

Learning from history:

why we should remember the German University in Breslau (now Wrocław)

BRESLAU AND ITS SUCCESSES

In its day (about 1830–1920), the medical school of the University of Breslau was one of the most famous in the world, yet today it is almost forgotten. In the *Dictionary of Medical Eponyms*,¹ we find 33 eponyms related to doctors working in Breslau. The university was founded in 1811 by King Friedrich Wilhelm III of Prussia and eventually named the 'Silesian Friedrich Wilhelm University in Breslau'. Why did it become so important? When Germany was finally united in 1870, Breslau was the chief town of Silesia and Silesia was an immensely prosperous steel and coal mining area. The population of Silesia was ethnically diverse: Germans, Poles, and Jews. For the emancipated Jews, medicine was one of the few professions open that promised a possibility of social advancement. Entry to the university for Poles and Jews was reduced after the *Kulturkampf* of Bismarck (1871–1876) and completely stopped once the Nazis were in power (1933).

In that period the German-speaking world was the acknowledged leader in the application of modern science to medicine. In contrast Britain's only major contribution was Lister's introduction of antiseptics, an advance that was widely accepted in the German world while Lister was still being ignored at home. Among the many German advances, we might mention Koch's demonstration of the microbial origin of many diseases (Koch's postulates) and Ehrlich's development of histological stains — on the back of the German dye industry — and, following on from this, of antibiotic chemotherapy.

In what areas did the University of Breslau excel? I would like to focus on two: surgery and neurology. The leading surgeon was Jan Mikulicz-Radecki (1850–1905). He had a German father and a Polish mother. When asked what his nationality was, he would answer, 'surgeon'. When he left Krakow for Breslau in 1887, the Jewish community there thanked him, saying '*... that he made no distinction between rich and poor, between Jews and Christians*'. He was Professor of Surgery in Breslau from 1890 to his death in 1905. Asepsis was strongly emphasised. He introduced advances into almost all areas of surgery. With his trainee Ferdinand Sauerbruch (1875–1951), he was one of the first to operate on the lung, in a negative pressure chamber at the hospital in Breslau. Sauerbruch went on to become

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the leading German surgeon between the wars. Based in Berlin, he believed in a complete separation between professional life and obedience to the state. As a result, he could work closely with the Nazis, heading up the German medical research council whose research included 'research' on prisoners in the concentration camps.

TURNING TO THE DARK SIDE

Turning to neurology, Otfried Foerster (1873–1941) was the first German neurologist to advocate treatment — physical treatment. Previously neurologists had confined themselves to diagnosis. Many US neurologists trained at Foerster's clinic. Sir Ludwig Guttmann (1899–1980), the neurologist who founded Stoke Mandeville hospital and pioneered the physical treatment of paraplegia, was trained by Foerster at Breslau. Jewish, Guttmann was forced out of Germany in 1939 and came to the UK. Foerster was succeeded in 1941 by Victor von Weizsäcker (1886–1957), who, though closely linked to it, was not a member of the Nazi Party. It is with von Weizsäcker that we enter a dark period in the history of the University of Breslau.

Before we embark on the last chapter of the university's history, we need to understand that in 1944 Poland was moved 200 kilometres to the east by the Allied powers. All Germans were expelled from Breslau. In the east of pre-war Poland, which had been annexed by the Soviet Union, all ethnic Poles were put in cattle trucks and moved to the ex-German territories. In the case of Breslau/Wrocław the new inhabitants mostly came from the city of Lwów (now Lviv in Ukraine). They brought with them Lwów University's professors and a new Polish University in Wrocław was started.

CHILD EUTHANASIA

To return to the last, dark, chapter of the German University's existence, near Breslau is the town of Loben (now Lubliniec in Poland).

Here there was a hospital with a clinic for child and adolescent psychiatry run by Dr Elisabeth Hecker (1895–1986). The formal euthanasia programme for mentally defectives of the Third Reich (T4) had nominally been shut down in 1941 after brave protests from many Germans, including Bishop von Galen, but child euthanasia continued.²

Dr Hecker brought in mentally retarded children from families and institutions all over Silesia. After a rigorous 6-week programme of testing she decided if they were fit for training for routine industrial work, or '*Schwachsinn*' (feeble-minded). Those found to be feeble-minded or epileptic by Dr Hecker were transferred to clinic B, run by Dr Ernst Buchalik (1905–20th century). Here the children, already starving, were given several times the therapeutic dose of phenobarbital (Luminal) as a sedative — not a lethal dose. Nevertheless, the intention was to kill them, and all perished within days or weeks. The brains were then sent to the neuropathological institute in Breslau where they were examined by Dr Hans Joachim Scherer (1906–1945), working in Dr von Weizsäcker's department in the university. The estimate of 200 murders rests on a meticulous record of doses of Luminal administered by Dr Buchalik and kept by him in a bound notebook, which was found by the Poles in 1945 when they recaptured the area. After the war, three of the doctors concerned fled. What is difficult for us to take in is that the three of them continued their careers in East or West Germany without let or hindrance until retirement (Dr Scherer had died in an air aid in 1945).

It is easy to judge Drs Hecker, Buchalik, and von Weizsäcker. But it is more useful to use these events to examine our own actions. Are any patients being sedated with a view to hastening death in our hospitals and practices in the UK today?

The recent Gosport hospital scandal has brought to the forefront of all our minds that

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such a situation occurred in the UK in the 1990s. Professor Sir Brian Jarman stated on the *Today* programme on 21 June that:

*'The Gosport situation may be repeated because information on death rates was not properly assessed by health officials.'*³

NEURAL TUBE DEFECTS

Consider first the treatment hydrocephalus with spina bifida. After a phase of very active treatment in the 1960s, associated in the UK with the name of the neurosurgeon Dr Zachary, there was a reaction. In 1971 John Lorber, who had been one of the pioneers of active treatment in the 1960s, advocated the sedation of the worst affected babies, so that they would not feed, but die.⁴ More recently, the prognosis with active treatment has much improved, because intermittent self-catheterisation avoids the renal failure in early adult life that blighted the original programme. The whole controversy is well reviewed by Dr Pruitt.⁵ In England the topic has somewhat fallen from public view because the incidence of live births with spina bifida has fallen; around 80% of pregnancies with this condition are now terminated.⁶ Universal fortification of flour with folic acid, as practised in the US since 1998, would have prevented an estimated 2000 pregnancies with a neural tube defect in the UK in the years 1998–2016. Fortification of flour with folic acid should, therefore, be a priority UK public health policy.⁶

THE PLACE OF SEDATION IN TERMINAL CARE

Of more direct concern to GPs is the proper use of subcutaneous midazolam. Whereas appropriate doses of opioid analgesics have been repeatedly shown not to shorten life, midazolam can lead to loss of consciousness, cessation of feeding and drinking, and hence might shorten life. Studies to date, summarised in a Cochrane review,⁷ show no shortening of survival time from admission or referral to death in the sedated group. None of these studies were randomised controlled studies.

Moreover, these studies were carried out in specialised institutions for the dying (95% of the patients had cancer). Only two out of fourteen studies included 'hospice at home' patients. The mean duration of sedation from initiation to death ranged from 19 hours to 3.4 days. This is a very different population from those for whom we are responsible, and who are currently receiving terminal care at home, or in residential and nursing homes.

Although there is a place for midazolam in severely agitated patients, are our staff, community nurses and others, appropriately trained in the use of these drugs? These are drugs that are typically left to the discretion of the community nurses to administer at the end of life.

And what of the staff in care homes, often migrant workers on minimum wage? Are they paid enough? Do we offer them sufficient support and training for this most responsible job of looking after our elderly at the end of their lives?

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RICHARD THE GREAT

Shortly after starting at *BJGP* in 1999 to edit *The Back Pages*, I received an email summarising the weekly content of the Big Four Generalist Journals — *Lancet*, *BMJ*, *NEJM*, and *JAMA*. The author, Richard Lehman, a full-time GP in Banbury, Oxfordshire. The content was laser sharp, effortlessly evidence based, and looked at the quality of the evidence, irrespective of evidence source (often Pharma) and wholly disrespecting the grandeur of the Big Four Generalist Journals. *'More tosh from the Lancet'*; *'Paradigm-HF epitomises everything that is wrong with heart failure studies'*. And so on.

Then more. The style wholly seductive and polymathic. Postscripts re. Plant of the Week. Literary digressions from Sumerian prehistory, to *The Anatomy of Melancholy*, to Blake and TS Eliot and the great canon of Russian literature. Recipes featuring foraging that pre-date Nomu. Took me too long but eventually signed Richard up for *BJGP* monthly *Flora Medica*. Eventually he was brain-hunted by the *BMJ* — a higher-profile weekly publication and, I sincerely hope, a modest fee.

Two key words. Weekly. Week after week for almost 20 years. For me, and all of my students, and specialist trainees, and postgrad students, and partners. A body of work that is unquestionably one of the greatest publishing achievements by any GP, anywhere, in the last two decades.

And witty. Most columns raised a smile, some a smirk, and occasionally a guffaw. Richard Lehman in late June has written his last blog for the *BMJ*. We all of us raise a glass of red wine, and a small foraged mushroom tartlet, in his general direction. Thank you!

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