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Physicians and torture: lessons from the Nazi doctors

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Abstract

How is it possible? What are the personal, professional and political contexts that allow physicians to use their skills to torture and kill rather than heal? What are the psychological characteristics and the social, cultural and political factors that predispose physicians to participate in human rights abuses? What can be done to recognize at-risk situations and attempt to provide corrective or preventive strategies? This article examines case studies from Nazi Germany in an attempt to answer these questions. Subjects discussed include the psychology of the individual perpetrator, dehumanization, numbing, splitting, omnipotence, medicalization, group dynamics, obedience to authority, diffusion of responsibility, theories of aggression, training, cultural and social contexts, accountability and prevention.

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Torture is a particularly horrible crime, and any participation of physicians in torture has always been difficult to comprehend. As General Telford Taylor

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explained to the American judges at the trial of the Nazi doctors in Nuremberg, Germany (called the “Doctors’ Trial”), “To kill, to maim, and to torture is criminal under all modern systems of law ... yet these [physician] defendants, all of whom were fully able to comprehend the nature of their acts ... are responsible for wholesale murder and unspeakably cruel tortures.”¹ Taylor told the judges that it was the obligation of the United States “to all peoples of the world to show why and how these things happened”, with the goal of establishing the factual record and trying to prevent a repetition in the future. The Nazi doctors defended themselves primarily by arguing that they were engaged in necessary wartime medical research and were following the orders of their superiors.² These defences were rejected because they were at odds with the Nuremberg Principles, articulated at the conclusion of the multinational war crimes trial in 1946, that there are crimes against humanity (such as torture) for which individuals can be held to be criminally responsible for having committed them, and that obeying orders is no defence.³

Almost sixty years later the question of torture during wartime, and the role of physicians in torture, is again a source of consternation and controversy. Steven Miles, for example, relying primarily on US Department of Defence documents, has noted that at the prisons of Abu Ghraib, Iraq, and the US Naval base at Guantánamo Bay, Cuba, “at the operational level, medical personnel evaluated detainees for interrogation, and monitored coercive interrogation, allowed interrogators to use medical records to develop interrogation approaches, falsified medical records and death certificates, and failed to provide basic health care”.⁴ The International Committee of the Red Cross, on the basis of an inspection of the Guantánamo Bay prison in June 2004, commented that physical and mental coercion of prisoners there is “tantamount to torture”, and specifically labelled the active role of physicians in interrogations as “a flagrant violation of medical ethics”.⁵

Bloche and Marks, on the basis of their interviews with physicians involved in interrogations at Guantánamo Bay and in Iraq, reported the belief of some of the physicians “that physicians serving in these roles do not act as physicians and are therefore not bound by patient-oriented ethics”.⁶ Psychiatrist Robert Jay Lifton suggested that the reports of US physicians’ involvement in torture in Iraq, Afghanistan and Guantánamo echo those of the Nazi doctors who were “the most extreme example of doctors becoming socialized to atrocity”.⁷ Nonetheless, the muting of the criticism of such torture prompted

1 *United States v. Karl Brandt et al.*, 9 December 1946 (Telford Taylor, opening statement of the prosecution).

2 George J. Annas and Michael A. Grodin (eds.), *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*, Oxford University Press, New York, 1992.

3 *Ibid.*

4 Steven H. Miles, “Abu Ghraib: its legacy for military medicine”, *Lancet*, Vol. 364 (2004), pp. 725–9.

5 Neil A. Lewis, “Red Cross finds detainee abuse in Guantánamo”, *New York Times*, 30 November 2004, p. 1.

6 M. Gregg Bloche and Jonathon H. Marks, “When doctors go to war”, *New England Journal of Medicine*, Vol. 352 (2005), pp. 3–6.

7 Robert J. Lifton, “Doctors and torture”, *New England Journal of Medicine*, Vol. 351 (2004), pp. 415–16.

Elie Wiesel to ask why the “shameful torture to which Muslim prisoners were subjected by American soldiers [has not] been condemned by legal professionals and military doctors alike”.⁸ The challenges of the war on terror present an opportunity for medical and legal professional organizations to work together transnationally to uphold medical ethics and international humanitarian law, respectively, rather than to search for ways to avoid legal or ethical dictates.

Thirty years ago, Sagan and Jonsen observed that because the medical skills used for healing can be maliciously perverted “with devastating effects on the spirit and the body”, it is “incumbent upon the medical profession and upon all of its practitioners to protest in effective ways against torture as an instrument of political control”.⁹ Such protests can help in the war against terrorism. Neither the use of torture nor violations of human rights, as another professor of law, the Jesuit Robert Drinan, has observed, will “induce other nations to follow the less traveled road that leads to democracy and equality”, but the “mobilization of shame” and the “moral power” of example can do so.¹⁰ In this article, we use insights gained from the actions of the Nazi doctors to help us understand the continuing role of physicians in torture.

Racial hygiene, murder and genocide

At Nuremberg, Telford Taylor understood the need to recognize and actively denounce the evils of the Holocaust, and implored the international community to take a stand against evil. In the foreword to *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*, Professor Elie Wiesel asked, “How was it that physicians could have been involved in such atrocities?”¹¹ One might well ask how any human beings could have been involved. But what Wiesel and Taylor recognized was that physicians have a special moral standing in their communities and in society at large: by nature of their advanced education and their oath to serve and protect humanity, physicians have voluntarily undertaken a special responsibility. What were the personal, professional and political contexts that allowed physicians to use their skills to torture and kill rather than to help and heal? Some insight into the events of the Holocaust – and the use of torture today – can be provided by historical accounts of the role of medicine and physicians in relation to racial hygiene theories, the medicalization of social ills and the meshing of medicine with national socialist ideology.

8 Elie Wiesel, “Without conscience”, *New England Journal of Medicine*, Vol. 352 (2005), pp. 1511–13.

9 Leonard A. Sagan and Albert Jonsen, “Medical ethics and torture”, *New England Journal of Medicine*, Vol. 295 (1976), p. 1427.

10 Robert F. Drinan, *The Mobilization of Shame*, Yale University Press, New Haven, Conn., 2001, p. 94.

11 Elie Wiesel, foreword to Annas and Grodin, above note 2, pp. vii–ix.

The idea of racial hygiene emerged at the turn of the twentieth century, and the racial policies of the Third Reich were in many ways adapted from eugenics practices developed in the United States in the early twentieth century.¹² Before the National Socialist Party came to power in Germany, there were already several institutes on racial hygiene at various German universities. The theories at these institutes grew out of the “science of eugenics” employed in the United States to justify government support for the twenty-three separate state laws which allowed for the involuntary sterilization of individuals.¹³ In the US Supreme Court decision *Buck v. Bell*, referring to the fact that the state can draft people into military service, the Court concluded,

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.¹⁴

Ultimately, the Nazis would carry this ideology beyond sterilization. They not only eliminated “undesirables” from their society, but also developed multiple programmes for the creation of a “master race”, including the *Lebensborn* programme, which encouraged members of the SS to have children with women who had Aryan traits.¹⁵ All the while they highlighted the “therapeutic” facet of their programmes, claiming that destroying the unworthy was “purely a healing treatment”.¹⁶

Eugenics was only one of many facets of the biological front the National Socialists put on their policies. Nazi leaders considered their political philosophy to be “applied biology”, and adopted many public health policies in addition to those guided by social Darwinism, including anti-tobacco initiatives.¹⁷ They gave a medical connotation to their political movement, and often referred to Hitler as the “great doctor of the German people”.¹⁸ Perhaps attracted by the medical

12 Stefan Kühl, *The Nazi Connection: Eugenics, American Racism, and German National Socialism*, Oxford University Press, Oxford, 1994.

13 Andre N. Sofair and Lauris C. Kaldjian, “Eugenic sterilization and a qualified Nazi analogy: the United States and Germany 1930–1945”, *Annals of Internal Medicine*, Vol. 132 (2000), pp. 312–19.

14 *Buck v. Bell*, 274 US 200 (1927).

15 Mark Landler, “Results of secret Nazi breeding program: Ordinary folks”, *New York Times*, 7 November 2006.

16 Robert Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, Basic Books, New York, 1986.

17 Robert N. Proctor, “The anti-tobacco campaign of the Nazis: a little known aspect of public health in Germany, 1933–45”, *British Medical Journal*, Vol. 313 (1996), pp. 1450–3.

18 Wolfgang Weyers, *Death of Medicine in Nazi Germany: Dermatology and Dermatopathology under the Swastika*, Ardor Scribendi, Ltd., Philadelphia, 1998.

metaphors, doctors flocked to the cause of National Socialism. Sixty-five per cent of all German doctors became Nazi Party members.¹⁹ By 1937, the representation of doctors in the SS – the most vicious arm of the Nazi Party – was seven times higher than that of the average for the employed male population and by 1942, 50 per cent of all German doctors had joined the Nazi Party.²⁰ Joining a political party is one thing, using its ideology to justify the torture and extermination of an entire people is quite another. To see why some physicians and scientists take that extreme step, we must examine the perpetrators within a framework of individual and group psychology, as well as in the larger social context.

Psychology of the individual perpetrator

First, it is impossible to explain the acts of torturers and murderers without understanding something of the psychology of human behaviour, including the concepts of self-deception, the unconscious, drive, defence, aggression, narcissism, a permissive superego, and social service for an ideal. These psychological ideas are rooted in philosophical theories about human nature. Before examining an individual psyche, it is important to consider the view one has of humanity. There is a fundamental tension between classic and romantic visions of human reality, which is highly relevant to an examination of perpetrators of torture. In the “classic” view, we all intrinsically have the capacity to do evil and are very precariously constrained by order and tradition; in other words, we all have the potential to be torturers. In the “romantic” view, men and women are intrinsically good but are spoiled by circumstance and culture – this vision of human reality is full of possibilities currently constrained by society. Under this dual framework, individuals are either perpetrators of evil prevented from acting by socialization and social constraints, or moral beings turned into torturers by evil social contexts. But the truth of human psychology is probably not so extreme.

Dehumanization

There are several psychological mechanisms by which individuals can overcome the social conditioning that prevents them from becoming perpetrators of atrocities. Dehumanization is a key psychoanalytic defence mechanism which allows individuals to avoid fully processing troubling events. Dehumanization of the self and of others draws on other defence mechanisms, including unconscious

19 James Waller, *Becoming Evil: How Ordinary People Commit Genocide and Mass Killing*, Oxford University Press, New York, 2002.

20 Robert N. Proctor, “Nazi doctors, racial medicine, and human experimentation”, in Annas and Grodin, above note 2, pp. 17–31.

denial, repression, depersonalization, isolation of affect and compartmentalization (the elimination of meaning by disconnecting related mental elements and walling them off from each other).²¹ Ultimately, dehumanization allows the perpetrator to go beyond hatred and anger, and commit atrocious acts as if they were part of every day life.

There are two types of dehumanization processes. First, there is self-directed dehumanization, a diminution of an individual's own sense of humanness and self-image, which is often seen in cases of complex post-traumatic stress disorder (CPTSD); for torture survivors or other persons exposed to extended trauma this process is a form of self-protection.²² The second type is object-directed dehumanization, where others are perceived to lack human attributes. The two processes are mutually reinforcing, as reducing the self adds to reducing the object, and reducing the object adds to reducing the self. Perpetrators accomplish the dehumanizing process by making the other (the object) dirty, filthy and physically less than human. One could argue that there is an increased ability to dehumanize others today as a side effect of the advent of technology, as modern warfare, automation, urbanization, specialization, bureaucratization and the mass media all contribute to the isolation of individuals. Anonymity and impersonality cause a fragmented sense of one's role in society, contributing to dehumanization. Sometimes dehumanization can be adaptive; for example, in a crisis, dehumanization of the injured or sick allows for an efficient rescue. Certain occupations classically teach and perhaps require selective dehumanization, including law enforcement and the military and medical professions. This enables professionals to detach from full emotional responsiveness in the moment, but it also can be very dangerous.

Splitting

Dehumanization by itself cannot completely explain the healing–killing paradox. Splitting as a model of personality enables people to deal with trauma.²³ This is a form of self-deception in which the unconscious mind can wall off the conflict to eliminate incompatibilities with self-image, separating thought and even actual events from feeling. For a perpetrator, splitting can be used to rationalize and justify his actions, and through reaction formation he can convince himself that he is doing good, or even that he is a hero. Robert Lifton's interviews of Nazi physicians and their surviving families revealed how far splitting or "doubling" (as Lifton terms it) went for those individuals. The Nazi physicians split the self: they saw themselves as healers with special powers, practically omnipotent, and killing

21 Viola Bernard, Perry Ottenberg and Fritz Redl, "Dehumanization: a composite psychological defense in relation to modern war", in Milton Schwebel (ed.), *Behavioral Science and Human Survival*, Behavioral Science Press, Palo Alto, Cal., 1965.

22 Stanley W. Jackson, "Aspects of culture in psychoanalytic theory and practice", *Journal of the American Psychoanalytic Association*, Vol. 16 (1968), pp. 651–70.

23 Lifton, above note 16.

24 Ibid.

became a part of healing – in their minds, one had to kill the enemy to heal one’s people, one’s military unit and one’s self.²⁴ Under this mental paradigm, there is no paradox in using Red Cross trucks to carry victims to a death camp or in wearing white coats while systematically killing children for experimentation: medicine becomes the equivalent of war, and physicians medicalize and humanize killing even while they dehumanize the victim.

Numbing

Splitting is combined with numbing to distance the perpetrator more effectively from the victim. Psychic numbing diminishes the capacity to feel. Blocking feelings leads to extreme repression, including denial to the point of disavowal of what one perceives and de-realization to the point that the victims never existed in the perpetrators’ consciousness. One Polish survivor who worked in the medical block of a concentration camp partly defended Polish doctors who mistreated Jewish inmates by noting that “people grow indifferent to certain things. Like the doctor who cuts up a dead body [to do a post-mortem examination] develops a certain resistance”.²⁵ However, this numbing process was not completely successful, as many physicians selecting at the “ramps” still needed to self-medicate with heavy drinking.²⁶

Omnipotence

Concentration camp officials’ omnipotent control over life and death was balanced by the Nazis’ vision of themselves as one important part of a larger omnipotent social machine.²⁷ The medical profession is susceptible to feelings of omnipotence, and Holocaust survivor Bruno Bettelheim suggests that “it is this pride in professional skill and knowledge, irrespective of moral implications”, that makes physicians vulnerable to becoming perpetrators.²⁸ Ultimately, however, doctors are impotent to control death and disease, and this is part of the death anxiety that many physicians have. For those doctors who took an active part in Nazi abuses, omnipotence merged with sadism – they took pleasure in domination and control – but they still needed to eradicate their own vulnerability and susceptibility to pain and death; there is a powerlessness associated with omnipotence. They merged their anxiety over powerlessness into their pride at being part of their country’s war machine. The Nazi Party was able to manipulate particular psychological vulnerabilities of individuals as it pressed them into serving the wishes of the group. In the mental struggle to maintain their

25 Ibid.

26 Waller, above note 19.

27 Lifton, above note 16.

28 Bruno Bettelheim, foreword to Miklos Nyiszli, *Auschwitz: A Doctor’s Eyewitness Account*, Arcade Publishing, New York, 1993, pp. v–xviii.

professional identity, the Nazi physicians saw Hitler as the “father physician”, and became unified as a group beneath him.

Medicalization

The Nazi doctors put an abstract, purely medical, technical, and professional construction on their activities; for example, telling themselves that the doctor’s task is to alleviate suffering, they would use medical and technical skills to diminish the pain of the victims while setting up mass murder. They became absorbed in the technical aspects of medical work, examining inmates as a criterion for sending them to the gas chambers.²⁹ They became robotic in what they did and the process of murdering became a performance; in their medical uniforms, acting as the Nazi male ideal, they used their professional power to ward off their death anxiety, killing to hold back death. Medical professionals have a special capacity to split: while an individual is part of the healing profession then everything he does must be healing. Through these justifications and within the larger social context of “political medicine”, the Nazi doctors were able mentally to connect healing with their murderous actions.

Psychology of groups of perpetrators

In identifying themselves as part of a larger machine working to “heal” society, Nazi physicians diffused responsibility, transferring it to the group rather than taking individual responsibility for their actions. They achieved group unity through the creation of special group language – euphemisms for the evil acts they carried out. They saw themselves as part of a “special” group, as elite and important. There was a certain sense of belonging and being part of a movement. This group unity was facilitated by specialized training, ritualization of their actions and, as discussed above, the self-directed dehumanization and splitting that allowed them to subsume individual identity while acting in a professional capacity.

Two key psychology experiments in the United States after the Second World War examined obedience to authority and diffusion of responsibility in groups, and further demonstrated the ease with which previously well-adjusted individuals can engage in evil activities.

Obedience to authority

Beginning in 1961, Stanley Milgram performed a set of experiments at Yale University in which subjects were asked to “deliver electro-shocks” to another

29 Lifton, above note 16.

30 Stanley Milgram, “Behavioral study of obedience”, *Journal of Abnormal and Social Psychology*, Vol. 67 (1963), pp. 371–8.

person. Sixty-five per cent of the subjects used what they believed were dangerously high levels of shocks when the experimenter told them to do so.³⁰ In a later experiment, one-third of subjects continued the shocks when they were close enough to touch the person being shocked.³¹ The key to these experiments is that someone else – an authority figure – accepted responsibility for the final outcome. Milgram postulated three categories of reasons for obeying or disobeying authority: first, a personal history of a family or school background that encourages obedience or defiance, that is, learned object relations; second, a feeling of comfort derived from obeying authority, which is known as “binding”; and third, the sense of discomfort people get when they disobey authority.³² All the test subjects believed that the experimenter was responsible for any consequences, and presumed the legitimacy of the experiment.

When considering the effect that group dynamics can have on individuals, it is important to note what draws certain persons towards certain groups. Authority-oriented persons have a preference for hierarchy and clearly demarcated power relationships – they enjoy obeying and giving orders.³³ Such persons value obedience highly, and if self-guidance is impossible will seek external guidance, joining groups such as the military to provide an opportunity for external orders and to fill inner emptiness. Interviews with the widows of SS officers reveal that several such men reported a “need to belong”.³⁴ Authority-seeking persons also avoid confrontation with authority figures (such as strict and abusive parents), instead seeking to attain closeness with them in order to feel secure. These individuals may be even more likely to respond to authority than the average people who acted as subjects in Milgram’s experiments.

Diffusion of responsibility

Ten years after Milgram’s landmark work, Philip Zimbardo simulated prison life among college students in the famous Prison Experiment at Stanford University, randomly assigning housemates to be either a guard or a prisoner. Within six days, the subjects had changed from university students who were friends and roommates to abusive controlling guards and servile prisoners.³⁵ Prisoners became passive, dependent and helpless. Guards expressed feelings of power and group belonging. They placed all the responsibility for their actions on the researchers and the group as a whole, rather than accepting blame for individual actions. The experiment became violent, and had to be ended early. Zimbardo, who had acted both as prison superintendent and as principal investigator,

31 Waller, above note 19.

32 Stanley Milgram, *Obedience to Authority: An Experimental View*, Harper Collins, New York, 1973.

33 Waller, above note 19.

34 Tom Segev, *Soldiers of Evil: The Commandants of Nazi Concentration Camps*, McGraw-Hill, New York, 1988.

35 Craig Haney, W. Curtis Banks and Philip G. Zimbardo, “Interpersonal dynamics in a simulated prison”, *International Journal of Criminology and Penology*, Vol. 1 (1973), pp. 69–97.

concluded that the experiment demonstrated the ways in which situational factors can cause inhumane behaviour, in this way corresponding with the Milgram experiments.

The manner in which the subjects of these experiments placed all responsibility on the shoulders of the principal investigators and/or the group parallels the manner in which the perpetrators of the Holocaust denied the possibility of being blamed when they had merely been following orders. Hitler often stated of his military conquests that he took the responsibility upon himself, and in doing so, provided the basis for his subordinates to exempt themselves psychologically from moral standards or judgement.³⁶ This diffusion of responsibility can occur in *any* situation of mass violence, whether hierarchically structured or not.

Theories of aggression

Some theories of aggression focus on individuals as perpetrators, and particularly on the idea that the desire to inflict violence on others is a condition and/or expression of primary sexual drive.³⁷ This idea focuses on sadists for whom inflicting violence is sexually exciting and whose aggression is in the service of Eros. Sadism is in all people, but in some it splits off from regulating factors and becomes a dominant urge – in these people there is a competitive wish for dominance over others. The satisfaction that comes from winning or from dominating another person becomes an uncontrollable urge in sadists. Similarly, sociopaths lack control over their urge to hurt others. As a result, sadists and sociopaths do not function effectively in the systematic infliction of violence through torture or genocide; they tend towards killing or hurting individuals. Sadism, as such, is not a sufficient explanation for the behaviour of perpetrators of torture and mass violence.

Group behaviour tends to rely on diminishing the conscious individual personality, focusing thoughts and feelings in a common direction and giving emotion and the unconscious dominance over reason and judgement. As a result, ordinary persons whose urges are more easily subsumed than those of sadists or sociopaths are more effective killers, especially in a hierarchically structured setting such as the military. Interviews with a particular group of perpetrators, the Nazi Party's elite *Schutzstaffel* or SS, showed that they were not psychopaths but ordinary men.³⁸ As Hannah Arendt suggested in her work on the Eichmann trial, the evil perpetrated by Eichmann and the SS was not a function of deeply rooted malevolence, but merely a lack of imaginative capacity and a result of not thinking

36 Fritz Redl, "The superego in uniform", in Nevitt Sanford and Craig Comstock (eds.), *Sanctions for Evil*, Jossey-Bass Inc, San Francisco, 1971.

37 Debra Kaminer and Dan J. Stein, "Sadistic Personality Disorder in perpetrators of human rights abuses: a South African case study", *Journal of Personality Disorders*, Vol. 15 (6) (2001), pp. 475–86.

38 Lifton, above note 16, p. 14.

39 Hannah Arendt, *Eichmann in Jerusalem: A Report on the Banality of Evil*, Penguin Books, New York, 1963.

out the impact of their actions.³⁹ Her idea of the “banality of evil”, though much criticized as downplaying the significance of traumatic acts of violence, captures the ease with which some evil acts are perpetrated. For example, it was not difficult to get doctors to kill 100,000 German mental patients. Given the sheer number of people required as active participants or at least complicit in that “euthanasia” programme, it is highly unlikely that all the doctors involved were deviants. Instead, the fragmentation and division of labour allowed each individual to excuse their participation by saying that they “only” did their particular assigned tasks.

The uniqueness of the group

Why do people participate in torture? Theories of obedience and diffusion of responsibility explain how individuals may be drawn into groups that perpetrate evil such as torture, but it is harder to understand how these groups initiate torture in the first place. One might assume that the purpose of torturers is to elicit information or an admission of guilt, to intimidate, to justify repression or revenge, real or perceived, to establish superiority or to elevate themselves, but that does not address the psychology of the group which creates and facilitates situations of torture. Groups such as the Nazis used oaths of loyalty to bind each individual, and used rituals to create a mystical atmosphere which drew members further in and separates them from the outside. When a group has a shared mystique and common values, the members develop camaraderie, a devotion to the organizational ideology and cause, and a sense that they are part of the elite. They take pride in performing difficult and important acts, and become completely subordinated to the organization. After a certain level of indoctrination, it becomes difficult to deviate from or defy the group. This binding prevents individual members from resisting participation in torture.

Usefulness of training

Beyond the binding to a group, individuals often receive special training to mould them into torturers (see Table 1). The indoctrination and training of a torturer often includes abuse; in the Nazi regime, for instance, members of the SS were carefully selected, beginning with individuals who were comfortable obeying authority, often because of a personal history (family or school background) that encouraged obedience. Starting with that foundation, groups are able to shape torturers through a series of steps. First, members are screened for intellect, physical ability and a powerful positive identification with the political regime.⁴⁰ This not only helps groups find individuals with the abilities they want, but also fosters an idea among members that inclusion is special and the group is elite, differentiating its members from others. New members are bound to the group

40 Mika Haritos-Fatouros, “The official torturer”, in Ronald D. Crelinsten and Alex P. Schmid (eds.), *The Politics of Pain: Torturers and Their Masters*, Westview Press, Boulder, Colo., 1994.

Table 1. *The formation of a torturer*

Select for personal history of obeying authority
Screen for intellect, physical strength and positive identification with politics
Bind with initiation rites, isolation, new rules, new values
Use elitist language
Dehumanize and blame
Harass, intimidate, desensitize, promote instinctive responses
Reward obedience
Employ social modelling of group violence
Make violence a regular, routine occurrence
Practise controlled violence

through basic training, a set of initiation rites which often include isolation from people outside the group, and the imposition of new rules and values. From this beginning, members develop an elitist attitude and an in-group language. They learn to dehumanize themselves as well as outsiders – to subsume their individual identities within that of the group. Leaders harass and intimidate recruits, preventing logical thinking and instilling instinctive responses.⁴¹ Rewards are given for obedience, and socialization of the group includes witnessing group violence, often in the form of the intimidation of recalcitrant members.⁴² As a result, members become desensitized to violence; both seeing and perpetrating violence become routine. All this training adds up to complete control of the group over its members.

Physician vulnerability

With this understanding of group psychology it is easy to see how members of the military are susceptible to becoming perpetrators. It may be less obvious why medical doctors are vulnerable (see Table 2). One must remind oneself that physicians are experts at compartmentalization, who deal with life and death every

Table 2. *Why physicians are vulnerable to becoming perpetrators*

Compartmentalization
Tendencies towards sadism, voyeurism
Healing through hurting, repressing awareness of violence
Use of science to objectify violence
Use of metaphors and euphemisms
Tendency to justify and rationalize
Impersonal medical detachment
Narcissistic sense of superiority

41 Lifton, above note 16.

42 Janice T. Gibson and Mika Haritos-Fatouros, “The Education of a Torturer,” *Psychology Today*, November 1986, pp. 50–8.

day and whose profession carries a sense of power. The motivation for choosing a career as a physician is often a fantasy of power, either sadistic or voyeuristic, as medicine gives licence to look, touch and control. Doctors treat patients as impersonal medical cases so that they can more easily process what they have to do – taking a scientific approach to remain detached in their work, they heal by attacking and killing disease with surgery or therapy or whatever tools they have available. Medical students also go through an initiation ordeal. In the anatomy class they handle a dehumanized cadaver or watch operations without knowing the patients, and are made to feel shame for any lapses in which they show too much “weakness” or inability to dehumanize patients.⁴³ Medicine as a profession contains the rudiments of evil, and some of the most humane of medical acts are only small steps away from real evil. For example, although surgery to amputate a gangrenous limb is a healing act, it involves the cutting and maiming of the human body, which in non-medical circumstances would be a harmful, criminal act.

During the Holocaust, Joseph Mengele was *the* paradigmatic Nazi doctor. In the concentration camps he often assumed a dual role with his child victims, acting like a parent by playing games and giving them sweets, before brutally killing them in his experiments on twins. He exhibited signs of obsessive-compulsive disorder, fixating on cleanliness and perfection in his experiments even when the patients he treated would shortly be consigned to their death.⁴⁴ In his twenty-one months at Auschwitz, Mengele performed elaborate research on twin children, probing, infecting, cutting and exposing them to painful procedures without any anaesthetic and ultimately murdering them. One of his assistants, Miklos Nyiszli, described the experiments:

In the workroom next to the dissecting room fourteen Gypsy twins were waiting and crying bitterly. Dr. Mengele didn't say a single word to us and prepared a 10 cc and 5 cc syringe. From a box he took Evipal and from another box he took chloroform, which was in 20 cc glass containers, and put these on the operating table. After the first twin was brought in ... a fourteen year old girl ... Dr. Mengele ordered me to undress the girl and put her head on the dissecting table. Then he injected the Evipal into her right arm intravenously. After the child had fallen asleep, he felt for the left ventricle of the heart and injected 10 cc of chloroform. After one little twitch the child was dead, whereupon Dr. Mengele had her taken into the corpse chamber. In this manner all fourteen twins were killed during the night.⁴⁵

One of the victims of Mengele's twin experiments offered a more personal account:

43 Heidi Lempp and Clive Seale, “The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching”, *British Medical Journal*, Vol. 329 (2004), pp. 770–3.

44 Olga Lengyel, *Five Chimneys*, Ziff Davis, Chicago, 1947.

45 Miklos Nyiszli, *Auschwitz: A Doctor's Eyewitness Account*, trans. Richard Seaver, Arcade Publishing, New York, 1993 (1960).

It wasn't because his face was terrifying. His face could look very pleasant. But the atmosphere in the barracks before he came and the preparation by the supervisors was creating that atmosphere of terror and horror that Mengele was coming. So everybody had to stand still. He would, for example, notice on one of the bunk beds that a twin was dead. He would yell and scream, "What happened? How is it possible that this twin died?" But of course, I understand it today. An experiment had been spoiled.⁴⁶

Mengele, although perhaps the most notorious, was not the only Nazi physician who could dissociate the deaths he caused and the deaths that merely occurred "by accident" in the camps. SS doctors would kill and then have a meal, flog and then dress for dinner, torture and then listen to the opera, and return to the camps. They used euphemisms to disavow the violence and dissociate their feelings; what they did was "medical camp duty"; they "evacuated", "transferred" and "resettled" Europe's Jewish population.⁴⁷ With this special language, killing was no longer killing; it was a routine bureaucratic action.

Some types of doctor may be more or less predisposed to dehumanize patients, viewing them purely as medical cases – surgeons, for example, whose main interaction with their patients is violent and occurs while the patient is unconscious. But performing a healing function, psychic numbing, diffusion of responsibility, de-realization, and compartmentalization, which occur within many different sectors of the medical profession, all lead to decreased feeling. Thus doctors anywhere, regardless of their speciality, have the potential to become perpetrators, and in Nazi Germany and other countries, many do.

The cultural and social contexts conducive to perpetrators

The Nazi Party ideology was portrayed in a medicalized way which attracted doctors. Writing in *Mein Kampf* on the German State, Hitler said, "anyone who wants to cure this era, which is inwardly sick and rotten, must first of all summon up the courage to make clear the cause of this disease".⁴⁸ In this "scientific" metaphor, the ultimate victims of the Nazi government were a threat – they posed a danger of contagion which could "infect" the German body politic, and without "purification" would pollute race and class. In this imagery, doctors were placed in the role of shaman, treating not individuals but rather the group, becoming "physicians to the volk [people]".⁴⁹ The white-coated doctor became the black-robed priest, a professional capable of leading the biological soldiers on a mission of medical purification, eradicating the impaired and incurable.

46 Eva M. Kor and Mary Wright, *Echoes from Auschwitz: Dr. Mengele's Twins – The Story of Eva and Miriam Mozes*, CANDLES Press, Terra Haute, Ind., 1995.

47 Waller, above note 19.

48 Adolf Hitler, *Mein Kampf*, Houghton Mifflin: Boston, 1943 (1925–6), p. 435.

49 Weyers, above note 18.

50 Hans-Georg Güse and Norbert Schmacke, "Psychiatry and the origins of Nazism," *International Journal of Health Services*, Vol. 10 (2) (1980), pp. 177–96.

Their mission began with the elimination of disabled persons. Psychiatrists and psychoanalysts played a major role in the killing of as many as 100,000 mentally and physically disabled persons between 1939 and 1941 in a project named Action T4, short for Tiergartenstrasse 4, which was the address of the Foundation for Welfare and Institutional Care.⁵⁰ Nazi politicians and doctors used the term “euthanasia” to describe the killings.⁵¹ However, these killings were not euthanasia in the usual definition of a “mercy killing”, to relieve extreme suffering of a patient. The individuals murdered were usually not suffering and certainly did not ask to be killed. They were killed merely to relieve the state of the burden of their care. Advertisements across Germany proclaimed the cost to the taxpayer of supporting disabled persons to be immense. This programme was carried out in wartime, when the public could more easily accept murderous action for the benefit of the state, but it was foreshadowed by the sterilization programme begun in 1933.

In July 1933 the Nazi government passed the Law for the Prevention of Hereditarily Diseased Offspring, requiring that physicians report every case of hereditary disease they came across, except in women over the age of 45.⁵² Genetic Health Courts were created to decide who ought to be sterilized, and by the end of the Nazi regime had ordered the forced sterilization of over 400,000 people.⁵³ The sterilization programme targeted mental disorders such as schizophrenia, manic depressive disorder and alcoholism, along with inheritable physical diseases.

This medicalized and political “solution” to mental disorders and disability may have played a role in drawing psychiatrists and psychoanalysts into the regime. The Third Reich is often portrayed as decrying psychoanalysis; the Nazi Party ceremoniously burned the works of Freud along with those of Marx and other “Jewish” thinkers who were seen as threatening the National Socialist state.⁵⁴ Despite this, some analysts remained in Germany to become a part of the Göring Institute. Those who stayed changed their ideas to mesh with the ideology of the ruling party, ultimately playing a large role in getting rid of “untreatable patients”. Science was bent to the service of the Nazi Party, and the new guiding spirit of Nazified psychoanalysis was employed to develop mental health treatments that aligned with the Third Reich’s racist ideology.⁵⁵

Many different social contexts combine to create a situation in which any person may become a torturer. Under the Nazi regime, the integration of medical–scientific and political ideologies, as well as economic pressures and social concerns about “race”, made it easier for certain individuals to dehumanize their

51 Michael Burleigh, *Ethics and Extermination: Reflections on Nazi Genocide*, Cambridge University Press, Cambridge, 1997.

52 Proctor, above note 20.

53 Johannes Meyer-Lindenberg, “The Holocaust and German psychiatry,” *British Journal of Psychiatry*, Vol. 159 (1991), pp. 7–12.

54 Rose Spiegel, Gerard Chrzanowski and Arthur H. Feiner, “On Psychoanalysis in the Third Reich,” *Contemporary Psychoanalysis*, Vol. 11 (4) (1975), pp. 477–510.

55 Geoffrey Cocks, *Psychotherapy in the Third Reich: The Göring Institute*, 2nd edn, Transaction Publishers, New Brunswick, Conn., 1997.

fellow citizens. The fervent nationalism and overwhelming support for the Third Reich made it difficult for people to lodge rational protests against the extermination of other human beings. In any situation in which human beings are divided into groups – the genetically pure versus the weak, the citizens versus the foreigners, the wealthy versus the poor – the oppression of and discrimination against the non-favoured group are facilitated.

Medicine betrayed: an international problem

The atrocities perpetrated by the Nazis more than half a century ago may be the most prominent human rights abuses in the global consciousness; nonetheless torture and other inhumane acts are still widely carried out today. Torture is practised in over 150 countries, and has even been seen as a necessary evil in the global “war on terror”.⁵⁶ In many countries there is documented evidence of physician involvement, and torture can be particularly destructive when healers are involved. One victim of torture in Argentina, Jacobo Timmerman, reported his experience with physician-perpetrators:

[H]e took my arm and very smoothly said “you know Jacobo that we doctors have many secrets ... you see here ... this blue is one of your arteries and I can inject here. You know that we have some substances that make you talk but always so painful because it affects your brain ... so why can’t you just talk and we can be friends.” His presence was a symbol that a scientific instrument is with you when you are torturers.⁵⁷

All forms of torture undermine the victim’s sense of security and self-worth, but physician involvement shatters the victim’s trust more completely. Physicians may be involved before, during or after torture, and may perform many separate roles: supervising, observing, assisting, falsifying medical records and sometimes treating a patient so that the torture can continue.

Those who attempt to point out the many factors contributing to this abuse are sometimes criticized as excusing the perpetrators. But the situationist perspective does not absolve perpetrators from responsibility; rather, it holds more people accountable for acts, including both participants and complicit facilitators. An awareness that there are many different causes for these atrocious situations merely helps to make people recognize attitudes and contexts that may be contributing to dehumanizing and torture-facilitating situations, and can help to prevent such abuses from being repeated. Suggesting that those who torture are just a few deviants would allow us to shut our eyes to the fact that such things can, and will, happen again unless we act to stop them.

56 Amnesty International, *Annual Report 2006: The State of the World’s Human Rights*, available at <http://web.amnesty.org/report2006/index-eng>; and Physicians for Human Rights, *Break Them Down: Systematic Use of Psychological Torture by U.S. Forces*, Physicians for Human Rights, Cambridge, Mass., 2005.

57 Jacobo Timmerman, *Prisoner without a Name, Cell without a Number*, Penguin Books, Harmondsworth, 1982.

Table 3. *Elements in the formation of perpetrators***Individual psychology***Predispositional trait*

Obedience to authority

Developed traits

Dehumanization

Splitting

Numbing

Omnipotence

Group psychology

Diffusion of responsibility

Theories of aggression

Usefulness of training

Uniqueness of group

Social context

Three elements are necessary to make a torturer (see table above). First, the torturer must possess certain dispositional personality traits; second, situational factors must be conducive to the perpetration of torture; and third, military training and group identifications may promote perpetration. Torturers come from the ranks of ordinary men and women. Although perpetrators have often had a strict upbringing and are deferential to authority, there is no one single personal factor which will cause a person to become a perpetrator of torture. The decision to obey authority figures is enhanced by binding factors – taking oaths, swearing allegiance, developing group adherence and the creation of special language and rituals. When individuals are slowly pushed over the line of decency and where violence comes to be seen as a normal occurrence, anyone can become a torturer.

This is not to say that torturing is ever an easy undertaking or that becoming a perpetrator has no consequences. Torturers show evidence of strain on the job and often use alcohol to cope in addition to psychological coping mechanisms which include moral disengagement through mental restructuring and justifications, dehumanizing and blaming the victims, using euphemistic language and splitting. All these mechanisms are assisted by specialized military training, which involves screening recruits for intellect and then playing on their political beliefs and encouraging obedience. This training allows diffusion of responsibility to the group and reinforces the individual rationalizations that are used by each soldier to cope with his or her acts.

The prevalence of torture around the world has raised awareness of the need for prevention efforts, although more research is needed on how to prevent torture. There are several important levels of prevention (see Table 4). Primary prevention includes educating physicians, the military and the public about human rights, ethics and the potential for violence, so that they will recognize and resist it. Secondary prevention involves the establishment of enforceable and enforced legal codes of human rights and minimum rules for the humane

Table 4. *The prevention of torture*

Primary:	educate physicians, military and public to recognize potential for violence and familiarize them with human rights.
Secondary:	stop physicians from becoming involved, monitor high-risk situations, protect whistle-blowers, recognize that persons with mixed/dual loyalty are at high risk.
Tertiary:	hold perpetrators accountable and have mechanisms in place to punish them.

treatment of prisoners. By monitoring high-risk situations, identifying doctors or soldiers who could be involved and protecting whistle-blowers, secondary prevention can work to minimize the spread of torture. Finally, tertiary prevention consists of taking action against perpetrators, holding them accountable and having established legal mechanisms available for doing so, in order to deter further acts of torture.

A number of actions short of criminal prosecution can be taken against lawyers and physicians complicit in torture. In 1993, together with our colleague Leonard Glantz, we proposed the establishment of an International Medical Tribunal that could hear cases and publicly condemn the actions of individual physicians who violate international standards of medical ethics.⁵⁸ Even though such a tribunal would not be able to punish with criminal sanctions, its decisions could result in the professional isolation of such physicians and be a powerful deterrent to grossly unethical conduct.⁵⁹ Unlike a criminal tribunal, in which charges would have to be proved beyond reasonable doubt and additional defences, including good-faith interpretation of medical ethics, would be available, these due process elements would not be present before the proposed professional tribunal. This is not only because criminal penalties could not be imposed, but primarily because the goal is deterrence and the protection of the public, not punishment. In this arena, proof of complicity by a preponderance of the evidence would be sufficient, and no defence of good faith would be available – because the believers in torture threaten to harm the public (and the precepts of medical ethics) as much as ignorant or incompetent lawyers and physicians do. One measure of this harm is the decline in our country's reputation in the world. Another is our military's ethical standards: a 2006 survey of battlefield ethics conducted among US military personnel in Iraq, for example, found that only 47 per cent of US army soldiers and only 38 per cent of Marines agreed that non-combatants should be treated with dignity and respect; and more than one-third

58 Michael A. Grodin, George J. Annas and Leonard H. Glantz, "Medicine and human rights: a proposal for international action", *Hastings Center Report*, Vol. 23 (8) (1993), p. 11. See also George J. Annas and Michael A. Grodin (Jonathon M. Mann et al., eds.), "Medicine and human rights: reflections on the fiftieth anniversary of the Doctors' Trial", in *Health and Human Rights*, Vol. 301 (1999); Luis Justo, "Doctors, interrogation, and torture", *British Medical Journal*, Vol. 322 (2006), pp. 1462, 1464.

59 Critics have argued that our proposal is unnecessary and perhaps counterproductive in the presence of the new International Criminal Court. See, e.g., Benjamin Mason Meier, "International criminal prosecution of physicians: a critique of Professors Annas and Grodin's proposed international medical tribunal", *American Journal of Law & Medicine*, Vol. 30 (2004), pp. 419, 421.

of both soldiers and Marines believed that torture should be allowed to save the life of a fellow soldier (more than 40 per cent) or to obtain other important information about insurgents (slightly less than 40 per cent).⁶⁰

In the absence of such an international forum, the other primary avenue available is the licensing board responsible for granting the medical or legal licence. In the case of physicians, an action seeking the revocation of a physician's licence could be brought before the medical board. Licence revocation is an action taken not to punish a physician, but to protect the public. It is not a criminal proceeding, and thus the due process rules of a criminal proceeding do not apply. However, on the few occasions when an attempt has hitherto been made to that effect, it has not been successful, mainly because the board has seen the action as primarily political rather than ethical.⁶¹ The California medical licensing board has, for instance, refused to hear the case brought against one of the military physicians responsible for treatment of prisoners at Guantánamo because it believes the case should be heard, if at all, by the military itself.⁶² We think that the California licensing board is simply wrong about this. Physicians cannot practise in the military unless they are licensed by the state licensing board. Retention of that licence requires conformity with the precepts of medical ethics; when these are violated, even – or perhaps especially – in compliance with the wishes of the state, revocation or suspension of the medical licence is completely appropriate.⁶³

We are all the potential victims of physicians who have become human rights outlaws. But the individuals who have suffered torture or cruel and inhuman treatment facilitated by them or actually ordered or conducted by them deserve more than simply having those outlaws brought to justice. They deserve not only a public acknowledgment of the unlawful and unethical abuse inflicted on them, but also just compensation for their injuries.⁶⁴

Preventing torture and cruel and inhuman treatment is everyone's business, but three professions seem especially well-suited to prevent torture: physicians, lawyers and military officers. Each one of them also has special obligations. Physicians have special obligations because of their universally

60 Mental Health Advisory Team IV, Office of the Surgeon, Multinational Force-Iraq Office of the Surgeon General, US Army Medical Command, Operation Iraqi Freedom 05–07, Final Report 35 (2006), available at http://www.armymedicine.army.mil/news/mhat/mhat_iv/MHAT_IV_Report_17NOV06.pdf.

61 See, e.g., *Thorburn v. Department of Corrections*, 78 Cal. Rptr. 2d 584, 590–1 (Cal. Ct. App. 1998). See generally Joan M. LeGraw and Michael A. Grodin, "Health professionals and lethal injection execution in the United States", *Human Rights Quarterly*, Vol. 24 (2002), p. 382 (asserting that physicians' participation in lethal injections violates medical ethics).

62 The complaint against John S. Edmondson was filed with the California Medical Board on 6 July 2005, and alleged a variety of medical ethics violations in the treatment of prisoners. See Janice Hopkins Tanne, "Lawyers will appeal ruling that cleared Guantánamo doctor of ethics violations", available at <http://www.bmj.com/cgi/content/full/331/7510.180-b> (last visited 23 July 2005).

63 This is of course true of lawyers as well, and complaints of complicity or aiding and abetting in the commission of war crimes serve equally as justification for revoking attorneys' licences. See George J. Annas, "Human rights outlaws: Nuremberg, Geneva, and the global war on terror", *Boston University Law Review*, Vol. 87 (2007), pp. 427–66.

64 So far, efforts to obtain compensation have been unsuccessful. See, e.g., *In re Iraq & Afghanistan Detainees Litigation*, 479 F. Supp. 2d 85 (DDC 2007).

recognized and respected role as healers. Lawyers have special obligations to respect and uphold the law, including international humanitarian law. And military officers have special obligations to follow the international laws of war, including the Geneva Conventions. Any violation of international human rights law, and especially a serious violation of the Geneva Conventions or aiding and abetting such violation, should be sufficient grounds for a licensing authority to question the person's fitness to be a physician or lawyer, and those found to be human rights outlaws should lose the privilege of practising their professions. The re-emergence of physician complicity in torture presents an opportunity for the medical and legal professional organizations to work together transnationally to uphold both medical ethics and human rights.⁶⁵

65 Two non-governmental organizations dedicated to doing this are Physicians for Human Rights and Global Lawyers and Physicians. See, e.g., Physicians for Human Rights, *Leave No Marks: Enhanced Interrogation Techniques and the Risk of Criminality*, Physicians for Human Rights, Cambridge, Mass., 2007.