

Review article

# Psychiatry and political–institutional abuse from the historical perspective: The ethical lessons of the Nuremberg Trial on their 60th anniversary

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## Abstract

Sixty years ago at the Nuremberg Trials, 23 Nazi leaders were tried as war criminals, in what was known as “The Doctors’ Trial”. This trial exposed a perverse system of the criminal use of medicine in the fields of public health and human research. These practices, in which racial hygiene constituted one of the fundamental principles and euthanasia programmes were the most obvious consequence, violated the majority of known bioethical principles. Psychiatry played a central role in these programmes, and the mentally ill were the principal victims. The aim of the present work is to review, from the historical perspective, the antecedents of the shameful euthanasia programmes for the mentally ill, the procedures involved in their implementation and the use of mentally ill people as research material. The Nuremberg Code, a direct consequence of the Doctors’ Trial, is considered to be the first international code of ethics for research with human beings, and represented an attempt to prevent any repeat of the tragedy that occurred under Nazism. Nevertheless, the last 60 years have seen continued government-endorsed psychiatric abuse and illegitimate use of psychoactive drugs in countries such as the Soviet Union or China, and even in some with a long democratic tradition, such as the United States. Even today, the improper use of psychiatry on behalf of governments is seen to be occurring in numerous parts of the globe: religious repression in China, enforced hospitalization in Russia, administration of psychoactive drugs in immigrant detention centres in Australia, and the application of the death penalty by lethal injection and psychiatric participation in coercive interrogation at military prisons, in relation to the USA. The Declaration of Madrid in 1996 constituted the most recent attempt to eradicate, from the ethical point of view, these horrendous practices. Various strategies can be used to combat such abuses, though it is uncertain how effective they are in preventing them.

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**Keywords:** Eugenics; History of psychiatry; Medical ethics; Nazism; Psychiatric abuse; Psychiatric research

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**Abbreviations:** AMA, American Medical Association; CIA, Central Intelligence Agency; HRW, Human Rights Watch; IMTFE, International Military Tribunal for the Far East; LSD, lysergic acid diethylamide; WMA, World Medical Association; WPA, World Psychiatric Association.

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## 1. Introduction

After World War II, between 1945 and 1949, the former leaders of the Nazi regime were charged and tried as war criminals by an International Military Tribunal at the famous Nuremberg Trials. Exactly 60 years ago, in December 1946, proceedings began in the trial of 23 doctors or collaborators implicated in the crimes of this totalitarian regime (The Doctors' Trial). This trial exposed a perverse racist ideology which sanctioned and institutionalized criminal behaviour in relation to public health and human research. Among those dragged into this vortex were a considerable number of medical professionals, and in particular psychiatrists, whose transgressions included the use of psychotropic drugs.

A direct consequence of this trial was the drafting, in 1947, of the Nuremberg Code, considered to be the first international code of ethics for research with human beings, and aimed at preventing any kind of repeat of the atrocities committed in Nazi Germany. The Nuremberg Code was drawn up to safeguard the rights of patients and of those involved in human research, and although it has not been formally adopted as a legal norm by any nation or medical organization, it has had a profound influence on human rights and bioethics. It has formed the basis of subsequent norms and codes both in the field of biomedicine in general (Declaration of Helsinki, 1964), and that of psychiatry and psychopharmacology in particular (Declaration of Hawaii, 1977).

Although these direct consequences of the Nuremberg Trial have led to considerable progress in the area of human rights, in the last 60 years numerous cases of the illegitimate use of psychoactive drugs and the institutional abuse of psychiatry have come to light (though never on the scale of the events in Germany during the Third Reich). These have occurred in totalitarian regimes and states with long histories of democracy. The present work considers the historical development of the political abuse of psychiatry and of unethical institutional research with mentally ill people, principally through the Nazi tragedy, but also through a brief, non-comprehensive account of some more recent abuses.

## 2. Historical landmarks in the development of ethical principles in medicine

The concept of ethics (*ethikos*, “theory of living”) is associated today with diverse aspects of human life, within the more general sphere of moral philosophy. Thus, it can be

defined as “the study of conduct with respect to whether an action is right or wrong, and to the goodness and badness of the motives and ends of the action” (Bloch et al., 1999; p. 2). Within the field of medicine, a first mention of ethics appears in the Code of Hammurabi (2050 B.C.), which makes provision for punishing doctors who cause harm to their patients in the exercise of their therapeutic activity (Wecht, 2005). In Ancient Greece, an absence of regulation for the practice of medicine, together with a certain popular mistrust of doctors, led to the drafting of a series of behavioural rules that later formed the basis of what became known as the Hippocratic Oath, considered to be the paradigm of professional ethics and moral responsibility (Lain Entralgo, 1970). The Hippocratic Oath was possibly drawn up by disciples of Hippocrates around 400 B.C., and in its second half deals with ethical problems. In keeping with its maxim that “I will keep the sick from harm and injustice”, it imposes respect for confidentiality, the prohibition of sexual abuse of patients and the acceptance to do no medical act that exceeds one's knowledge or experience. It makes reference to the responsible use of medicines and to the ethical and professional duties of those who administer them (Edelstein, 1967; Musto, 1999).

Although the Hippocratic Oath is enormously significant historically, other medical codes have also been significant. These include the *Charaka Samhita* of Hindu Ayurvedic medicine, written between 1000 and 2000 B.C., the *Ecclesiastic* (from the Latin *eclesiastes*, “prophet”), a sacred book written in Alexandria around 190 B.C., the *Book of Asaf Harofé* (6th century) from the Hebrew culture, and three texts by Eastern doctors, the Persian Ali ibn al'Abbas (10th century), the Chinaman Chen Shih-Kung (1617), and another Persian, Mohammed Hosin Aghili (1770) (Bloch and Pargiter, 1999; Herranz, 2003).

The most notable contribution to the codification of ethics in medicine was made by the English doctor Thomas Percival. His Code, published in 1803 (*Code of institutes and precepts adapted to the professional conduct of physicians and surgeons*), is a veritable manual of medical ethics and manners, based on the independence and moral authority of doctors and on care of and respect for the patient (Belkin, 1998). In relation to psychiatric care, Percival writes: “... a physician, who attends an asylum for insanity, is under an obligation of honor as well as of humanity to secure to the unhappy sufferers, committed to his charge, all the tenderness and indulgence compatible with steady and effectual government. And the strait waistcoat, with

other improvements in modern practice, now preclude the necessity of coercion by corporal punishment” (Percival, 1803; p. 126). However, full protection for the patients is still a long way off, since Percival justifies “beating of a lunatic, in such a manner as the circumstances may require” (Percival, 1803; p. 126). This document formed the basis of the ethical code adopted in 1847 by the American Medical Association (AMA) (AMA, 1847). Two years later, in 1849, Worthington Hooker, a Connecticut doctor, published an article entitled *Physician and patient: or, a practical view of the mutual duties, relations and interests of the medical profession and the community*, considered by some authors as the first specific work of medical ethics. In relation to psychiatric care, Hooker recommended not intentionally deceiving madmen, beginning treatment as early as possible, and that the costs be borne by the Authorities (Bloch and Pargiter, 1999; Musto, 1999). Likewise, the first attempts at regulating experimentation with human beings date from the late 19th century, when New Hampshire senator Jacob H. Gallinger drew up some documents and rules for this field (Arboleda-Flórez, 2005), though their political relevance was practically nil.

During the 19th century, the psychiatrist was acquiring more and more social power, being able to exert as instrument of people management with a supposed mental disorder towards certain institutions. In this sense, it is interesting to remember the approach of Gracia (2004) on the historical process of physician possibilitation as an especially important power agent. With this flourishing of scientific culture came the first published works on research and experimentation with psychiatric patients, at the time largely excluded from the ethical requirements observed today, even though certain ethical controversies arose. For example, a doctor from Ohio, Robert Bartholow, studied the effects on the surface of the brain of electrical stimulation through cranial ulceration, in a woman who died a few days later. The results, published in a prestigious American journal in 1874 (Bartholow, 1874), opened up a debate in other media. An editorial published in the *British Medical Journal* criticized hardly this investigation (BMJ Editorial, 1874). These controversies continued throughout the first half of the 20th century.

However, it was mostly not until after World War II, following the trials over medical atrocities committed under the Nazi regime, that the first codes dealing specifically with ethics appeared, initially in the field of general medicine (Nuremberg Code, 1947; Declaration of Geneva, 1948; International Code of Medical Ethics, 1949; Declaration of Helsinki, 1964), and subsequently in that of psychiatry (Declaration of Hawaii, 1977; Declaration of Madrid, 1996).

### 3. Psychiatry during the German National Socialist regime

German medicine and psychiatry had enjoyed an excellent international reputation before the National Socialists came to power in 1933, the year some authors refer to as “the year German psychiatry went bankrupt” (Peters, 2004). Even in one of the fields we are concerned with here, that of biomedical research, there was great interest on the part of the medical

community in ethical issues. In the so-called “Neisser scandal” of 1900, prostitutes were used for research on a vaccine against syphilis, without being informed or giving consent (Vollman and Winau, 1996). In the wake of this, the government of the Prussian Reich introduced a series of ethical regulations on human experimentation with new therapeutic tools. Later, in 1931, the Ministry of Health published its *Guidelines for New Therapies and Experimentation in Humans*, which referred to the principles of beneficence, non-maleficence, autonomy of the patient, and the legal doctrine of informed consent, prohibiting experimentation on the dying and with the economically or socially destitute (Vollman and Winau, 1996). These norms were indeed even stricter than those subsequently enshrined in the Nuremberg Code or the Declaration of Helsinki (Birley, 2000).

#### 3.1. The first controversies in psychiatric ethics: the rise of eugenicist theories

The first third of the 20th century saw a sharp increase in popularity of theories based on eugenics, whose espousal would eventually lead to the tragedy of the Holocaust. Prestigious scientist, taking inspiration from popular Darwinist perspectives regarding natural selection among species and “survival of the fittest”, widely propounded such ideas after 1900, even from beyond the frontiers of Germany (Fig. 1A). Ernst Rüdin, Professor of Psychiatry at the universities of Basel and (later) of Munich, and Director of the Department of Genealogy and Demography at the Kaiser-Wilhelm Institute in Munich (Fig. 1B), claimed to have demonstrated the hereditary nature of schizophrenia (*dementia praecox*) (Rüdin, 1916). This would mean that mental disorders were refractory to any type of therapeutic intervention. The solution proposed by Rüdin and other geneticists was “the cleansing of the genes of the race”, that is, the elimination of the “rotten matter of the social body”. Another reputable psychiatrist, Alfred Hoche, Professor at the University of Freiburg, in a book published in 1920 and co-written with the lawyer Karl Binding (*Die Freigabe der Vernichtung Lebensunwerten Lebens — Permitting the Destruction of Unworthy Life*), defended the active euthanasia of some mental patients. Binding and Hoche declared that doctors should sometimes commit themselves to the idea of taking the life of certain mentally ill patients, who are “empty human shells”, in the interest of achieving a much better community.

It was on these pseudoscientific bases that the Nazi government would later introduce a policy of “racial hygiene” in Germany, with extremely harmful political, social and scientific consequences (Alexander, 1949; Proctor, 1988; Muller-Hill, 1991; Aly et al., 1994; Kevles, 1995; Biéder, 1996; Palma-Aguirre et al., 2003). The aim of this political and social movement was to enhance the reproductive rate of the so-called “Aryan race”. It drew its inspiration not only from the Darwinist concepts referred to above, but also from a cocktail of the philosophical ideas of Friedrich Nietzsche, the modified positivist theories, and a deep-rooted anti-Semitism. An important publication in the context of this movement was *Menschliche Erblchkeitslehre und Rassenhygiene (Principles*



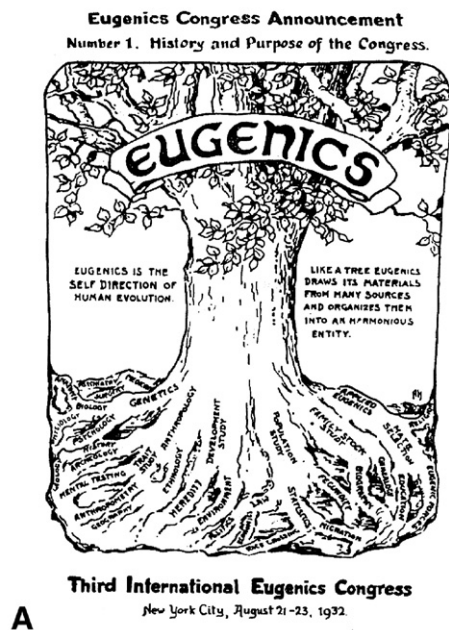


Fig. 1. Eugenic science enjoyed great prestige during the first third of the 20th century, being supported by reputable physicians and geneticists: A: Announcement of the Third International Congress of Eugenics, held in New York, August 21–23, 1932, with the motto “Eugenics is the self direction of human evolution”, and chaired by Ernst Rüdin. B: Ernst Rüdin (1874–1952), Professor of Psychiatry and Director of the Department of Genealogy and Demography at the Kaiser-Wilhelm Institute in Munich, photographed around 1936.

of *Human Heredity and Racial Hygiene*), by three of the most eminent German geneticists of the era: Professor Eugen Fischer, Director of the prestigious Kaiser-Wilhelm Institute of Human Genetics and Anthropology, Fritz Lenz, Professor of Anthropology at Munich University, and the geneticist and botanist Erwin Baur. The book became a cult work and a significant reference, with five editions between 1921 and 1940.

Therefore prominent members of the medical community promoted ‘racial science’ and eugenics. In conjunction with racist political ideology, this opened Pandora’s box during the Nazi period (Proctor, 1988). Sterilization of mentally ill people was the springboard for generalized extermination (Peters, 2004; Seeman, 2005). Medicine thus was central to the eugenics and race hygiene movement, and anti-Semitism was medicalized.

### 3.2. The German Sterilization Act: the prelude to tragedy

On January 30, 1933, Adolf Hitler became Chancellor of Germany and began to implement, in accordance with the election promises that brought him to power, racist policies in defence of a “superior race” (Wertham, 1966; Bachrach, 2004). The Nazi government was soon enacting a series of laws referring to racial segregation and protection of the race, drawn up with the collaboration of certain sectors of the German medical community. Among the first of these laws was the *Gesetz zur Verhütung erbkranken Nachwuchses*, or Law for the Prevention of Genetically Defective Progeny (better known as the *Sterilization Act*), passed on 14th July, 1933 (Fig. 2A). This law permitted, on the approval of a tribunal made up of two doctors and a judge, the enforced sterilization of subjects with any of the following

diagnoses: congenital feeble-mindedness, schizophrenia, “circular madness” (manic-depressive psychosis), hereditary epilepsy, hereditary St Vitus’ dance (Huntington’s chorea), congenital blindness and deafness, pronounced bodily malformations of a hereditary nature, or severe chronic alcoholism (Pichot, 1983; Hanauske-Abel, 1996; Bachrach, 2004; Seeman, 2005). The law was applied together with the *Gesetz Gegen Gefährliche Gewohnheits Verbrecher*, or *Act against Dangerous Criminals*, which had the same goal and was applied by means of the same methods (Meusch, 2001; Dudley and Gale, 2002).

The eventual aim of these laws was to eliminate a complete generation of subjects with genetic deficiencies, so as to “purify” the gene pool and improve the “Germanic race”. In order to popularize these programmes, the government mounted wide-ranging propaganda campaigns, which included posters (Fig. 2B), documentaries, radio advertisements, textbooks and popular educational programmes aimed at winning over different professional groups (Bachrach, 2004). The Nazi propaganda machine was tremendously effective as a tool for the perversion of conscience and public opinion (Alexander, 1949).

One of the prime movers of the *Sterilization Act* was the Commissioner of the German Society for Mental and Racial Hygiene, Ernst Rüdin. Under the auspices of the Interior Ministry, he organized a series of courses and seminars for psychiatrists, aimed at preparing them for and involving them in the application of the new Reich laws for the “treatment” of hereditary diseases and “racial hygiene”. The justification of the ideas behind these courses was as follows (Cocks, 1994; Birley, 2000): The elimination of defective genes is not in itself sufficient for conserving the health and energy of our nation; for this,



Fig. 2. The concept of racial hygiene became accepted in the early years of the Nazi regime: A: Publication of the law on enforced sterilization in the Official Bulletin of the Reich, 14th July, 1933. B: The propaganda of the National Socialist regime was extremely active, as reflected in this poster published in 1936, showing some of “the burdens borne by German society”, in relation to the mentally ill and disabled. The legend of the poster is explicit: “this burden is borne by you. A patient has cost an average of 50,000 marks by the age of 60”.

elimination of the conglomerate of the common gene must be complemented with positive measures. Some sections of the German medical fraternity readily accepted this law, which placed immense power in the hands of specialists in psychiatry, since it was they who would give diagnoses on whether patients, for example, suffered from schizophrenia, and should thus be sterilized, or whether they were free from mental disorder. Enforced sterilization was carried out in clinics for mental or disabled patients, generally by means of surgical procedures, though where this was not possible they were exposed to radium or X-rays. The sterilizations began in 1934, and effectively ended with the outbreak of World War II, with a final total of 350,000 persons sterilized (0.5% of the total population) and an incidence of deaths during the surgical procedures of 1–5% (Singer, 1998).

The psychiatrists and geneticists responsible for drafting these laws, among them Rüdin and Fischer, were aware that their application would lead to the enforced sterilization of some persons without hereditary diseases. They must also have known that a recessive hereditary disease could only be eliminated if sterilization were practised over centuries. Hitler himself wrote that it would be necessary to comply with the law for 600 years to obtain a significant result. Amid a certain general enthusiasm during the early years of the Third Reich, the psychiatrists involved in the application of these laws, and those who passively accepted them, argued that they were conceived for the benefit of the nation and the health of subsequent generations, and not for the individual patient (Kaupen-Haas, 1988; Biéder, 1996). Concepts such as those of *cause majeure* or “holy mission” were invoked (Lifton, 1986; Dudley and Gale, 2002). Thus, prestigious German doctors found themselves sucked into the whirlpool of Nazism, among them, for example, the famous neuropathologist Julius

Hallervorden or the Professors of Psychiatry at Heidelberg, Carl Schneider, and at Tübingen, Hermann Hoffmann (Helmchen, 1998). Few psychiatrists could dissociate themselves totally from this grotesque machinery.

However, it would be unfair to generalize, implicating all German physicians of the period in these practices, or attributing this type of activity exclusively to the German medical community. Eugenicist theories enjoyed a measure of general prestige in the first half of the 20th century, with eugenicist institutions and associations proliferating all over Europe, organizing many conferences and scientific meetings. In the name of the eugenics concept, sterilization programmes were introduced in many Western countries, among them the United States (Proctor, 1988). By way of example, the State of Indiana approved in 1907 a law restricting immigration and sanctioning the sterilization of “social misfits”, in the context of rising black immigration and an increase in poverty in the fast-growing cities. Other states soon began introducing similar sterilization laws (12 states in 1913), including Virginia, where it remained in force until 1972 and permitted 7500 interventions, on the basis of alleged “feeble-mindedness”, antisocial behaviour or “imbecility”, in accordance with scores on IQ tests (Kevles, 1995). Between 1907 and the mid-1970s, over 70,000 persons were sterilized in the United States (Baron, 1997). In European countries such as Denmark, Finland and Sweden, the 1930s and 1940s also saw the enactment of sterilization laws on the US model.

### 3.3. The Nuremberg Laws and the Euthanasia Programme of the Nazi regime: the road to the Holocaust

After the passing of the *Sterilization Act*, the Nazis enacted, during 1934 and 1935, a series of laws called generically the



Nuremberg Laws (not to be confused with the Nuremberg Code, published in 1946). These referred to “the purification of the blood of the German people”, through the prohibition, for example, of sexual and marital relations between Jews and “Aryans”, and the subjection of couples to premarital medical examinations, in order to prevent the propagation of “racially damaging diseases” (Proctor, 1988; Weindling, 1989).

The involvement of members of the medical profession in the implementation of these laws was essential. Some authors, indeed, postulate that the Nuremberg Laws served to position the general medical community firmly as the instrument of racist policies of the Nazi government. In fact, after the introduction of these laws, the incomes of German doctors increased considerably — increases that may have favoured a certain relaxation of the ethical principles inherent in medical practice (Hanauske-Abel, 1996). It is significant that at a certain point in the Third Reich, up to 45% of German doctors were members of the Nazi party (Seeman, 2005), among them a significant number of psychiatrists (Dudley and Gale, 2002).

With the Nuremberg Laws in place and war imminent (a war which would necessitate the freeing-up of thousands of hospital beds for wounded soldiers), Hitler signed, on 1st September 1939, a Decree (Fig. 3A) which was applied with effect from that same day, the official date of the outbreak of World War II. This document, drawn up by ten advisors, including Leonardo Conti, Secretary for Health at the Ministry of the Interior, and Hans Heinrich Lammers, Director of the Reich Chancellery (Singer, 1998), specified that “incurable patients, after a critical assessment of the state of their illness, were permitted a euthanasic death” (Peters, 2004). It should be borne in mind, in this regard, that the mentally ill were considered, even in scientific texts of the period, as inferior beings (*minderwertig*), even being referred to in some medical circles as “empty human shells” (*Leere Menschenhüllen*) or “lives that are not worth living” (*Lebensunwertes Leben*) (Fig. 3B) (Lifton, 1986; Friedlander, 1995).

This Decree constituted the basis of the Euthanasia Programme (*Gnaden Tod*, “mercy death”), popularly known as Operation T4 or Action T4, due to the location of its administrative office at number 4 Tiergartenstrasse in Berlin (Fig. 4A) (Aly et al., 1994; Meusch, 2001; ARCFI, 2004; Seeman, 2005), and led to the mass extermination of patients with “deficiencies” or mental pathologies (Strous, 2006). The supervision, and development of the Programme was the responsibility of Reichsleiter Philip Bouhler, Head of the Führer’s Chancellery, and the operative direction of Karl Brandt, Hitler’s personal doctor (Fig. 4B). Several prestigious psychiatrists were employed as advisers, among them Professors Paul Nitsche, Werner Heyde and Friedrich Mennecke. Similarly, and even before the introduction of this Programme, German doctors were obliged to report “malformed neonates” or “idiots”. Thus, children under age three thus categorized (and later those under 16) were assembled in 21 specialized sections or departments, distributed throughout the Reich, for the purpose of their elimination (Pichot, 1983; Seeman, 2005). It has been estimated that in this way some 5000 children were murdered up to 1945 (Steinberg, 2004).

The *modus operandi* of Action T4 fitted in perfectly with the sinister bureaucratic organization of National Socialist Germany. Subjects targeted by this Operation were examined to reveal their abilities, and a report was drawn up on each of them. They were then transferred to the T4 services, where they were to be subjected to “special treatment”. The majority of mentally ill people were killed at one of the six regional extermination centres (Brandenburg, Bernburg, Hartheim, Grafeneck, Sonnenstein and Hadamar) throughout the Reich (Fig. 5). This occurred through the inhaling of carbon monoxide, the method tested by Brandt at the Brandenburg Psychiatric Hospital, in rooms camouflaged as laundry rooms or showers. The bodies were then rapidly incinerated in crematory ovens.

Action T4 was later extended to cover a wider spectrum of subjects unfit for society. It eventually included people who

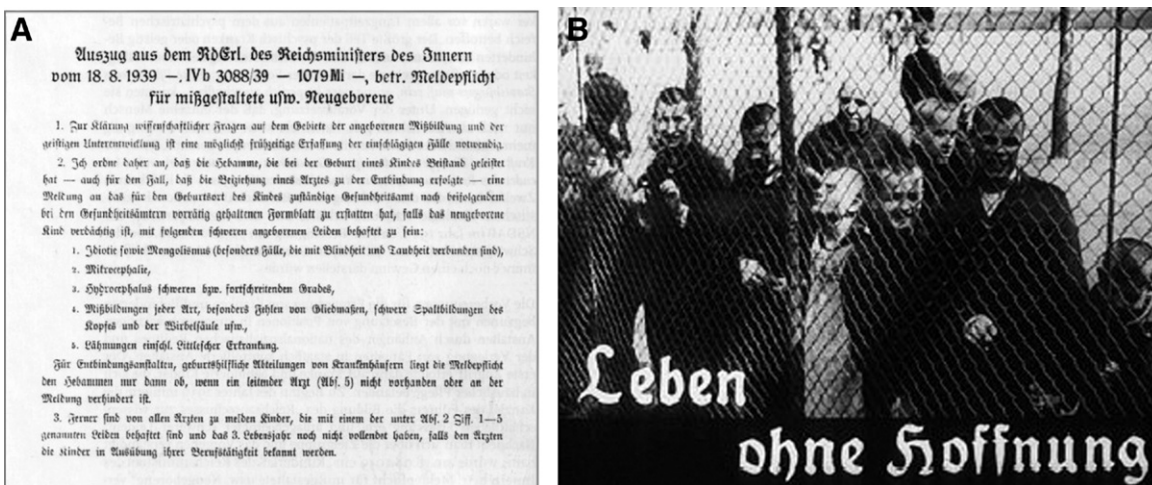


Fig. 3. The Nazi euthanasia machine started up in 1939. A: Government Order of August 18, 1939, enabling the subsequent Decree signed by the Führer, which authorized Action T4. B: Still photograph from a film produced by the Ministry of Propaganda of the Third Reich, showing psychiatric patients at an unidentified institution, with the title, “life without hope”. With this type of propaganda, the Nazi leaders hoped to gain support among the population for their Euthanasia Programme. Image from the United States Holocaust Memorial Museum (Washington D.C., USA).



Fig. 4. Key elements of the Euthanasia Programme. A: Building that housed the administrative office in which Operation T4 was conceived and from which it was run, at number 4 Tiergartenstrasse in Berlin. The building had actually been confiscated from a Jewish family. B: Karl Brandt (1904–1948), SS General, Hitler's personal doctor, Reich Commissioner for Public Health and Director of Operation T4. Brandt was tried for crimes against humanity at the Nuremberg Trial, sentenced to death and hanged on June 2nd, 1948.

could constitute a threat to society, those with links to criminality and those who behaved antisocially (Proctor, 1988), and finally prostitutes, common criminals, tramps or drifters and homosexuals (Aly et al., 1994). In turn, the program was expanded to deal with prisoners in concentration camps and in occupied countries (Operation 14f13). It should not be forgotten that the first Commandant of the Treblinka camp was indeed a psychiatrist, Irmfried Eberl, Director of the Brandenburg Psychiatric Clinic. The exterminations were carried out in asylums and especially in hospitals organized for this purpose, where they became part of the institution's routine. In total, Operation T4, at the heart of which were medical personnel, was responsible for the deaths of an estimated 200,000 psychiatric patients, concentration camp prisoners who had fallen ill, patients with major depression and political dissidents (Galla-

gher, 1990; Goldhagen, 1996; Dudley and Gale, 2002; ARCFI, 2004; Peters, 2004). This practice served as the model for the subsequent implementation of the so called "Final Solution" to the Jewish question, though the enormous numbers of victims planned in this case required the use of more efficient killing agents than carbon monoxide, such as Zyklon B gas (Alexander, 1949; Pichot, 1983; ARCFI, 2004).

Two years after its inception, in August 1941, Action T4 was suspended, due to popular protests mostly organized by the Catholic bishop Clemens Graf von Galen and to the concentration of effort and resources on the war against the Soviet Union. However, this did not mean the end of the murders, which continued in a more covert fashion, out of sight of public opinion, normally by means of less violent methods. These included reducing food rations to a minimum to cause the

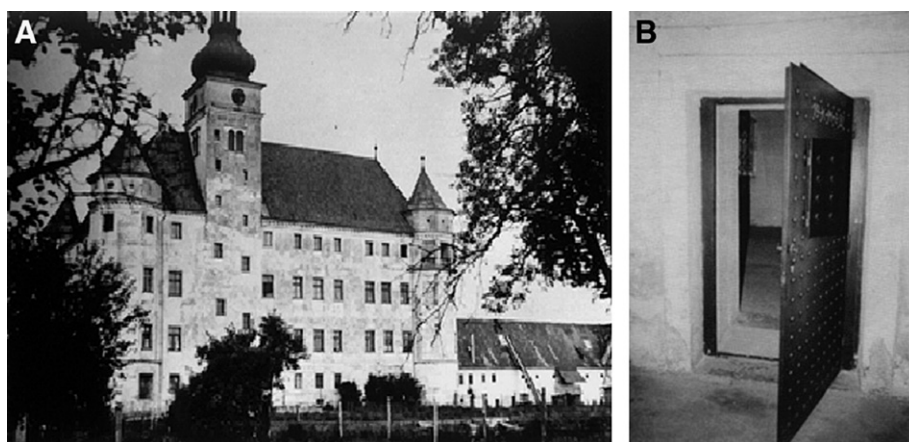


Fig. 5. Hartheim clinic-castle (A), one of the six regional extermination centres of the Euthanasia Programme, and door into the gas chamber (B) at this institution, where a large number of mentally ill patients were murdered.



death of patients through malnutrition, or turning off the heating in hospitals in winter (Madden, 2000; Meusch, 2001; ARCFI, 2004; Strous, 2006). Such procedures, carried out in the “healthcare” institutions themselves, have been described as “Wild Euthanasia”. For these purposes an *ad hoc* organization was created, legitimized by the Nazi government under the direction of Bouhler and Brandt, linked directly to the Reich Interior Ministry and called “Operation Brandt” (Meusch, 2001; ARCFI, 2004; Strous, 2006). In some institutions, doctors, psychiatrists and nurses hastened the patients’ deaths through the prolonged administration of low doses of barbiturates, leading to terminal pneumonia (Madden, 2000); elsewhere, exterminations were carried out less discreetly, through the lethal injection of drugs, such as opiates and scopolamine.

The extent of the involvement of the German psychiatric community in extermination programmes was such that even some doctors from other specialized fields, also interrogated after the war over their participation in biological experimentation, such as Hallervorden, went so far as to state: “I think that the cause of psychiatry was permanently injured by these activities, and that psychiatrists have lost the respect of the German people forever” (Harvard Law School Library, Item No. 170, 2006).

Nevertheless, while some psychiatric professionals unreservedly supported these programmes and many kept quiet after their implementation, it would also be fair to acknowledge those who refused to participate in these “covert murders”, such as Karl Bonhoeffer, Professor of Psychiatry at the University of Breslau and Chief of the Psychiatry Department of the Charité Hospital in Berlin, and those who even protested publicly, with all the professional and personal risks that entailed, such as Göttingen University’s Professor Gottfried Ewald or Hans G. Creutzfeldt, Director of the Psychiatry and Neurology Division at the University of Kiel (Lifton, 1986).

### 3.4. Patients as research material in the Third Reich

Despite the implication of the medical community in the sterilization and euthanasia programmes described above, the most worrying expression of the link between doctors and the Nazis was the use of human beings as research and laboratory material, not only amid the horror of the death camps, but also in hospitals and universities themselves (Weyers, 1998). A graphic reflection of the grotesque nature of the experiments is that some of the bodies were reported to have exploded after the patients’ death (Seidelman, 1996). Among the candidates to be recruited as victims for such atrocities were, in addition to Jews, other persecuted ethnic and social groups, such as gypsies, Slavs, homosexuals and, of course, the physically and mentally disabled. Some of those responsible for these activities justified them in the following way: If the sick have to die anyway, as a result of the expert assessment of one of my colleagues, why not make use of them while alive or after their execution for research?

The Nazis’ allies employed a similar approach in Asia. The Imperial Japanese Army created a series of medical research units that were involved in thousands of crimes and horrendous experiments with human prisoners. Among these was the

infamous Unit 731 (Fig. 6), run by Lieutenant-General Ishii Shiro, a doctor specializing in microbiology. After the outbreak of the Second Sino-Japanese War, in 1937, Unit 731 was set up in Manchuria, close to the city of Harbin, where a programme of bacteriological research was begun, using prisoners of war, political detainees, and mentally ill and disabled Chinese subjects. Victims were inoculated with the germs of cholera, typhus, diphtheria, botulism, anthrax, brucellosis, dysentery, syphilis, and so on. It is estimated that these programmes, which lasted up to 1945, were responsible for the deaths of up to 10,000 people (Williams and Wallace, 1989; Harris, 1994).

Although the human experimentation carried out by the Nazis was much more common in other and more well-documented medical fields (genetics, gynaecology, general surgery, traumatology, etc.), it also extended to the specific field of neuropsychiatry. For example, there were two extensive research projects on diverse forms of mental retardation and epilepsy under the direction of Carl Schneider (who held the chair of Psychiatry at Heidelberg) and Hans Heinze (Director of the Goerden/Brandenburg Psychiatric Hospital), though in the latter case historians disagree on how far the study actually progressed. These projects involved the assessment and exhaustive long-term study of living patients, from both the neuropsychological and physiological perspectives, and the completion of the research through the anatomopathological examination of their brains, after the subjects’ death in accordance with the euthanasia programme at one of the specialized institutions mentioned above.

In a third case, Professor Hallervorden, Sub-Director of the Kaiser-Wilhelm Institut für Hirnforschung (Institute for Brain Research) in Berlin-Buch, had personally visited one of the euthanasia centres (at the Brandenburg prison, next to the Goerden hospital) to coordinate the extraction of brains in patients recently executed. Given that he knew the patients’ diagnoses prior to their execution, he could choose the brains that were most interesting for his research (Gallagher, 1990;



Fig. 6. Photograph of the infamous Unit 731 of the Imperial Japanese Army. Staffed largely by medical specialists, and located in the Chinese region of Manchuria, it was the site of barbarous murders committed within the framework of medical research programmes on germ warfare. Disabled and mentally ill persons were the most frequent victims of the programmes implemented at this Unit.



Friedlander, 1995). Hallervorden even invited to Berlin the psychiatrist responsible for the extermination centre to work with him for a period at his Institute, also sending one of his assistants to the killing centre with the purpose of speeding up the preparation of the samples (Moreno, 2000). In the document catalogued as L-170 (Fig. 7), a part of the evidence against the Nazi doctors at Nuremberg, it is specified that “Dr. Hallervorden had obtained 500 brains from the killing centers for the insane. These patients had been killed in various institutions with carbon monoxide gas”. In his testimony, Hallervorden remarked that “there was wonderful material among those brains, beautiful mental defectives, mal-formations and early infantile diseases”. However, in line with the view habitually expressed by many German medical professionals, he added “Where they came from and how they came to me was really none of my business” (Harvard Law School Library, Item No. 170, 2006).

But these were not the only ethically inadmissible research practices customary during the Nazi period, even if they are the most well-known. In 1940, Schneider founded a research institute in Wiesloch (Forschungsanstalt des Reichsausschusses) where he worked with other notorious psychiatrists of ominous memory, such as Friedrich Mennecke. At this Institute, in addition to the histopathological study of the brains of mentally ill patients from the extermination centres (including special departments for children), there were highly dubious experiments with drugs and electroshock techniques (Aly et al., 1994). Further examples of psychiatrists involved in this type of research are Hans Wilhelm Koning, who studied the effects of electric shock in schizoid patients and healthy prisoners, or Bruno Weber, Director of the Institute of Hygiene at Auschwitz, who carried out “brainwashing” experiments involving the administration to patients of chemical compounds based on barbiturates and opiates (Lifton, 1986).

OFFICE OF U.S. CHIEF OF COUNSEL  
FOR THE PROSECUTION OF AXIS CRIMINALITY  
APO 113 Date 23 AUGUST 1945

Doc. No. L-170

STAFF EVIDENCE ANALYSIS

DESCRIPTION OF ATTACHED DOCUMENT (Under following headings):

Title and Nature: Neuropathology and Neuropsychology, etc. in wartime Germany written by Major Leo Alexander, MD, FRODO, published by OIGC, containing references to killing centers for the insane.

Date: Undated Original (x) Copy ( ) Language: English

If not English, is translation attached: Yes ( ) No ( )

LOCATION OF ORIGINAL (also WITNESS if applicable) as of 1945:

PERSONS DELICATED:

REFERENCES TO INDEX HEADINGS (Key to Par. nos. of Summary below):

ATROCITIES: Against Civilians (1)

NECESSARY PROCESSING TO PUT IN EVIDENTIARY FORM: L-170:

Authentication by Major Alexander.

SUMMARY OF RELEVANT POINTS (with page references):

1. Patients in mental institutions were killed by gas in such large numbers that autopsies were impossible. The brains, however, were suspended in formalin and sent to laboratories for examination. Nurses and attendants selected the persons to be killed, and they degenerated to picking out the patients who looked sick, or who were problems, or whom they simply disliked. (20-21).

Note: This is only a small part of the report, but it might be used in connection with the report on execution of mental patients. (L-169)

Fig. 7. Detail of the L-170 report, drawn up on August 23, 1945, for the International Military Tribunal in the Nuremberg Trial of the Nazi doctors, and written by the psychiatrist Leo Alexander. The report deals with German medical research during the war in the field of neuropathology. Harvard Law School Library Item No. 2451.



Fig. 8. Photographs of the Nuremberg Trial of the Nazi doctors, popularly known as *The Doctors Trial*. A: Members of the Tribunal: Judge Walter B. Beals, Presiding Judge, Chief Justice of the Supreme Court of the State of Washington; Judge Harold L. Sebring, Member, Associate Justice of the Supreme Court of Florida; Judge Johnson T. Crawford, Member, Formerly Judge of a District Court of the State of Oklahoma; Judge Victor O. Swearingen, Alternate Member, Formerly Special Assistant to the Attorney General of the United States. B: Nazi doctors during the Nuremberg Trial (12 December, 1946). Of the 23 doctors charged with crimes against humanity, 7 were sentenced to death and hanged at Landsberg prison on June 2nd, 1948.

Fortunately, many of these projects had to be suspended, since in the wake of the German defeat at Stalingrad the majority of the doctors participating in them were called up by the military. However, it is clear that many German doctors had shown a dereliction of duty to their patients and renounced the ethical principles inherent to the practice of their profession. The real contribution to the advance of medical science made by these research programmes based on state-endorsed crime was practically nil. In the words of Leo T. Alexander, one of the American medical advisors working for the prosecution of those responsible, and one of the men behind the Nuremberg Code: “The result was a significant advance in the science of killing, or ktenology” (Alexander, 1949).

#### 4. The Nuremberg Trials and the Nuremberg Code

After the World War II, between 1945 and 1949, a series of trials – the so-called Nuremberg Trials – took place in the eponymous German city, in which the former Nazi leaders were charged and tried as war criminals by an International Military Tribunal, made up of judges from the four Allied nations: the United States, Great Britain, France and the Soviet Union (Mitscherlich and Mielke, 1949; Geiderman, 2002). At one of these trials, 20 doctors and 3 collaborators were charged with “crimes against humanity” (United States of America vs. Karl Brandt, et al.) (Fig. 8). The court sentenced 7 of them to death (including Karl Brandt), giving prison sentences to another 9 and acquitting the remaining 7, though some of those most

directly responsible for the programmes of euthanasia and human experimentation committed suicide before being brought to trial (such as Philip Bouhler, Leonardo Conti, Carl Schneider, Irmfried Eberl or Maximilian de Crinis). Others were executed by Soviet troops (Paul Nitsche) or died in the course of the war, while others escaped justice (Mitscherlich and Mielke, 1949; Geiderman, 2002) — among them Rüdin, one of the key players in the eugenicist policies of the Nazi regime. Although he was arrested at the end of the war, and tried by a local German court in 1947, he was eventually acquitted on the grounds that his involvement with the Nazi crimes was purely circumstantial (Gottesman and Bertelsen, 1996).

Curiously, the Japanese doctors involved in crimes against humanity, such as Ishii Shiro and other members of Unit 731, were not prosecuted at the Tokyo Trials (International Military Tribunal for the Far East, IMTFE), which began on 27th April, 1946. Some authors postulate that they escaped prosecution in exchange for handing over to the Allies the scientific results on germ warfare techniques accumulated in nearly 10 years of evil and inhumane experimentation (Gold, 1995).

In response to the atrocities committed by Nazi doctors and scientists in the field of human research, revealed in the course of the Nuremberg war crimes trials, the Nuremberg Code was published in August 1947. This Code, which was designed to prevent any repetition of the tragedy resulting from barbarous attacks on human rights and human wellbeing, is the first international code for research with human beings, and is based on the Hippocratic precept of *primum non nocere* (“first, do no harm”). It laid down norms for experimentation on human beings, with special emphasis on the need to obtain the person’s

Table 1

Ethical principles of the Nuremberg Code

- |    |   |
|----|---|
| 1  | The voluntary consent of the human subject is absolutely essential.   |
| 2  | The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.  |
| 3  | The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.   |
| 4  | The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.   |
| 5  | No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.   |
| 6  | The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.  |
| 7  | Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.  |
| 8  | The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.   |
| 9  | During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seemed to him to be impossible.  |
| 10 | During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probably [sic] cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject. |



Fig. 9. Statement by the psychiatrist Leo Alexander (1905–1985) to the members of the International Military Tribunal in relation to the experiments carried out by the Nazi doctors on trial. Alexander, a Major in the US Army, was one of the scientific advisors to the Tribunal, and one of those responsible for drafting the Nuremberg Code.

informed consent, which has since then been considered the cornerstone of the protection of patients’ rights. Those responsible for drawing up the Code were two American doctors who participated as advisors to the Tribunal in the trial of the Nazi doctors: the psychiatrist Leo T. Alexander (Fig. 9) and the physiologist Andrew C. Ivy (Shuster, 1997). The Nuremberg Code consists of a declaration of 10 principles, focusing basically on the protection of the rights of persons participating in medical research (Table 1) (Annas and Grodin, 1992; Shuster, 1997). The Code thus managed to combine the Hippocratic ethic and the protection of patients’ rights in a single document, which requires not only that clinicians and researchers protect patients’ interests, but that subjects themselves also participate actively in their own protection.

Although the Nuremberg Code has not been formally adopted as a legal norm by any nation or medical association, it has had a profound influence in the area of human rights and bioethics, since its basic requirement, informed consent, has been accepted worldwide, is enshrined within numerous international laws relating to human rights, and constitutes the basis of the International Ethical Guidelines for Biomedical Research Involving Human Subjects, published in 1982 (Grodin and Annas, 1996).

## 5. Governmental and psychopharmacological abuse in other countries: the story of a continuum

With regard to the institutional abuse of psychiatry and the illegitimate use of psychoactive drugs, we would be committing a gross oversight if we were to attribute this type of activity



exclusively to the German medical community during the National Socialist regime. Such practices were taking place before and have done so since the publication of the Nuremberg Code, principally in countries with totalitarian regimes, such as the former Soviet Union (Bloch, 1991), China and Chile, but also in countries with a long tradition of democracy, such as the United States, Great Britain or Australia. In the former cases, the information available on instances of abuse is extremely scarce, since they did not come to the attention of the public at the time, and those responsible have never been brought to trial.

### 5.1. Dictatorial totalitarian regimes

Institutional psychiatric abuse in the Soviet Union was not essentially motivated by eugenics or racism or “ethnic cleansing”, but rather, as a weapon for eliminating diverse forms of dissidence and social behaviours that were unacceptable to the regime (Chodoff, 1999). However, despite different objectives from the Nazis, many of the procedures were quite similar. Indeed, among the horrors of Stalinism we can find parallels with events that occurred in Nazi death camps such as Auschwitz. The collaboration between the state psychiatric machinery and the police who tortured prisoners is amply documented (Wiesel, 2005). Moreover, while initially the victims of psychiatric abuse were political dissidents, these practices were subsequently extended to nationalists, persons with religious beliefs, potential emigrants and people that were generally “bothersome” (Chodoff, 1974, 1999; Spencer, 2000). In many cases detainees were falsely imputed with psychiatric disorders, through the exclusive application of the Moscow School of Psychiatry diagnostic system, after which, without any possibility of appeal, they were confined in institutions that could be considered as “psychiatric prisons” (Chodoff, 1974, 1999). The diagnostic criteria of this psychiatric school, developed in the 1960s by its founder, Professor Andrei V. Snezhnevsky, allowed subjects with problems of social adjustment and political dissidents to be diagnosed with “mild schizophrenia” or “inactive schizophrenia”, which provided grounds for committing them to an asylum.

During the 1960s, 1970s and 1980s, the Soviet Union continued to use psychiatric hospitals for the internment of political dissidents, as in the famous case of General Piotr G. Grigorenko (Chodoff, 1974). They were kept in close proximity to dangerous criminals and violent mental patients, and were administered overdoses of neuroleptics for punitive purposes (Podrabinek, 1980). Grigorenko, a steelworker who became a war hero after World War II, was promoted to General in 1956, eventually becoming Commander-in-Chief of the Red Army. In 1961 he denounced the totalitarian abuses of the Stalinist leaders, for which he was expelled from the Communist Party, deported to Siberia and interned in different prisons and psychiatric hospitals. Psychiatrists at the Serbsky Research Institute of General and Forensic Psychiatry in Moscow diagnosed Grigorenko as suffering from a personality disorder with “reformist ideas, inflated opinion of his own personality, intense affective component and conviction of the correctness of his actions”. He spent periods in different psychiatric institutions

between 1964 and 1976, being classed as a “*psikhuskha*” (psychiatric prisoner). After being exiled to the United States, where he was found to be suffering from no mental disorder whatsoever, he became an important human rights activist, denouncing the psychiatric abuses of the Soviet regime. In this framework of government-endorsed abuse, as was the case in Germany, some prestigious psychiatrists (such as the so-called “mercenaries” at the Serbsky Institute) participated actively in the programmes, and a small number resisted, but the majority, without actively participating, tolerated them (Chodoff, 1999).

The types of psychotropic drugs used in such practices were in the majority of cases unknown, given the illegal nature of the activities. Police interrogations of prisoners involved the use of barbiturates such as sodium amobarbital, sometimes administered in conjunction with psychotomimetic agents (caffeine, lysergic acid, psilocybin, mescaline, etc.), with the goal of producing disinhibition. Sulfazin, a 1% solution of elemental sulphur in oil, which was used to treat schizophrenia before the introduction of antipsychotic agents in the 1950s, and which was later abandoned completely, was administered with purely punitive aims. Sulfazin induced febrile episodes over a period of several days, as well as intense pain in the injected area (generally the buttocks). As a result of such measures, the “dissident-patients” were in a state of deep exhaustion, both physical and emotional (Podrabinek, 1980).

These types of practice are also reported to have been widespread in communist China, after the Cultural Revolution, and in pre-war Japan (Harding, 1991; Spencer, 2000; Munro, 2002a). In the case of China, the information available is scarce, since the political regime that purportedly practised (and continues to practise) such abuses is still in power, and much of the information that has filtered out has been due to the efforts of human rights organizations (HRW, 2002). According to Kirschner (1984), there are three reasons for the administration of psychotropic drugs to the political and religious dissidents in totalitarian states is threefold: as a means to explain its admission to psychiatric institutions; as a purely punitive tool (administration, for example, of classic neuroleptics to toxic dosages to induce extrapyramidal effects that accelerated the dissident’s physical and mental deterioration); and as a strategy for force the dissidents to denounce their ideas and/or anti-government activities.

Other examples of the abuse of psychopharmacology in authoritarian regimes can be found in the administration, during World War II, of high doses of amphetamine-based psychostimulants to Japanese fighter pilots, popularly known as “kamikaze pilots”, with the aim of minimizing fatigue, enhancing performance and alertness and raising levels of self-confidence and combativeness (Escotado, 1989). It is well documented, in this regard, how these famous suicide pilots were “invited” to consume high doses of amphetamines before flying into American ships, but this drug was also used for improving the performance of workers in war-related industries back in Japan. Even so, it should be borne in mind that these types of chemical agent were also used during the war by the Allied armies to reduce feelings of tiredness and hunger in soldiers at the front and to stimulate them in the hostile conditions of combat (Cabrera, 2006).



Finally, totalitarian states may administer psychotropic drugs as part of the systematic practice of torture. The use of psychotropics in torture sessions to sedate, confuse or agitate the victims, constitutes a flagrant violation of professional ethical codes by doctors assigned to the police corps carrying out these practices (Kirschner, 1984). An example is the Chilean dictatorship of 1973, where the application of sodium thiopental by sanitary personnel previously to the interrogation of the prisoners has been confirmed (Jadresic, 1980).

### 5.2. Democratic and liberal regimes

Outside the context of war, psychiatric and psychopharmacological abuse by government institutions has also occurred in non-totalitarian states. From the 1950s, and under the direction of leading psychiatrists, both the US Army and the Central Intelligence Agency (CIA) carried out numerous experiments with different chemical agents, such as that codenamed MK-Ultra, which was developed between the 1950s and the 1970s (Lee and Shlain, 1985). A sub-project of this programme was approved in July 1953 by Sidney Gottlieb, with the objective of advancing “the study of the biochemical, neurophysiological, sociological, clinical and psychiatric aspects of LSD”. With this purpose, in addition to the application of LSD to particular groups (CIA employees, military personnel, mental patients, etc.), the Agency recruited prostitutes, who would trick businessmen into visiting brothels. Once there, the men were secretly injected with LSD and their behaviour was observed. Other psychotropic agents were also used and tested, including mescaline, psilocybin, scopolamine, heroin, marijuana, amphetamines and barbiturates. With regard to the two last-named substances, an intravenous application technique was designed whereby sodium pentothal was injected into one of the subject’s arms and amphetamines into the other. The barbiturate was administered first, and when this began to induce a state of sleep, the amphetamines were injected, causing a confused condition in which researchers expected to obtain certain responses in a guided interrogation. The death of a subject due to the adverse effects of the combination of the two drugs led to the project being abandoned. Similarly, other subjects involved in these experiments died as a consequence of the administration of hallucinogenic substances, such as mescaline. In December 1974, the *New York Times* exposed the existence of this programme, and both the US Congress and the White House set up commissions (the Church Commission and the Rockefeller Commission, respectively) to investigate it. The Rockefeller Commission concluded that the participants in these experiments “were exposed to serious danger of death or injury without their informed consent, without medical supervision and without the necessary monitoring to determine possible long-term effects” (Rockefeller Commission Report, 1976). Following the recommendations of the Church Commission, in 1976 US President Gerald R. Ford issued an Executive Order on Intelligence Activities. Among other things, this prohibited “experimentation with drugs on human subjects, except with

the informed consent, in writing and witnessed by a disinterested party, of each such human subject” (Executive Order 11905, Feb. 19, 1976).

Declassified CIA documents have also confirmed how, in the second half of the 20th century, famous psychiatrists, psychologists, pharmacologists and neurosurgeons, as well as prestigious healthcare institutions and universities, worked with the CIA and the Army on programmes for studying amnesiac states induced with psychoactive drugs (Ross, 2000). An example of such collaboration is provided by the work of Ewen Cameron in the latter half of the 1950s at the Psychiatry Department of the Allan Memorial Institute in Montreal (Canada). With financial backing from the CIA, Cameron, who had been a member of the Medical Tribunal at the Nuremberg Trials, and held the Presidency of the American Psychiatric Association (APA) from 1952 to 1953, developed his “Psychic Driving” technique (Cameron, 1956). This is a primitive version of what is vulgarly known today as “brainwashing”. With this technique, involving the administration of barbiturates, such as sodium amytal or sodium pentothal, Cameron aimed to take advantage of prolonged sleep (a kind of barbituric narcosis) to force patients to listen to persuasive messages, which, in this case, were designed as therapy for speeding up their recovery. But in spite of the eminently clinical objectives, this work was widely criticized in the mass media at the time.

### 6. From the Nuremberg Code to the Declaration of Madrid

In the 1970s, the World Psychiatric Association (WPA) took note that there were no specific texts setting out ethical procedures in the practice of psychiatry, in any of its applications. One of the aspects that most acutely alerted the psychiatric community to the problem and prompted the drafting of such a document was the political abuse and improper application of psychiatry and its tools in countries such as the former Soviet Union, Rumania and South Africa, which became known to an international public in the early 1970s (Helmchen and Okasha, 2000; Welsh and Deahl, 2002). Thus, the WPA asked Swedish psychiatrist Clarence Blomquist (Fig. 10A), Professor of Medical Ethics at the Karolinska Institut in Stockholm (Ottozon, 2000), to draft a Declaration of ethical principles, which was finally adopted by the WPA General Assembly in Hawaii in 1977 (Okasha, 2003). The Declaration of Hawaii became the first document produced by the psychiatric profession on ethical questions, and included, in relation to human experimentation, the specific requirement, for the first time in history, of obtaining informed consent before including a patient in a research study.

The 1970s also saw the culmination, in the United States, of a series of popular protests in support of the right to protection of participants in drugs trials. The potential threat to human values and civil rights involved in these trials led to Congress appointing a commission, The National Commission for the Protection of Human Subjects of Biomedical Research, to guarantee respect for the rights of subjects. This commission met on the outskirts of Baltimore, at the Belmont Center, where it drafted a document known as the Belmont Report (1978). This report stated the three

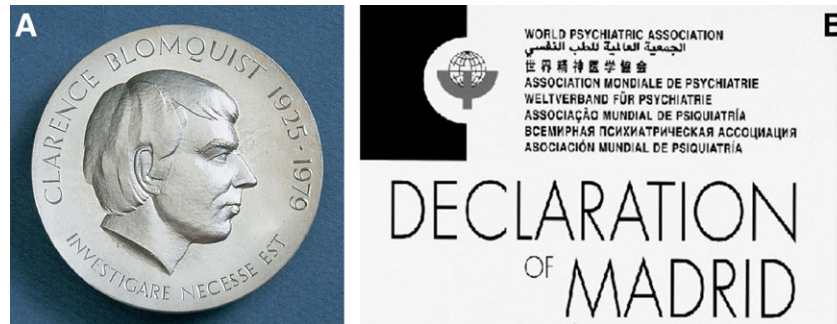


Fig. 10. Progress in the field of psychiatric ethics in recent decades has been highly significant: A: Image of the psychiatrist Clarence Blomquist (1925–1979), from the Karolinska Institut (Stockholm, Sweden), who drafted the first code of ethics for psychiatrists; the image is taken from a medal of the Swedish Society of Medicine. B: logo of The Declaration of Madrid, approved by the WPA General Assembly in August, 1996.

basic ethical principles that should guide all clinical pharmacological research with human beings and its applications: the principle of respect for persons and their autonomy, the principle of beneficence and the principle of justice.

As occurred with the Declaration of Helsinki (Foster et al., 2001) in the case of general medicine, the Declaration of Hawaii was updated at successive meetings of the WPA General Assembly (Table 2), and new ethical principles – such as those of the Belmont Report – were incorporated. Psychiatrists, in the context of their relationship with the mentally ill, should be guided always by respect for patients, prioritizing their well being and physical integrity. It was in this direction that the WPA approved, at its 1996 General Assembly, a set of ethical guidelines that formed the basis of the Declaration of Madrid (Fig. 10B). Likewise, the Ethics Committee of the WPA created a series of norms for specific situations, which were approved at the World Psychiatry Congress in Madrid on the 25th August, 1996, and referred to aspects such as euthanasia, torture and the death penalty (WPA, 1996). The Declaration of Madrid was revised at the General Assembly in Hamburg on 8th August, 1999, to include ethical considerations in relation to the communications media, racial or cultural discrimination, and genetic research and consultancy, and on 26th August, 2002, in Yokohama, to include, among other aspects, those related to transgression of the limits of the clinical relationship and violation of the confidence between psychiatrists and patients. The most recent revision came on 30th June, 2005, in Cairo (Table 2), incorporating a special section on the protection of the rights of psychiatrists against the pressure exerted on them by totalitarian regimes to obtain political benefits. Currently, all Psychiatry Associations with full membership of the WPA have endorsed the Declaration of Madrid (Helmchen and Okasha, 2000; Okasha, 2003).

## 7. Recent developments and final reflections

The Nuremberg Trial, which brought to justice the Nazi doctors involved in the crimes and abuses described here, gave rise to the creation of new ethical codes, and to the establishment by the World Medical Association (WMA) and national medical and psychiatric associations of their standards of medical ethics (WMA, 1984). However, despite the achievements of the second half of the 20th century in relation to ethical legislation in psychiatry and the use of psychopharmacological

agents, improper governmental uses of psychiatry and abuses of vulnerable groups continue to be reported in numerous countries. Human rights organizations and scientific and professional bodies, such as the WPA, have denounced this situation. By way of examples, it is sufficient to mention religious repression in China, enforced hospitalization in Russia, administration of psychoactive drugs in immigrant detention centres in Australia, or the application of the death penalty by lethal injection in the United States.

Since April 1999, members of the religious–spiritual group Falun Gong have been massively and forcibly interned, in the People's Republic of China, in a network of psychiatric hospitals controlled by the Ministry of Public Security, and called “Ankang” (“Peace and Health”) (Appelbaum, 2001). These people were forcibly sedated, strapped to beds, isolated for long periods in darkness, and subjected to electroconvulsive therapy and other types of injustice, such as being given inadequate food, having limited access to water and being denied healthcare. As a condition for their liberation they were forced to renounce Falun Gong, and obliged to pay large sums of money for their hospitalization and treatment. Human Rights Watch (HRW) and other organizations have protested about these abuses (Munro, 2002b). However, the obstructive nature of the government's response to those seeking to investigate the matter appear to confirm that, indeed, the Chinese government may be maintaining a clandestine network of psychiatric centres for “punishing” and “re-educating” opponents of the totalitarian regime, as occurred in the former Soviet Union (Appelbaum, 2001). Precisely with regard to this, the European Court of

Table 2  
Ethical codes specific to the psychiatric field

|                                   |                                     |                  |      |
|-----------------------------------|-------------------------------------|------------------|------|
| • Declaration of Hawaii           | World Psychiatric Association (WPA) | Honolulu, Hawaii | 1977 |
| • Declaration of Hawaii (revised) | World Psychiatric Association (WPA) | Vienna, Austria  | 1983 |
| • Declaration of Madrid           | WPA General Assembly                | Madrid, Spain    | 1996 |
| • Declaration of Madrid (revised) | WPA General Assembly                | Hamburg, Germany | 1999 |
| • Declaration of Madrid (revised) | WPA General Assembly                | Yokohama, Japan  | 2002 |
| • Declaration of Madrid (revised) | WPA General Assembly                | Cairo, Egypt     | 2005 |

Human Rights has confirmed the systematic psychiatric abuse practised in the Russian Federation in relation to enforced hospitalization, and above all to the treatment of children and persons with disorders due to substance abuse (MHG, 2004).

But institutional abuse of mental health professionals and through the administration of psychoactive drugs continues in countries with democratic traditions. The Australian government has pursued a policy of indefinite detention of asylum-seekers, and the administration of sedatives such as diazepam in the immigrant detention centres – in contravention of the international human rights conventions to which Australia is a signatory – has been common practice (Dudley, 2003). As far as the United States is concerned, the death penalty by lethal injection remains in force in 37 states, and since its reintroduction by the Supreme Court in 1976 more than 950 people have been executed. The normal execution procedure consists in the sequential administration of sodium thiopental, pancuronium bromide and potassium chloride. Regardless of the perversity and inhuman nature of the death penalty *per se*, some authors have postulated that this procedure provides victims with inadequate anaesthesia, leading to additional suffering (Koniaris et al., 2005). Likewise, there is growing concern over the enforced medication of prisoners condemned to death by other methods, with the aim of their achieving, quite artificially, a state of competency for execution (Grabo and Sapoznikow, 2002; Jones, 2004). As a recent editorial of *The Lancet* pertinently argued, “capital punishment is not only an atrocity, but also a stain on the record of the world’s most powerful democracy” (Lancet Editorial, 2005).

We also note here recent abuses of psychiatry in the context of ‘the war on terror’ and allegations of torture at Guantanamo Bay and Abu Ghraib. At this writing, Australian detainee David Hicks, for example, has been held for many months in solitary confinement in a darkened cell that receives no natural light. Such sensory deprivation is a calculated form of psychological torture. Detainees have been subjected to wholesale violations of medical privacy, and psychiatrists and psychologists participate in coercive interrogations outside the ordinary treatment relationship. Moreover, these departures from ordinary clinical ethics have been underwritten by the statements from national professional organizations, such as the American Psychiatric Association and the American Psychological Association, a development which has been decried by various commentators (Bloche and Marks, 2005; Wilks, 2005).

Understanding the context and reasons for such practices is important, since change has to occur in the detention context and in the professional response. In the case of Nazi doctors and psychiatrists, the medical killing of psychiatric patients was an open secret with gradations of collective knowing. Perpetrators’ motivations included duress, peer pressure, authoritarianism, careerism, and ideology. Denial was possible through use of deceptive language, bureaucratic routines and attention to technique, dissociation and numbing, and notions such as ‘a greater cause’ or ‘sacred mission’. Psychiatrists shared this ideology, were state-controlled, and tended to objectify patients (Dudley and Gale, 2002). In the case of mental health professionals’ participation in the war on terror at Guantanamo, for example, or state-sponsored abusive policies of deterrence, as

in Australia, the reasons are similarly multi causal. Social or political imperatives and prevailing ideology should not be underestimated. Following the recent suicides of detainees in the US Guantanamo Bay detention complex, US military and government representatives referred to these suicides as acts of ‘asymmetrical warfare’, and a ‘good PR stunt’ (Sydney Morning Herald, 14th June 2006). The lack of effective mechanisms to challenge and the failure of medical community to do so, unethical secret contracts, and poor understanding of basic ethical principles, and fears of reprisal and peer pressure are also significant.

In order to avoid continued governmental abuse in these fields, a range of strategies is needed. These need include among other things, updated and publicised international pacts, agreements and treaties, continuing education for doctors and mental health professionals acting in dual areas of responsibility at undergraduate and postgraduate level (Wilks, 2005), and close vigilance on the part of human rights organizations. It also may involve psychiatrists and mental health professionals acting as advocates to governments for the civil rights of citizens (even those like Mr. Hicks who are accused of serious crimes), and to honour treaty obligations to vulnerable non citizens who have already been exposed to systematic human rights violations (for example, refugees).

Stepping out the shadow of Nuremberg, the ethical precepts set out exactly half a century later in the Declaration of Madrid constitute a giant step forward: “Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts. Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.... In relation to euthanasia, the psychiatrist should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability” (WPA, 1996). The Declaration of Madrid should be considered as a sentinel to guard against any backsliding into practices that have brought such shame on the medical and psychiatric professions. At this juncture, it is unclear, however, whether the above strategies, considered separately (for example, educating doctors about genocide) or as a group together, will be effective, nor whether we will be capable of learning the lessons inherent in these events.

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