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Health-Insurance Policy and Berufsverbote in the Nazi Takeover

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Drawing upon new archives and documents, Leibfried and Tennstedt take us deeper into the Nazi period. We would expect the purges of Jewish physicians and the use of health care to build a master race, but the transformation of sickness funds from local organizations run by workers that provided the spawning ground for important experiments in social medicine to a rather uniform national structure is not commonly known or admitted. Nor might we expect the zeal with which leaders of medical societies persecuted their colleagues who ran clinics and other facilities for workers. The authors claim that after World War II the democratic tradition of sickness funds was not restored as the hegemony of the medical profession built up during the Nazi period continued in West Germany. Equally disappointing to them as Marxists was the East German response of totally centralizing workers' health care in a government bureaucracy.

The standard literature on medical history¹ and the history of social policy and related areas does not confront at all the empirical developments addressed in this essay: the relationship between social policy and the Nazi use of Berufsverbote. These purges of professionals in Germany are barely alluded to in writings on social policy, since the focus of description is usually on administrative and legal changes per se (see Leichter 1979, pp. 133 ff.). When they are discussed, the implicit explanation is that there was some mishandling of ethnic minorities, a matter of pure justice quite independent of any major politics or social policy. What literature there is (see Mitscherlich and Mielke 1978) usually focuses on the medical experiments and racial policies of the Nazis. Structural issues of social policy are overlooked, and personification prevails. The formative processes of the "political power of physicians" (Stone 1980, p. 18) and their role in the "health market"

thus tends to be ignored. The standard German literature (Hentschel 1983, pp. 137 ff.) holds that social policy was an island that withstood the Nazi floods, and that the Nazis were aberrant individuals of no relevance to social policy over the long run but only of relevance for the minority issue. This focus tends to dissolve structural issues into total bedeviling and pure moral outrage about all sorts of medical malpractice of a wide assortment of individual doctors (Mausbach and Bromberger 1979; Roth 1980, pp. 152 ff.). This chapter attempts to overcome these weaknesses by combining biographical detail with a structural analysis of policy, for key individuals helped create and institutionalize new health policies. Administrators and doctors from 1890 on formed "health policy reform clusters," which gave rise to many major innovations in health-service delivery until 1933, when they were destroyed.

The democratic character and sensitivity of both the local sickness funds and the professional delivery of service were seriously undermined by the Third Reich and were not restored in the Federal Republic (FRG; West Germany) after World War II. It might well be that these shifts, which have occurred in living memory, are still of such emotional significance that detachment and embarrassment may not be disentangled from reality. At first glance an outsider might find that in the FRG, through the Law of Self-Government and Changes in the Area of Social Insurance of February 22, 1951, "the social insurance system was 'essentially restored' to its pre-1933 status" (Leichter 1979, p. 139). *This is not so, even on the legal-administrative level. The self-government of the local sickness funds had been based, from 1883 until 1934, on a two-thirds majority of the representatives of the insured on the fund's board. These representatives, who were mostly connected with the major labor unions, faced a one-third representation of the employers. This structure of some 50 years' standing came to be the dominant view of German classical self-government in this area. Its destruction was in a sense perpetuated when two-thirds parity was not reestablished after World War II; in 1951 the structure was changed to one of parity, and "self-government" was thus paralyzed by any dissent among the representatives of the insured (Dobbernack 1951). During the first national mobilization of conservatives against the local funds, a similar change was attempted, unsuccessfully, in 1911, when all major social insurance legislation was codified in the National Insurance Code (Reichsversicherungsordnung). The undoing of the classical structure of self-government in 1951 did not come about without a broad, vigorous*

battle by the unions and the Social Democrats, and this was also the case with the general co-determination issue of 1952, which took a similarly abortive course (Tennstedt 1976, pp. 146 ff.). Furthermore, restoration in any practical sense would have meant recruiting personnel displaced in 1933 and/or equivalent progressive activists in social policy for leading positions. Neither of these options was taken. Rather, the tendency was to continue employment of people hired in the 1930s, who subsequently rose to leading positions at the local and national levels of the sickness funds. Stone (1980, p. 83) correctly observes that today "self-administration in practice is quite weak," but does not explain why.

Besides the undermining of self-government, there is another reason. Incrementally since the turn of the century, as the physicians organized nationally, but in giant steps in 1931–32 and after 1933, the "freedom" of managing medical-service delivery at the pleasure of the local sickness funds was limited; the ambulatory clinics, to be analyzed below, are a case in point. The original 1883 sickness insurance legislation, 87 paragraphs short, was completely focused on the structure of the funds and on the relationship of the insured to the funds as overseen by the state. It left the ways and means of service delivery completely up to the fund and thus to the local social power relationships between funds and physicians. Today's overwhelming and expansive body of regulation shapes medical services, standardizes delivery options, and creates a "self-government" of the physicians, to which much of the remaining authority in that area is delegated. Thus, the disappropriation of fund powers and subsequent regulations has preempted much of the traditional territory relevant to a self-government of the insured. Here also, the Third Reich was a major step in effecting this tilting of the Weimar balance of powers toward the organized medical profession. It did so, again, by dismantling organized union opposition, increasing the extent of regulated service delivery, and pioneering much of the professional self-regulation of the physicians in the delivery of services to the insured (Tennstedt 1976, pp. 137–142).

In contrast to such developments in the FRG after World War II, in the GDR several of the leading sickness-fund officials or social-reform activists of Weimar vintage—among them Helmut Lehmann, Fritz Bohlmann, Carl Litke, Erwin Fischer, Walter Axel Friedeberger—were attracted to the reorganization of social insurance in the GDR. These people had been either Social Democrats or functionaries of the non-denominational trade unions in the Weimar period, but had not been

communists. They were thus attracted to state service as experts in social insurance, but not to the Communist Party, which on the political level had its own set of social politicians. Unifying sickness insurance (that is, doing away with the division of factory, professional, and local funds) and restructuring the delivery of medical services by the use of ambulatory clinics and general measures against infectious diseases, became prominent objectives of health policy. Thus, initially, more of the Weimar social-hygiene tradition was taken up in the GDR than in the FRG—this also shows up statistically, since infant mortality, tuberculosis, and infectious diseases in general have had and still have a much lower incidence in the GDR than in the FRG. Nevertheless, the GDR and the FRG are equally unsuccessful in dealing with today's prominent chronic sicknesses, especially heart, circulatory, and degenerative diseases.

Though many of the reforms in the GDR after 1945 partook of the Weimar reform spirit (and its personnel), especially in the perfection and systematization of the ambulatory clinic or polyclinic (i.e., ambulatory care in hospitals) approach, they nevertheless had lost much of the Weimar pioneer spirit and regulatory functions, since the circumstances of the development of these clinics after 1945 in the GDR were completely changed. In Weimar these clinics and such reforms were "nonconformist," since they were structurally at odds with a generally private market in health delivery, drugs, etc. (with respect to which they fulfilled a regulatory function). After 1945 in the GDR these clinics were just the extension of the general "socialization of the means of production" to most elements of the health sphere, leaving no room for a special regulatory scope with respect to a differently structured health market.

Six major points stand out as to why this essay is central to an analysis of the development of German social policy:

- For the first time, original archival material—the files of the former National Labor Ministry (now in Potsdam)—has been used to analyze the effects of the National Socialist takeover of health policy in Prussia, specifically on the sickness-insurance scheme. (Historical Prussia coincides roughly with the northern half of today's Federal Republic of Germany.)
- This detailed study highlights that in certain respects the Nazi regime focused on destroying the role of the German labor movement in the formation and implementation of social policy, as well as on destroying

the medical programs of social and socialist activists. Jewish physicians were frequent spokesmen for these groups. In health policy, the unions and these professionals, backed here and there by a ministerial bureaucracy with reformist inclinations, were firmly linked to each other, be it as a lobby for reforms (as in the area of venereal-disease prevention, public infant care, and public-health expansion at the communal level) or through day-to-day cooperation in sickness funds, ambulatory clinics, panel practice, or screening clinics. Jewish doctors in the main industrial cities, especially Berlin, had consistently supported health reform initiatives of diverse sorts. As providers of social services, they opposed or at least transcended the private-practice outlook of the medical profession's association, and they believed that the self-government of the sickness funds, with their strong union base, made progress in social service delivery possible.

- Berufsverbote—in scale and substance only vaguely reminiscent of an old guild practice of excluding unqualified craftsmen—was used after 1933 to destroy social reformers in medicine and not simply to quell individual “disloyalty” or regulate the medical market by removing surplus professionals. Thus, Berufsverbote was a means of changing the democratic structure of social-policy steering and delivery. The whole national framework of health policy was altered. At the individual level, “delivery” may not have seemed to change much; “a doctor is a doctor.” But if one takes seriously research showing that trust is a significant aspect of the healing process, then destroying the sensitivity of these physicians and their delivery institutions to the working class they served made a great difference, even though it does not lend itself to easy measurement by prevailing health statistics.
- This research aims at reestablishing the tradition of analyzing social policy in its historical context, which has all but disappeared since 1933. This “critical” empirical tradition arose before and around the turn of the century, became partly submerged during the Weimar period, was suppressed politically after 1933, and remained dormant as a legacy of the Nazi period after 1945, often lost in the pure disciplinary divisions of labor in the social sciences. Social-policy debate thus is dominated by legal, administrative-science, economic, sociological, or socio-psychological paradigms per se and has after 1945 also been bound to present-day events, crowding out its historical roots. Continuities between the Nazi period and contemporary policies

are still too painful to contemplate. What little historical perspective there is entails jumping safely back to the nineteenth century or perhaps to the Weimar Republic.

- This essay indirectly contributes to the debate on the political theory of the state (Miliband, O'Connor, Offe, Poulantzas, et al.), especially with respect to the Nazi state. For example, many have the impression that the political force behind the policy of "purification" (Säuberung) and destruction was the state and its bureaucracy, especially the National Ministry of Labor. One might also think that the ministry was blocked or neutralized in its efforts by a private profession—the doctors—oriented toward an "ethics of helping" and socialized in the professional spirit of collegiality. But in fact the process of destruction developed in exactly the opposite way, especially insofar as the practice of Berufsverbote among the organized physicians themselves is concerned. Aided by the Nazi Physicians Association, the "gleichgeschaltete"² major medical associations pressed for purges within their own ranks, and their local branches were zealous in their implementation. It was the state bureaucracy, the National Ministry of Labor, that controlled and contained the overzealous professional bodies and reinstated quite a few "communist" and "non-Aryan" (Jewish) doctors to their insurance practice. Thus, social policy reflected a pluralistic structure of political power in the Nazi state, as Neumann (1942) first analyzed. This study thus illustrates the pervasive importance of private interests—here, the medical profession—in mobilizing political power for the Nazi state.
- Finally, these points are illustrated by material from Prussia, especially Berlin, with an excursion into the fate of sickness-fund innovation in the countryside of the Lower Weser region. Berlin was a special case of general significance for health-policy development. As the capital of Prussia, the Reich's leading state, and the capital of the Reich, it contained the most important state and national bureaucracies in the health field. Naturally, unions, political parties, and other national organizations in the health field had their head office or an important branch office in Berlin. Also, Berlin was the largest city and had been a trend setter or laboratory for health reforms since the nineteenth century; thus, it was attractive to physicians with an intellectual and literary bent. If important successes occurred in the countryside or in other larger cities or states, one would often find that the people involved there had strong links to the Berlin "reform cluster." From

the standpoint of normalcy, health care in Berlin would seem atypical. From the standpoint of health reforms and health policy, Berlin was the place to look at and from the Nazi perspective the place to bring under control to achieve unchallenged ideological and practical hegemony in the health-policy field. Similar but more minor events of the same nature could be studied in Frankfurt am Main, Munich, Leipzig, and Saxony in general. The Berlin analysis here centers first on the infrastructure of personnel in sickness funds and then later on the parallels among reformist physicians in health policy, rather than on Berlin's service-delivery institutions and their fate. In this way the health reform lobby of Berlin is most readily depicted. The report on the Lower Weser region shows, in the case of ambulatory clinics, one of the most contentious health-policy items in the Weimar Republic: how Berlin developments spread beyond Berlin. This part of the analysis deals with an institution actually delivering health services to the working-class base of the sickness funds. Other institutions (sexual advice centers, communal physicians' practices, etc.) would reveal similar patterns of development and destruction.

Framing the Issue

The *Wiederherstellung des Berufsbeamtentums* (reestablishment of a professional civil service) of 1933 gave the Nazi regime a firm grip on the whole government. How this law was developed and framed has been studied in detail (Adam 1972; Mommsen 1966), but not much attention has been paid to its quantitative and qualitative consequences (Scheur 1967). There is good reason to believe that such consequences were most severe in the area of sickness insurance and the delivery of medical services. The sickness funds, which had the status of independent public entities, and their national organizations, especially the local sickness funds (*Ortskrankenkassen*), had for almost 50 years been close to the general labor movement (Tennstedt 1977). Thus, a law attempting to purge "nationally unreliable" (national *unzuverlässige*) elements and "non-Aryan" (i.e. Jewish) persons from public service, should have most severely affected this sector and did so. This purge destroyed the self-government of the funds, which rested mostly on unpaid work of union members (honorary officials) on the sickness-fund committees, and led to its long-term eradication. It was undertaken parallel to the purge of all "non-Aryan" and "nationally unreliable" panel doctors, i.e., all doctors holding a (panel) license from sickness

funds which assured them of their livelihood by reimbursing for services to the insured. These purges so thoroughly destroyed a reform tradition in German social policy that it is today almost forgotten. It is these destructions in health policy we will focus on, since they were much more incisive than all later measures taken in social insurance by the National Socialist regime (cf. Teppe 1977, pp. 195 ff.; Peters 1973, p. 105; Scheur 1967).

The Destruction of Union-Oriented Social Policy in the Sickness Funds

The Dismantling of Self-Government in Sickness Insurance

In 1932 there were 32,026 members of the boards of local sickness funds and there were 49,494 representatives of the insured, serving as members of the basic parliamentary structure in the local sickness funds (*Statistik des deutschen Reiches* 443, p. 11). These people were mostly members of the trade unions. After the German trade unions had been dismantled—their headquarters occupied, their papers prohibited, their leading representatives imprisoned and discharged, their other employed functionaries discharged, their property confiscated—on May 2 and 3 of 1933 (Beier 1975), a law was immediately passed against the self-government structure in social insurance: the Law Pertaining to Honorary Offices in Social Insurance and Reichsversorgung (veterans and similar benefits) of May 18, 1933 (Tennstedt 1977, pp. 184 ff.). According to this statute, honorary officials could be displaced even if they did not satisfy the criteria formulated by the *Gesetz zur Wiederherstellung des Berufsbeamtentums* (that is, even if they were not “non-Aryan” or “nationally unreliable”). For example, they could be displaced if they had been elected on a ticket of an “economic association” (i.e., a trade union), or if they had achieved such office in other ways on a similar sort of basis and if this association or its “gleichgeschaltete” successor had declared by September 30, 1933, that such officials did not enjoy the organization’s support any more. This officious and vague wording was meant to catch all honorary officials in the sickness-fund self-government, whatever their union organization had been.

The Nazi “successor organizations” of the trade unions, which had dominated the self-government election in social insurance of 1927 (*Vertretung*, 1929), were the German Workers Front (*Deutsche Ar-*

beitsfront; DAF) and the National Socialist Organization at Factory Level (Nationalsozialistische Betriebszellenorganisation; NSBO; see Beier 1975 and Schumann 1958). These measures of Gleichschaltung concerned two types of unions: the "free" (i.e., nondenominational, non-Christian) unions, which constituted the overwhelming part of the Weimar trade-union movement, were unified in the ADGB (Allgemeiner Deutscher Gewerkschafts Bund; General German Workmen's Federation), and cooperated loosely with the Social Democrats; and the Christian unions, which were rather small and were affiliated with the Zentrum (Center) Party. Dismantling the major "socialist" unions of the ADGB was important to the Nazis, who perceived them as a major opposing force. One may therefore realistically suppose that these successor organizations withdrew their trust, at least from all those officials who were members of the free unions. If so, about three-quarters of the representatives of the insured in the parliamentary bodies of the sickness-insurance scheme would have been displaced, judging by the results of the 1927 elections. With respect to the boards of the sickness funds, in 45.6 percent of all cases the free trade unions occupied all the seats of the insured on the boards, in 12.5 percent of all cases they had the majority of the seats on the board, and in 7.7 percent of the cases there was no union representation at all. The major part of the sickness funds (especially the local and quite a few factory funds) were dominated by the free trade unions, and correspondingly the displacement effects of the law under discussion were felt here most.

While these measures were being implemented in 1933, the National Ministry of Labor appointed commissary officials to run the boards and the parliamentary bodies of 103 sickness funds and 45 of their associations. The local sickness funds were a special target for commissary takeovers (91 of 103). These takeovers affected 3.16 million members, 27.7 percent of the total membership of all local sickness funds (Knoll 1933; Tennstedt 1977, p. 187). All such measures were then overlaid by the Law on Infrastructure of Social Insurance of July 5, 1934, which superimposed the "Führer" principle on these changes by requiring that "the power of decision rest not with a multi-headed unit but with one responsible man."

Measures against Officials of the Sickness Funds

In his "Social Theory of Capitalism," Heimann (1928) called attention to a "secondary, but in social reality most important characteristic [of

social policy or social insurance] . . . which is the career possibilities for tens of thousands of people from the working classes that exist in the self-government bureaucracy of social insurance. This is what self-government of the insured in the sickness funds is all about. The importance of this fact should never be underestimated, because it provides broad opportunity for the development of administrative talent and business education, thus reinforcing the strength of the working-class social movement." Historical evidence validates this opinion.

If one looks at the development of self-government in sickness insurance between 1848 and 1933 and pays special attention to the elections of insured workers to self-governing local sickness funds, one finds the phenomenon Heimann describes. The development of politically significant working-class self-government in the 1883 national insurance scheme does not date back to the start, but rather to the 1890s, and focuses principally on the local sickness funds, where local officials and pensioned officers of the armed forces were replaced by self-educated blue-collar and white-collar workers on the rise (Tennstedt 1977; Tennstedt 1983, pp. 429 ff.). These workers thus continued a much older tradition of working-class involvement in health politics, dating back to the middle of the nineteenth century (Frevert 1983), in which "private associations" of workers (Unterstützungskassen) were the dominant mode of "self-government" with marginal state regulation.

These workers in the 1890s had been engaged in socialist causes in the free trade unions and/or the Social Democratic Party and had thus been exposed to sanctions, including the loss of jobs and blacklisting. Also, one should remember that people of this political persuasion had no chance for a public job; only in the course of World War I was "the barring of all members of the trade unions from public offices and public jobs discontinued, which had caused so much entrenched embitterment in such a senseless way. Such persons would neither be licensed nor elected nor called to any jobs, from night watchman and postal worker to mayor and leading ministerial official. Suddenly the socialists were not 'elements without a fatherland' anymore; they were not 'enemies of the state' anymore and they could become Prussian civil servants or even officers, at least reserve officers." (Kessler 1929, p. 458; see also Fenske 1973, p. 339; Morsey 1972, p. 101)

There was no special education for the administrative personnel of the sickness funds. The journal of the German sickness funds, *Deutsche Krankenkassenzeitung*, whose first editor had been Paul Kampffmeyer, reported in 1906: "We have rejoiced quite often when, via employment

by the sickness funds, a dozen or so bureaucratic entanglements were attacked. An administration and a state in which a man without status or examination counts as a nothing is being contrasted by a branch of government where leading officials, without much ado, can make a civil servant out of a carpenter or a locksmith." The first administrative examinations in this area were introduced by the sickness fund of Dresden in 1897, and in 1906 the Leipzig fund followed suit. It took until 1925–1930 for such examinations to be legally required by state administrative decree (Breithaupt 1925, 1929).

It was against this widely respected tradition that Nazi policies from 1933 on were directed. As Knoll states in his introduction to the major administrative monograph on the process of purging the sickness funds: "The unions dominated the sickness funds almost completely, and their personnel policy in this domain of social insurance, which is so important for the economy and workers, was completely a matter of self-government. Thus they had always tried to restrict the influence of the state in this area. . . . accordingly the civil servants law was to have a rather severe effect on the sickness funds." (Knoll and Keller 1934, p. 2) (See Engel and Eisenberg 1932 as to the nature of the attack.) The leading administrative official of the local sickness fund in Nuremberg, Hans Zimmermann, who had been forced on the local sickness fund as a commissary in 1933, stated in 1938: "After the Machtergreifung [Nazi takeover] the Führer also had to change the sickness funds. The issue was to win back the sickness funds and devote them to the original purpose, that is, to insure all working Germans, and thus to free them from domination by Marxists and Jews." (Zimmermann 1938, p. 388)

There are no general quantitative evaluations of the effects of this legal purge on sickness insurance. To do this post hoc implies some difficult judgments. Some of the administrative personnel of the funds were purged without due process or factual inquiry, since they were thought "unfit" to serve the new regime. Some of the dismissal notices were suspended in 1933 and 1934 or were put on a contractual basis, supposedly relying on the free will of both parties involved. This led either to a legally correct dismissal or to the pensioning off of administrative personnel because of "occupational disability."

We will elucidate this purge by concentrating on the largest sickness fund of the Reich, the local fund of the city of Berlin—probably the fund hardest hit by these purges. According to the available sources (especially an internal report, dated November 4, 1933, by Dr. Alexander

Grünewald, an official in the National Ministry of Labor), 613 dismissals occurred, of which 120 were to be revoked at the time. There exists a comprehensive collection of the personnel files of those to be dismissed; it documents 439 dismissal cases and lists varying legal justifications for dismissal outlined in table 1.

A general overview of the legally effective dismissals, probably compiled at the end of 1934, lists only 255 dismissals for the Berlin local sickness fund. This compilation, which was based on reports of the Prussian Supervisory Agencies in the Insurance Areas (*Oberversicherungsämter*) and which lists a total of 1,496 dismissals in Prussia (Leibfried and Tennstedt 1979, p. 34), thus is useful in estimating the minimum number of dismissals that took place at the time. There is no accurate way to relate these dismissals to the overall personnel situation. It is nevertheless apparent that two main factors triggered these dismissals: the proportion of personnel of the respective sickness fund thought to be in some trade union or socialist group, and the intensity of local Nazi party efforts, later reinforced through sickness-fund commissaries. If we take into account that the Prussian statistics are estimates, "adjusted" to minimize dismissals (Tennstedt 1977, pp. 189 ff., note 25), our estimate would be that about 2,500–4,000 sickness-fund employees were dismissed in all of the German Reich at this time. In 1932 there were 25,715 persons employed full-time with all sickness funds in the Reich (*Statistik des Deutschen Reiches* 1934, p. 11). Thus, at least 10 percent of these employees were dismissed, 30 percent of whom were active in the trade unions. Since the purges centered on the local sickness funds, it seems more appropriate to relate the number of dismissals only to their personnel. These funds employed 18,652 persons. Thus, about 15–25 percent of local sickness-fund employees were purged.

These quantitatively significant purges also effected a qualitative break in German social-policy tradition. The sickness funds, especially the local ones, had by themselves and by uniting on the regional and the national level been "missionary agencies in the area of public health" (Kampffmeyer 1903) and had become a social-policy avant garde of the trade unions and of the Social Democratic Party. This had already taken place at a time when, in the words of the non-socialist economist Karl Bücher, the bourgeois parties had "shied away from the social policy waters," since "socialism was for them what the red flag was to the bull in a bullfight and since they would fight against anything, whatever it might be, proposed by the Social Democratic Party" (Bücher

Table 1
Reasons for dismissal from Berlin local sickness fund, 1933.

| Section of BBG ^a legitimizing dismissal | § 2a | § 3 | §§ 3/4 | § 4 | §§ 4/6 | § 6 | non BGB dismissals |
|---|-------------------------------|-----------------------------|--------|--|--------|---|-----------------------|
| Content of section, i.e. reason for dismissal | Not qualified ^b | Not "Aryan" ^c | | Past or present political activity does not give a sure indication of the civil servant's unquestioning loyalty to the national state at any time. ^d | | Economy and efficiency of administration ^e | |
| Number of persons dismissed | 18 | 28 | 3 | 205 | 130 | 52 | 3 |

a. BBG = Professional Civil Service law = Law on Reestablishing the Civil Service.

b. "Lacking the required or customary training for their career or other suitability."

c. "Of non-Aryan descent."

d. "Who, in view of their previous political activity, offer no guarantee that they would always side with the national state without reservation."

e. "For simplification of administration."

1919, p. 244). Only in the last few years do we find culminating evidence that today's trade unions have rediscovered an interest in this destroyed and thus forgotten tradition in health policy and health-service delivery (Standfest 1977; Hansen et al. 1981).

The Purge of the Berlin Local Sickness Fund

The local sickness fund of the national capital, Berlin, was the largest local sickness fund at the time of the Third Reich, with 433,974 members. It had been especially active in social-policy reform in Imperial Germany and in the Weimar Republic. The name of Albert Cohen, the leading administrative official of the Berlin fund, almost symbolized a social policy program (Stargardt et al. 1976, pp. 810 ff.). This sickness fund had led the movement toward "integrating" health services at the local level by creating hospitals, ambulatory clinics, x-ray institutes, dental clinics, and health baths owned by the sickness fund. Such institutionalization had always been opposed by professional associations of doctors, dentists, and druggists, among others.

In view of this pioneer tradition and of the National Socialist propaganda against political Bonzen (bonces) (a highly derogatory term used quite outside its original meaning of Japanese priests—an English equivalent might be "mafiosi") and "misuse of funds" in the local sickness funds, it seems appropriate to focus on the example of the personnel changes at the Berlin fund. Ludwig Brucker had dismissed 613 persons in 1933–1934 and replaced them with 560 persons hired permanently and 170 persons hired "provisionally," whom we believe stayed permanently.³ Here are some reasons for dismissal (Zentrales Staatsarchiv RAM 5569;775, 827, 548, 562, 549, 835, 555, 546):

Circuit rider (official visiting the insured at home to ascertain claims and to advise) K. H.: "H. is known to be very involved in Marxist issues. In addition to being a member of the Social Democratic Party, he was a member of the 'Hammerschaft' [suborganization of the Reichsbanner, a social democrat and free union defense organization of the Weimar Republic; the Hammerschaft operated primarily at the factory level—S.L./F.T.] from its beginning. We have been informed, that H. has always worn a three-arrow button ['Drei-Pfeile-Abzeichen'; these pro-republican symbols stood for unity, activism, and discipline and signified the pro-republican activities of social democrats, free unions, and the Reichsbanner—S.L./F.T.]. He has done so even after the Nazi takeover and the elections of March 5, 1933. H. has ridiculed the swastika flag. Until very recently, he even spat in front of it."

Correspondent W. N.: "He has been extremely derisive. For example he said about the Führer: 'this ape is a foreigner, he should be thrown out.'"

Employee W. K.: "We could not prove that K. was a member of the Communist party, but our investigation has proven that he has had strong Communist leanings."

Cleaning-woman A. J.: "Mrs. J. and her two sons are well known in all of the neighborhood because of their Communist leanings and are thus in ill repute. Her sons are dangerous Communists who do not shy away from anything. They have acquired a reputation as typical red-front-screamers and as heroes with their knives. Their first names are Ali and Franz. Mrs. J. is a rather reserved person but she has the same political inclinations as her sons."

Helper F. S.: "She has been a member of the Social Democratic Party and since 1927 a member of the ZDA [Zentralverband der Angestellten—National Union of White Collar Workers—S.L./F.T.]. We could not prove any political activities of hers. She did, according to evidence presented by some employees, talk ill about the new administration of the fund and the present government."

Helper G. R.: "We could not prove any political activities of R.'s, but we suppose that he has been influenced by his father to be hostile against our state and our movement. His father has been a member of the Communist Party since 1918 and has shown the flag with the sickle on various political occasions. The father was barred from the Communist Party since he had acted against it (parteiwidriges Verhalten), then joined the SPD and flagged 'schwarz-rot-gold' [the colors of the Weimar Republic, which the Nazis despised and ridiculed—S.L./F.T.].

The purge did not lead to a hiring of apolitical bureaucrats; rather, right-wing politicians were brought in. Of the 560 "permanent" new employees, between 235 and 260 were "old fighters" (alte Kämpfer)—that is, they had joined the Nazi party quite some time before 1933 and had membership numbers below 100,000. The wave of dismissals within the Berlin fund thus led to a wave of hirings of untrained persons—quite different, though, from the untrained persons in the founding period of the sickness funds. Then, the funds recruited experienced workers who were union members and who had been trained by the union education program to master white-collar work and to promote service initiatives. Their political orientation, if any, was strongly toward the Social Democratic party; later on, almost no Communist Party members were active in "self-government" structures, except in one

town in Saxony during the Weimar Republic.⁴ The untrained personnel hired in 1933 consisted mostly of inexperienced or long-unemployed workers who had been estranged from any union movement and had no educational aspirations. Their loyalty was mainly to a political party, and their experience mostly one of political (not economic) struggle in the streets and the beer halls. Since the Nazi party had built up only very small suborganizations for welfare and medical purposes, which were of almost no relevance as training grounds for personnel after the takeover of the sickness funds by the Nazis, these party hacks had few skills and little knowledge. Also, social policy in general was not an area to which the Nazis had paid much attention or in which they had gained much practical expertise before 1933. By contrast, competence, capability, and experience in health policy were an intrinsic characteristic of the working-class struggles in the 1890s, since they built on an old tradition of working-class self-organization in health matters as part of the union movement (Tennstedt 1983, pp. 90 ff., 164 ff., 219 ff., 242 ff., 305 ff., 429 ff.; Frevert 1983). In 1933 the health-policy matters and health problems of the working-class clientele of the funds were quite foreign to the post-putsch personnel. The fact that they were not elected by working-class rank and file, as had been the practice since the 1890s, but had been appointed by party officers, reflected the general policies of the Nazi movement toward autonomous unions (Schumann 1958).

The massive hiring disrupted work at the Berlin sickness fund. Since more people were hired than fired, the office became overstaffed. Only 500 of the earlier employees of the fund remained in their jobs, so that in the fall of 1933 a total of 1,230 employees administered the insurance claims of about 450,000 fund members. The department administering contributions was staffed by 46 old employees and 167 newly hired ones, and the department handling the fund's services was staffed by only 45 old employees and 255 newly hired ones. Since the influx was so massive and took place in a very short time, there was not much chance of on-the-job adaptation, and the work process at the Berlin office came close to breaking down completely. In April 1934 a pile of 200,000 sickness applications sat unprocessed. Visitors to the fund, including members of the Nazi party, complained about the lack of discipline among fund personnel; throughout their office hours they would eat and drink alcohol.

The National Labor Ministry attempted to correct these conditions by nominating a new commissary and new directors to the fund, but

these attempts met resistance. On October 27, 1933, the Gestapo occupied the fund's administrative quarters and confiscated six handguns, which were in possession of the "old fighters." A plan to "forcefully remove" the new state commissary for the local sickness fund and the new directors was thus aborted.

Further inquiry into this revolt resulted in an investigation of the training and abilities of the newly hired personnel. Their fear of impending examinations led the "old fighters" to draft a statement saying: ". . . we will resist any examination. We have continuously contributed to building a Third Reich and thus have had no time to prepare for exams in any way. . . . It would take quite a lot of time until we could take such exams, not even to speak of the second exam. Since all jobs providing decent pay have been held up to now by the 'old bonces,' and since we are only employed as helpers, we are obliged as National Socialists to resist any examination whatsoever." These fears and this statement are a consequence of the hiring policies of Ludwig Brucker, the former commissary, who wrote: "Now that we have smashed the walls of the liberal, Marxist, Jewish fortress as a result of a prolonged struggle, we must employ those old fighters who achieved this victory. . . . the major mistake in implementing this policy has been to demand from [these storm troopers] competence, capability, and experience. Such demands cannot possibly be fulfilled. . . . The toughness of these fighters will in a very short time compensate for missing competence and experience. It will even lead to a much higher level of service, which the hitherto trained administrator could never achieve, since they were not prepared by moral principles of obedience to race as the [storm trooper] is. . . ."

Indeed, the National Ministry of Labor felt compelled to pay some respect to this position. According to the Second Decree for Restructuring the Sickness Insurance Scheme of November 4, 1933, the funds were obliged to be especially considerate of front-line fighters in World War I, "approved fighters for the national revolution," and disabled persons. According to the Fourth Decree regulating this matter, such examinations also needed to take into account "general citizens' training" (the National Socialist view of the world) and "racial and hereditary matters."

Whatever the interventions from above, the situation at the local Berlin sickness fund did not change very much. Rumors abounded, and intrigues among personnel increased and impeded work. Instead of dealing with the obvious—the backlog, the qualification problem, and staff morale—some of the new directors, who had obtained their

jobs through the Nazi takeover, instigated one bureaucratic innovation after another, such as double bookkeeping, to demonstrate their "competence." In addition, some of the new directors were prosecuted by the state attorney for mishandling of insurance funds. On October 1, 1934, 16 local sickness funds in the geographic area of Berlin and its suburbs that had not belonged to the Berlin fund were united with it. Since these other funds had experienced dismissal rates of only 20–40 percent, it was hoped that the merger would improve the rate of qualified personnel within the Berlin fund. At the same time, the unification led to a surplus of 865 employees. The National Statistical Office had already pointed out in a letter dated June 9, 1934, that the Berlin fund had one administrative employee for every 324 insured, whereas the average in all of the Reich was 1:547. The situation was so messy that an independent and expert report on the fund proclaimed a deadlock, and the state commissary for all of Berlin and the Prussian state, Dr. Julius Lippert, as well as Hitler's personal adviser, Dr. Willi Meerwald, demanded further official investigations.

On January 4, 1935, the National Ministry of Labor found another chance for "changing course" and putting the ship afloat again: Four of the local fund directors were accused of embezzling 5,700 Reichs Mark (RM), dismissed, and imprisoned on remand. The state commissary, who had proved quite helpless in remedying these Nazi activities, was replaced by an expert from the Ministry of Labor, Ministerialrat Dr. Manfred Hoffmeister. Again the "old fighters" resisted the reform, and one of the dismissed directors spoke on their behalf in his appeal: "It is impossible to demand that 'old fighters' cooperate with their old enemies in one office and work together with them. The men feel ridiculed by the National Labor Ministry, which is quite unpopular anyhow." In a letter to the Labor Ministry, the new commissary wrote that the politics of the Nazi party within the Berlin sickness fund had been "arbitrary, immoral, and completely at odds with any professionally correct work in a local sickness fund." After a while these measures by the Labor Ministry brought the Berlin situation under control again and at least established bureaucratic regularity there.

Measures against the Regional and National Associations of the Sickness Funds

Most historical work on social insurance in Germany does not pay much attention to the role of regional and national associations within

sickness insurance, which had developed at the end of the last century on the basis of self-government and had become more and more important as time went on (Tennstedt 1977, pp. 83 ff., 133 ff.). These sickness-fund associations, which were, so to speak, behind and above all the individual funds, remained independent and soon became the backbone of the whole sickness-fund movement.

Several factors contributed to this development. Small sickness funds could only muster a rather small administrative infrastructure. Even if they had a full-time leading administrator, he would usually not be able to deal with all the problems that accumulated over the years. Only the larger local sickness funds could, as a rule, muster a full-time leading administrator and, as the case may be, specialists in certain administrative problem areas. The small local funds and the funds of certain professional groups would probably have broken down had they been required to build up the necessary administrative infrastructure and had they not founded a professional backbone of regional or national associations.

The main purpose of these associations was to simplify and standardize administration and to improve administrative economy. The sickness funds took a lot of pride in their comparatively low administrative costs and in the absence of "bureaucratism." These associations, which in no way dealt directly with the insured, grew more important during the Weimar Republic. They were private associations of the sickness funds, which were themselves public bodies, since this was the only legal option to associate nationally without parliamentary consent.⁵ Nevertheless, these private associations by nature fulfilled public tasks. Even so, the state did not grant official public status to them until 1937. To appreciate the importance of the destruction in this area in 1933, one must consider the work of the associations of local sickness funds in more detail.

In 1894 the first national association of sickness funds, the Central Association of Local Sickness Funds in the German Reich (Centralverband von Krankenkassenvereinigungen im Deutschen Reich) was founded (Tennstedt 1977, pp. 84 ff.). In 1903 its administrative headquarters was moved from Leipzig to Dresden, and at the same time this association became more strongly entrenched in the Social Democratic and free-trade-union movement. This development was mainly achieved by the work of Julius Fraesdorf, Eduard Graef, and Albert Cohen. The advisory function of the National Association was expanded. Its board and the leading administrative officials started to lobby for

social-policy reforms at the national level and to initiate local reforms in the sickness funds in the area of social hygiene and preventive medicine. Physicians who were close to the working-class movements for different reasons and in different ways played an instrumental role. The physicians active in this respect were Raphael Friedeberg, Dr. Friedrich Landmann, Alfred Blaschko, Alfred Grotjahn, and Ignaz Zadeksen.

In 1914 the "Lehmann era" began. The National Association of German Sickness Funds was chartered, and in 1924 its administrative headquarters was moved to Berlin. Helmut Lehmann, the new leading administrative official (and after 1945 a leading official in the GDR's rebuilding of social policy) had been active in social policy before 1914, and in 1916 he published a "pocket book" on court decisions pertaining to sickness insurance administration. This book, which Lehmann had evolved from his private filing system, later became the basis of one of the first looseleaf commentaries in the legal area. These publishing activities, which were private at first, became part of the association's duties after 1914 when a Publishing Company of German Sickness Funds was founded. The publishing company expanded from 1927 to 1932 by founding the Publisher for Social Medicine Joint Stock Company. After 1916 a further subsidiary organization, the General Pensioners Fund of German Sickness Funds, was activated, and in 1923 a Druggist Services Company (Heilmittel-Versorgungs-A.G.) became active. All these companies were backup organizations for the local funds, providing organizational routines through commentaries, forms, materials on innovative practices in social medicine, pension insurance for fund personnel and standardized and cheaper medical equipment and drugs. This in-kind provision of services by the funds received strong national support. Eventually these associations and their activities formed an infrastructure of support for the funds, run democratically by peers and colleagues.

The associational landscape in Berlin on which the 1933 purges were inflicted differed from the one at the national level. The Association of Sickness Funds in the Area of the Sickness Fund Supervisory Agency of Berlin (Verband der Krankenkassen im Bezirk des Versicherungsamts Berlin), founded in 1919, was an association of a different type, even though it pursued similar goals. It evolved from the Central Commission of the Berlin Sickness Funds (Centralcommission der Krankenkassen Berlins), which was founded in 1896. This regional association, provided for in section 407 of the National Insurance Code, was much more

comprehensive than the national association described above, which included only local sickness funds. The Berlin association included not only most Berlin local sickness funds but also some of that city's factory and guild sickness funds, for a total of about 1 million insured. Thus, it was much broader in scope and included health service delivery organizations operating in quite different social-policy climates: union-run local sickness funds, employer-run factory funds, and craft-run guild or "professional" funds. This Berlin association, administered by Max Ebel and Carl Schulz, ran two hospitals and 38 ambulatory clinics. It was the major deliverer of in-kind health services in the Reich, and it operated outside the normal "medical market" controlled by the Hartmannbund (the equivalent of a German Medical Association).

The Berlin association initiated important ventures in regulating the normal medical market. For example, it founded a Drug Commission, which had members from the Berlin Druggists' Association, the professional sickness funds (Ersatzkassen), the physicians' organization, and the central health office of the city of Berlin. They collaborated on "limiting in a rational manner the plethora of drugs and special remedies produced after the war by the chemical industries." The group compiled and published the pathbreaking Greater Berlin Drug Prescription Book, which listed all drugs and special remedies reimbursed by the funds. If other drugs or special remedies were to be prescribed, the doctor would have to apply to this commission. The publication of this Drug Prescription Book led to a restriction of drugs and special remedies used, and also in many cases to lower prices. The producers of the medicines paid the funds a negotiated amount or a percentage of sales. The Drug Commission, at first a provisional body, was put on a continuous footing by contractual agreement in 1925 with the Berlin Druggists' Association, the regional association of sickness funds, and the regional association of factory sickness funds. This so-called Cap Agreement was also later subscribed to by the professional sickness funds. The reimbursements by the producers were used to finance the Drug Prescription Book, a journal (*Der Kassenarzt*), and other enlightened projects. Dr. Julius Moses, one of the major Social Democratic figures in health policy at the national level (Nadav 1982; Nemitz 1974), edited *Der Kassenarzt* and made it an important focus of health reform and struggle against the monopolistic actions of the Hartmannbund.

These associations and their own service-delivery institutions were continuously under attack by the organized professionals (physicians, dentists, druggists) and by industry as examples of "socialization," of

a "nationalization of health services" in a localized version (Weber 1927; Mahner 1930, 1932). The case study of the ambulatory clinics in the river Weser port region, which follows, sketches the development and the end of one such struggle in detail. Since the Nazi regime (at least initially) pursued policies attractive to the middle classes, it seized on arguments by professional associations against these institutions and smashed the fund-owned service-delivery institutions as well as the boards of those sickness funds that had built up such institutions. By administrative decree the National Ministry of Labor was now empowered to take control of the sickness-fund associations and of their enterprises or the enterprises of their members.

On March 24, 1933, Ludwig Brucker was appointed a Commissary for the National Association of German Sickness Funds. He removed the whole board of this association and dismissed all the employees, with the exception of the registrar. The leading administrative official, Helmut Lehmann, was taken into police custody. Brucker not only replaced the top national functionaries but also took over the authorities of the regional associations. On April 11, 1933, he had it publicly declared in the National Socialist journal *Der Angriff* that a "purification action against the sickness funds" was necessary and that he, "in accord with the National Ministry of Labor and as a commissary leader of the former Marxist National Association of German Sickness Funds," had "radically intervened in the internal affairs of this national association, which comprised about 12 million insured." Brucker also announced to the press that he had taken "a number of economy measures by abandoning all sickness-fund institutions and activities that did not belong to the proper activities of the association. . . . A series of elaborate interconnections between these institutions have been discovered, whose purpose is not easy to identify." This press release was not well received by the National Ministry of Labor. Ministerialdirektor Dr. Hans Engel jotted: "Put the brakes on Mr. B., he just can't go on this way." At first there was no success in stopping Ludwig Brucker. On May 8, 1933, he instigated another publication in the *Deutsche Zeitung* on "the private businesses of Red sickness-fund 'bonces' and the misuse of funds at the National Association by Ahrens and Lehmann."

Brucker's measures against Lehmann as the leading administrative official of the National Association and as a major shareholder of that association's private subsidiaries created substantial conflict for the civil servants at the National Ministry of Labor. Lehmann was one of the few persecuted functionaries who did not shy away from going to court.

These dismissals did not have sufficient legal support in the amended civil service law. Thus, Ministerialrat Dr. Alexander Grünewald noted in his files on December 30, 1933, that the court judge of the Kammergericht (the Prussian Superior Civil Court) presiding in this case, Dr. Karl Hellmut Heyderhoff, had remarked: "How is it that just any minister could issue any administrative decrees? After all, we do have a constitution." He tended to disallow the dismissals. Grünewald commented that such a likely result "from the viewpoint of the Reich's authority is intolerable." On January 16, 1934, he noted: "It would be desirable if these proceedings could be tabled," and the court was informed that amendments of the law to this effect were being prepared. These amendments were passed on February 16, 1934. Another note by Grünewald in his files indicates that these amendments were a rather dubious legal measure specifically taken against Lehmann: "Should the issue of regulating any contractual arrangements arise in cabinet discussions, we can point out that these amendments are of practical relevance only in the case of L. . . . To issue and publish this law is urgent, since the next session of the Landgericht Berlin in this case is scheduled for February 23, and this law is of importance for the outcome of this case."

Remarkable in this struggle are the actions of Lehmann's attorney, Walther Döhring. In the court proceedings at the Landgericht he talked about the "quacks" (Bönhasen) at the National Ministry of Labor, and on January 4, 1935, he wrote to the ministry:

The "revolutionary" measure of appointing a State Commissary for the new National Association of Local Sickness Funds also needs to be justified in terms of the existing legal order, in part itself promulgated by the revolution, and thus the first appointment of Commissary Brucker has been declared void by a decision of the Kammergericht of November 27, 1933, because it did not conform to any such legal principles. To deal with the consequences of such a null and void measure by dubious amendments indicates strong disrespect for the judgment of a high court. . . . in view of this situation the law of February 16, 1934, especially its article 3 §1, may not be construed as being retroactive. In view of the sloppy drafting and sloppy implementation of the law of March 17, 1933, all persons involved could expect that the measures of the commissary, who in the meantime has been removed for personal causes, would be declared void. These persons will now have to recognize that they should not have conformed to what was then said to be law but rather to what is now retroactively introduced as new law. In this way the national government is trying to compensate for the sloppiness of its first series of measures by a new series of sloppy measures. . . . The English courts, in their self-conscious habits, would know without hesitation and with some precision how to deal with

such sloppy work. It is mainly the consequence of our German judicial system and its underdeveloped self-consciousness that it does not educate lawmakers in a clear and precise use of legal language.

Grünewald notified the attorney general on February 14, 1934, of the content of this letter and requested that "everything necessary be undertaken." The files finally reveal that the attorney general initiated disciplinary proceedings against this attorney via the attorney general's office at the Kammergericht.

The Case of the Lower Weser Region

The service-delivery institutions which the sickness funds ran until they were dismantled by the Nazi regime owed their existence to a legal and administrative principle of social insurance known as the in-kind principle (*Sachleistungsprinzip*). In the context of health insurance, the in-kind principle placed an obligation on the fund to deliver a service to the insured. It dates back to the 1890s, when it was first used against the traditional, private, working-class funds to raise their costs of existence by obliging them to assure the service itself and not just money for shopping for services in a private market. At the same time, it provided for an expansive, controlling role of the "public" local funds in the developing medical submarkets. This obligation could not be fulfilled by "cashing out" insurance claims and delivering the insured to a private medical marketplace. The principle also was of some significance as a means of regulating the private medical market and as a means of developing preventive health policy.

This sphere of a "social economy" of health delivery was broadly conceived. It included public x-ray institutes, public opticians' services, public massage and bath facilities, public provision of drugs, public provision of dental and all other ambulatory medical services, and public provision of stationary health services. ("Public" in each case denotes sickness funds and not communal or state services, which coexisted in some areas.) In all these cases the "social economy" was not pervasive. It never replaced private delivery in the whole Reich in one sector. Its role was usually either to help regulate the normal and dominating "medical markets" by creating countervailing powers or to provide delivery substituting for a nonexistent local, regional, or national market.

This "social economy" (*Eigenwirtschaft*)—i.e., the sphere of public enterprises run by the sickness funds—is well symbolized by the am-

bulatory clinics founded at the time of the Weimar Republic (Tennstedt 1977, pp. 150–180; Hansen et al. 1981, pp. 152–499). The struggle over these institutions was the most visible at the time, because it involved a strongly developing professional organization involving doctors, was conducted at a national level, and involved highly visible action such as a national physicians' strike and a national boycott by the German Medical Association. Nevertheless, such ambulatory sickness-fund clinics existed only in two regions. More clinics existed in the framework of the accident insurance program. Since it was employer-run, the lines of conflict remained much more submerged than in the union-run local sickness funds. These sickness-fund clinics were an attempt to overcome the privatized structure of the medical market, with its individualizing, fragmenting, and organizational consequences. They hired physicians on salary, concentrated them and the necessary equipment in a fund-administered building and made the services available to the insured at their choice.

These ambulatory clinics were important after 1924 in Berlin and Geestemünde, but were destroyed in 1933 under those pressure of the organized providers who allied themselves with Nazi organizations and whose onslaught had built up since the turn of the century as a middle-class "storming of the funds" (Hoffmann 1912). To balance our Berlin-centered argument, the following analysis will focus on the rise and fall of the ambulatory clinics of the funds in Geestemünde, a process extensively researched by Hansen et al. (1981), who also studied the Berlin case.

At the end of 1923 there was a physicians' strike in all of the Reich, as there had been in 1920. The reason for this strike was an Emergency Decree of the National Government of October 30, 1923. The panel doctors, who were mostly organized with the Hartmannbund, opposed the obligations to the sickness funds put upon them by this decree. They especially opposed the supervision of the delivery of medical services by the sickness-fund boards, which they thought to be much too strong. Even though their protests were of some success, that did not head off a strike in December of 1923, which was later justified by demands for higher fees. For the duration of the strike, the insured were treated by the doctors not as panel patients but rather as private patients who had to pay their own way.

The sickness funds in Berlin and in the cities in the Lower Weser region took the offensive and made sure they provided in-kind medical services to their members so that they would not have to pay the

especially high fees (*Kampfhonorare*) demanded by the doctors during this so-called "contractless situation." These funds advertised for and hired doctors, often from out of town, who then took charge of provisional ambulatory clinics which the sickness funds had set up during the strike. The development of such institutions, run and owned by the local funds, occurred in Berlin on a much larger scale than it did in the cities of the Lower Weser region. At certain points the Berlin sickness funds ran more than 40 ambulatory clinics, which were headed by Dr. Felix Koenigsberger until 1925 and then until 1933 by Dr. Kurt Bendix. Dr. Walter Axel Friedeberger (after 1959 to be Deputy Secretary of Health of the GDR) was the deputy head of these clinics as long as they existed.

The local sickness fund of Geestemünde ran one ambulatory clinic in Geestemünde and one in Lehe. In addition, the local funds of Bremerhaven and Lehe supported a common ambulatory clinic of their own, the Medical Department of Bremerhaven. These clinics were opened in 1924 with two doctors apiece, which made them rather small and unspecialized in comparison with those developing in Berlin. Nevertheless, they seem to have been much better integrated with the local working class than were private, fee-for-service physicians.

The ambulatory clinic of Geestemünde was rather popular with the insured. Already in 1924 up to 500 persons daily consulted this institution. The demand was so high that at the end of 1928 the local sickness fund decided to build a special building for the ambulatory clinic. The leading physician of the clinic, Otto Kissel, was very active in designing the new clinic. Otto Okrass, the leading administrative official of the Geestemünde fund, who closely cooperated with Albert Kohn in Berlin, was the other major person behind this plan, because he had been originally responsible for implementing the idea of ambulatory clinics in the area. The new clinic had its own laboratory and was centered around a large x-ray machine of the newest design. It sponsored all sorts of rooms for different kinds of physical therapy. In addition, it had its own health baths, inhalation rooms, and living quarters for the doctors employed in the building. The two doctors were supported by four nurses, a bookkeeper, and a supervisor. Public lectures, courses, and instructional material of all sorts on questions of social hygiene and preventive medicine were provided to the insured as a routine in the clinic's work. With the exception of the baths, the Medical Department of Bremerhaven delivered the same services as did the Geestemünde clinic.

The responsible administrative officials of the sickness funds in the Lower Weser cities left no doubt that these ambulatory clinics were not to be thought of as stop-gap devices in time of strike. Instead, they were thought of as institutions that, by their continuity of services, could prevent future strikes of the local private physicians, and that would also be more effective in delivering medical services to the members and provide more "outreach." The funds made it known publicly that now the poorest of the poor in the region could also obtain the best of medical help. Patients would obtain all help in one place and thus would not have to walk all over the region and lose a lot of time getting different services in different places. The hours of the ambulatory clinics were extended to prevent long waiting periods, and physicians' help could be obtained at any time of day or night. Otto Okrass emphasized that, for economic reasons, the private physicians would be unable to support such comprehensive medical-service delivery.

With the opening of a subsidiary of the Geestemünde ambulatory clinic in the Lehe quarter of Bremerhaven in July 1926, the expansion phase of ambulatory clinics in this region ended. The "social economy" of the sickness funds seems to have been much in demand and rather popular with the insured. The data on the use of these clinics by the insured and their family members show that about one-fourth of all the cases of sickness in the Lower Weser region were taken care of here, and it needs to be underlined that the insured had free choice between visiting these clinics and seeing a private physician at the fund's expense. During much of the time of these institutions' existence, only four physicians in permanent employment were responsible for delivering service. However, the popularity of these institutions meant that these doctors had become major competition for the 45 private physicians practicing in the region.

Thus, conflict accompanied the ambulatory clinics from their birth to their death in 1933. On the physicians' side were the local organization of the Hartmannbund and the Association of the Panel Doctors in the Lower Weser Region; the local sickness funds were on the other side. The local press constantly reported on these emotionally charged struggles. The private physicians thought of the clinics as illegal, since they had discontinued their strike and had offered their services to the funds in accordance with the conditions that had obtained before the strike broke out. The funds, on the other hand, did not want to give up their ambulatory clinics. In addition, they hoped to decrease the number of panel doctors in the region. Thus, the struggle over the ambulatory

clinics turned into a struggle over the general shape of the medical market in the region, with the focus on the principle of maximizing the "system of free choice of (private) physicians" in the region. This struggle was carried out on all arbitration levels within the sickness-insurance scheme. The organized panel doctors in the proceedings at the National Insurance Bureau in Berlin stated that "these warehouses of medical treatment must disappear from the earth, which will only be beneficial to the insured in the Lower Weser region" (Stadtarchiv Bremerhaven 020-1712). But even the highest court of arbitration decided in favor of the legality of ambulatory clinics: The sickness funds had only, as was demanded of them in their by-laws, taken the necessary measures to ward off interruptions of medical services to their insured. This did not end the conflict, however.

The local panel doctors still thought of the ambulatory clinics as institutions that were purely a consequence of the "Marxist power lust" of the sickness-fund bureaucrats—a stand that can be taken only if one shares in an uncompromising free-enterprise ideology, to which regulating the medical market is in principle a foreign, "Marxist" idea. The idea of peaceful collaboration with the ambulatory-clinic doctors was denounced. Negotiations between the sickness funds and the local association of panel doctors were abortive. All interim contracts between the two parties were agreed to only after all arbitration procedures had been exhausted. A contract between the local sickness fund at Geesemünde and the corresponding association of panel doctors, which had been agreed to after drawn-out negotiations, was prolonged year by year, as renegotiation proved impossible. Only after the Nazi takeover and the destruction of the ambulatory clinics could a new contract be negotiated.

After all means had been exhausted to declare the ambulatory clinics illegal, the attacks of the organized physicians were directed against the physicians employed there. The physicians who had offered their services to the Berlin sickness funds during the strike had already received threatening anonymous letters and had been threatened by roughnecks. The physicians' organizations thought of these doctors as strikebreakers and disbarred them from membership in their organization. The Hartmannbund attempted to thus increase the social sanctions against such doctors and also attempted to bar them from membership in medical scientific organizations. Starting in 1925, the local association of panel doctors attempted by "permanent cold war" to bar these ambulatory-clinic doctors from panel practice, and they

thus hoped to win back patients who had attended the clinics. In addition, they tried to make any additional hiring of physicians by these clinics impossible, and in 1930 they attempted to seize on loose legal language to have the licenses of these physicians revoked.

These continuous attacks on the ambulatory clinics and their doctors did not succeed until 1933, when the local panel doctors found a powerful ally in the Third Reich. Three doctors who had worked for the ambulatory clinics in the Lower Weser cities were severely persecuted under the Nazi regime. The leading doctor of the Geestemünde clinic, Otto Kissel, was Jewish. Thus, he could not, as some colleagues of his were able to, take up panel practice when the authorities closed down the ambulatory clinic. Shortly before his natural (?) death in July of 1936, Kissel was denounced by a former patient who argued that the "racial belonging" of Dr. Kissel caused the patient's "bodily decay." (This was quite in line with the official propaganda of the party.)

Dr. Paul Marx, who had worked for a shorter period of time in the subsidiary Geestemünde clinic in Lehe in 1926–1927, was Jewish, but since he had fought on the front lines in World War I he was allowed to continue panel practice until 1938. He had to close down his practice then, since not only his panel practice but also his medical license was taken away from him for "racial reasons." Marx went underground to avoid being sent to a concentration camp and stayed in this "illegal" situation until his arrest by the Gestapo in July 1944. He was beaten and sent to the Flossenburg camp, where he survived further beatings. Freed as the war ended, he started a new practice, notwithstanding his eventually fatal disabilities stemming from his concentration-camp experience.

Dr. Walter Jungfermann had been an assistant to Dr. Ernst Rudolf Adam at the Medicine Department of Bremerhaven toward the end of the Weimar Republic. He was arrested repeatedly because of his anti-Nazi orientation, was continuously labeled "non-Aryan," and was beaten four times. One beating in October of 1939 led to serious head injuries. He died in 1965 from later complications of this beating. His career is rather typical of the humanistic and social practice that characterized many ambulatory-clinic physicians in Berlin and the Lower Weser region. Usually it was not "the socialization of health care" or some other grand political scheme that led them into practice in ambulatory clinics, but the potential for technically and socially better professional work. The death of Dr. Jungfermann was not atypical of doctors who chose to stay on or could not leave.

Let us now turn to the institutional consequences of the Nazi takeover for the ambulatory clinics in the Lower Weser cities. A closer look at Nazi health policy reveals three main tiers. Above and beyond population and racial policy, the Nazis took the offense against the "Red" and "bonce" institutions created for the working class by union social policy. In addition, the initially middle-class orientation of the Nazis in the health sector linked the party strongly with physicians, dentists, druggists, opticians, and other health professionals. This tipped the balance. Whereas the Social Democrats and the free trade unions had given support during the Weimar Republic to self-government in sickness insurance within the local sickness funds and thus had also provided a place for "social economy" in this area to expand, their influence was now erased. In addition, the Christian Labor orientation of the Weimar Ministry of Labor had provided a crucial protection at the level of the responsible agency of the national government; this protection now became quite fragile and spotty. Thus, the Gleichschaltung of the sickness funds and the destruction of their "social economy" were of special importance in 1933 to the interconnected interests of the Nazis, the professional associations, and the professional markets. This was the case in Bremerhaven, Geestemünde, and Lehe, and not just in Berlin.

With political opponents removed, the Nazi party and the health-care professionals took action. The First Decree for Establishing a New Order in Sickness Insurance of March 1, 1933, established special control powers over the sickness funds and allowed investigations of the "social economy" institutions run by the funds. If found "uneconomical," these institutions were to be closed.

On April 18, 1933 the chief members of the board and the leading administrative official of the Geestemünde and Lehe sickness funds, Otto Okrass, attended a conference at the Insurance Bureau in Wesermünde. They were confronted with the new legal situation, and its consequences for the ambulatory clinics were especially stressed. An immediate economic study of the dental clinics and the ambulatory clinics was recommended (Stadtarchiv Bremerhaven 020-14-4). This meeting was preceded by demands from the Association of Panel Doctors in the Lower Weser Region, i.e. the professional association of insurance physicians, who were allied with the National Socialist Physicians Union, to close the ambulatory clinics immediately. These two doctors' associations sent the same demand to the Ministry of Labor. They argued that the ambulatory clinics were uneconomical because

one physician in the ambulatory clinic took away the income of four physicians in private practice. The irony of calling such economy uneconomical seems to have eluded them. The memorandum states:

That these warehouses are enemies of the middle class is already shown by the fact that, proportional to their expansion, the economic space—in this case of physicians in private practice—is being destroyed. Neither the national good nor moral principles legitimate such a development, as deviation from the principle “the common good supersedes individual advantage” shows. . . . These institutions are a product of scheming, brutalized power, and are an expression of the obvious trend to gag a free profession and continuously prepare it for socialism. No profession is less suitable for such socialism than the medical one. This way of discharging a doctor’s duties may be compared only to large factories and consumer cooperatives. Quite apart from the fact that such ways of delivering medical services by medical bureaucrats, who can neither rely on a patient’s trust nor have any compassion for their patients, are incompatible with the essence of the healing process, not only can we do without such institutions, but in addition they violate sound economic principles according to which the free-enterprise spirit, creativity, individual endeavors, and personal responsibility should find roots with a maximum number of citizens.

The next month saw the measures described earlier to purge the sickness funds of indigenous workers put into practice. From October 9 to October 11 the ambulatory clinic in Geestemünde was audited. Otto Okrass had already informed the auditor that the Geestemünde local sickness fund intended to close down its “social economy” institutions by December 31. This corresponded to the demands of the local and the Nazi physicians’ associations. “The costs per case in the ambulatory clinic are substantially higher than with private panel physicians” [this statement is factually false—cf. Hansen et al. 1981, pp. 314 ff.] . . . “therefore,” the auditor reasoned, even though he had already agreed with Otto Okrass in advance of the audit on all the specifics of the dismantling, “the closing of the ambulatory clinic is advised” (Niedersächsisches Staatsarchiv Stade OVA: acc. 18–64 F 35a Nr. 7). Thus, the decision to close these clinics and like institutions, which had politically already been taken, found its post hoc expert rationalization in the auditor’s report.

With the clinics dismantled, the “free” physicians finally were able to attain their goals in the context of the “national revolution.” As the clinics closed, the lump sum per capita fees paid out to the local physicians were raised from 10.95 RM to 13.77 RM. As a final gesture, the former clinics were used as administrative headquarters for the district leadership of the Nazi party and its organizations.

Whether the sickness funds received any compensation for this destruction after World War II could not be discovered, but it is unlikely. Nevertheless, it is remarkable that the Association of Panel Doctors in the Lower Weser Region had its headquarters on the lower floor of the major Geestemünde ambulatory clinic for a short time after World War II. Thus, the former enemies of the ambulatory clinics came to occupy the former "fortress" and were in no way obliged after 1945 to undo the health-policy damage they had completed in 1933. On the contrary, any alternative ideas about health delivery in the region remained displaced.

The destruction of the Medical Department of Bremerhaven took a similar course. Here Christian Brandau, the commissary and SA member, displayed a dashing style. The administrative headquarters of the local sickness fund was occupied by the SA. All personnel were dismissed as a "precaution" effective October 1, 1933, and all medical appliances of the Medical Division were sold dirt-cheap locally. Brandau was later reprimanded by another auditor for his rash dismantling: "If the local sickness fund of Bremerhaven together with the funds of Geestemünde and Lehe, which had their own ambulatory clinics and participated in the common dental clinic, had insisted on negotiations with the associations of the physicians and the different dental professions, the chances for a more favorable way of dismantling would have grown substantially." (Niedersächsisches Staatsarchiv Stade OVA acc. 18-64 F 35a Nr. 7)

It seems proper to finish this section on the consequences of the Nazi takeover for the sickness-fund administration with a short analysis of the effects on the fund personnel in the Lower Weser region. The first *Berufsverbot* in that region affected Bernhard Vogelsang, a rather active member of the free trade unions and a Social Democrat. He had been elected on January 1, 1933, by the requisite two-thirds majority of the representatives of the insured to the position of leading administrative official of the Bremerhaven local sickness fund. Interestingly, this case of *Berufsverbot* predates the general Nazi takeover and elucidates the role some employer representatives in the self-government structure of the funds played under these conditions. They used the swelling "national revolution" to get rid of Vogelsang, whom they thought of as an uncomfortable administrator. They appealed to the Insurance Bureau in Bremerhaven, attacking the validity of his election by enclosing a flyer, signed by Vogelsang, in which the nomination of Adolf Hitler as chancellor was criticized harshly and described as "a symbol

of the impending attack against all rights of the working-class movement" (Stadtarchiv Bremerhaven F 288-24). The Bremerhaven Insurance Bureau caved in and upheld the appeal.

After the Nazi takeover and parallel to the purges of sickness funds all over the Reich, the Bremerhaven fund was "cleaned out." Of its 16 employees, almost a dozen were fired and replaced by SA men and "old fighters" of the National Socialist movement. Here again Christian Brandau played a decisive role.

The "purification" of the local sickness funds in Geestemünde and Lehe took place in three consecutive and ever more intense phases. At first the changing of the legal infrastructure of hiring had indirect but nevertheless very effective consequences for the employment situation. Of the 26 employees of these funds, three went into early retirement, all of them members of the Social Democratic party (SPD) or the Reichsbanner. Among them was the leading physician of the Geestemünde ambulatory clinic, Otto Kissel. Beyond that, an increased incidence of serious illnesses among the employees is notable, and retirement due to disability increased.

After the union personnel had been purged from the self-government structure of the funds, there was room for a second phase of "purification" through Berufsverbote. The new chairman of the board of the Geestemünde local fund dismissed the deputy administrator of the fund (Heinrich Brinkmann) and the supervisor of the building. Both these dismissals were on grounds of membership in the SPD and the Reichsbanner. In addition, three women employees were dismissed according to paragraph 6 of the Law on Establishment of a Professional Civil Service, which allowed for dismissals to "simplify administration." In contrast to the men, two of these women were in a position to appeal successfully with the proper insurance bureaus; however, their appeals were based more on questions of equal treatment than on political reasons.

At the end of 1933 the situation turned for the worse. The leader of the Nazi party district of Lower Saxony had intervened with the Higher Insurance Bureau to increase the pressure for more dismissals at the local sickness funds. The employees had already been asked to list their political activities and answer questions pertaining to "racial" origin. Twenty-one members of the SPD and the Reichsbanner had to declare themselves, and this stimulated further "clean up" operations. The Higher Insurance Bureau advised the boards of the local sickness funds to dismiss all employees who had been members of the Reichs-

banner or the SPD. Seven further employees were dismissed. This resulted in a series of appeals, which were not decided upon until late 1934—most unfavorably. In summary, of the 37 persons employed with the sickness funds of Geestemünde and Lehe and in its “social economy” institutions (excepting the dental clinics) at the beginning of 1933, only 10 employees remained in the service of these funds at the end of 1934. These funds thus were purged more strongly than the national averages would indicate. This fact is due to the importance of “social economy” institutions for the sickness funds in this region and the conspicuous struggle over their institutionalization in a small town, which made some employees easier targets for recrimination in 1933.

Conclusion

The Nazi destruction of the sickness funds’ ability to deliver medical services is important today because this ability continues to be suppressed (Rohwer-Kahlmann 1982; Hansen et al. 1981; Tennstedt 1981). In 1955, the parliament of the FRG imposed a legal freeze by passing the *Gesetz über das Kassenarztrecht* (Act on Panel Doctors), which stopped further development of sickness-fund clinics by making it contingent on the agreement of the physicians’ organizations (Naschold 1967; Safran 1967). This clause was part of an overall regulation of the status of panel doctors and their hegemony over treatment. Even though ambulatory clinics were done away with *de facto* in the Nazi period, the National Ministry of Labor had been able to resist efforts to make them generally illegal. Such efforts met partial success only in 1955, and have been extended into other realms of health policy by the national civil court (Rohwer-Kahlmann 1982). Thus a short post-World War II era of social reform, which aimed at a uniform and universal coverage and again involved Berlin (Reidegeld 1982) and Bremerhaven, came to an end (Hockerts 1980, pp. 149 ff.).

As our short sketch of the history of self-government of the sickness funds has already indicated, we find much continuity in the politics of service delivery of the 1930s, the 1940s, and the 1950s. The social policy of the FRG did not return to pre-1933 self-government conditions. Rather, it consciously or unconsciously perpetuates much of the destruction effected by the Third Reich’s social policy. In the case of in-kind delivery of services it even went much further by giving such

destruction a halo of legality, which it did not even have under the Third Reich (Hansen et al. 1981, pp. 547 ff.).

Measures Against Jewish and Socialist Physicians, Dentists, and Dental Technicians

The first part of this study dealt with the effects of the Nazi takeover of the administration of health insurance, the result of which was that the traditional connection between the labor movement and insurance sickness funds, in which these funds represented the vanguard of social policy for the unions and the Social Democratic party, was destroyed by eliminating honorary union officers and thus eliminating the self-administration of the funds. "National unreliaables" and "non-Aryans" in full-time jobs at the funds were removed. These processes must be considered among the decisive actions concerning institutional social policy of the Nazi period, for none of the later changes in health insurance had such a profound impact. Thus was destroyed one of the elements of the "health policy reform cluster" which had formed in Germany since the turn of the century and which was responsible for most of the innovation in the health area.

It will become clear in the following that in respect to health policy National Socialism attacked and destroyed the German labor movement and the Jewish citizens as a functional, homogeneous entity. It was primarily the self-administered worker sickness funds that provided social space for progress in health policy, be it in technical improvement or in service-delivery innovations. It was chiefly Jewish panel doctors who delivered the services and propagated reforms in the insurance context. They had settled in industrial or other boom areas—mainly in big cities, and especially in Berlin, the pace setter of health reform in industrial Germany. Destruction of a labor-oriented health and social policy could not be limited to demolishing the administrative structure, as described in previous sections. It also had to hit the service infrastructure, the physicians, the other decisive elements of the "health policy reform cluster."

Looking for progressive tendencies in health policy only in the sickness funds would be a rather incomplete approach. Health reform at the local government level (Loewenstein 1981) became at least as important in dealing with rapid industrialization and large-scale immigration of agricultural workers or farmers into the cities. As the membership of the sickness funds expanded, moving in large steps

toward universal coverage, and as the output of the funds shifted radically from monetary transfers to delivery of services and as they consequently developed preventive and advisory capacities, the "local government" approach and the insurance approach overlapped and combined. This became evident with the development of local hospitals around the turn of the century (Labisch 1981; Labisch 1981–82) in which the sickness funds played a decisive role as "financiers" of institutional medical care and as the co-founders and co-sponsors of free clinics and advice centers. If prior institutions of a similar nature had existed at all, they were either bound confessionally or tied to old feudal privilege, or they were private polyclinics or polyclinics attached to the universities. These forms of service delivery were not adequate to deal with rapid industrialization and urbanization as it took place primarily in northern Germany. These processes of reinstitutionalizing health policy would not be comprehensible if attention were to focus on the institutional sphere only. Rather, a focus on personnel delivering service and promoting reform will be another key to understanding the social forces involved.

Socialist physicians played an important role in these developments, especially where the industrial working class was socially dominant (as in the larger northern cities and in Munich). In Germany (and Austria), socialist intellectuals and academics of the time were often physicians, most often with a Jewish background. Physicians spearheading the socialist movement could rely on a well-established tradition: the medical reform movement of 1848, during which Virchow had labeled doctors natural spokesmen for the poor; the preventive and hygiene movement that started in the 1860s; and British investigations of the conditions of the working classes, initiated there by physicians and factory inspectors and continuously reported in Germany through Karl Marx, Friedrich Engels, August Bebel, et al. Also, quite a few physicians who strongly identified with the shift to medicine as a natural science were attracted to social-Darwinist undercurrents in German Social Democratic circles.

As the labor movement was able to overcome the restrictions of an election system based on ownership of property at the local level and took over substantial areas of self-government in the health-insurance sickness funds, these physicians helped design and partly implement health-service delivery or local social policy in general. Their politics were also crucial in breaking down cultural barriers and political mistrust against professionalized medical institutions and services. This resistance

was well entrenched in the working class of the time and quite visible in the support of quacks and faith healers in working-class quarters. In addition, these doctors gained in their daily medical practice a deep understanding of working-class conditions that informed their social policies.

The cooperation between socialist physicians and the labor movement began in the 1890s with the sickness funds and the health self-help movement in the Labor Health Boards (Arbeitersanitätskommissionen) and the Labor Samaritan Association (Arbeitersamariterbund) (Labisch 1978). These physicians and labor groups organized a strike of working-class patients against scandalous conditions of treatment at the major Berlin charity hospital, which led to the modernization and expansion of the hospital. Through their activities in city government and in city health boards, they shaped the developing local health-service structure of hospitals, sanatoriums, infant and child care facilities, advice centers, etc. They were also quite active in fighting infectious diseases, in research on industrial hygiene, and in the treatment of industrial diseases.

The mediating function of the socialist physicians is especially apparent as the general medical profession prepared for a "general strike" against the sickness funds. The general political conditions in Imperial Germany, though, were not conducive to broad and overall success of such initiatives, because they were mostly private and faced strong political opposition. Only with the start of the Weimar period, with the democratization of the Reich after 1918, did such initiatives have a chance to shift to the public sphere on a large scale, involving all the labor unions, the Social Democratic party, the sickness funds, and the local or state social-policy bureaucracy. In this respect the beginning of the Weimar period is a landmark for such health-policy reforms. They attracted national political attention and broad support in the new constitutional openness of the republic. Economic conditions for such reforms, however, were much worse than they had been before 1914. Yet the long-term economic malaise made the preventive and welfare dimensions of health services all the more critical at both the local and the national level. Thus, statistical-epidemiological research at the fund level or the local government level developed. The analysis of social conditions and social patterns of disease focused on preventive activities. Ambulatory clinics played a key role in this work and also in developing an integrated, social-therapeutical approach to patient care. All in all, in theory and in practice, the social-hygiene component of the health sector became dominant after 1918. Thus, socialist phy-

sicians (most of them Jews) and their local and national organizations (whose members had stressed the research and practice of social hygiene for a long time) played a leading role in health policy of the Weimar Republic. This was especially true in Berlin, which had been and still was a laboratory for almost every conceivable reform in health policy. Naturally, the dismantlings starting in 1933 would have special repercussions also for the medical personnel involved in the "health-policy reform cluster."

The History of the Jewish Contribution to Medicine

The licensing of physicians, dentists, and dental technicians was regulated anew in the context of legislation for the "reestablishment of the professional civil service." It was above all Jewish physicians who were affected. The prominent role of Jewish physicians in the development of medicine as a science in Germany has already been studied (Kaznelson 1962; Oppenheimer et al. 1971; Engelmann 1979), but their role in medical-service delivery and health reform has gone unnoticed. By practicing in the medical profession, Jews could at the same time link up with two very old Jewish religious traditions: idealistic selflessness and helping the poor. This social tradition and the experience of discrimination (Ackerknecht 1979) may have moved Jewish physicians to join or be sympathetic to the German labor movement. From this point of view, the persecution of Jewish physicians was of particular relevance to the end of a worker-oriented and union-oriented social policy.

Silbergleit (1930, p. 116) calculated on the basis of the 1925 census that there were 4,579 Jewish physicians in Prussia in that year, of whom 3,670 were independent and 835 were employed in clinics. These numbers, however, refer only to physicians who identified themselves as belonging to the Jewish religion. Their portion in the total number of physicians in Prussia at that time came to a little more than 15 percent. The National Socialist concept of non-Aryan physician was more broadly conceived. Hadrich (1934) reported that there were 6,488 Jewish physicians when the so-called Aryan legislation was introduced (see also Aron 1935). Thus, out of a total of 50,000 physicians the proportion identified as Jewish was 13 percent. But again the "non-Aryan" physicians who were active as scientists, university teachers, hospital administrators, head physicians, assistant physicians, and civil servants

were not taken into account here, which makes the estimate incomplete on its own terms.

The significance of Jewish physicians in the large cities in Germany was considerable. In July 1933, 3,423 out of a total of 6,558 Berlin physicians, or 52.2 percent, were "non-Aryans." The relative proportion of Jews among physicians accredited for insurance practice was surely higher, for in October 1933, after the first "act of elimination," 2,077 out of 3,481 panel doctors in Berlin—that is 59.7 percent—were "non-Aryans." In other large cities, usually between 25 and 30 percent of the physicians were "non-Aryans," a lower percentage than in Berlin, where 37 percent of all Jewish panel doctors may have resided.

The situation in the large cities, and in Berlin in particular, was first of all a reflection of the urbanization of the Jews. Practically a third of the German Jews lived in Berlin. This urban movement, largely to Berlin and Breslau, had been intensified by the loss of the province of Poznan after the First World War (Adler-Rudel 1959; Breslauer 1909). The larger proportion of Jews in the city population opened corresponding possibilities for a Jew in insurance practice. Because of the prevailing discrimination against Jews in the provinces, be it in university careers, civil service, large industry, the chemical industry, or the medical corps and hospitals, Jews concentrated in the cities. The large cities, with their new hygienic and social improvements, demanded medical specialization and medical reforms—a challenge medically, administratively, and politically. Thus, it is no wonder that the proportion of specialists among Jewish physicians was particularly high, and that hygiene, public health, and like issues attracted their attention, integrating them into the "health-policy reform cluster." Jewish physicians took a prominent part in combating infant mortality, tuberculosis (the proletarian disease), and venereal diseases through programs in social hygiene, partly implemented through their own private and insurance practices. Two outstanding doctors who should be mentioned here for their exemplary practice in this respect are Raphael Friedeberg and Alfred Blaschko (Bock and Tennstedt 1978; Tennstedt 1979).

The Implementation of Berufsverbote among Panel Doctors

On April 22, 1933, and June 2, 1933, the National Ministry of Labor put into effect two regulations that basically excluded "non-Aryans" from further activity in local sickness funds or national health insurance. Exceptions were made for those who had fought at the front during

the First World War, including those who had worked in military hospitals for infectious diseases, and for those who had established practices before August 1, 1914 (Goldschmidt 1979). Beyond this, the provisions of these laws excluded from insurance practice all previously accredited physicians, dentists, and dental technicians who had engaged in communist activities (Karstedt 1934, pp. 179 ff.).

The associations of panel doctors and dentists were charged with communicating their decision to the person affected and to the executive committee of the German Medical Association. They had to give reasons for their decision. The excluded physician then had the right to appeal first to the German Medical Association and then to the Minister of Labor, who made the final decision. These cases had to be settled by the end of 1933 in accord with the regulations of April 22 and June 2, 1933. They represented only the first phase of proceedings against Jewish physicians. Actions against them went on in other forms, including total exclusion from medical practice by delicensing and massive persecution (Ostrowski 1963).

The statistical records on the purely quantitative effects of these regulations are incomplete. One might take as a point of reference that there were 35,000 physicians and 8,000 dentists accredited for insurance practice on January 1, 1933, in Germany. There were about 12,000 dental technicians. How many of these were active for the sickness funds is unknown. Global data of the respective proportion of "non-Aryans" do not exist.

From the information on the exclusions from medical or dental panel practice that can be established with certainty, and from what one would assume on the basis of experience, about half of the physicians excluded by the local Panel Doctors' Associations appealed. From the data on all appeals against exclusion from panel practice that can be established with certainty, and from the fact that the ratio of appeals to exclusions is roughly 1:2, one would estimate that at least 2,800 physicians, 500 dentists, and 200 dental technicians had been excluded from insurance practice by December 31, 1933 (table 2).

The "proceedings" of the Associations of Panel Doctors against their colleagues varied with the degree of attack on the insurance funds and with the locale (they were particularly ruthless in Berlin). The waiting periods for admission to the panel of insurance doctors varied in length, and for young physicians this made things particularly difficult. After all, admission to insurance practice was limited, and the medical profession in large cities was officially considered overcrowded even after

Table 2

Appeals against exclusions by panel doctors' associations from panel national health insurance practice, 1933.

| | Physicians | Dentists | Dental technicians |
|---|------------|----------|--------------------|
| Exclusions of the panel doctors' association appealed to Ministry of Labor: | | | |
| exclusion due to non-Aryan descent | 1,030 | 206 | 79 |
| exclusion due to communist activity | 338 | 37 | 13 |
| exclusion for other reasons | 9 | 3 | 3 |
| Total appeals | 1,377 | 246 | 95 |
| Appeals denied by National Ministry of Labor | 827 | 174 | 52 |
| of these, due to communist activity | 91 | 16 | 3 |

Source: Karstedt 1934, p. 181.

these exclusions had taken place. Young SA or Nazi physicians received preference in filling "vacated" panel-doctor positions. The new leading officials of the Panel Doctors' Association in Berlin were the SA physicians Martin Claus and Erwin Villain. Later, Dr. Heinrich Grote and Dr. Hans Deuschl, two ranking Nazi officials, acquired increasing influence upon the practice of Berufsverbote. In particular, Claus had a prominent part in the spiteful arrests and mistreatment of 40 "Marxist" and "Jewish" physicians and professors in July 1933, which attracted general public attention (Leibfried and Tennstedt 1979, p. 95; Goldschmidt 1979, pp. 24 ff.).

These actions prompted a classic conflict between party enthusiasts, who wanted to execute their policies as quickly as possible, and government bureaucrats, who insisted on rules, evidence, due process, and proper procedures. The National Ministry of Labor attempted to bridle these "old warriors," but was only partially successful. The official ministerial expert, Dr. Schwartz, noted on August 21, 1933, that

Out of 50 appeals entered against decisions of the Panel Doctors' Association of Berlin between August 12 and 21, 1933, 27 have had to

be upheld. Only in 23 cases was the decision of the Panel Doctors' Association justified. The Hartmannbund [which was the appeals court of first resort] already recognized the 27 cases as untenable with one or two exceptions. These numbers confirm the observation that the Panel Doctors' Association of Berlin announced the dismissals in many cases with a wantonness that cannot be exceeded. If one bears in mind that physicians affected had been almost altogether excluded from panel practice since July 1, 1933, the result is that an enormous sum of injustice and material damage has been brought about by the proceedings of the Panel Doctors' Association of Berlin. (Zentrales Staatsarchiv RAM 5135:157)

The chief reviewer of the Ministry, Dr. Oskar Karstedt, noted on September 15, 1933, that the method of operation of the Panel Doctors' Association of Berlin was particularly bad, using rumors and gossip from irresponsible persons as valid evidence. While the bureaucrats in the Ministry were trying to maintain due process and civil rights, Hitler's National Physician General, Dr. Gerhard Wagner, complained of "a high degree of irritation against the previous decisions of the National Ministry of Labor among physicians" (Zentrales Staatsarchiv RAM 5135:91). On July 27, 1933, he responded to the answer he received as follows: "It is unfortunately sufficiently known to us that the Ministry of Labor abides by the provisions of federal law. We National Socialists, however, believe that the meaning of the National Socialist revolution cannot be exhausted in these provisions of federal law. In the final analysis the benefit of the German people stands once again above all as the supreme law." (Zentrales Staatsarchiv RAM 5134:99) Nevertheless, the particular personal contacts (already mentioned) which some officials of the Ministry of Labor maintained with leading members of the Nazi party probably then caused Wagner at least to try in some sense to bridle his overenthusiastic and fanatical accomplices in Berlin. This manifested itself chiefly in his dismissing at the end of October 1933 Martin Claus, Medical Standard Bearer of the Horst Wessel Brigade, as his deputy for Berlin. He thus withdrew the person chiefly responsible for the concrete practice of Berufsverbote by suspending panel accreditation. At the same time, however, he called it untenable in the long run that, even after the actions of Claus, over 60 percent of the "non-Aryan" panel doctors in Berlin were still active. The ordinance relevant to this was published in the *Deutsches Ärzteblatt*, which was distributed to physicians all over Germany. Claus published alongside this ordinance an "explanation" in the *Berliner Ärztescorrespondenz* (a local physicians' journal) on November 4, 1933, which was supposed to make it clear that his "resignation" was engineered by the Ministry of Labor,

with Wagner as its agent. According to him, the Ministry bore responsibility for the "catastrophic development of panel and welfare doctors' care of the population," which had dishonored him as a National Socialist. Claus felt that he and his co-workers had been crudely offended and slandered by officials of the Ministry. Yet Wagner had explained to him shortly before that these disputes with the Ministry did not concern him.

After this "explanation," Wagner excluded Claus even from the Nazi Federation of Physicians, with full knowledge and approval of the party's chief of staff, Martin Bormann. Thereupon, Claus behaved as though he had been personally persecuted. He agitated to such an extent that Wagner had to present himself before the Führer's deputy, Rudolf Hess, and receive authorization to "proceed as severely as possible against further perpetrators of intrigue." On November 11 the Gestapo decreed an end to the *Berliner Ärztescorrespondenz*, the official physicians' journal of Berlin (Leibfried and Tennstedt 1979, p. 93). Interestingly, it was Wagner who later initiated continuing education courses for Jewish physicians in Berlin and entrusted them with the health administration of the Jewish community of Berlin so that only Jews would treat Jews. Highly qualified Jewish instructors from Berlin held continuing education courses until increasingly repressive measures forced emigration and with it the end of this program (Ostrowski 1963). These "small steps" and the contacts, motivations, interests, and rivalries that underlay them have received little notice until now.

Mason (1977) states that these interest and party struggles had "unmistakably the character of transitional phenomena which gradually lost significance with the step-by-step construction of a new form of government." This, however, is probably not quite so, because, as Neumann observed in his classic analysis (in Mason 1977, p. 357): "The party did not succeed in breaking up the power of bureaucracy in the army and navy, justice and administration. The Party controlled only the policy, youth, and propaganda."

Mason is more correct when he writes that the state bureaucracy was concerned with "preserving tried and true organizational structures in the state, the economy, and all areas of public life from the revolutionary intervention of the National Socialist Movement which was leading to chaos." This conclusion is supported by the fact that the Ministry of Labor brought about the overthrow of Claus, a Nazi functionary outside the area of competence proper to the Ministry. Basically, such rivalries between the ministerial bureaucracy and the party did

not necessarily have such relatively positive effects, because "the ministerial bureaucracy [was] a closed caste which tolerate[d] no outsiders in its ranks. . . . Its members [were] neither for nor against National Socialism, but for the ministerial bureaucracy." (Neumann, in Mason 1977, p. 433)

In addition to this, the Ministry of Labor maintained its reputation of being "filled with many upright democrats," mostly of the Weimar Centrist (Catholic) party. On the side of the higher party echelons, calculations of power politics were probably decisive in cases of "softness" of this sort. They were dependent upon the specialists of the ministerial bureaucracy in the Ministry of Labor, which alone controlled the complicated apparatus of the social security system. Subsequent history shows that the physicians who remained with Wagner and Leonardo Conti (the chief physician for the SS) were no better in any humanitarian sense.

Arbitrary arrests and conflicts with Labor Ministry officials were not confined to Berlin. Dr. Oskar Karstedt, in the National Ministry of Labor, had to complain about the Düsseldorf Panel Doctors' Association in a manner similar to the way he complained about the Berlin Panel Doctors' Association; the former had made assertions that "already at first glance turned out to be wholly untenable" (Zentrales Staatsarchiv RAM 5135:152). Thus, "the National Minister of Labor for his part had to take the trouble to obtain further clarification in hundreds of cases, chiefly in the sense of elucidation by suitable authorities or by those which otherwise could be of help. This was all the more necessary because a formal hearing of witnesses by the Minister of Labor himself was possible only in exceptional cases. On the other hand, however, everything had to be done in the sense of constitutional procedure to clear up the case as thoroughly as possible." (Karstedt 1934, p. 181) As far as can be seen, decisions in favor of the physicians in question were mostly related to cases of the following types: "soldier at the front," "active at the front as a physician," and "communist activity not proved." The director of the Hartmannbund, Dr. Hermann Lautsch, had examined in a preliminary manner and approved 86, 64, and 110 appeals on these grounds, respectively. The numbers of appeals allowed by the Ministry of Labor were considerably higher: 124, 96, and 231. The relatively high allowance of appeals for charges of communism was due to the fact that numerous Panel Doctors' Associations and the chief director of the Hartmannbund included as grounds for dismissal "any membership in Social Democratic organizations or cooperation

with their subsidiaries." However, the Ministry of Labor could not abide by this procedure. Nazi party leaders protested against Karstedt's allowing so many appeals, and they made him discuss all cases in which he wished to deviate from the vote of the Hartmannbund in favor of the complainant with a group of senior party physicians, Drs. Deuschl, Grote, and Haedenkamp.

Dr. Karl Haedenkamp, after World War II a leading official of the West German National Physicians' Organizations, was not, like his two colleagues, an SA or SS doctor with the particular trust of the National Physicians General, but was director of the Berlin office of the Hartmannbund and was also probably considered somewhat trustworthy as a former DNVP (German National People's Party) member of parliament. In fact he cooperated more with the ministerial bureaucracy than with the Physicians General.

Suspension from panel practice in effect ended a doctor's secure existence in almost every respect, for most private health insurance groups conformed to decisions of the Panel Doctors' Associations. They sent out or published exclusion lists of physicians and dentists (Leibfried and Tennstedt 1979, pp. 241-269). The Association of Private Health Insurance Companies of Germany, with its headquarters in Leipzig, sent out these exclusion lists with the title List of Physicians Hostile to the State. Karstedt found this "disagreeable and hardly tolerable politically," especially since it affected physicians who had "acquired great merit with the public." He did not, however, see any possibility of taking steps against their "being defamed by a private enterprise in the manner characterized" (Zentrales Staatsarchiv RAM 5147:540). However, in very large cities some doctors of high reknown and specialization could not subsist without some insurance backup, public or private. Thus, for most of the physicians affected there remained only changing careers or leaving. For this reason, 806 Berlin physicians left between 1933 and 1934, as did 150 physicians from Munich (Reichsmedizinischer Kalender 1933, 1934). Some 3,000 Jewish physicians fled from Germany at this time, to which purely political exiles, or persecutions due to homosexuality would have to be added (Leibfried 1982, pp. 9 ff.). Also added should be the delicensing of women in certain cases (ibid.). The data compiled by the National Office for German Jews on the exact shape of the persecution and flight of Jewish physicians between 1934 and 1938 (table 3) allow some conclusions as to the nature of emigration: Emigration peaked in 1933-34 and in 1936. Exodus from the Reich was always higher than exodus from Berlin. The only

Table 3

Exodus of Jewish physicians from Germany as a whole and Berlin in particular, 1933–1938.

| | Germany | | Berlin | |
|--------------------------------|---|---|---|---|
| | Number Jewish physicians at beginning of time period (% with panel license) | Number Jewish physicians fleeing during time period | Number Jewish physicians at beginning of time period (% with panel license) | Number Jewish physicians fleeing during time period |
| Jan. 1, 1934 to June 30, 1934 | 9,000 (—) | 2,000 | 3,423 (—) | 874 |
| July 1, 1934 to Dec. 31, 1934 | 7,000 (57) | 1,000 | 2,549 (55) | 149 |
| Jan. 1, 1935 to Dec. 31, 1935 | 6,000 (60) | 1,000 | 2,400 (—) | 355 |
| Jan. 1, 1936 to Dec. 31, 1936 | 5,000 (56) | 1,700 | 2,145 (52) | 645 |
| Jan. 1, 1937 to Sept. 30, 1938 | 3,300 (—) | 148 | 1,500 (—) | +123 |
| Total left as of Oct. 1, 1938 | 3,152 | | 1,623 | |

Source: Leibfried 1982, p. 11.

exception is 1933, when Berlin lost 25.5 percent of its Jewish doctors and the Reich 17 percent. Two factors need to be kept in mind here: the special role of Berlin in health policy and the correspondingly excessive efforts of the Nazi doctors to purge Berlin. Also, Berlin was the first place turned to by Jewish and socialist physicians who fled the countryside or the smaller cities, where repression was extreme. Berlin was the largest city, so it guaranteed some anonymity, and it provided easier ways of escape since all the foreign embassies were there. Thus, the emigration from Berlin after 1933 was usually low because of quotas related to intra-German migration into Berlin. From January to September 1938 the number of Jewish doctors in Berlin grew by 8.5 percent while it diminished nationally by 4.5 percent. Also, Berlin was the only town in Germany with a large market for private practice quite independent of any insurance reimbursements, which allowed the chance of subsistence to at least some physicians. As table 3 shows, in 1938 there were still 3,152 Jewish doctors left in the Reich, 1,623 of them in Berlin.

For most of these physicians exodus meant a wholly new beginning. Most were destitute. Their German medical examinations were not recognized, so they had to begin medical studies all over again if they wished to resume practice (Pearle 1981; Leibfried 1982). They turned to a variety of countries—at the beginning, in 1933, mostly to Palestine; later on more often to the United States. Younger physicians were more likely to leave, older ones more likely to stay. This age distribution is quite important, because those doctors left in Germany were the most immobile and most vulnerable to the persecutions still to come. Complete data only exist for 1933, and good estimates of similar precision from the same source exist for 1934.

In 1934, 1,307 physicians left officially (2.4 percent of all German doctors), 572 of whom came from Berlin. Two-thirds were 30–45 years old, over one-tenth were younger and not even a quarter were older. The corresponding age distribution for all German doctors was: 50 percent/10 percent/40 percent. Whereas 6.85 percent of all doctors were women, 16 percent of emigrating physicians were women (Dornedden 1935, p. 515).

Of 67 of the 104 Berlin physicians declared to be “enemies of the state” (Leibfried 1982, pp. 18–19), 5 died under the Nazi regime, 2 died in the USSR under Stalin, 43 stayed abroad (20 in the US, 11 in Palestine), and 6 returned to Germany after World War II. Thus, a whole generation of socialist physicians with the experience and the

political values of health reforms during the Weimar period were eliminated from policy-making after 1945 (Boenheim et al. 1981; Frankenthal 1981, pp. 266 ff.).

These events are touched upon in Schadewaldt et al. 1975 (p. 143):

There are many examples of collegiality triumphing over the thought of race, and of persecuted Jewish colleagues receiving substantial assistance. On the other hand, the official organizations did not in fact protest against the Aryanzation paragraphs. Rather, the members of their governing bodies attempted to prevent the strongest infringements through individual assistance. It remains a scandal, however, that the "German Federation of Medical Associations" urged the international board not to comply with the wishes of those physicians or medical students who wished to emigrate from Germany and who requested medical positions elsewhere.

The lack of protests, indeed the demand for an international boycott of Jewish émigrés, can be associated with a particular National Socialist exposure of the remaining members of this profession. Thus, membership in the National Socialist Physicians' Federation grew rapidly in this period. Already in 1935, 14,500 physicians belonged to it, almost a third of the non-Jewish German physicians. In 1940, the state leader of the National Socialist German Physicians' Federation in Württemberg, Dr. Eugen Staehle, remarked on the period of the early 1930s with a certain pride (Staehle 1940, p. 10; see also Kudlien 1979, p. 354): "No other academic profession found its way to the NSDAP (the Nazi party) to this extent and as early as the healing professions." This statement is confirmed by current research. In comparing teachers (who used to be considered the most Nazified profession) with physicians, Kater (1979) writes:

After January 30, 1933, there were professions in Germany that were in no way as exposed to social and political pressures for conformance with Nazi politics as were the teachers and that nevertheless had quite a high membership rate in NS organizations. . . . A typical example are the doctors. All in all, about 45 percent of the Reich's physicians, seemingly by their own choosing, became members of the NSDAP, about twice the rate of the teaching profession. About 26 percent of the male doctors were active in the SA versus 11 percent of the teachers. The SS had 7.3 percent of all male physicians within its ranks, compared with 0.4 percent of the teachers. In 1937 physicians were represented seven times as much in the SS as in the whole labor force, whereas teachers participated only a little over their proportion. . . .

This legislation was only the beginning of the persecution of Jewish physicians, but a few constitutional procedures were preserved, as presented above. Thus, Dr. Heinrich Grote wrote retrospectively:

Corresponding to the purge of the professional civil service, steps were taken toward purging the medical profession of Jewish and communist elements. This activity, which required a great deal of work on into 1934, did not in any case lead to the results hoped for. The legal provisions laid down by the Reichspräsident at that time provided that proof of communist activity had to be brought against these communist elements in order to be able to exclude them from panel practice. But the Marxists or communists often knew how to camouflage themselves in time or to destroy their material, so that it was not always possible to produce airtight proof of communist activity. Furthermore, those Jewish physicians who had taken part in the war as soldiers at the front or who had already established themselves by 1914 were allowed to continue their panel practice. That even today a third of all accredited panel doctors are Jewish shows how unsatisfactory this solution finally turned out to be. (Grote 1938, p. 11)

The persecutions continued until the "complete elimination of Jewish physicians" took place with the fourth ordinance to the Law on Citizenship of July 25, 1938. Paragraph 1 of this ordinance states: "Licenses (approbations) of Jewish physicians expire on September 30, 1933." The professional designation of physician was basically disallowed for Jews. In a few months, by the end of 1938, only 185 Jewish "treaters of the sick" (Krankenbehandler) were still active in Germany, whereas there had been 709 on October 1, 1938. The journal *Ortskrankenkasse* (Local Sickness Fund), which owed many excellent articles to the Jewish hygienists of the Weimar Republic, reported on this in traitorous "officialese" in a 1938 article headlined No Jewish Doctors Anymore: "As opposed to previous partial solutions, the fourth ordinance of the Imperial Civil Code now brings about the complete elimination of Jews from the health profession. Obviously measures have been taken in advance to guarantee sufficient medical care after the elimination of the Jews." The journal did not provide proof for the last assertion. The conditions in the concentration camps, the mass annihilation of the Jews which was initiated soon thereafter, and the Second World War were soon to make this a minor problem.

Berufsverbote and the Association of Socialist Physicians

The Association of Socialist Physicians played a special role in the exclusion of physicians from insurance practice on account of political activity. Oskar Karstedt (1934, p. 183) records:

The number of persons excluded because of membership in the Communist Party or its associated organizations is comparatively small. Significantly greater is the number of those who, without their having

been affiliated with a clearly communist organization, consciously or unconsciously advanced communism through their membership or activity in associations, such as the Association of Socialist Physicians, The Fichte Federation [a sports organization of the labor movement], certain (not all) Worker Samaritan Columns, and similar institutions. Accordingly, their appeals had to be rejected.

To understand the link between *Berufsverbote* and the Association of Socialist Physicians made in this statement, one needs some background. At the turn of the century, the rapidly intensifying economic conflicts between the insurance funds and physicians led to the founding of the Hartmannbund. The main questions under dispute for these physician-employees were collective vs. individual contracts, free choice of physician vs. limited selection, and physicians' income (Tennstedt 1977, pp. 75 ff., 125 ff.). These disputes led to 873 doctors' strikes and boycotts through 1911. Then the Hartmannbund planned a general strike for 1914, when the reformed and codified national health insurance of 1911 was to take effect. This strike was averted at the last minute by the "Berlin Agreement."

This general situation put those physicians attached to the labor movement in a difficult position. On the one hand, they supported and worked for health insurance, especially with the funds oriented to social democratic principles and to free trade unions. On the other hand, they could accept the humiliating practices of the funds no more than they could the official policies of the medical profession. They believed that physicians and health insurance funds should join hands in promoting the interests of workers and implementing the programs of social hygiene.

Based on an analysis of this situation (Kollwitz 1913, p. 222), Dr. Karl Kollwitz and three prominent socialist physicians founded the Social Democratic Physicians' Association (Tennstedt 1982). This association was supposed to mediate between funds and physicians for the benefit of the sick. Members presented papers before health insurance associations on social hygiene and health policy and in the process educated and recruited more prominent physicians.

As time passed, the Social Democratic Physicians' Association split and recombined in different ways. During the Weimar Republic, the association expanded its political spectrum to embrace left-wing communists, who did not (or did not fully entertain) the pragmatic approach of the Social Democratic Party. Members stood for socialized medicine and demonstration experiments to translate the results of research on social hygiene into medical and political practice. A number of prominent

physicians held key posts on the board of the association. However, these mediating institutions (Wickham, 1979, pp. 8–9), which promoted workers' interests above party lines, split in 1924 over disputes about ambulatory clinics (Hansen et al. 1981, pp. 155 ff., 433 ff.). The majority of the old guard founded the Association of Socialist Physicians, in which membership was largely independent of party affiliation. It had members all over Germany and published its own journal, *Der sozialistische Arzt* (The Socialist Physician).

Meanwhile the Social Democratic Physicians' Association amalgamated with the Social Democratic Physicians' Federation in 1926 to form a Study Group, which became part of the Social Democratic party (SPD). All SPD physicians belonged to it, and its tasks were to promote SPD health policy in the party organization, in public health organization, and in the labor unions, and to attract and train physicians with similar attitudes. The leadership and organization of the Study Group corresponded to that of the SPD. Some of the most prominent pioneers in social medicine participated, among them Dr. Julius Moses, a Reichstag member and the SPD health expert at the national level; Dr. Raphael Silberstein; Alfred Grotjahn, a pioneer of social hygiene academically and the first professor for the subject area; Beno Chajes, a leading academic in industrial hygiene; Dr. Franz-Karl Meyer-Brodnitz, a leading industrial hygienist of the labor unions, and Dr. Felix Koenigsberger, the founder of the Berlin ambulatory clinics.

The Association of Socialist Physicians was the only professional association with both Social Democrats and communists as members. Its mixed membership is apparent from its list of major board members after 1925. Whereas Dr. Georg Loewenstein, Dr. Salo Drucker, and to some extent Dr. Ernst Simmel stayed close to the SPD line, Dr. Ewald Fabian, Dr. Franz Rosenthal, Dr. Minna Flake, and Dr. Leo Klauber were either independent socialists or associated with the Communist Party. Loewenstein was responsible for the programmatics of the association (Loewenstein 1981); Fabian was the long-time editor of *Der sozialistische Arzt*. Thus, the association came into repeated conflict with the upper party echelons of the SPD. Simmel was repeatedly summoned before the SPD's governing body, and for years *Vorwärts* (Forward), the official party paper of the SPD, blocked his columns for the association. The Social Democrats had become so attached to the establishment that by 1929 they made sure that no representatives of or sympathizers with the Communist Party had even an indirect voice. The opposition between the two parties made "being above politics"

difficult. Some KPD members were also thrown out of the Association of Socialist Physicians in 1929 after publicly demanding "fierce struggle against the traitorous actions of the Social Democrats" in the Berlin Physicians' Chamber. All in all, the members' common interest in improving and studying social hygiene and the idea of neutralizing the rapidly spreading nationalist and National Socialist movement in the professional associations is the most likely uniting bond among the members of this group. (See also Frankenthal 1981, pp. 182 ff.) The activity of the association, beyond publishing the journal, was to conduct public lectures and seminars and public campaigns on certain health issues. Politically these physicians also stood for elections in the Berlin Physicians' Chamber, a professional regulatory body concerned with continuous education, fees, struggle about the shape of health delivery, and professional ethics. Also, it was especially the Berlin association which was most active internationally, at least in stimulating the founding of similar organizations in Czechoslovakia (Loewenstein 1981, pp. 235 ff.) and England (Honigsbaum 1979, p. 260) and sponsoring international meetings of like-minded physicians, as 1931 at Karlsbad.

In other cities, branches of the association were less politicized and focused on discussing technical questions of health insurance, public health, and social hygiene. Outside of Berlin, local centers of activities of the socialist physicians were Chemnitz, Leipzig, Frankfurt am Main, München, and Breslau. In these cities the local associations had almost only Social Democrats as members, the majority of whom were Jewish physicians.

To ruin a man's career in 1933–34 for affiliation with one of these socialist associations seems all out of proportion, unless the goal was to destroy any base for shaping health-care services according to worker-based socialist values (Boenheim et al. 1981). As one senior administrator of the Hartmannbund, Dr. Hermann Lautsch, aptly summarized such destruction, "Our perspective in passing judgment on these appeals is informed by the principle: in dubio non pro re, sed contra rem—when in doubt, [decide] not for but against." (Zentrales Staatsarchiv RAM 5135:169).

Notes

1. A systematic review can be found on pp. 431 ff. of Labisch 1980.
2. *Gleichschaltung* is a smokescreen term of Nazi origin; technically it means something like "coordination," even though it was actually used for the de-

struction or supplanting of all organizations in the political and social sphere that were at odds with Nazi policy.

3. Except where otherwise noted, data and quoted material in this section and the next are from Zentrales Staatsarchiv RAM 5135, 5136, 5360, 5361, 5382–5384, and 5569.

4. Communists were most likely to be active in private practice or in public health directly; a few were employed in ambulatory clinics.

5. This private combination of public bodies is not specific to social policy but is often found in "state interventionist" domains in Germany.

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