Justice at Nuremberg: Leo Alexander and the Nazi doctors' trial

By Ulf Schmidt. Palgrave Macmillan, Basingstoke 2004. 400pp. £60.

The execution of Charles I in 1649 sent shock waves through Europe.¹ Of course, kings had been deposed and privately murdered before: Edward II, Richard II, Henry VI. But Charles was brought to trial in the most public place in the kingdom in Westminster Hall, by men whose action was based on principle. It was a show trial, but nevertheless a process of law. The king denied the legality of the court, saying 'You have shown no lawful authority to satisfy any reasonable man'. His prosecutors said that Charles had 'maliciously levied war against the... people'.

These themes of the legitimacy of the court, of 'victor's justice' in show trials playing to a huge audience, of waging 'aggressive war', were to feature in the trials in Nuremberg in 1947. The trials of the Nazi doctors, presided over by American judges, followed the more famous trials of Nazi leaders. Twenty three defendants were accused of murder, torture and multiple atrocities in the name of medical science. It was the association of criminal offences with medical science that made these trials so important in the development of research ethics. The Nuremberg Code that the judges expounded provided the first international standard of what was permissible in experimentation on human subjects. This story is told by Ulf Schmidt in this enthralling and meticulously documented account.

Schmidt focuses his narrative on two related themes: the life of Leo Alexander, the court's expert consultant, and the origins of the Code. Born into a wealthy Jewish family in Vienna, Alexander drifted into research in eugenics, emigrated first to China and then, with some difficulty, to the United States, because of the growing anti-Semitism in Germany. Between 1933 and 1941 he made major contributions to our understanding of Wernicke's disease, recognising the disease in vitamin B1 deficient pigeons. This gave rise to some witty doggerel from the eminent physician, Lewis Thomas, who composed 20 lines that began:

*Hail to Alexander, that giant Man of Science,
And all the happy pigeons, his little waddling clients,
A happy lot, I truly wot, to meditate upon ...*²

But Alexander wanted to join the US army and finally did so in 1943. When the time came his expertise in neurology and psychiatry coupled with fluent German gave him the opportunity of a lifetime.

The trials created many problems: the practical ones of selecting judges, arranging maximum publicity, preventing the defendants from achieving public sympathy, finding witnesses who were alive and could testify to avoid hearsay evidence. There were more historically significant problems too: how to focus on the concept of genocide when the 'euthanasia' programme had been directed against the German state's own people and, even more dramatically, how to insist on ethical standards in medical experimentation when no such standards had been formally laid down in any Western state save only – ironically – Germany. It was this latter problem that led to one of the most dramatic incidents in the trial when defence lawyers turned a prosecution witness's testimony against the prosecution by luring the witness into a general statement of unaccept-

able research without consent, then presenting evidence of the large scale malaria experiments on 800 American prisoners. Perhaps that episode has been told more dramatically elsewhere,³ but Schmidt relates it in detail. At risk, of course, was the legitimacy and entire future of experimentation on humans. The Code (described initially as 'a good code for barbarians') made it possible to carry out the experimentation and also led to the foundation of the World Medical Association and the 'twisted road to Helsinki' – to the Helsinki Code that still sets the standard for ethical research.

Alexander was an outspoken and self-confident personality who went on in perhaps his most famous publication to examine the factors that led doctors to adopt a crudely utilitarian Hegelian perspective towards human beings.⁴ He believed that once doctors had started to think in terms of 'valuable' and 'invaluable' members of society, and accepted the premise that 'life unworthy of life' existed, the moral fibre of the profession began to disintegrate. He realised, long before Holocaust historians, that the 'euthanasia' programme provided vital expertise and personnel for the killing centres in the occupied Eastern territories. Schmidt concludes his account by discussing the relevance of Nuremberg to research ethics in later scandals in Britain and America.

In a special issue of the *BMJ* published 50 years after the trials, it was commented:

*...if biomedical insights grant physicians sudden new explanatory and technological powers, if economic trends intensify pressures to rationalise healthcare costs and develop utilitarian strategies, if state political forces directly enlist the medical profession in an agenda of social and economic transformation, and if an ideology of hate and stigmatisation permits the dehumanisation of one sector of the populace, then we may see a turning towards something we had relegated to bitter mid-20th century memory.*⁵

Sixty years after the end of the conflict that led to such atrocities, the author of this book shows us that history has many messages that we can still debate with profit.

References

- 1 Wedgewood CV. *The trial of Charles I*. London: Collins, 1964.
- 2 Thomas L. *The youngest science: notes of a medicine watcher*. Oxford: Oxford University Press, 1985.
- 3 Harkness JM. Nuremberg and the issue of wartime experiments on US prisoners. *JAMA* 1996;276(20):1672–5.
- 4 Alexander L. Medical science under dictatorship. *New Engl J Med* 1949;241:39–47.
- 5 Leaning J. War crimes and medical science. *BMJ* 1996;313:1413–5.

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Biopsychosocial medicine: an integrated approach to understanding illness

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This book is the edited proceedings of a two-day conference, which in 2002 set out to explore the usefulness of the 'biopsychosocial'

(BPS) model of medicine as propounded by George Engel (1913-2000) in a 1977 paper in *Science*.¹ The contributors are divided about whether this was a reaction to the narrow and restrictive 'biomedical reductionism' that had become dominant in medicine, or whether it grew out of an internecine turf war in American psychiatry. Engel had a foot in both medicine and psychiatry. He was brought up by his uncle Emmanuel Libman (of Libman-Sacks endocarditis fame) and became an internist. In his younger days he described psychoanalysis as 'hogwash', but in 1941 was virtually forced by his boss, Soma Weiss, to do ward work and research with the psychiatrist John Romano, who was fully integrated into the medical service. In 1946 Romano persuaded Engel to move with him to Rochester where they integrated psychiatry and medicine in the curriculum and in the same year Engel began to undergo psychoanalysis himself.

Whether Engel was a prophet of a new age is open to question and his seminal paper contains no data and no explicit plan of action. As Edward Shorter points out in the admirable historical survey that forms the first chapter of this book, Engel was part of a long tradition of people who preached holistic medicine. In the 1880s Hermann Nothnagel in Vienna described medicine as 'treating sick people not diseases' and in 1927, Francis Peabody wrote an eloquent treatise called 'The care of the patient'. The state of medicine and psychiatry has been a frequent topic of discussion in our household. My psychiatrist wife thinks psychiatry has gone to the dogs, with its practitioners making a diagnosis from the *DSM* (the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders*), and then prescribing pills. I lament that scopes and catheters in medicine have squeezed out history-taking and treating the patient as a person.

Arguably Engel's most important paper was 'A life setting conducive to illness: the giving-up-given-up complex', published in 1968.² By the time of the 1977 *Science* paper he was swimming against a tide of effective drugs in both medicine and psychiatry. Several contributors to *Biopsychosocial medicine* mention the discovery of *Helicobacter pylori* which dealt the *coup de grâce* to psychosomatic research on peptic ulcers. George Davey Smith, in typically iconoclastic fashion, points out that spiral bacteria were described in the stomach in 1899 and antibiotics advocated for peptic ulcers in 1948. For him, this means that the discovery of *H. pylori* was delayed for years by the BPS model and the mindset it created. Yet lots of people have *H. pylori* without ulcers and even more have dyspepsia without *H. pylori*. A dip into the psychological or social background will often give valuable clues to the aetiology of the latter, a point made in this volume by Drossman in connection with irritable bowel syndrome (IBS). Yet, in an era when clinics have to run to time, who dares open Pandora's box in outpatients?

One problem with the BPS model is that it is seen as the antithesis of the 'medical model', and indeed its adherents often use the latter as a term of opprobrium. Both seem to me to have their place. George Davey Smith says that, if he were to have a heart attack, he wants a doctor who is up to date with the best somatic treatments. This is fine and I doubt that even the most diehard psychoanalyst would disagree. Nevertheless one would hope that this cardiologist steeped in evidence would realise that the patient is a person with a life outside the coronary care unit. On the other hand the cardio-

logist may be less good at dealing with chronic disease or the large group of patients who in Peabody's time were talked about as having 'nothing the matter with them'.³ They are particularly badly served by 'organic' doctors; repeated tests may lead to the assumption that an (organic) diagnosis has not been made because the crucial test has not been done. Those with non-specific chest pain, IBS, fibromyalgia and chronic fatigue syndrome are surely the people for whom the BPS model is ideal, as recognised by Simon Wessely in his witty and wise foreword to the book.

The 12 speakers at this meeting are rather a mixed bag and the result is a rather patchy book. I like to see the discussions printed as they are here, but often they seem to go round in circles. Had I not been asked to review it, I don't think I would have read the whole book. Nevertheless, there is much food for thought. The chapter by Jos Kleijnen is highly recommended to all who believe in the biblical certainty of randomised controlled trials.

The sad truth about the schism between medicine and psychiatry in the twenty-first century is emphasised by Simon Wessely, who points out that when he sees patients in the general hospital they first detail the problems with their soma. In the Maudsley over the road, they invariably kick off with their sadness and anxiety. Yet, further probing invariably shows that those with fatigue and pain have sadness and those who are sad have fatigue and pain. An internist who ignores the psyche is not doing a good job – which is all I think Engel was trying to say.

References

- 1 Engel GL. The need for a new medical model: a challenge to biomedicine. *Science* 1977;196:129–36.
- 2 Engel GL. A life setting conducive to illness: the giving-up—given-up complex. *Bull Menninger Clin* 1968;32(6):355–65.
- 3 Peabody FW. The care of the patient. *JAMA* 1927;88:877–82.

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Recovery after stroke

Edited by Michael P Barnes, Bruce H Dobkin, and Julien Bogousslavsky. Cambridge University Press, Cambridge 2005. 668pp. £95.

Even ten years ago the idea that a book on stroke recovery extending to over 600 pages could be written would have been met with disbelief. Only since the publication of the review of meta-analysis of the stroke unit trials has there really been a belief that stroke is a treatable condition. Even now the funds allocated to stroke research are pitiful, compared to comparable conditions, in terms of their public health implications. For every £1 spent on stroke, £20 is spent on heart disease and £50 on cancer, with only a small proportion of the stroke research monies going on the longer-term consequences of stroke compared to acute pharmacological interventions. This is the case not just in the UK but also in the USA and the rest of Europe.

This book is a welcome addition to the stroke literature, which has few equivalent texts. It is beautifully presented and is well referenced up until 2003. In 25 chapters authored by contributors from