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Review

"Euthanasia": a confusing term, abused under the Nazi regime and misused in present end-of-life debate

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Abstract

Background Legal provisions in The Netherlands and Belgium currently allow physicians to actively end a patient's life at his or her request under certain conditions. The term that is used for this is "euthanasia."

Discussion The same term, "euthanasia," was used in Germany during the Nazi regime for a program of cleansing the "German nation" in which untold thousands of persons were denied human empathy or medical care and were thereby condemned to death. The medical profession played a leading role in the planning, administration, and supervision of this "euthanasia" program, with a large proportion of German physicians proactively shirking all moral responsibility and ultimately paving the way for the Holocaust.

Conclusion The term "euthanasia" was so abused during the Nazi regime as a camouflage word for murder of selected subpopulations with the willing participation of physicians, we believe that, regardless of the benevolent goals of current euthanasia practices, for historical reasons the term "euthanasia" must not be used with regards to current end-of-life care.

Keywords Euthanasia - National Socialism - End-of-life care - Racial hygiene - Intensive care

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Introduction

It has been shown that there is wide variation as to withholding and withdrawing of life-sustaining treatments in intensive care units (ICUs) across Europe [1, 2]. Limiting such treatments appears to be more acceptable within northern European societal systems and among Christian physicians than in southern European societal systems and among Jewish and Moslem physicians. Also, there is an untoward terminological variation regarding the limitation of life-sustaining treatments [3, 4]. Especially the term "euthanasia" has been used inappropriately in this context, which reflects neither its historical connotations nor its present

use in The Netherlands and Belgium. Redundant and synonymous expressions abound, such as "active euthanasia," "voluntary euthanasia," and "physician-assisted death." This review discusses the historical context of the term "euthanasia" and argues against using it for present medical procedures.

Definition of "euthanasia"

"Euthanasia" derives from the Greek word εὐθανασία, meaning "good death" or the facilitation of a good death. According to a modern definition [5], "Euthanasia occurs when one person intentionally causes the death of another person, motivated by the desire to promote the best interest of the person who dies and using the most gentle means that are available to achieve this end." This end, a "good death", can be described as an "end of life without pain, comforted, peaceful, experiencing dignity and respect as well as closeness to family" [6].

Euthanasia in The Netherlands and in Belgium

The intention to facilitate a "good death" for those suffering from unbearable (medical) conditions has been a cornerstone of the Dutch and Belgian legal provisions since 2002 which allow a physician to end another person's life at his/her request. The Dutch provisions even include active help with suicide [7, 8]. This matter has been extensively reviewed elsewhere [9, 10, 11, 12, 13, 14, 15]. Briefly, patients living in The Netherlands and enduring hopeless and unbearable suffering can make a request for euthanasia, provided there is no acceptable alternative treatment. Under certain circumstances euthanasia can also be requested using an advance directive. Even minors from the age of 12years on are allowed to make such request; however, their parents (or legal representatives) need to be included in the decision-making process. The request for euthanasia must be voluntary, consistent, and informed. Physicians willing to honor such request need to thoroughly examine the individual case and obtain a second opinion from another independent physician. The Dutch provisions specify that euthanasia is neither a physician's obligation nor a patient's right. Each request that is honored needs to be reported to the coroner and a special regional euthanasia review committee which examines whether the rules are properly applied. In the case of medical or procedural shortcomings, the physician providing euthanasia may still be subject to legal action by professional or public courts. Similar conditions hold for Belgium, although rules for minors under 18years of age are stricter [10].

Despite a detailed set of rules the practice of euthanasia in The Netherlands still confronts a number of unanswered questions. Firstly, the term "unbearable suffering" leaves a wide room for interpretation. On the one hand, individuals may have a very particular understanding of conditions which they are no longer willing to endure. Meanwhile, even a general weariness of life has been debated as a sufficient reason to grant euthanasia [16]. However, such requests have been honored only very rarely [13, 17]. On the other hand, attesting to a state of "intolerable suffering" may be subject to coercion by family or society, since an earlier death may be easier to cope with and economically advantageous. Interestingly, according to a recent publication, most patients requesting euthanasia in The Netherlands are cancer patients (about 90%). The most prominent reasons for the request are "pointless suffering," "deterioration or loss of dignity," and "weakness or tiredness" [17].

Secondly, debate continues as to whether a competent person can make a request for euthanasia in advance, which is then respected at a future time when his/her condition has become unbearable, but when he/she will no longer be able to request euthanasia in an informed manner [13, 14]. Thirdly, the number of requests for euthanasia, the number granted, and the number of reports to the review committee rose in The Netherlands between 1990 and 2001 (Table1) [12, 13]. However, the number of euthanasia cases reported in 2001 is only about

one-half of those performed in the same year. Thus almost one-half of the euthanasia procedures appear to be performed without assessment by the review committees.

Possibly the Dutch and Belgian legal provisions derive from benevolent Monistic theories about euthanasia at the beginning of the twentieth century [18]. The present rules, however, appear to leave room for coercion, and the Dutch procedures do not seem to be followed in a high proportion of cases. Also, euthanasia as defined in these two legal systems is hardly ever applicable for end-of-life care in ICUs because most patients in an ICU have generally lost the capacity to make consistent and informed requests [19]. The rather nonchalant use of the term "euthanasia" in these two legal systems is remarkable given its abuse in recent history, which did not spare The Netherlands and Belgium. To better clarify this abuse some remarks on historical movements appear warranted.

Table 1 Euthanasia and physician-assisted suicide in The Netherlands: 1990, 1995, 2001

	1990	1995	2001
Deaths	128,800	135,700	140,400
Euthanasia requested	8,900	9,700	9,700
Euthanasia granted	2,300	3,200	3,500
Physician-assisted suicides	400	400	300
Killing without consent	1,000	900	900
Reports to committee (% of euthanasia cases)	18	41	54

Eugenics and racial hygiene in the late nineteenth and the early twentieth centuries

In the nineteenth century, Darwin's theory of the evolution of man ("The Origin of Species," 1859) introduced, among others, the principles of adaptation and selection. Soon the concept of a primarily fortuitous natural mechanism of selection was transformed into an intended man-made process of selecting out by "Social Darwinism," most notably represented by Herbert Spencer, who had actually coined the phrase "survival of the fittest." Social Darwinism was an elitist belief claiming that the rich and powerful are better adapted to the social and economic circumstances of the time than the less fortunate and powerful. This belief was used to justify the exploitation of underprivileged subpopulations as well as the implementation of eugenics programs.

The eugenics movement, popular in the United States and some European countries in the early twentieth century, was represented by a rather heterogeneous group of scientists, namely physicians and social scientists. They shared the Darwinist idea of natural selection and tried to cultivate better human beings by preserving "good genes" and removing "undesirable genes" from the population. Some scientists opted for positive selection, namely through breeding, or no interference with nature at all. An increasing majority, however, opted for the application of negative selection tools to help nature selecting a fitter society. These tools consisted of (forced) sterilization, quarantine, abortion, and even "euthanasia" of those thought to carry undesirable genetic material.

Alfred Ploetz introduced the term "racial hygiene" (*Rassenhygiene*) in 1895 as a German term for eugenics. Racial hygiene was supposed to balance personal and social hygiene, yet the attention was shifted from the individual and the environment towards the genetic pool of the society. Often the German population was equated with a human organism, and "undesired genes" with parasites that needed to be weeded. Over time the advocates of racial hygiene in Germany appeared to focus increasingly on shaping a superior race, the "Aryan" race. Scientific knowledge was intermingled with pseudoscientific findings and ideological agendas,

and the resulting *idée fixe* was that the German race needed to be freed from extraneous racial elements [20, 21, 22, 23, 24, 25, 26].

After World War I, Germany experienced a period of political unrest, economic instability, and social dislocations. Major parts of the population were impoverished, unemployed and uprooted, and many citizens felt deprived of their pride and their hope. In accordance with the zeitgeist, the lawyer Karl Binding and the psychiatrist Alfred Hoche raised the question of whether a society in a social and economic emergency was morally obliged to nourish 'life unworthy of life' (*lebensunwertes Leben*), as they coined it [27]. Burleigh [28] has observed that, "Two points about the tract were crucial. Firstly, is was symptomatic of how received Judeo-Christian or humanitarian values were breaking down, with concern for narrow or wider collectivities, such as the good of a class, the economy, race or nation usurping respect for the rights and value of the individual. Secondly, it argued that in emergency wartime circumstances, where the healthy were making enormous sacrifices, one could justify the 'sacrifice' of 'not merely absolutely valueless, but negatively valued existences'".

Despite increasingly militant claims within the racial hygiene movement no eugenics programs were implemented nationwide in Germany during the Weimar Republic (1918–1933). This was to change almost immediately under the Nazi regime [21, 25].

Implementation of racial hygiene programs during the Nazi era

Nazism can be characterized as, among other things, a totalitarian ideology that places a greater priority on the "people" and the "nation" over the individual. The ideologically inherent xenophobia and racism—mainly anti-Semitism—resulted both in the overestimation of the "Aryan" race and in programs to maintain its alleged superiority by constant ethnic cleansing. Also, Nazism claimed the right to acquire new geographic territory for its superior race, at the expense of inferior races, if necessary by belligerent means.

After the Nazis took over the legislative and executive power in Germany in 1933, cooperation flourished between their ideologues and the advocates of aggressive racial hygiene policies. Programs for breeding were put into place, sterilization laws and marital laws were passed ("Law for the Prevention of Hereditarily Diseased Progeny," 1933; "The Nuremberg Laws," 1935), and the registration of persons with presumed genetic defects was enforced [20, 22, 23, 24]. Also, public campaigns were conducted against certain subpopulations. For example, Nazi publications compared the costs of maintaining hereditarily diseased individuals with the investments into healthy families (Fig.1). Even schoolbooks used these comparisons for lessons in mathematics. For instance, one could find the following assignment in a Nazi mathematics textbook: "A mentally ill person costs 4RM [Reichsmark] daily, a cripple 5.50RM, and a criminal 3.50RM. Often a civil servant, an employee, and an unskilled worker have only 4RM, barely 3.50RM, or not even 2RM per family member at their disposal. In Germany approximately 300,000 mentally ill persons, epileptics, etc. are being cared for in designated institutions. What is the total annual cost [of their care], taking 4RM as the daily cost [per patient]? How many matrimonial loans of 1000 RM could be granted from this amount per year?" Those not fitting the racial ideal of Nordic supremacy were many: the mentally and physically disabled, alcoholics, nomads, those unwilling to work (*Arbeitsscheue*), certainly Jews and gypsies, and nonconformists in general. All these groups appeared to not support the "community of the racially pure and healthy German people," and they were subsequently stigmatized, deprived of rights and benefits, and increasingly excluded from normal societal life.

Fig. 1 Typical denouncement of hereditarily diseased persons. *Left* “A genetically diseased person costs the public RM 5.5 daily”; *right* “A genetically healthy family can eat for 1 day on RM 5.5.” *RM* Reichsmark (*Reichsmark*), the German currency at the time

It is important to note that the German medical community had been engaged early in Nazi programs. Physicians joined the Nazi party earlier and in greater numbers than any other professional group. Support for the Nazi movement had both political and socioeconomic reasons. Specifically, younger German physicians sought to increase their influence and income by replacing established Jewish colleagues. The National Socialist Physicians' League was formed in 1929 and represented about 6% of the entire German medical profession even before 1933. The League sought to coordinate Nazi medical policy and helped to rid the medical community of Jews. Many physicians actively and voluntarily participated in Nazi racial hygiene programs. Especially with regards to forced sterilization, physicians were overzealous in fulfilling the set quotas. Indeed, the average revenue for physicians generally increased under the Nazis, and the plethora of Nazi suborganizations created additional jobs for physicians. By 1942, nearly one-half of all physicians in Germany were Nazi party members [20, 22, 24, 25, 29, 30, 31].

Euthanasia under the Nazi regime

In October 1939, Hitler issued a decree to commission certain physicians to grant a “mercy death” (*Gnadentod*) to (German) patients judged “incurably sick by medical examination” [32]. This measure became known as the T4 program, named after its headquarters at the address of “Tiergartenstrasse 4” in Berlin. Judging strictly from its wording, the intention of this decree appears very similar to the present understanding of “euthanasia.” However, under the Nazi regime true medical examinations of the patients subjected to the program did not take place, the patients were not necessarily incurably sick, and there was no “mercy.” The official date for the issuance of the decree establishing the T4-program was deliberately backdated to coincide with the beginning of World War II. The program was aimed at “cleaning the deck for the coming war,” and what was euphemistically called “euthanasia,” in reality was ethnic cleansing [20, 21, 22, 29]. In retrospect, the publication of Binding and Hoche had had a noticeable impact on “life unworthy of life.” In a first phase more than 5,000 disabled children were killed in mental institutions by starvation, neglect, or poisoning. In a second phase the program was extended to Jewish, gypsy, and “difficult” children, as well as to adults, again, mainly those in mental institutions. Usually it was commissioned physicians who selected the victims by chart review and without further physical examination. Increasingly, the victims were bussed to a small number of special institutions throughout Germany, for instance, Brandenburg, Hadamar, Eglfing-Haar, and Grafeneck (Fig.2), in some of which technical provisions for gassing and cremation had been installed. The busses used for transportation had darkened windows, intended less to prevent those being transported from looking out than to spare the healthy populace (*Volksgenossen*) the looks of the disabled inside (Fig.3). Some of

these institutions had an outwardly appealing appearance, and Nazi propaganda tried to feign a cosy atmosphere of community at them. The victims, however, were never part of that community (Fig.4).

Fig. 2 A view of Grafeneck

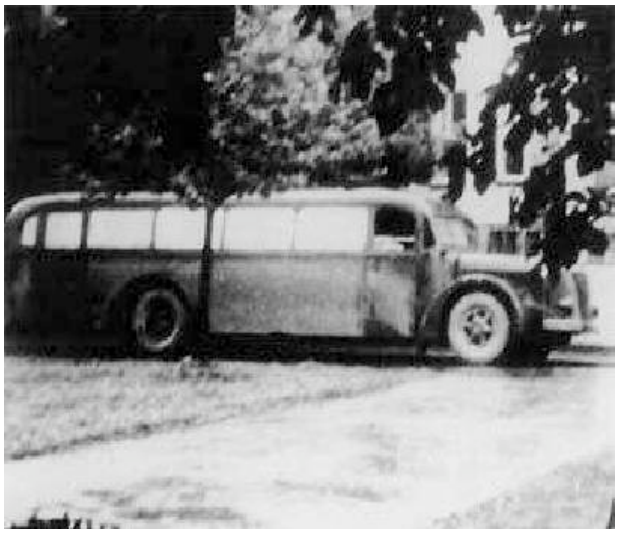

Fig. 3 Typical T4 bus (windows darkened)

Fig. 4 A view of the Grafeneck leisure room (*left*) and gassing barracks (*right*)

Notably, there appeared to be relatively little resistance to the “euthanasia” program, neither from the public, nor from clergy, or the mental institutions themselves. Even most families were willing to believe falsified death certificates because they could not fathom that transfer of their loved ones to selected centers “for special treatment” meant selection for death sentence. Also, families often appeared to be relieved of the emotional burden of having to care for a mentally disabled child, especially since having such a child in the family was increasingly being depicted as a racial disgrace.

In terms of the ideological goals of the Nazi regime, the T4 program proved efficient: by August 1941, approx. 70,000 patients in German mental hospitals had been killed, increasingly by gassing and subsequent cremation. Even after the official end of the program due to some protest, mainly from Bishop von Galen, so-called “wild euthanasia” continued in several institutions as part of their “routine procedures.” The total toll of the T4 program will never be known precisely. It is estimated that approx. 6,000 children and up to 200,000 adults were killed by the end of the Nazi regime [22, 23, 24, 25].

German biomedical scientists, especially physicians, played a proactive and leading role in the initiation, administration, and implementation of all major Nazi racial programs. The “euthanasia” program, however, was implemented under thorough control of physicians, and it paved the way for the Holocaust. Without the technical knowledge and the experience of the personnel from the T4 program, many of whom later held influential positions in concentration camps, the extermination of the Jews would probably not have been possible [24, 25, 28, 33]. At the end, it was physicians who selected the Jews at the death ramp in Auschwitz-Birkenau extermination camp for immediate gassing or for murder through forced labor, starvation, medical experiments, and persistently cruel treatment (Fig.5).

Fig. 5 Selection by physicians at “The Ramp” in Auschwitz-Birkenau extermination camp

The moral failure of German physicians as a professional body in the Nazi era was that they denied thousands, if not millions, of individuals human empathy and personal care, and treated them as herds of subhuman creatures instead. Most physicians involved were not seduced to attempting to “perfect” an imperfect race: they actively broke their oath in order to augment their personal power and their societal standing.

In the “Physicians' Trial” in Nuremberg (1946–1947) only 20 Nazi physicians and biomedical scientists were accused, and seven were acquitted. The first German report on the involvement of physicians in Nazi racial programs by Mitscherlich and Mielke [34] was neglected and hushed up by the German postwar professional bodies [22, 35]. Only after a long “epoch of unrepentant silence” [33] have articles about the German medical profession's involvement in Nazi programs become more widely published and circulated over the past

20years [22, 24, 29, 36].

Summary

The term “euthanasia,” as it is used in the present Dutch and Belgian legal provisions, refers to the facilitation of a gentle death by a physician at a patient's request and consent. Subsequently, euthanasia is usually not applicable in ICUs because most patients in ICUs can no longer make an informed request. Under the Nazi regime, however, the term “euthanasia” was abused as a camouflage word for manslaughter and murder of innocent subgroups of the population on the grounds of disabilities, religious beliefs, and discordant individual values, with no consent whatsoever. It is unrealistic to believe that the term “euthanasia” will be changed in the present legal provisions. However, at least when debating and publishing about end-of-life care, we should refrain from using this historically loaded term any longer.

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