

## DIVERSION

# Odol, Autobahne and a non-smoking Führer: Reflections on the innocence of public health

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### The 'Hygiene Eye'

Karl August Lingner (1861–1916) made his fortune as the manufacturer of Odol mouthwash, a product with bactericidal properties that fulfilled the demands of consumers who were impressed by the advances in bacteriology of the late nineteenth century. He believed in the importance of population health for a strong nation, and developed an interest in health education. He was convinced that the same commercial techniques that had been used for selling Odol would also be useful for selling other hygienic principles. He therefore decided to organize the first international hygiene exhibition, modelled after trade exhibitions and using state-of-the-art visual displays.

The exhibition opened in Dresden in 1911. Lingner had engaged outstanding artists to make a number of stunning displays, the most spectacular of which was 'the transparent man'—a life-size model of a male body with a skin of transparent glass. The German Social Medicine Association and the state public health administration participated in the exhibition, and there were lectures and displays for racial hygiene and against alcohol abuse. The symbol of the exhibition was the 'hygiene eye', the all-seeing eye of the hygiene movement that became the trademark of the health education movement.<sup>1</sup>

The exhibition was a great success and drew more than 5 million visitors. Lingner decided that he could do more, and started planning for a national hygiene museum that finally opened in 1930 during the second international hygiene exhibition. The museum still exists and its history mirrors the history of German public health, with all its triumphs and tragedies. After 1933 it served Nazi racial ideology, and propagated racial hygiene. After 1945 it immediately took up its role again, but now under communist rule, and coordinated health education in the German Democratic Republic until 1989. After the fall of the Berlin wall it was quickly changed into a typically 'modern' museum with interactive devices, commercial sponsors, and a mission that emphasizes its role as an independent discussion forum for social and ethical issues.<sup>2</sup>

It is well known that Nazi doctors collaborated in the Holocaust, violating their Hippocratic oath in the interests of the German race. They conducted horrible experiments on concentration camp inmates, committed 'euthanasia' on hundreds of thousands of people with mental and physical disabilities, and carried out large-scale sterilization of the 'unfit'. It is less well known that the Nazis also had public health policies that we today would regard as very progressive. The best-documented example is that of their anti-smoking policies. Nazi scientists were the first to discover the link between tobacco smoking and lung cancer, and the leaders of the Third Reich had very strict non-smoking policies including bans on smoking and extensive health education campaigns. In some of these the non-smoking Führer was used as an example for the German people, and anti-tobacco activists pointed out that while Churchill, Stalin, and Roosevelt were all smokers, the three fascist leaders in Europe, Hitler, Mussolini, and Franco, were non-smokers.<sup>3</sup> The *International Journal of Epidemiology* as well as other scientific journals have recently paid considerable attention to this potentially painful part of the history of epidemiology and public health.<sup>4–7</sup>

### Fascism and health promotion

Can Nazi anti-smoking policies be seen simply as good ideas falling in bad hands? Or is there perhaps a hidden link between public health and fascism? The American historian who 'discovered' the Nazi anti-tobacco movement, Robert Proctor, concludes that neither anti-smoking campaigns nor 'Autobahne are inherently fascist'.<sup>5</sup>

But libertarian critics of public health paternalism have welcomed Proctor's analysis and claimed, 'that the relationship between fascism and public health is more symbiotic than Proctor admits'. 'Both fascist policies and modern public health ideology require a powerful state. (. . .) Can we say that Nazism produced good public health measures? Perhaps, but only if we are blind to the costs they imposed on individuals. Even if we accept that smoking contributes to lung cancer, this does not justify prohibiting adults to do what they want with their own lives'.<sup>8</sup> This type of reasoning, including the use of the term

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'health fascism', is actually recorded quite often in the popular media in Europe now that governments try to implement stricter anti-smoking regulations.

Even in Proctor's own analysis there is a link between public health and fascism, in the sense that Nazi anti-tobacco policies were rooted in a wider racial hygiene movement. Among other things, tobacco was considered a 'genetic poison', decreasing fertility and increasing the incidence of chromosomal damage. In fact, the racial hygiene movement started rather innocently, as a slight twist or extension only of the concept of 'social hygiene', the continental-European equivalent of 'public health' in the first half of the twentieth century. The term 'Sozialhygiene' was introduced into German by Von Pettenkofer, and originally referred to the implementation of public health legislation and social welfare measures. After 1900, Grotjahn redefined social hygiene as the science of the factors affecting the health of population groups, and of the measures necessary to spread hygienic values among individuals and their offspring. The benefits of social hygiene were to society as a whole, and this is what made it easy for social hygiene to develop into racial hygiene.<sup>1</sup>

A small but disquieting example that I only recently came across, and that therefore must have been kept hidden carefully, is that the journal of national-socialist doctors in the Netherlands in 1943–44 was called 'Volksgezondheid' (public health).<sup>9</sup> While the term 'social hygiene' has gone out of fashion long ago, we still use the term 'volksgezondheid' in The Netherlands without any shame or guilt, unaware of its slightly dubious past. In Germany, on the contrary, the term 'Volksgesundheits' is still taboo because of its connection with Nazi health policy. This Nazi contamination has cast suspicion on all of public health in Germany, and partly explains the weakness of public health practice and public health research, including epidemiology, in this country up till the present day.

Let me put it as a provocative question: is there something in public health that puts its practitioners at risk of being 'fascists in disguise'? Let's not say 'no' too quickly, for two reasons. The first is that not only Nazi Germany, but also the enlightened democracies of western Europe and North America have implemented public health measures in which individual human rights have been overruled completely for the benefit of the health of the population as a whole. To quote but two notorious examples: Social-democratic Sweden has had a legally enforced sterilisation program of the 'socially unfit' (mentally ill, mentally deficient, epileptics, . . .) that lasted into the 1970s.<sup>10</sup> The US Public Health Service has between 1932 and 1972 conducted a study of the natural history of untreated syphilis among 400 black men who were withheld effective treatment without having given informed consent—for which official apologies came only in 1997, from President Clinton.<sup>11</sup>

## The value system of public health

Such horror stories are rare, but there is a second and more fundamental reason why we shouldn't reject an accusation of 'fascist' tendencies too quickly. The problem is that the value system of the public health profession may not sufficiently protect it against violations of individual human rights. Public health people tend to see themselves as driven by a kind of large-scale altruism—an altruism that does not only cover one's

immediate neighbours with their current illnesses, but also healthy people who may become ill in the future, even if they are completely anonymous members of other populations.

Where does this large-scale altruism come from? It is likely to be a modern sentiment—it requires statistical and epidemiological knowledge and techniques for health improvement that can be applied on a large scale, and these date to, roughly, the seventeenth and eighteenth centuries. It is probably partly rooted in ordinary altruism, of which it may seem to be a logical and innocent extension. But histories of the development of public health show that it is also closely connected with 'political arithmetic': the theory that the strength of a nation depends on the size and health of its population.<sup>12</sup> In this eighteenth century theory that laid the foundations for statistics, epidemiology, and public health, the group interest clearly takes dominance above the individual interest.

Ethicists have reached similar conclusions. They have pointed out that the moral theory that underlies most public health actions is utilitarianism, which holds that actions are right in so far as they promote 'the greatest happiness (read: health) of the greatest number'. This is an attractive theory for public health professionals, because it provides their large-scale altruism with a quantitative method for determining what is a good, and what is a wrong decision. The problem with utilitarianism is, however, that it provides no guidance for how to deal with individual autonomy, another important value in Western societies.<sup>13</sup>

The conflict between the values embedded in utilitarianism and that of individual autonomy is particularly clear in the area of genetic screening, where a 'public health' approach that would focus on maximizing population health benefits is generally seen to be potentially dangerous, particularly if there are reproductive implications.<sup>14</sup> Genetic screening is just one example, and we have perhaps become too sensitised for its implications by the history of eugenics. But there are many other public health interventions where there is a similar conflict between what could be done to achieve 'the greatest health of the greatest number', and what should be done (or foregone) to respect individual autonomy.

For example, because so many risks to health are behaviourally mediated, public health is continuously struggling to avoid too strong forms of paternalism.<sup>15</sup> Health promotion interventions can often not simply be based on altruism, as is illustrated by anti-smoking policies. What options does a Good Samaritan with a public health inclination have when he meets a smoker? It is clearly unsatisfactory to wait until the smoker falls ill, and then display his altruistic behaviour to the full. Should he hand him a leaflet with information on the health risks of smoking, and leave the smoker in peace to make his well-informed choice? Should he design an internet-based anti-smoking intervention that has been carefully tailored to the 'stages of change' and attitudes of the smoker, so that the latter is effectively persuaded to stop smoking? Should he buy the smoker nicotine replacement therapy? Or should he force him to stop smoking by raising tobacco excise taxes and, if need be, by forbidding the sales of tobacco entirely? The ethical foundations of all these options are unclear.<sup>16</sup>

In the case of smoking, some of these dilemmas have been solved by the discovery of the health effects of passive smoking. The fact that second-hand smoke can kill non-smokers has provided even libertarian politicians with a powerful argument

to interfere with smokers' behaviour. But there are many more examples of health-related behaviour that does not harm others, and where public health professionals have real difficulties reconciling their desire to promote population health with the necessity to respect individual autonomy. Seatbelt legislation is a classical example, and it is likely that the need to curb the obesity epidemic will pose many such dilemmas in the near future.

## Conclusion

The 'large-scale altruism' of public health thus has to be balanced somehow with the value of individual autonomy. One possible solution is to remind ourselves that the rightness or wrongness of actions is not only, and perhaps not even primarily, dependent on their consequences. This is difficult for public health professionals, because they tend to be 'consequentialists', entirely in line with their preference for utilitarianism.

It was Immanuel Kant (1724–1804) who first stated clearly that it is not the consequences of an act that make it right or wrong. Forcing a smoker to stop smoking may have good consequences, in the form of less illness and a longer life, but it may at the same time be wrong from a moral standpoint. Kant suggested that when we want to know if a proposed action is morally permissible, the question to ask ourselves is 'Can I, as a rational agent, consistently will that everyone should act as I am now proposing to act?'<sup>13</sup> This 'categorical imperative' requires us not to make exceptions of ourselves, even if we are the real experts, and may help to protect us against authoritarian mistakes in public health.

Fortunately for public health, this principle does by no means rule out the possibility of paternalistic interventions. But it sets clear limits: public health professionals have to ask themselves whether most people would agree or not to a certain interference with their autonomy. Perhaps, if smokers would be aware of all the facts (e.g. that their nicotine dependence is a major interference with their autonomy), a large majority among them would not object to being gently forced to stop smoking. I certainly would not, just as I appreciate a little pressure to put on my seatbelt and to use the stairs instead of taking the elevator.

In recognition of Kant's principle, the 'code of ethics' developed by the American Public Health Association states that 'public health should achieve community health in a way that respects the rights of individuals in the community'. 'Public health policies, programmes, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.'<sup>17</sup> It seems to me that in order to preserve our innocence we should apply these principles wholeheartedly.

## References

- <sup>1</sup> Weindling P. *Health, Race and German Politics Between National Unification and Nazism 1870–1945*. Cambridge: Cambridge University Press, 1989.
- <sup>2</sup> *Deutsches Hygiene Museum, das Museum vom Menschen*. Dresden: Stiftung Deutsches Hygiene-museum, 2001.
- <sup>3</sup> Proctor RN. *The Nazi War on Cancer*. Princeton: Princeton University Press, 1999.
- <sup>4</sup> Davey Smith G, Ströbele SA, Egger M. Smoking and health promotion in Nazi Germany. *J Epidemiol Community Health* 1994;**48**:220–23.
- <sup>5</sup> Proctor RN. The anti-tobacco campaign of the Nazis: a little known aspect of public health in Germany, 1933–45. *BMJ* 1996;**313**:1450–53.
- <sup>6</sup> Schairer HU. Commentary: In memorial of my father, Prof. Dr. med. Dietrich Eberhard Schairer. *Int J Epidemiol* 2001;**30**:28–29.
- <sup>7</sup> Zimmermann S, Egger M, Hossfeld U. Commentary: Pioneering research into smoking and health in Nazi Germany—the 'Wissenschaftliches Institut zur Erforschung der Tabakgefahren' in Jena. *Int J Epidemiol* 2001;**30**:35–37.
- <sup>8</sup> Lemieux P. Heil Health. Review of Proctor's *The Nazi War on Cancer*. *The Independent Review* 1999;4, no. 2. Available at: <http://www.pierrelemieux.org/artProctor.html> (Accessed June 1, 2003). Proctor RN. Author's protest. *National Post*, October 7, 1999. Available at: <http://www.pierrelemieux.org/artProctor.html> (Accessed June 1, 2003).
- <sup>9</sup> Noorman J. *Om de kwaliteit van het nageslacht; eugenetica in Nederland 1900–1950*. Nijmegen: SUN, 1989.
- <sup>10</sup> Johannisson K. The People's Health: Public Health Policies in Sweden. In: Porter D (ed.). *The History of Public Health and the Modern State*. Amsterdam/Atlanta: Editions Rodopi, 1994.
- <sup>11</sup> Jones JH. *Bad Blood; The Tuskegee Syphilis Experiment*. New and expanded edition. New York: The Free Press, 1993.
- <sup>12</sup> Rosen G. *A History of Public Health*. Expanded edition. Baltimore: Johns Hopkins University press, 1993.
- <sup>13</sup> Beauchamp DE, Steinbock B. Introduction: Ethical theory and public health. In: Beauchamp DE, Steinbock B (eds). *New Ethics for the Public's Health*. New York: Oxford University Press, 1999.
- <sup>14</sup> Ten Kate LP. Community genetics. *Community Genet* 1999;**2**:1.
- <sup>15</sup> Dworkin G. Paternalism. In: Beauchamp DE, Steinbock B (eds). *New Ethics for the Public's Health*. New York: Oxford University Press, 1999.
- <sup>16</sup> Buchanan DR. *An Ethic for Health Promotion*. New York/Oxford: Oxford University Press, 2000.
- <sup>17</sup> American Public Health Association. Public Health Code of Ethics. Available at: <http://www.apha.org/codeofethics/ethics.htm> (Accessed May 31, 2003).

