliated, such as Jews in Nazi Germany being forced to wear yellow armbands or dissidents in the Cultural Revolution being forced to wear grotesque haircuts and costumes, onlookers find it easier to despise them. [However,] all these cases involve coercion, so once again they are ruled out by autonomy and respect for persons. So, even when breaches of dignity lead to an identifiable harm, it's ultimately autonomy and respect for persons that gives us the grounds for condemning it. (Pinker 2009, p. 31)

Notice, however, that Pinker implicitly makes something of a concession here by stipulating that many of these cases surely do involve breaches of dignity, even if autonomy and respect for persons do the heavy lifting in terms of justifying actual protections for patients and research participants.

We raise a question that Pinker gets close to asking, but never does: Do these principles of bioethics *always* offer protection against indignities? Do these concepts sufficiently *explain* the wrongs associated with violations of dignity? Do they provide us with sufficient *guidance* about what to do when violations of dignity occur? We think the answer is 'No.' However, a search for a more robust notion of human dignity—one the extends beyond "respect for persons," "autonomy," and "beneficence," etc.—*can* affirmatively answer these demands.

Specifically, we need to reconsider whether the ambiguity of human dignity actually renders it useless. While the substantive emptiness of the construct may mean that it does not do much to direct our actions, it may nonetheless be valuable. We argue that it is precisely because it is both substantively empty and the source of ongoing consensus, that we can return to human dignity with new challenges and questions for bioethics. In much the same way that principles of bioethics were originally derived by evaluation of socio-historical events from the point of view of violations of human dignity,[2] we can continue to generate new moral vocabularies in bioethics by orienting ourselves to real-world violations of dignity (Habermas 2012).

16.3 Human Dignity, Bioethics, and the Holocaust

The principles of bioethics have an ideological lineage rooted in the atrocities of the Holocaust and the Nuremburg codes that followed. However, in the US context, they crystallized around other watershed events such as the Tuskegee Syphilis and

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[2] For a discussion of human dignity as the grounding for deontological norms in biomedical ethics, see Rothhaar (2010).

Willowbrook experiments (in the research context) and cases such as Karen Ann Quinlan and Dax Cowart (in the clinical context) (Hinote and Wasserman 2020). The seeds of medical ethics planted at Nuremburg did not really begin to grow in the United States until the 1970s. For more than two decades following the end of WWII, human research subjects, including children, were subjected to medical experiments without regard for their autonomy or best interest (or where the logic of benefit was contorted beyond recognition) (Beauchamp 2014).

This presents an interesting question. How could the revelation of the horrors of the Holocaust have been met with a comparatively tepid response? Why did it take another 25 years, and many more unethical experiments, to begin serious attempts at an ethical consensus for medical research and (later) clinical practice?

One answer is rooted in the uniqueness of the Holocaust. During the Doctors' Trial at Nuremburg, the U.S. faced the embarrassment that Nazi physicians learned from and emulated American medical research and pro-eugenics laws and policies, including *Buck v. Bell* (Okrent 2019; see also Rubenfeld 2014). The fact that the Holocaust itself—and especially the medical experiments conducted at Auschwitz—were so gruesome and so unprecedented in their scale allowed US medical researchers to imagine that their own practices were not implicated. This kind of "American Exceptionalism," framed the Holocaust generally, and the participation of physicians within it, as an aberration, a breakdown in an otherwise strong professional ethic (Brody 2014). Katz asserts that American medical leaders saw the Nuremburg Code—with its institutionalization of patient and research participants' rights—as "a good code for barbarians but an unnecessary code for ordinary physician-scientists" (Katz 1992). This response ignores deep similarities between American and Nazi German medical research, including the longstanding high regard that U.S. doctors had for their German counterparts in the early decades of the twentieth century through the start of WWII (Duffy 1993). It also supposes that Nazi medicine abandoned the medical ethics of the day, while, in fact, Nazi physicians had developed *their own* theories of bioethics. For example, Rudolf Ramm's 1942 book *Medical Jurisprudence and the Rules of the Medical Profession* explicated a distinctly Nazi medical ethics and was widely distributed in Germany (Ramm 2019).

In this light, we cannot understand contemporary bioethics as the emergence of ethics itself, but rather the postulation of a kind of ethics that responds to, among other historical events, the horrors of the Holocaust. In particular, the Nazi personification of the "social organism" and the related fetishization of "social health," subverted the notion of the individual as a moral entity and projected it onto that of the collective. Notions of individual self-determination or the idea that the right way to define welfare is fundamentally in terms of individual well-being can be read as antithetical to those kinds of extreme collectivism. But while the elaboration of a largely individualist medical ethics feels right, particularly in response to Nazi medical ethics and the atrocities it allowed, it rests on an inevitably ambiguous metaphysics.

The idea of society as an organism has a kind of empirical clarity. Similarly, hedonic versions of individual well-being, which certainly form part of our account of bioethics, rest clearly in human animal's ability to feel pain (and, of course, also raise oft-avoided questions about why this does not accord non-human animals moral standing). But just why human beings are worthy of dignity or respect requires a metaphysics of the human that is difficult to ground empirically. This challenges the ability to produce a secular account of human dignity and a corresponding account of our moral obligations to respect persons. The answer to this challenge in Western bioethics has centered on the reduction of the notion of "respect" to the notion of self-determination through choice-making, rendering it more discrete, observable, and measurable. In turn, the concept is more widely agreeable across groups which may hold radically different metaphysical commitments, but which nonetheless arrive at the same conclusion about the right of individuals to make decisions about their own lives.

The codification of respect for persons into autonomy, however, disregards important qualities of humanism and moral life. Insofar as we can trace the origins of contemporary bioethics to the Holocaust, we can also return to that history to ask what lessons might have been left behind. Take for example this first-hand account of the medical experiments at Auschwitz, written by someone identified by the Claims Conference as Ms. M.:

> I was about five weeks in Auschwitz alone, separated from my family, my parents, two sisters and two brothers when Dr. Mengele pulled me out of a queue as we were on the way from the c-lager [camp] to the gas chamber. I was the only one picked that day personally by Mengele and his assistant. They took me to his [laboratory], where I met other children. They were screaming from pain. Black and blue bodies covered with blood. I collapsed from horror and terror and fainted. A bucket of cold water was thrown on me to revive me. As soon as I stood up, I was whipped with a leather whip which broke my flesh, then I was told the whipping was a sample of what I would receive if I did not follow instructions and orders. I was used as a guinea pig for medical experiments. I was never ever given painkillers or anesthetics. Every day I suffered excruciating pain. I was injected with drugs and chemicals. My body most of the time was connected to tubes which inserted some drugs in to my body. Many days I was tied up for hours. Some days they made cuts in to my body and left the wounds open for them to study. Most of the time there nothing to eat. Every day my body was numb with pain. There was no more skin left on my body for them to put injections or tubes … One day we woke up and the place was empty. We were left with open infected wounds and no food. We all were half dead with no energy or life left in us. [One] day … Russian soldiers tried to shake me to see if I was alone or dead. They felt a tiny beat in my heart and quickly picked me up and took me to a hospital. (Claims Conference 2020)

Certainly, the bioethics principles of autonomy, non-maleficence, and beneficence can make some sense of the moral failings in this account. But at the same time, it feels insufficient to say that what was unethical about the treatment of Ms. M. as a child was only that she was harmed, or that her best interests were not promoted. It would feel equally insufficient to say of an adult experiencing such treatment that the moral failing resided in the fact that she did not provide informed consent for her participation in the experiment. These are all true statements, but they are only partial accounts of what went wrong. The screams of these children, the violation of their innocence, the abject cruelty they experienced orbit other moral notions. There is in this description a kind of sorrow lying beyond the account of morality captured by the principles of bioethics and which those abstract and idealized principles cannot adequately depict.

In the same way that the mid-level principle of autonomy identifies something important about what is wrong in the narrative above, we can return to the amorphous construct of human dignity to ask what else is wrong, beyond the coercion and the harm it recounts. This points to the utility of human dignity as a kind of non-ideal bioethics, one that, while substantively empty, can let us ask real questions about how we ought to act, particularly in an imperfect moral universe where we must actually live our lives. The Holocaust has particular lessons here as well.

16.4 The Holocaust and Non-ideal Theory in Bioethics

One of the core debates in contemporary political philosophy concerns the relationship between two different kinds of approaches to thinking about social justice and the responsibilities that individuals have to promote social justice. Debates about the value of 'ideal theory' versus 'non-ideal theory' take place on three axes that are relevant for thinking about the role of the Holocaust in our thinking about bioethics.[3] In particular, the concept of human dignity is useful for framing a non-ideal theory bioethics, one grounded in the details of real histories, including and perhaps especially the Holocaust and its aftermath. This kind of account is necessary to supplement an ideal theory bioethics that is grounded in the principles of autonomy, beneficence, justice, and non-maleficence.[4]

On the first axis, ideal theory focuses on what we ought to do when most other people are ethical (this is sometimes called 'full compliance theory'), while non-ideal theory focuses on what we ought to do when many or most people are not doing what they should (sometimes called 'partial compliance theory') (Rawls 1999, p. 8, 215; see also Murphy 2000). Some of the rules of full compliance theory bioethics always apply. For example, we always ought to act with beneficence and to respect autonomy. But we need a bigger toolkit for thinking about ethical actions in medicine when we are surrounded by competing obligations, and sometimes even outright moral failures (Levine et al. 2019). For example, are healthcare personnel supposed to be self-sacrificial heroes to make up for the shortcomings of others? When and how do they have the right or the obligation to protect themselves from forms of moral injury or moral distress caused by the failure of others to do what they should? How far do the obligations to treat patients extend? For example, we know that poverty causes illness. What then are the obligations of physicians to address poverty and other kinds of social, structural conditions?

Second, ideal theory tells us what justice and ethics *are*, while non-ideal theory aims to tell us *what to do*. Ideal theory is the realm of pure philosophy, where ethical

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[3] Importantly, "non-ideal theory" is the term that describes a sort of theorizing grounded in the imperfect realities of our world. This is not to suggest that non-ideal theories are suboptimal (i.e., not as good as "ideal" theories), but rather that they are responsive to the non-ideal worlds we actually live in; see Laura Valentini (2012); see also the taxonomy in Robeyns (2008).

[4] For examples of others who have applied the idea of idea/non-ideal theory to bioethics, see Goodin (2012), Kittay (2008), Luna (2015), Sreenivasan (2012).

investigation aims to get us to *true beliefs* about ethics and justice, even if those true beliefs do not tell us how to live our lives. G.A. Cohen famously wrote that the relevant question for theories of justice "is not what we should do but what we should think, even when what we should think makes no practical difference" (Cohen 2008). In contrast, non-ideal theorizing aims to give concrete guidance for our lives today, and that requires us to identify empirically-informed and historically contingent rules of action. While an ideal theory bioethics may do a good job telling us what medicine *ought* to look like, it may not do a good job of telling us *what to do* in our current world. Yes, we want dignity for patients and providers, and yes, we also want to value autonomy and act beneficently. But what should we do when those things are impossible? What should we do when healthcare institutions fall short? What should we do in contexts of scarcity or triage? How should we live in the context of so much injustice? Non-ideal bioethics offers help to answer these kinds of questions.

Third, ideal theory tells us what the perfectly just world looks like; it identifies the goal at which we are aimed. In contrast, non-ideal theoryfocuses on diagnosing existing injustices, and making the world somewhat less horrible. Utopian thinking is, of its nature, a kind of ideal theory, and it has been central to political philosophy, from Plato's *Republic* to Rawls's *Theory of Justice*. But the mere fact that you *have* a goal does not tell you *how* to approach that goal, or even *whether* you ought to aim for that goal in your current circumstances. Attempts at utopian revolution often backfire disastrously. Often, the best thing you can do is make an existing system somewhat less unjust, even if that makes some forms of contemporary injustice even more intransigent (Gaus 2016). Non-ideal theory focuses on these more concrete and transitional projects by orienting us to the evils and injustices that we are motivated to resist, and not only goals we are trying to pursue. Amartya Sen (2011) argues that non-ideal theory correctly notes that our motivations are more often about resisting existing injustices than pursuing justice as an ideal: "What moves us, reasonably enough, is not the realization that the world falls short of being completely just—which few of us expect—but that there are clearly remediable injustices around us which we want to eliminate." In turn, a non-ideal bioethics is always oriented to ongoing injustices, and the histories of oppression and inhumanity that have informed current practices. A non-ideal bioethics aims at a better world, but is always practically engaged in resisting current wrongs, and at avoiding the resurgence of evils that we have previously faced.

A non-ideal bioethics for today's world benefits from deep and sustained engagement with the facts of the Holocaust, and with the impact of the Holocaust on the current practice of medicine and medical research. Take for example, Gisella Perl, the Jewish physician who worked under the supervision of Josef Mengele in the women's hospital at Auschwitz. Because pregnancy was punishable by death, Perl performed not only abortions, but infanticide, in an effort to save the lives of the women prisoners. In this and many other ways, she resisted, where she could, Mengele's dictates, using all sorts of deception. In her book, *I Was a Doctor in Auschwitz*, she offers a painful and honest account of just one such incident:

> The third day, Yolanda's little boy was born. I put her into the hospital, saying that she had pneumonia—an illness not punishable by death—and hid her child for two days, unable to destroy him. Then I could hide him no longer. I knew that if he were discovered, it would mean death to Yolanda, to myself, and to all these pregnant women whom my skill could still save. I took the warm little body in my hands, kissed the smooth face, caressed the long hair—then strangled him and buried his body under a mountain of corpses waiting to be cremated. (Perl 1948, p. 83)

As with the narrative above, the moral anguish captured in this account, both that of Perl herself and our own, as we read and reflect on these unimaginable circumstances, cannot be reduced to ideal-type principles like autonomy and beneficence. Of course, we could say that Perl's actions were in the "best interests" of Yolanda, perhaps neutral with respect to 'harms' to the infant since he was likely to be killed anyway. But such an analysis would be offensive to the richer moral sentiments captured here. There is a sorrow that pervades the account even for many of us who would judge Perl's actions ethical. There are in this account other ethical concepts that are at least as helpful as autonomy and beneficence in terms of making sense of what is right and wrong in this narrative. Notions of cruelty, inhumanity, and desperation surely must inform our ethical analysis of Perl's decisions. These moral sentiments capture the lived experience of the ethical dilemmas she faced in a way that the principles of ethics do not. Indeed, many ideals of ethics ran up against the real-world context in which Perl had to try to live out her profession as a moral actor. We might even say, somewhat ironically, that Perl lied and cheated her way through the Holocaust and that she was right to do it. In light of Perl's story, we can see the clear limits of the concepts of autonomy, non-maleficence, and beneficence, and we must acknowledge the need to look for other moral tools.

A deep study of the Holocaust illuminates our understanding of what is morally required of physicians and other healthcare providers when they *cannot count on other people to do what is right*. There are stories of heroism, especially among the Jewish doctors who continued to care for people in the ghettos and in the camps, often under impossible conditions (Oberman et al. 2010; Reis and Wald 2009; Wasserman and Yoskowitz 2019). There are also the many stories of non-Jewish physicians and healthcare workers who resisted the Nazi regime, often at great risk to their careers and even, at times, their lives. Even amidst tragic circumstances and insurmountable odds, they found ways to assert their humanity and to make even the most horrible of worlds (e.g., the ghettoes and camps) a little less horrible. From the point of ideal theory, it may be easy to condemn the kind of compromises that sometimes had to be made, or at least the way in which we might make sense of them seems like a tortured application of insufficient tools. But a non-ideal orientation points us to much more difficult questions about what we ought to do when people around us are acting badly. While we can reasonably hope that none of today's physicians will face moral failures like the Holocaust, we should recognize that they will often face the moral shortcomings of the other people with whom they work and the larger social systems within which they work.

An engagement with the facts of the Holocaust helps us to construct a non-ideal bioethics that is always *practical* because it is dynamically responsive to the actual situations in which we are trying to decide how to act. We are theorists—in sociology and philosophy—and we appreciate the value of theory for its own sake. But a bioethics theory should always orient us to action and towards resisting injustice. The Holocaust is not a theory. It is not a set of principles. It is an evil that demands a response. To think about and study the Holocaust is to try to answer questions about what we would have done, or what we should have done, in light of our knowledge about the choices that many people actually did make.

Finally, the Holocaust forces us to think about bioethics as less of a journey towards what we believe is good, and more of a fight against what we know is bad. This kind of non-ideal bioethics is not just about striving for a goal of treating patients well. It is not only about building autonomy, nonmaleficence, beneficence, and justice into patient care. It is also always about refusing to become cruel and inhumane. It is about responding to desperate circumstances with courage and compromise, when living up to the ideals of bioethics is not possible.

An orientation to a non-ideal bioethics is also important because we can feel abandoned by ideal-type principles as we try to navigate our imperfect worlds. The history of the Holocaust reminds us that bioethics is a fight against real enemies and dangers. There are forces in contemporary social institutions and in the perennial failures of human character that ensure that the dignity and autonomy of patients are always at risk. Confrontation with the Holocaust helps to ensure that people will feel the full force of what is at stake when we argue for values in medicine.

Bioethics is relatively new and was, forged, in part, from the ashes of the Holocaust.[5] We make a mistake if we think that the fervor of bioethics' early advocates will be automatically inherited by today's students. John Stuart Mill raised this worry when he argued that *fighting for new ideas* cultivates a passionate commitment that may not be adopted by those who are merely *taught those ideas* as part of the received wisdom:

> [W]hen [an idea] has come to be an hereditary creed, and to be received passively, not actively…there is a progressive tendency to forget all of the belief except the formularies, or to give it a dull and torpid assent, as if accepting it on trust dispensed with the necessity of realizing it in consciousness. (Mill 1859, p. 73)

A Holocaust bioethics makes the notion of human dignity more than just an empty creed. It instead fills people with a sense of the great values that are at stake and the great disasters that one must aim to avoid (Lerner and Rothman 1995). In this way, even in its substantive emptiness, the idea of "dignity" holds out a call to action and an opportunity to wrestle with the moral dimensions of the world as it really is. Today, the great challenge for bioethics is that many of its cornerstone ideas risk becoming merely parts of an 'hereditary creed'. However, just as these ideas were derived by reflection on moral atrocities, including the Holocaust, we can return over and over to the history of the Holocaust to ask ourselves what we ought to do, right here and right now.

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[5] This is particularly true with respect to certain key concepts such as voluntary informed consent; see Arthur L. Caplan, "The Meaning of the Holocaust for Bioethics," *The Hastings Center Report*, 19, No. 4. (1989): 2–3.

16.5 The Usefulness of Human Dignity

A non-ideal bioethics, especially one grounded in the realities of the Holocaust, can help us to better understand the meaning of human dignity and to complement the moral vocabulary that constitutes the 'ideal bioethics' (e.g. of 'autonomy' and 'beneficence'). Here too, we can look towards political philosophy to guide such an endeavor. Let us return to Habermas, who argues that attention to human moral failings, institutional limits, and the facts about real-world cruelties and injustices can orient us to a richer sense of what human dignity involves:

> The appeal to human rights feeds off the outrage of the humiliated at the violation of their human dignity. … [C]hanging historical conditions have merely made us aware of something that was inscribed in human rights implicitly from the outset—the normative substance of the equal dignity of every human being that human rights only spell out. (Habermas 2012, p. 66)

The problematical nature of the concept of human dignity has been the source of consternation, but this is also precisely what makes the concept an important source of moral reckoning. As Edmund Pellegrino writes:

> …intelligibility of so elusive a notion as dignity must be grounded in our lived experiences of dignity either personally or collectively or, as the rest of the world experienced the Holocaust and the other horrors of the last century, vicariously. This will require an effort to philosophize about dignity as a concept arising from, and returning to, experience in the real world of everyday life. (Pelligrino 2008, p. 516)

Grappling with the horrors of the Holocaust gave birth to efforts to articulate international consensus on human rights, and later, consensus around core bioethical principles. It is precisely because of its ambiguity that we can return to the concept of human dignity to address the insufficiencies of established mid-level principles like autonomy. It is also its substantive emptiness that makes it useful as a source of critical reflection and a wellspring of new moral ideas, particularly those which can help us navigate the imperfect, real world contexts of medicine today.

In this respect, we can look back to the notion of human dignity and what the history of the Holocaust signals to us about moral action in several key ways.

The first concerns a real-world moral methodology that grounds and humanizes ethics. In particular, violations of human dignity that we can witness in the Holocaust set off alarms in our moral sentiments. As we read these accounts, most of us feel something ranging from anxiety to existential dread and, in turn, we can feel the insufficiency of how abstract bioethics principles attempt to explain them. While such sentiment reflects a beginning rather than an end to the work that needs to be done to explicate actual moral concepts that can guide our decision making, it is a commitment to the notion of human dignity, a recognition that dignity violations are often sensed before they are articulated, that can motivate this work. The lesson here centers on the instrumental value of sentiment and intuition for calling bioethics forward.[6]

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[6] Wink (2006, p. 85) notes something similar about using Holocaust history in the classroom: "For our growth and students' learning, there exists a need to suffer the loss of out-moded thinking and

If we wrestle to explain what is morally wrong in the accounts of Perl or Ms. M., the existing bioethics tools leave us wanting, and, hopefully, compelled to go further. Similarly, in actual clinical interactions, one's sense that something is wrong often motivates further thought, more robust conversation with the patient, or ethics consultations in the hospital. Done well, these efforts should be about articulating the moral content of the situation, rather than the mere application of ideal-type principles (even if those offer helpful guidance). One can imagine for example an instance of treatment over objection of a patient, which may be fully justified on the grounds of best interest, but for which there is a moral residue found in the guilt of the physician, the alienation of the patient, and the distress of the staff (Navin et al. 2019; Wasserman et al. 2019). These concerns are owed the same kind of clarity we now have surrounding the balance of autonomy against beneficence in many clinical scenarios.

Secondly, staring back into the abyss of human dignity, anchored by the history of the Holocaust, helps us reflect on ways to navigate the imperfect and often unethical institutions in which we, as actors, are nonetheless striving to be ethical. This is an ever-present phenomenon, but perhaps most keenly illuminated by the COVID-19 pandemic. For example, appeals to abstract principles of justice and fairness helped elucidate various proposals related to the ethical distribution of scarce resources such as PPE, ventilators, experimental therapies, and vaccines. These schemas fell notably short when confronted with the social histories of socioeconomic and race inequality that became so evident during the pandemic. Black Americans, for example, faced disproportionate burdens during the pandemic, both in terms of prevalence and acuity. Yet protocols for rationing ventilators or vaccine distribution schemas tended to ignore this phenomenon. In fact, given the disproportionate burden of relevant clinical comorbidities among these populations, they are likely to have been disadvantaged in many of these rationing schemas. Certainly, incorporating these types of social factors into those schemas, which are already so complex as to be difficult to implement in real world clinical settings, represent a logistical challenge. But it also represents an insufficiency of the conceptual tools we use to navigate such moral challenges in bioethics in particular, the way in which fairness is operationalized is abstract and not grounded in real histories of racism and marginalization. Other moral tools can be derived and could be further specified, tools such as representation and reparation that are scarcely mentioned in the context of clinical ethics.

Third, and extending along the same lines as the concerns above, appeals to human dignity can help derive new concepts to guide medicine's commitment to humanism and social justice. Appeals to patient- and family-centered care have become canonical in contemporary medicine, but there is an interesting dearth of ethical justification for these. That is, shared decision making and patient-centered communication, are positioned, at best, as adjuncts to clinical ethics. We can see some ways in which shared decision making may help us navigate the tension between

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refine assumptions so that students can, in turn, dismantle their thinking, rise out of apathy and connect to emotion to break the sluggish cycle. Discovering one's feelings and giving language to those feelings is one response to apathy.".

autonomy and beneficence, but there is little by way of grounding these clearly in principles of ethics. Instead, these seemed to be assumed strategies of humanistic patient care, something that we intuitively feel is a good thing, but for which the moral foundations have not been clearly articulated (at least not in the same way that autonomy, non-maleficence, and beneficence have). Explicating precisely why centering patient narratives, not just their specific autonomous treatment preferences, in the context of caregiving represents a moral obligation can benefit by appeals to human dignity and refinement of relevant moral concepts from there. Not to do so risks relegating the various manifestations of patient centered care to merely a clinical strategy, something that serves providers rather than patients (Vinson 2016).

Concerns for social justice and the obligations of medicine to participate in the rectification of health inequalities beyond the clinical interaction may also benefit from appeals to human dignity and the lessons from the Holocaust. The Holocaust was predicated on a severe kind of othering. This same alienation pervades our society in ways that have health consequences for patients. While medicine has something of an arms-length relationship to public health, one that is supportive but understood as an effort distinct from clinical practice, appeals to human dignity may call this way of understanding clinical medicine into question. Sitting across from a homeless patient in a clinical encounter, it is problematic to divest the way that larger social inequalities have been inscribed on the body of that patient. Ethical care of that patient, then, demands a true coming together of those extra-clinical realities and the body in the clinic. Efforts at promoting structural competency in clinical medicine are a start to re-imaging the scope of clinical practice in this way (Metzl and Hansen 2014). However, as with patient centered care, without a strong moral foundation, one that can perhaps be extracted by staring into the emptiness of human dignity, and aided by appeal to various historical narratives, efforts to bring together the micro-level clinical moment with the macro-level social conditions in which patients live may be relegated to something strategic or supererogatory.

Finally, there is in the insufficiency of the dominant conceptual tools of bioethics an important lesson for all students of medicine and bioethics, no matter what their age or stage of career. That is, moral life is always, of necessity, an unfinished project. The moral concepts derived in response to specific historical moments serve particular social functions within medicine. These always will represent a partial address of the moral content of our complex and messy real lives. In this respect, we must always demand to know more, to go further, to turn back toward those histories and to examine what has occurred since to refine our moral sensibilities and our ethical tools. Correspondingly, our own professional identities and the value commitments we personally bring to our professions are always in a similar development. Reflecting on the history of medicine in the Holocaust helps us contribute not only to the collective moral project of bioethics, but also to our personal moral projects of professional identity formation (Reis et al. 2019). The emptiness of the construct of human dignity is precisely what allows it to compel us forward in this way. Its ambiguity is what makes it so useful.

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