Grey Matters: Turning a Blind Eye: An Ethical Assessment

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If you say, ?But we knew nothing about this,? does not he who weighs the heart perceive it?
--Proverbs 24:12a

The phrase ?to turn a blind eye? means to deliberately refuse to acknowledge something that one knows to be true. Etymologists credit its origin to Vice Admiral Horatio Lord Nelson, who, at the naval battle of Copenhagen in 1801, willfully disobeyed a signal to withdraw because he was confident of success. Having a more accurate view of the battle, Nelson acknowledged the signal but ordered it not to be repeated to his fleet. Turning to his flag captain, he was reported to have said, ?You know, Foley, I have only one eye ? and I have a right to be blind sometimes.? Putting the telescope to his blind eye, he remarked, ?I really do not see the signal.?¹ Nelson?s triumph at Copenhagen was a key victory for the British Royal Navy in the Napoleonic Wars.

Decisive action sometimes requires disregarding conflicting signals. In hazy situations such signals may indicate incorrect, incomplete, or misinterpreted facts. In other situations the signals are correct, but weightier matters may be at stake. Some signals assist while others impede progress. To neglect all signals is reckless, but to take notice of them all is to be encumbered in minutiae, if not stalled in doubt. Wise leadership involves discernment of which signals one ought
to heed and how and when to respond in order to decide on the right action. That discernment entails the ethical task of assigning priority to various signals and rightly ordering the principles that guide responsive action.

When ethical principles are improperly ordered, turning a blind eye to inconvenient truths can lead to serious error. Some signals we ignore at great peril. A paramount signal in medicine is the Hippocratic maxim *primum non nocere* (first, do no harm). The Hippocratic mandate to place the needs of patients above competing interests has guided the practice of Western medicine for centuries. Physicians who follow the Hippocratic Oath abide by the standard that, *whatever houses I may visit, I will come for the benefit of the sick*.

The Oath, writes Allen Verhey, *treats medicine as a form of human activity with goods internal to it and standards of excellence implicit in it, not simply as an assortment of skills which can be made to serve extrinsic goods with merely technological excellence*.

Much of the history of medical ethics concerns efforts to avoid turning a blind eye to human suffering while intentionally turning a blind eye to external influences that compete or interfere with the care of patients. The practice of medicine in general adheres to the highest ethical standards, but exceptions do occur. Sadly, highly educated and scientifically trained professionals are not immune to the tendency to turn a blind eye in the wrong direction. Especially grotesque is the example of Nazi physicians who violated the Hippocratic Oath they had sworn. One need not look just to the brutality of the concentration camps to recognize that a dense moral fog had descended on medicine under the Third Reich in mid-twentieth century Germany. The break with Hippocratism began insidiously. The 1920 book, *Release and Destruction of Lives not Worth Living*, by Alfred Hoche and Karl Binding signaled a sea change in German culture and introduced the idea that there is human *life unworthy of life* (*Lebensunwertes Leben*). The break widened with doctrines of racial hygiene and utilitarian justifications for ending the lives of those perceived as having no right to live. About that break, Nigel Cameron writes, *The signal point of departure from the humane tradition of Western medicine lies in the euthanasia programme with which pre-war Germany busied itself, exterminating its own citizens and beginning with mentally defective children*.

In 1939, Adolph Hitler issued an order requiring physicians to report any child in their care up to the age of three with certain physical deformities or mental defects. A selection committee reviewed the questionnaires submitted by physicians and, without examining the children in person or consulting families or guardians, from a distance determined which children would be transported to extermination facilities, some of which were within prominent hospitals. The methods of killing included slow poisoning by pills with the intent of mimicking death due to natural causes, lethal injections, and gassing with cyanide or chemical warfare agents. More than 5000 children were killed in this first phase of the German euthanasia program.

Shortly thereafter, Hitler extended the program to adults and issued an order authorizing certain physicians *to grant a mercy death to patients judged incurably sick* in order to rid society of its weak, handicapped, costly, and *inferior* members. Code-named Aktion T-4, the German adult euthanasia program perfected the method of killing by gas chambers disguised as showers and
set the stage for the systematic murder of Jews, homosexuals, communists, Gypsies, Slavs, and political prisoners in the death camps. Young, inexperienced physicians were promoted to manage the efficient facilities. From 1939 to 1941, more than 70,000 patients from more than a hundred German hospitals were killed. The Aktion T-4 business director Hans Hefelmann later testified that no doctor was ever ordered to participate in the euthanasia program; they came of their own volition. Such large-scale operations are not easily kept quiet. Suscipsions grew, and rumors spread, but many turned a blind eye.

Richard L. Rubenstein writes, Once German physicians realized that they had an almost limitless supply of human beings at their disposal for experiments, some very respectable professors at medical schools and research institutes seized the unique opportunity. One such professor was Julius Hallervorden, a neurologist who trained in Konigsberg and Berlin. Hallervorden was a prolific author of scientific publications and rose to the position of Chair of Neuropathology at the Kaiser Wilhelm Institute in Berlin-Buch. The degenerative brain disorder Hallervorden-Spatz disease still bears his name. Hallervorden was also the pathologist at the Brandenburg-Goerden State Hospital, which was one of the six centers of the killing process. Although Hallervorden did not directly participate in the killing of patients, he took advantage of the opportunity for scientific research available to him due to his proximity to the euthanasia program. During the summer of 1942, he wrote that he was able to dissect 500 brains from feebleminded individuals. In an interview with American neuropsychiatrist Leo Alexander, Hallervorden recounted his involvement with Aktion T-4 as follows: Look here now, boys, if you are going to kill all these people, at least take the brains out so that the material could be utilized. They asked me: How many can you examine? and so I told them an unlimited number the more the better. I gave them fixatives, jars and boxes and instructions for removing and fixing the brains and then they came bringing them like the delivery van from the furniture company. There was wonderful material among these brains, beautiful mental defectives, malformations and early infantile disease. I accepted these brains of course. Where they came from and how they came to me, was really none of my business.

Nelson and Hallervorden both turned a blind eye, but the comparison stops there. Even in that turning, there are morally significant differences between their actions. Nelson took upon himself the responsibility for what he believed to be the right action and became a national hero. Hallervorden attempted to wash his hands of others wrongdoing while seeking to gain from its byproduct. Hallervorden?s error exposes the ethical flaw in starkly utilitarian reasoning that disregards the moral principle of respecting human dignity. Hallervorden?s greatest blindness was not to the killing around him from which he felt insulated as long as he looked the other way but to his own complicity with evil.

The ethical evaluation of moral complicity is complex. Robert Orr has outlined a number of considerations that help to weigh questions of complicity. The first is timing, and, related to it, incentivization. For Hallervorden, since his ongoing arrangement with the executioners may have facilitated future immoral acts, this would incur greater moral culpability than association with an act that had already been completed. Rather than turning from a wrong once realized, Hallervorden continued to accept brains from the executioners. A second question is proximity. The executions were carried out at the very hospital where Hallervorden had a senior faculty appointment. A third question is the degree of certitude. A student training under Hallervorden might have been unaware of the source of pathological material and thus noncomplicit in its
acquisition. Hallervorden’s statements, however, leave no doubt that he knew that innocent people had been killed. A fourth question in determining moral complicity is knowledge of association. For example, a medical student using the *Pernkopf Anatomy Atlas* might be unaware that the detailed illustrations in that text were drawn from the dissected bodies of murdered Holocaust victims. However, when there is clear awareness of the source of medical material or scientific knowledge gained, as Hallervorden in this case admits, then the degree of blame seems more clear. The fifth and perhaps most important question relevant to the presence or absence of guilt concerns intent. Since intent is subjective, it must be inferred. Hallervorden’s primary intent cannot be known with certainty but seems to have been morally commendable and directed toward a different goal (medical scientific knowledge) than that for which the immoral act was performed. If, however, the executioners tried to ease their consciences by accepting the neurologist’s promise that the brains would not go to waste but would be used to advance science, then the neurologist would have implicitly encouraged the immoral act, thus incurring some degree of moral complicity.

Hallervorden apparently rationalized that the commendable end of advancing scientific knowledge gave him the right to be blind sometimes to the means by which that end was attained, especially if he did not participate directly. The sharpest ethical scalpel, however, cannot completely separate means from ends, as if only one mattered. Robert George writes, “The conviction that a little evil may rightly be done for the sake of a greater good, or for the sake of preventing a greater evil, puts human beings on the path to losing their grip on good and evil altogether.”

Turning a blind eye to signals to pull back from doing good may be appropriate. No method of moral reasoning succeeds, however, in justifying turning a blind eye to the violation of basic human rights. Nor should physicians turn a blind eye to the instructive lessons of history. In all situations, one should strive for clear ethical vision.

This essay concludes by returning to the open seas to illustrate how decisions and acts affect other people in unexpected ways. Four years after Lord Nelson turned his blind eye in Copenhagen, he led the British Royal Navy in its most decisive victory against the French and Spanish Navy at the battle of Trafalgar. Shortly before that battle, one morning off the coast of Cadiz, one of Lord Nelson’s scouts was keeping watch in an outlying frigate when he saw dimly through the lifting fog a galley of Barbary corsairs fleeing at the sight of the well-armed British frigate and leaving behind an American vessel they had captured. The British officer fired a few choice shots at the Barbary galley, but in a moment it had disappeared and was seen no more. The British then boarded the American vessel, which was a brigantine with a cargo of lumber that had sailed from Edenton, North Carolina and was bound for Marseilles. The British freed the American captives bound up below deck who, at the hands of the pirates, had been destined to be killed or sold into slavery in North Africa. Among them was a young, as yet unmarried man responsible for the sale of the cargo. His name was John Cheshire, the third great-grandfather of this writer.
Editor's Note: The views expressed herein are Dr. Cheshire's own and do not necessarily reflect the position of Mayo Clinic. This article originally appeared in Ethics & Medicine: An International Journal of Bioethics Volume 27, Issue 1, Spring 2011, and is used with permission.


2. Hippocrates, Epidemics, Book I, Section XI.


8. Ibid.

9. Ibid.

10. Ibid.

11. Ibid.


15. Ibid.


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