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Medical Ethics in Times of Crisis

Physicians under Military Dictatorships in South America

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Introduction

During the last two decades, a dictatorial era left its mark on the societies of Argentina, Chile and Uruguay. Although the military regimes in this region appear to belong to the past, they have nonetheless left deeply embedded scars on the social fabric of the countries involved. The focus of this study is on the repercussions of that experience for individuals and institutions.

With regard to physicians in the countries in question, it is known that some actively supported the dictatorial regimes, indeed that some committed crimes in their complicity with the respective dictatorship. On the other hand, a number of others participated in overt or clandestine opposition and were subject to the repressive measures of state terrorism. However, there is still scant knowledge of the ways in which a long-term state of martial law in those societies impacted on the lives of doctors and their professional practices.

The clear involvement of doctors in regimes of totalitarian domination has been documented since the Nuremberg Trials. Other examples of experiments devaluing human life, like those carried out by Japanese doctors in occupied China, psychiatric abuse in the former Soviet Union, and the extensive experiments with human beings in the United States testify to the vulnerability of medical ethics when the interests of those in power take precedence.

In the South American countries dealt with here, unlike what took place following the end of Nazi rule, the implicated physicians have only incidentally been brought to justice for their confirmed participation in violations of human rights. There is little likelihood of effecting an explanatory proceeding similar to the Nuremberg Trials; on the contrary, general amnesties for those who took part in the terror seem to be more prevalent and define the sociocultural and political panorama.

This study of medical ethics during totalitarian regimes does not intend to pass judgment on any individual or institution. The attempt, rather, is to comprehend the perspective of those doctors who lived under the dictatorships, and in this way, to help examine the issues at the intersection of medical ethics and human rights; our goal is therefore to gather and to analyze facts for a future discussion.

This investigation is concerned with the conflicts and specific problems within everyday general medicine under the circumstances of the dictatorial period. The status of an “extreme situation” acquires, in the context of this study, a central significance in the evaluation of the experiences described by the doctors. This work is aimed at contributing to an inductive processing of the experiences and attitudes of doctors in those years.

With this in mind, we embark on an investigation of a somewhat novel terrain since, until now, there has been little investigation of personal and professional experiences from the perspectives of supporters and victims under totalitarian regimes. It is much more common to make general judgments about periods of terror than to try and identify how on the one hand the employment and abuse of power, and on the other hand complete submission to it has influenced individuals.

An example from daily life: a middle-aged man arrived at the private practice of a general physician because of a pain in his ears. A direct examination of the ear canals revealed small tears in both of the tympanic membranes and led the doctor to administer a treatment with local antibiotics and to recommend rest. The injury was a lesion without major complications, except for the fact that it was the result of pressure caused by a tear gas canister that had exploded near the patient, one that had been thrown by the police in order to disperse a spontaneous gathering in the capital.

The doctor could have asked about the causes of the injury and would have received a detailed report on the circumstances surrounding their origin. However, during the state of martial law he was obliged, by decree, to report to the authorities with respect to events occurring in his private practice. The patient would then be considered as having been injured in a deliberate confrontation with the police and would have had to undergo a thorough investigation of his personal affairs, with unpleasant consequences for him regardless of the findings.

By not inquiring into the reasons for the tympanic perforations, though, the doctor may have failed to secure important information, for example, the man's work environment, and thus have made a misdiagnosis, which would then lead to chronic injury.

This is an example of the everyday medical experience during the dictatorships. It provides a glimpse of the permanent pressures the medical practice was subjected to in Argentina, Chile and Uruguay under state terrorism. The following questions can be applied to the situation described: How could the doctor have handled a situation of that nature? Were there proven courses of action available, directed toward simultaneously ensuring the rights of the patient and the personal safety of the physician? If so, was the doctor's attitude toward the military regime important? Could he have escaped that critical situation by shielding himself behind an attitude of non-involvement? And if so, how was that voluntary neutrality perceived?

Such requirements determined the daily response of doctors in the countries investigated. An express consideration and in-depth processing of situations of this type permit us to deal with crucial aspects of the professional and personal lives of doctors. These aspects have long been held as difficult to comprehend, if not

frankly imponderable, since they explain the behavior of practicing doctors with respect to ethical conflicts at extreme times. This, we think, has an extraordinary significance for the period following the dictatorships.

To achieve a specific understanding of the situation in each of the three countries requires a detailed analysis of socio-historical antecedents, a systematic presentation of the interaction between medicine and the military dictatorship. It also requires an empirical investigation of predisposition to ethical-professional conduct of those who experienced such circumstances and who were practicing medicine or were medical students at the time.

In the documentary section of this book, we first address the historical and social contexts in the recent past of the three countries, particularly as regards their effects on the mental health of individuals and of the general population. Considerations include: tendencies toward a process of “national renovation", critical in creating individual subordination to the omnipotent state forces; the treatment accorded the opposition by military governments, that is, the extent to which the devaluation of human rights and the propagation of terror as ad hoc strategies of those in power was established. The significance of fear and its repercussions in daily life, as well as the structural influence of the dictatorship following the return to democracy, complete this retrospective look at the conditions that acted decisively on the mental health of the majority of the population during and after the years of military dictatorship.

Continuing, we seek to systematically clarify the circumstances that characterized the situation of doctors under a totalitarian regime, both in the recent history of the South American countries and under Nazism in Germany. The parallel exploration of this subject proves indispensable to this study since, as with the Nazi regime, the role of doctors was of great importance to the actions of the military dictatorships.

While, on the one hand, numerous physicians became preferred targets of persecution by the repressive regimes by virtue of their involvement in societies marked by flagrant differences in economic status and with a high degree of social conscience among intellectuals, other doctors actively participated in repression, applying their professional competence. The second part of the documentary section deals with the participation by physicians in activities of opposition and collaboration within the three countries. The types of crimes against humanity that were perpetrated by doctors are exposed here, as are the extent to which awareness of the abuse of professional knowledge existed among doctors themselves. We also see the reactions provoked by these acts, how the repercussions of knowledge of the cooperation of some doctors with the military dictatorship influence physicians

and their organizations today, and how the personal attitude of doctors toward absolute authority was defined.

In Germany, medicine was exploited for National Socialist ideological and political purposes; an historical-cultural look at medicine in that era rounds out the documentary section. The following points are relevant in this respect: the repercussions, in medicine and society at large, of an anthropological doctrine that set out to promote a "pure race" and to "scientifically" strengthen the hegemonic claims of the "Nordic race"; the utilization of concentration camp prisoners for medical experimentation, justified by claiming the existence of a national emergency situation of open war, and the activities in opposition to Nazi politics of doctors at that time.

As a complement to this systematic description of relevant circumstances for physicians under the South American dictatorships and under Nazism, a comparison is also drawn between the two eras, highlighting, in condensed form, their similarities and differences.

In order to process the sociohistorical and medical-ethical antecedents, methods of text selection and analysis were employed. The data were collected over a lengthy period of time and were subjected to a systematic classification. The documentary section is based exclusively on verifiable sources. The majority of work cited comes from social-scientific studies of acknowledged reliability. While the origin of some of the reports and the information they contain may seem somewhat unconventional for an academic study, for example, those from Amnesty International, they nonetheless represent unique documented evidence and have additionally proved to be credible sources, despite the many denials by self-interested authorities.

However, this study will not be reduced exclusively to elaborating references obtained from secondary sources. Our attention is focused primarily on those doctors who experienced the years of dictatorship in each country. During the course of this investigation, we sought to gain an understanding of the attitude and behavior of doctors both then and now, and to learn their opinions on the state of the corresponding nation and their criteria for evaluating difficult aspects of medical ethics. In this way, we attempt to undertake a critical examination of the existential situation of doctors under totalitarian domination, as well as a preliminary evaluation of the personal consequences it involved.

An investigation intended to explore the social and cultural significance of those years for practicing physicians should, according to our criteria, try to integrate the following four dimensions, from the perspective of those who experienced the era and navigated its situations of conflict: the daily experience, both professional and general, during the state of martial law; the strength of the notion of the involve-

ment of doctors in repression; their current attitude toward that time; the significance of the dictatorial years in their personal history.

At the end of 1992 and the beginning of 1993, over a period of four months, we had the opportunity to conduct a field investigation in Argentina, Chile and Uruguay. During this time we found forty-eight doctors from the three countries who agreed to participate in a semi-structured narrative interview.

In the interviews with those doctors, eyewitnesses to the era, five thematic complexes were dealt with and, using open-ended questions, the subjects provided: a) a personal introduction and profile; b) an opinion of the military government based on personal experience; c) their position on violations of human rights perpetrated by doctors; d) their opinions on current areas of conflict within medical ethics; and e) responses to imaginary situations, placing themselves in the position of having to make ethical decisions.

A methodology of proven worth was unavailable to serve as a model for the empirical part of this study of medical ethics and human rights since, at least so far as we are aware, there are no studies in the scientific literature to serve as precedents. We thus found ourselves obliged, in this part of the investigation, to choose with as much care as possible from among the methodological instruments of diverse disciplines, particularly anthropology, psychiatry, and social psychology. The methodological procedure should satisfy three fundamental requirements: a) guaranteeing the anonymity of each interviewee with complete certitude; b) stating the declarations as literally as possible in the evaluation and presentation of results; and c) highlighting, through the different qualitative and quantitative methods of evaluation, the multiplicity of existent opinions as well as the possible relationships among statements concerning different subject matter.

We began this study with the assumption that the military intervention represented a milestone in the existence of all participants. They were personally affected by the events of the era and were obligated to adjust their “life plans” accordingly. Consequently, the degree of personal involvement and the individual strategies for withstanding and overcoming the circumstances constituted the central issues of the investigation.

We also presumed that violations of human rights (including at the hands of medical professionals) under the respective military dictatorship were widely acknowledged and, in contrast to what occurred following the Nazi regime, were not currently a strictly taboo subject. Consequently, we directed our attention to the ways in which our subjects dealt with this knowledge in the current post-dictatorial years with some striking results. By virtue of those postulates, and in light of our own experiences, the cognitive interest in the perception of problems arising recently in medical ethics, such as the transplant of organs, genetic tech-

nology, etc., provides a consistent frame of reference. The hypothesis that the professional moral conscience of participant doctors is closely related to their social self-definition, and that there is a correlation between the perception of difficult issues within medical ethics and the attitude taken towards them based on the biographical background of the interviewed doctors proved decisive to this approach.

The objective of our investigation, to gain knowledge of the work conditions, and attitudes of doctors during the military dictatorship from their own perspective made the consistent treatment to each and every one of the participants imperative. In the empirical section, there were long segments in which ethics were treated only in their argumentative dimension; there were no judgments or assessments from the author, and a rather deliberate renunciation of evaluative categories was practiced.

My attitude as author can be described for reasons of birthplace and profession as that of an empathetic observer who, in this treatise, tries to balance an intense desire to know and a necessary impartiality, after having lived twenty years of my life in another country. My medical studies were essentially completed in Chile, but my professional career, from the outset, has evolved in the Federal Republic of Germany. My principal interest in learning about these topics also had biographical roots, yet without a direct professional experience in the countries that were the subject of this investigation. For this reason, I wish to express my sincere gratitude to the participants, who responded candidly in the course of the interviews to the sometimes difficult questions, thereby providing me access to their own personal experiences during the dictatorship.

It is obvious that a humanitarian subject matter could only be investigated after the end of the military regimes, but although the direct influence of the state of martial law, a prolonged period of time characterized by extensive regulations, has passed, people are nonetheless still influenced by that era. The experiences of the time are assessed as being very vivid in the memories of the interviewed subjects and remain largely untarnished by distorting explanations and interpretations.

Within the framework of an investigation of this type it is possible to experience, albeit unintentionally, moments of conflict with the recent past. This was especially true of physicians who had been tortured, or else publicly accused of participating in torture, and who expressly tackled these issues in the interviews. It follows that it was not possible to develop an in-depth interaction with these individuals. Torture in the personal context of physicians who have been personally implicated should be the subject of a proper investigation: this initial approach to both victimized and suspected individuals may contribute to a detailed treatment of the topic in the near future.

From a methodological point of view, we placed great emphasis on the independent and differentiated observation of events under dictatorship in each country. Nevertheless, the fact that this investigation has been carried out from Hamburg has probably afforded new perspectives for viewing and evaluating the conditions in the South American countries on the basis of recent investigations of medicine in Nazi Germany. The National Socialist period constitutes an important frame of reference for this work. It can be assumed that its latent influence has led more to a factual clarification than to an obscuring of the interpretation of results in this investigation. Thus, for example, it is possible to observe the violations of medical ethics committed in the South American countries “in the name of the fatherland” or in the service of an ideology, in contrast to known experiences in the Nazi era, and subject them to a preliminary scientific analysis.

In this investigation we have accepted the challenge of immersing ourselves in the recent past of three countries through the study and analysis of sources and of interviews with eyewitnesses of that past. We can only hope that it contributes to the further revelation of knowledge of crimes against humanity and of acts of opposition performed by doctors against the dictatorships. We also hope that it contributes to the encouragement of a necessary ongoing discussion of medical ethics during times of crisis.

PART I: DOCUMENTARY INVESTIGATION

Psychosocial Framework in Argentina, Chile and Uruguay

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Medical Practices under the Influence of Totalitarian Domination in Germany and South America.

A. The Psychosocial Dimension of State Terrorism in South America

A.1 Socio-historical Context of State Terrorism in South America

1.1 Under the Aegis of State Terrorism

> *One wants to dislocate himself of the past: with reason because it is impossible to live in its shadow, since horror has no end if blame and violence have to be paid with blame and violence, because the past one would want to run away from is still very much alive...*
>
> Th. W. Adorno, *Eingriffe*

Establishing a complete and circumspect account of the military governments in the recent history of Argentina, Chile and Uruguay is no easy task. There are many obstacles obstructing an analysis that, if not neutral given that the study of social events requires a well-defined position by the analyst, is at least free of a priori judgements. We are in agreement with Bachelard 1974 in that: "Our knowledge of reality is like a light that always casts a shadow in some nook or cranny. It is never immediate, never complete. Reality's revelations are always recurrent. Reality is never "as we might imagine it" but rather always as we ought in fact to have thought".

It may appear risky to refer to the prevailing conditions of physicians in geopolitical terms: Southern Cone of Latin America. The three countries, however, share many aspects of their recent history. The intensification of social and economic conflicts and the search for new developmental paths in the sixties and the beginning of the seventies led, in each country, to an increasing political polarization in the majority of the population, a process from which doctors were not exempt. In an almost synchronous fashion, the role of the State entered into a deep institu-

tional crisis in the three countries and to resolve it, a more or less homogeneous method was implemented: military dictatorships were established in all three[1].

For the purposes of the present study, it is important to focus attention on three basic aspects of the recent histories of these countries: a) the conceptual system of military intervention, that is, the ideology that guided the military's actions and any foundational tendencies; b) the articulation of repressive activity under the aegis of State terrorism and the importance of fear as a psychosocial agent, and finally c) the legal handling of crimes against humanity in the post dictatorial period.

1.2 Coup D'état as a Last Resort

These de facto governments in the Southern Cone had the following characteristics in common: the Doctrine of National Security as an ideological basis for the procedures that followed the establishment of the military dictatorship; an authoritarian neoliberal theory for the development of economic politics, and organized violence as an instrument to annihilate any form of opposition.

Directed at the armed forces of the Latin American subcontinent, the doctrine emerged in the Cold War environment and was articulated as a response to the threat, perceived as global, of international communism[2]. In its perception of so-

[1] The military was in power in Argentina between 1976 and 1983; Chile, 1973-1989; and Uruguay, 1973-1985. Although in Argentina there had been previous military personnel who reached power after overthrowing elected presidents, the "process of national renewal", initiated after the toppling of the government of Isabel Perón, is conceptually new and comparable to the regimes of Chile and Uruguay (Heinz 1993: 73-108).

[2] Here it is necessary to make reference to the Santa Fe Document as a conceptual synthesis of politics with a lengthy tradition of the defense of Western culture in Latin America. The following are proposed within it: a) "revitalizing the system of security in the hemisphere, supporting the Interamerican Treaty of Reciprocal Assistance TIAR..."; b) "encouraging national security which will contribute to security, regionally as well as in the hemisphere, against internal or external threats to security"; and c) "reactivating, as a third element of our system of security in this hemisphere, our traditional military involvement in Latin America, offering military training and help to the Armed Forces of Latin America, with a particular emphasis on the youngest officials and on subordinates. Offer technical aid to all countries in this hemisphere in the struggle against terrorism, independently of the origins of the latter..." See: G. Ortiz et al., 1983, cited by J. Parra in "Doctrina de Seguridad Nacional" in CODESEDH/CODEPU (1987): International Seminar. Torture in Latin America. Buenos Aires.

cial reality, the communist threat combined relevant strategies and the principal enemies were perceived to be those who supported it, voluntarily or involuntarily, in each of the three countries.

In the increasing polarization of positions, the armed forces became the only institution to maintain a vertical and coherent organization. Owing to its simplicity in defining and proscribing the enemy, the Doctrine of National Security was the ideological means that united the activities of the armed forces. It created the conceptual basis to undertake a veritable witch hunt among opposition forces; a witch hunt from which health care professionals were not exempt.

With the breaking up of the State as an institution and the seemingly imminent assumption of power by international communism, the armed forces in the three countries proclaimed a "radical cure" to be inevitable, guaranteeing order and unity[3].

After the military coup, the excessive politicization of the citizenry was defined as the problem of greatest magnitude, which had to be dealt with by declaring politics and active politicians to be in adjournment. Thus, in 1980, the Chilean magazine *Armas y Servicios del Ejército* reported: "We all know that the world today is divided politically into Westerners and Easterners; that is, Democrats and Marxists. The struggle between both camps, even though they do it strategically, especially all the largest powers, is to the death[4]."

Even four years after the return to a parliamentary system in Argentina, General Caridi. "on behalf of the military" stated that "the growing importance of the terrorist phenomenon allowed only two alternatives: either its destruction in order to save the existence of the nation or permitting its victory and with it the irreparable loss of institutions and the way of life of the Argentineans" (cited in *Madres de la Plaza de Mayo* 1987, 32, p. 20).

Organized according to the economic conceptualization of Milton Friedman of the Chicago School, neoliberal theory tends to develop free market conditions in

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[3] To explain the events of the time, reference is often made to the theory of the evils. The evil of terrorism and the evil of repression, and the historical situation is considered a tragic crossroads: whatever decision was made involved tremendous social costs. Nonetheless, there doesn't appear to have existed actual conditions for an armed counteroffensive in any of the three countries, so the armed forces had to utilize their extraordinary combat power against a defenseless population and redefine the enemy as they progressed.

[4] Juan de la Rosa Ventura 1980: "The 'game' of human rights". In: *Armas y Servicios del Ejército* 19, Santiago.

national economies. In those Latin American countries, this meant an end to long-term economic policies such as State promotion of local industry (through trade barriers against imports as a gesture of national importance) and a decrease in the amount of state social spending. An economic policy of this type necessarily required the attribute of force in order to be consequently applied[5].

Adopting a position on global strategies of finances and national economies is not relevant to the purposes of this work. Nevertheless, it should be stressed that this economic policy involved a structural reduction of public spending in the area of health care; spending was lowered in the area of preventive medicine as was State attention to more disadvantaged regions. The restructuring of the health care system led to what has come to be called an institutional fragmentation, with a high degree of privatization of medical care and a visible deterioration in the health facilities and services dependent on the State (regarding this, see for Argentina: Isuani and Mercer 1988; for Chile: Sepúlveda 1991; and for Uruguay: Margolis 1984).

Based on experiences of psychological warfare, beginning in the First World War, organized violence arose as a strategy of acting on the mind in the Doctrine of National Security (see Riquelme 1991:31-42). “A mental scar is preferable to a physical one, because it delays in becoming apparent” states Watson demonstratively. In another part of his work, he makes reference to the pioneering work in this area within the American subcontinent:.. “The Brazilian armed forces have a guide, ‘Psychological Warfare’ (Ministry of War, Brazil, 1956), which includes three attached documents....” He concludes: “It would appear the Brazilian army ...can wage psychological warfare equally well against its own people or against strangers” (Watson 1978: 56, 329-330; also Sábato/CONADEP 1984: 9-10).

Convinced of the existence of a climate of insurgency in the three countries and considering the guerrillas as the most important area of military activity, the Doctrine of National Security concentrated its efforts on fighting it, through psychological warfare against its own citizenry and the establishment of a state of exception as a long term way of life for the citizens.

In defining what that era was like for Argentina, the Sábato Report says: “In the semantic delirium, headed by descriptions such as “Marxist-Leninist,” “unpatriot-

[5] On the situation in Uruguay: “One day, before the coup, a group of foreign businessmen and investors from Business International held a *work meeting* with representatives from the !FFAA (General Gregorio Alvarez, Navy captain Hugo Márquez and Colonel Abdón Raimúndez) explaining the need *to put an end to the strikes, depoliticize the working class and privatize the public sector*” G. Caetano and J. Rilla 1991: 17 (italics in original).

ic," "materialists and atheists," "enemies of Western and Christian values," anything was possible: from people who favored a social revolution to sensitive adolescents who went to shanty towns to help the inhabitants. Everyone would fall in the raids: leaders of trade unions who fought for a simple increase in salary, youngsters who had been members at a student center, journalists who weren't supportive of the dictatorship, psychologists and sociologists for belonging to suspicious professions, pacifist youth, nuns and priests who had taken the hopes of Christ to the slums. And friends of any of them, and friends of friends, people who had been reported because of personal vendettas or by prisoners subjected to torture. All of them, the majority innocent of terrorism or even of belonging to the guerrilla's combative groups..." (Sábato/CONADEP 1984: 9-10).

Concerning organized violence itself, the Report from the Commission of Truth and Reconciliation, an official document from the Chilean government after the return to democracy in 1991, points out: "The doctrine of counterinsurgency was reflected at different levels, in the lessons received and the practices inculcated in the training of the anti guerilla forces. The secrecy of the operations; "the interrogation techniques"; the teaching of forms of fighting and "special" death techniques and of setting up ambushes; the survival training, which often included committing self-degrading, or cruel acts, served to condition the students so that ethical levels could retreat and fade, until they disappeared". And it adds: "Counterinsurgency… was practiced in several Latin American countries, with very similar characteristics and during a similar period, by the armies and/or the police and/or local security services, confirming their common origins in this way. Moreover, between the different counterinsurgencies there existed a stronger cooperation than what is usual, and even common operations and organizations..." (Report from the Commission of Truth and Reconciliation, "Rettig Report" Chile. La Nación, 5-III-1991, p. 11).

Regarding Uruguay, R. Huhle states: "Once in power, the military showed themselves to be perhaps the most conscientious and dedicated to imposing the doctrine of national security that South America had known until that time. The country was covered by a web of controls which classified all of the population according to their degree of "dangerousness." The Uruguayan military decided on imprisonment as the basic method of repression, in contrast to their colleagues in Brazil, Argentina and Chile. Thus in Uruguay there were a relatively small amount of disappeared and assassinated individuals (many of which, in fact, correspond to acts of the Argentinean dictatorship), but also the greatest number of political prisoners relative to the population size. "Uruguay at present has 1,600 problems, because it does not have 1,600 dead people" declared the top military judge in 1979, and he attributed it to the "humanitarian spirit" of the armed forces. The

truth is that practically all of the prisoners were tortured and the prison conditions were extraordinarily difficult. The meticulousness of the military was also demonstrated in the application of torture, as a doctor was present in at least three of every four torture sessions (Huhle 1991: 75-108).

Each *de facto* government considered, during the high point of the period of repression— and particularly within the armed forces—, and at different levels, of organized violence against an opposition globally classified as "subversive" as a sign of loyalty to the regime and its implications.

1.3 Foundational Tendencies

Foundational tendencies refer to the sum of efforts dedicated to the creation of a "new order" and of "a renewed patriotism." The intrinsic value of such "visions" lies in their promotion of a high degree of unity among their eventual followers. Historical experience shows us that such ideals favor the deformation of individual sensitivity -doctors for the purposes of this study- in the case of ethical and moral conflicts. While there exists an objective, conceived to be transcendental, the prominent tendency is to subordinate oneself to it as an individual and accept that "the end justifies the means."[6]

The following claim by Pinochet is well known: "In Chile, not even a leaf falls from a tree without my knowledge" .Given the power, absolute in appearance, that the military was able to reach in each country following the respective coup d'ètat, it is worth asking if foundational projects didn't arise. Therefore, if each military government claimed to be the defenders of the endangered national values, it would seem that many of its efforts should be dedicated to the construction of a nation with a new character.

J. M. Bordaberry, president-elect of Uruguay at the time of the coup d'état on June 27, 1993, and afterward maintained in that role by the military, decided to promote an "integral solution" of the problems emerging during the democracy of representatives. This way, according to the historians Caetano and Rilla 1991:26, Bordaberry devoted himself intensely to such projects and on April 19, 1974: "...after invoking "a natural order of coexistence under the law" and the "historical values of our Christian civilization," he once again swore to the oath in "the great responsibility [...] of never again regressing [...] to the state of affairs that placed

[6] See the arguments of the defense in the trials of doctors accused of crimes against humanity in Germany and Japan, such as the work by R. J. Lifton 1988.

the Republic on the brink of chaos and dissolution," reiterating "that there would be no going back to a formal and hollow democracy" like that prior to 1973".

Concepts and ideas of that nature also existed in Chile, so that a short time after the coup d'état of September 11, 1973, the "Declaration of Principles of the Government of Chile" emerged, inspired by Chilean as well as Spanish authoritarian traditions. In its contextualization of events revolving around the coup d'état, the Rettig Commission qualifies the declaration: "[The Declaration is] an ambitious document which sought to lay down the doctrinal foundations for the actions of the military regime. While that declaration accepted and announced that power was certainly to arise out of a "universal, free, secret and well-informed vote," at the same time it called for a state based on the principles of Portales: the formation of a civilian/military movement, a democracy more in substance than in form. Armed forces and police who were to safeguard national security understood this in very broad terms, even more the military regime itself. According to the declaration, this was not to be merely an administrative hiatus between two political party governments. Rather by means of a "deep and prolonged action'' it was to rebuild Chile morally, institutionally, and materially, and to "*change the attitude of Chileans*." Hence these forces did not specify a fixed period for the junta to remain in power. Finally, it is worth noting that the Declaration was presented as inalterable, thus accentuating its foundational character" (Rettig Report, pp. 66-67; italics from the author).

In Uruguay these foundational efforts had led until 1980 to the drafting of a new constitution and, at the height of the process of achieving popular support for such a national redefinition, to making the intrinsic value of military activity stand out for the nation in the making:

The military profession is not just another profession. It constitutes a true State, a spirit and a lifestyle that defines a vocation of service to one's country… The time when our activity was reduced exclusively to the planning of operations, and to preparation and instruction, have passed… Today the war penetrates in unsuspected camps, subversion works actively and insidiously… Therefore, in order for the force of security to overcome the subversion, the responsibility cannot be assumed by soldiers with a merely professional mentality and spirit. The armed forces knew how to overcome these professional criteria that converted them into a military arm of a constitutional legality devoid of all sense of nationalism and patriotism (Caetano and Rilla 1991: 58).

To Chile there should be assigned a process of a more pragmatic nature which led, also in 1980, to the formulation of a new Constitution, about which the Rettig Report states: "Its features retained little or nothing of the 1974 "Declaration of Principles," they were traditional liberal and democratic principles, albeit with a

strongly authoritarian slant. They set a date for the military regime to end, however, and enshrined in the Constitution economic freedom, the primacy of private initiative, and the diminishing of the state's role" (Rettig Report, op. cit., p. 68).

A discussion of the validity of the elections and plebiscites conducted in the course of the military dictatorships seems pointless. Nonetheless, the recent experiences of these South American countries demonstrate some paradoxical results. First of all, it should be emphasized that the 1980 plebiscite on the new constitution in Uruguay led to a massive defeat of this procedure and transformed its agencies into members of a "dictatorship of transition" (Caetano and Rilla 1991:79). In the second example, while the Chilean plebiscite in 1980 led to the forced acceptance of the new Constitution via the election route, it also opened up the possibility of Pinochet being legally "unelected" in the next plebiscite, taking place in 1988. The plebiscite was to confirm Pinochet for another eight years, this time in a de jure presidency. However, the majority of voters opposed the continuation of the de facto government, despite a strong fear campaign unleashed by the dictatorship in place, and through their opposition vote permitted democratic elections to take place afterward.

In order to make a historical comparison between forms of totalitarian domination in Europe and Latin America, the opinion of A. Rouquié 1987:346 turns out to be interesting although it focuses particularly on Argentina: "The authoritarian regimes of Europe between 1920 and 1945 were aimed at the creation of a "new order," even a "thousand year Reich," as opposed to liberalism and democracy. The military dictatorships of Latin American today are first of all regimes without an ideology. The "national security doctrine" that those institutionalized military governments share to a lesser or greater degree furnishes a rhetoric that conceals their illegitimacy, rather than providing a new source of legitimacy. That doctrine was above all a way to forge a mobilizing consensus within the military institution around an image that was related to their professional alarmism. Their theories of war, by enlarging the spectrum of threats and locating them within the nation itself, gave a corporate basis for the army's intervention in politics, but they did not explain it. They could justify a lasting presence in positions of command in the state, but they did not establish a new power. In a word, the theory of national security in no way takes the place of an ideology, not in its consistency, or its diffusion, or its constituting function.

While in all military proclamations the wish to save the threatened homeland was sustained, a national foundation appears to have only been a chimera of ideol-

ogists close to the military and with little support in the civilian population[7]. There are no reasons to consider the viability of a foundational ideology specific to the era, that is, with a new historical definition of themselves on the part of the holders of power.

We should recall Karl Mannheim's quotation from the Nazi Ministry of Justice: "Formerly we were in the habit of saying, 'Is this right or wrong?' Today we must put the question thus: 'What would the Führer say?'" (Diagnosis of Our Time. London, 1943, p. 97). We see that a direct analogy with the situation studied in South America is quite limited: here the collective representation is of an authoritarian State that exercises organized violence openly and the messianic figure of a Virtual Führer doesn't exist or is of minimal importance. For the purposes of this study, that explains the absence of messianism in the majority of the involved civilians, and it remits us to a system that functions, more than anything, as a result of the exercise of terror as a form of domination over the general population[8].

1.4 War against One's Own Population: Psychological/Military Principles

Organized violence against one's own population came to be an essential characteristic of military activity in the three countries considered here. It represented a form of psychological warfare, since it had as express objectives the intimidation and subjugation of large groups through the employment of psychological actions. These were conceived in order to impose a passive acceptance of structures of authoritarian domination and to create a sensation of constant threat and personal powerlessness toward the military system among opponents.

This psychological war was carried out in three mutually complementary areas that can be considered as the principal forms of application of organized violence:

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[7] As a marginal but representative reflection of this absence of their own ideology, we notice the eagerness of some military personnel in the three countries, heads of respective States, to praise each other by alluding to their own patriotic values (Caetano & Rilla 1991: 28, 55).

[8] Confronted with the need for structural changes. a technocratic conception is imposed in these societies in which the goal of modernization is considered imperious, and manifests a lack of interest in the participation of a wide range of social strata (Personal commentary of E. La Mura).

a) The disappearance of opponents of the regime;
b) Systematic torture;
c) The control and manipulation of the mass media.

Since this organized violence can be considered as a premeditated and permanent aggression against the psychosocial health of the majority of the population, we propose to continue by developing its principal forms of manifestation and to show the consequences of its application on a population that is in principle defenseless.

In a study of this type, we should go beyond the indignation evoked by the practices of State terrorism. We think that reaction was indispensable during the dictatorships in order to conserve the nucleus of civic values and courage in society, and it was also a determinant factor in articulating a political stand for the opposition —a source of relevant information for our study. Nonetheless, in our work we must go further still: we are obliged to achieve a scientific understanding of the topic and, on the other hand, we have carried out this investigation from Germany, having been neither direct participants nor witnesses of the processes studied. This inhibits any temptation to become spokespeople and torchbearers of moral indignation, though it should be emphasized that this justified attitude has been itself represented in the affected countries[9].

1.4.1 The "Disappearance" of Opponents of the Regime

This method consisted of the capture of political opponents of the regime by the armed forces or intelligence officers or the uniformed police or, more often, by members of paramilitary groups who acted under the direction of members of the above organizations. Once captured, the affected were confined in places not known to be prisons and/or they were transferred from one place to another to avoid their being located.

[9] We wish to contribute also to the psychosocial efforts undertaken in these societies against fear, about which E. Galeano says: "Fear dries the mouth, moistens the hands and mutilates. Fear of knowing condemns us to ignorance; fear of doing condemns us to impotence. The military dictatorship, fear of listening, fear of saying, has converted us into deaf-mutes. Now the democracy has a fear of remembering. Ill with amnesia, we repeat history rather than change it. Fear, fear of living, fear of being, fear of loss, is the most difficult offspring of death". In *Nueva Sociedad*, 100, p. 197. Caracas.

The hope was to create a high degree of insecurity and personal powerlessness among relatives and friends of the detained. By not knowing the place of detainment of the “disappeared,” the relatives could not bring regular legal resources before the authorities, such as habeas corpus, nor arrange the defense of the detained through the appropriate legal authority. The wall of silence at the police stations or in the prisons when making inquiries about the whereabouts of the sought-after person served to reinforce the sentiments of insecurity and abandonment of the families and friends of the “disappeared", insofar as the detainment and disappearance of the loved one marginalized him or her from the “established order.”

During the past twenty years, there has been formal documentation of more than 30,000 cases of “disappeared” individuals in South America. However, the method of the disappearance of opponents of the regime was not the “genial invention” of some member of the repressive systems of those countries. Instead, it represented a massive application of an already common method within psychological warfare, one that probably began with the experiences gained by military theorists from the United States during the war in Indochina (Watson 1978: 357-367).

One of the historical antecedents of greatest relevance is already found in the transport of prisoners in “night and fog” operations from territories occupied by Nazi Germany, with the aim of breaking the Nationalist resistance of the respective countries, in agreement with the Keitel directive of 1941: “Efficient intimidation can only be achieved either by capital punishment or by measures by which the relatives of the criminal and the population do not know his fate” (Shirer 1960: 957).

Another, more immediate, antecedent is the experience of the war in Vietnam. Some social psychologists and cultural anthropologists from the United States who served as scientific advisers to their country’s armed forces made significant observations and reached fundamental conclusions on the defensive morale of the Vietnamese. What affected them most psychologically was not so much the death of their neighbors or relatives during the war actions in itself, but rather the fact of not being able to celebrate the traditional ceremonies for the fallen, giving expression to their pain as a ritual way of saying good bye to their dead. The absence of ceremonies of mourning broke the delicate cultural bonds that relate the living to the deceased. The family and the community felt deeply insecure, as if they had collectively violated a taboo; this tactic was called “errant souls” and was of very significant value in the psychological war against the Vietnamese population (Watson 1978: 357-367).

In South America, the disappearance of opponents of the regime only began to be used systematically during the mid-seventies, when it probably became clear that the population did not submissively accept the establishment of an authoritar-

ian and neoliberal model of society but that, on the contrary, both a passive and active resistance of long duration began.

The emotional effect that the “disappearances” produced in relatives and friends was characterized by highly contradictory situations and behavior. Inasmuch as the fact that the repressive forces systematically tortured their detainees was known, the relatives had feelings of helpless compassion (“I hope that he/she dies soon and doesn’t have to suffer so much"), mixed with others that demonstrated an “irrational” hope (“I hope that he/she is alive and will return to us soon”) (Ulloa 1986, Guinsberg 1985).

The relatives described this situation as a “permanent shock, a latent and permanent crisis situation, wherein the sadness and pain caused by the absence of the loved one are felt as unending.” There didn’t exist a situation of pain perceived as such, but rather a feeling of absence with no paths to resolution. Absence or loss of a loved one cannot be synonymous in that “the process of pain or suffering is essential to the assimilation of the loss… Through the pain one learns to accept the change that follows every death of a loved one. When this process of pain is not carried out completely (when it remains unresolved), there is little probability that a healthy adaptation to the loss suffered can be achieved” (Kavanaugh, cited in AI 1982: 177).

The feeling of absence of the loved one acquired then a lasting quality in the relatives and had a profound bearing on their social behavior. This attitude of the relatives toward people who were “disappeared” during the dictatorships has an effect even today and is expressed in the cultural and political activities of the pertinent organizations. (See materials from the International Seminars “Grandmothers of the May plaza”: affiliation - identity - restitution, Buenos Aires, April 11-13, 1992).

In terms of a reconstructed experience, relatives of the disappeared who experienced that “atrocious absurdity” passed through 3 phases that can be defined (Bonaparte 1984):

a) The immediate reaction, generally, fills one with conflict and anguish. Had one asked the appropriate questions without compromising others? Might one be acting unthinkingly and be placing the “disappeared” and some other of his relatives in greater danger? This often leads to a feeling of perplexity like that “of being struck by lightning.”

b) After some time there follows a phase of desperate search, wherein the families did everything possible and imaginable to learn of the whereabouts of the disappeared. “The absolute uncertainty about the fate of the prisoner produces an extremely great feeling of unease, and the hope of seeing him again instills into the relatives an absolute urgency in the actions they carry out” (AI 1982:118).

c) In the third phase, in general, the collective actions of the relatives took shape. Each of them has independently reached the conviction that an individual attitude does not lead to any success and he turns to group activity approach as a form of escaping this "tragic labyrinth[10]."

This collective activity when faced with the disappearance of opponents of a regime, for example that of the Madres de la Plaza de Mayo in Argentina, succeeded in that public opinion came to acknowledge the true quantitative dimensions of these crimes against humanity as well as their personal significance. Also, this way the design and development of psychotherapeutic treatments aimed at overcoming these traumatic experiences: "Chilean and Argentinean therapists consider that an important form for the relatives of the 'disappeared' consists of becoming incorporated with the work of solidarity groups[11]."

To appreciate the significance of the "disappearances" on the psychosocial health of the population, it appears important to us to consider that many of the relatives of the disappeared were children, all the more defenseless against this "psychological warfare tactic" (Watson 1978), and toward which society in general should confront its responsibility.

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[10] From a psychoanalytical perspective, Ulloa (1986) defines the situation of the relatives of the disappeared as tragic, in that they tolerate it in a private way. They struggle in a dead end where, on the one hand, there are feelings of grief and hatred for the disappeared and, on the other, feelings of powerlessness and negative identification with the authorities (who can put an end to the suffering of the disappeared). "Tragedy paralyzes… that circle can be escaped by means of the help of others… The drama provoked by the intervention of others once more reestablishes the dynamic components of suffering… That is the role played by human rights organizations where, while solidarity is developed, simultaneously, reflection takes place and feelings and actions from the participants are clarified".

[11] On this issue, the book "*Terrorismo de Estado: efectos psicológicos en los niños*" puts forth as a central thesis that: "It is legitimate to think that for these children, if the disturbing memory of the horrific past of which they were victims persists in their symptomatic behavior, and if they don't find (upon growing up) a social group which has found the truth and justice with the agents and systems that committed the crimes, they would have greatly reduced the possibilities of ridding themselves of their symptomatic memories. As such, the threat of a crystallization of the symptomatic violence condemns them to a current exhumation of the tragedy of their elders. This will not only take place in their generation, but -as is taught by the experience of Europe- in the generations that follow" .This book is a product of the combined work of relatives of detainees and individuals disappeared for political reasons and was edited by Paidós, Buenos Aires, 1987. See also: Allodi 1977; G. Maci and J. J. Fariña, presentation, Buenos Aires, September, 1983.

1.4.2 The Psychosocial Dimension of Systematic Torture

The systematic torture of opponents to the regime came to be a customary component in the social practice of the regimes in power in South America (cf. ONU, 9-XII-1975). The prospective study of the experience of torture, as related by its victims, allowed the recognition of a tendency toward technical perfectionism, so that we should speak of systematic torture. That is, torture supported in a scientific manner, whose effects on the individual and the people who surround him were pursued on the basis of canons of common interpretation and psychological warfare. The acknowledgment of this practice was exchanged across borders and served to strengthen the repressive systems of the "friendly countries".

There are already some investigations of the increasingly refined techniques for the torture of opponents (see AI 1985: *The Victims of Torture… A Report on the Use of Torture in the Eighties*, and Larsen, E. 1983: *In the Name of Human Rights*). The assumption that torturers would be people with latent psychological anomalies but in important positions, and who, owing to their unhealthy predispositions, would enjoy terrorizing their victims, can no longer be sustained. The practice of torture constitutes a technical entity in addition to psychological warfare and, in general —as it had been observed in the Process of Nuremberg and during the war in Algeria (Fanon 1963)—, can be carried out by any member of society with a "normal and ordinary" ethical framework (Bettelheim 1943). This can be done as long as his unconditional submission is given to an authority which frees him from the responsibility of his personal acts and presents his activities as a torturer as socially necessary (Reemtsma 1991).

Graham-Yooll provides the authorized opinion of an official from the Argentinean army on the matter: "The Argentinean experience is based on that of the French in Algeria… The communists cannot be defeated in another way… I never tortured. To torture is to inflict pain for personal pleasure. I punished the enemy carrying out orders from my superiors. And if you want to know, everything is transformed into a game with their rules: the subversive knows it. You have to get information from him. Time is on your side, but you cannot give him time because then he will win as soon as he starts to realize what you are doing. You have to work to defeat him as quickly as is possible. You regret causing him pain but you work quickly. You don't look him in the face, even if you put the electrodes in his mouth; and you have him blindfolded. The secret lies in not looking him in the eyes. The other secret is that there be no blood, that has to be left for the sick sons of bitches or the young brutes..." (Graham-Yooll 1985: 203-208).

In the framework of psychological warfare in South America , the systematic torture of political opponents had as objectives:

(a) Acquiring information from people accused of being members of a resistance party or group. Here, a broad gamut of psychological and physical punitive techniques was utilized, aimed at softening and breaking the resistance of the affected. Its main purpose was to obtain a compromising confession from the affected and his peers.

(b) The confrontation of individuals or social groups with an incident of State authority presented as omnipotent. As a result of this, the system of repressive power would lead to people feeling unprotected and to adopting an attitude of passive acceptance of the system. Specifically, they were made to witness the torture and maltreatment of people of prestige in terms of "exemplary lesson", for example, in the massive raids carried out in Chile during the last years of the dictatorship.

(c) Sowing mutual distrust among the opposition groups. As in the preceding objective, the point here was for the arbitrary captures and the mistreatments to produce reciprocal suspicions: it should spread the suspicion that each member of the group could be an informant. This method proved to be very costly and, in general produced limited results.

(d) Causing the psychosocial disability of supposed or acknowledged opponents of the regime. Here, as in the first objective, an attempt was made to cause a lasting injury to the psychosocial integrity of the individual.

The affected should emerge marked by "the invisible pain of torture" (Barudy and Vieytes 1985), such that his personality would leave the impression of having been destroyed, thereby arousing fear in their native social environment.

Owing to the information reported by psychotherapists of the affected, and to the direct testimony of victims of torture as well, the effects on psychosocial health have come to be recognized (Castillo, Dominguez, and Salamovich 1986). From a study carried out with victims of torture in Denmark in 1977, it emerges that for the affected "the worst consequences of torture are of a psychological and neurological nature. There are often reports of anguished states, irritability and depression" (Larsen 1983). The therapists emphasize the long-term effects of torture on the relatives of victims and, generally, on the people of their respective surroundings.

In Chile, preventive action against systematic torture was also carried out[12]. The extreme experiences suffered by of some people with the repressive system of

[12] As, for example, in the study topics: "Collective Threatening", "Study of a Group of Female Prisoners Who were Tortured", and "A Psychotherapeutic Experience with Political Prisoners Within the Prisons" .In: CODEPU: " *Tortura, documento de denuncia*" Santiago,

power were discussed in small local groups. In doing so, on the one hand, the silence around this type of experience was broken, since as Jean Amery says: "he who has undergone torture will never again feel welcome in this world"[13] .On the other hand, through the "socialization" of distressing experiences, they sought to overcome the disgrace and isolation frequent on the victims of torture, and also, by making the horror explicit, diminishing the premonitory anguish in case of detainment.

4.3 The Control of the Mass Media

One of the first measures in the course of a military dictatorship consisted of the voluntary or compulsory control of the media at large, with the aim of influencing public information in coercive and disciplinary terms. This manipulation of public opinion could be fairly blatant, as was the case in Chile immediately following the military coup, when the "masculine" pants of women were cut above the knee and the long "feminine" hair of young men was cut to the nape of the neck. This was reported in a jocular form at the time by the obsequious newspapers of the recently established dictatorship.

Nonetheless, this manipulation can also be developed in a more penetrating form, as in Argentina between 1976 and 1983. The media were used to increase the repressive effects on the relatives of the tactic of disappearance of persons through the continuous and systematic diffusion of certain announcements and slogans (Kordon et al., 1986). The aggressive and continuous diffusion of texts that were found in the media at large insinuated the following:

(i) That silence be maintained about the "disappeared", as if it were something dishonorable for the family and circle of friends;

(ii) That the parents of the family continuously reflect upon their possible responsibility for the behavior of their now-adult children in order to induce the conviction that their disappearance stemmed from the poor upbringing they re-

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Chile.

[13] Larsen informs: "The ecclesiastic authorities published 'Ten Commandments for the Politically Persecuted' .They are advised to do the following: if they are captured, to scream their name and their place of occupation to assess, despite being blindfolded, the location of and distance to the place where they are led; and they were exhorted to overcome the fear of denouncing before the courts the tortures inflicted on them and to also overcome the fear of insisting upon medical acknowledgment..." (Larsen 1983: 66).

ceived. This would be suggested through certain questions: “How did you raise your children?” “Do you know what your child is doing at this time?”;

(iii) That a collective decision be made as soon as possible in terms of forgetting the disappeared or giving him up for dead, insinuating that he had voluntarily abandoned his family and friends, for example by going abroad and that, for this “irresponsible” attitude, he should be punished with indifference and forgetting.

(iv) That the “disappearance” be considered as proof of the guilt of the affected, thereby having the responsibility for the event fall on him, for which indirect idiomatic spins were used: “he must have done something", “who knows what he was up to", etc.;

(v) That political dissidence be considered as a form of psychological disturbance, under the assumption that what is “normal” -ergo, mental health- consists of the acceptance of social reality such as it is, that is, accepting the mechanisms of totalitarian domination and social injustice and adapting passively to them. Not accepting the status quo would be evidence that the affected were immature people.

The aspects exposed here were developed through an intense propaganda campaign that utilized all the modern methods of publicity, such as brief messages on radio and television, indirect idiomatic spins, street signs, etc.

This systematic method of the social media assumes exemplary forms in Argentina. Through this procedure of publicity, a climate of profound insecurity was achieved. With it came a tendency for the family and friends of the disappeared and, the majority of the population in general to become convinced of a degree of latent guilt and of their own individual powerlessness. They worked towards subordination to the forces of the state; individuals should surrendered to state terrorism.

The concrete effects of this coordinated manipulation of everyday information are evident in the communication by A. Graham-Yooll (1985: 186): “A middle-aged couple made their children swear that they would keep the secret of the ‘disappearance’ of the oldest brother. Once a month the parents would write themselves a letter, on blue paper, telling of the news of an oldest son who wrote from Spain. They would circulate the letter among the aunts because they couldn’t endure the shame that would result for the whole family if it were known that one of the nephews had been kidnapped by the security forces under suspicion of being a member of a guerrilla cell”.

Puget 1989 introduces us with great clarity to the cultural and psychosocial atmosphere of Argentina at the time: “In attempting a brief description of the Argentinean social context, we emphasize that the dictatorship actively occupied itself

with producing ignorance, creating false expectations, silencing all thought contrary to the regime, utilizing fear and panic as instruments, transforming information into misinformation or corrupted information, predominantly utilizing paradoxical messages. Little by little, certain terms disappeared from the current language. The Language of Power spoke of the protection of families, of the creation of a new order (we recall Hitler), of having created a system of impunity according to which crime, torture, lies, the annulment of Human Rights were 'permitted' in order to recover 'national security'" (translated direct from original text).

The lasting psychosocial effects of this coercive propaganda have begun to be studied in Argentina in the post-dictatorial era (Candia 1986, Lagos 1988). The Commission of Psychoanalytic Investigation of the Argentine Psychoanalytic Association reaches the following conclusions in its preliminary communication about the effects of State terrorism in Argentina:

Reality shows us that in a society that emerges from a period of political repression there are remnants present, left by the existence of individuals who either disappeared, were assassinated, or tortured, or of exiled individuals who were separated definitively from their families. Also by the existence of those who were the instigators and the executors of the repressive system and who continue to live in the country (see Argentine Psychoanalytic Association).

The psychosocial effects of organized violence on individuals or small groups can be verified through the documentation of the experiences of those who have participated in it as direct or indirect victims. The overall social significance of the military intervention on social life cannot be estimated yet in its multiple implications (cf. in Puget & Kaes 1991 the texts of L. Ricon, J. Braun, M. L. Pellet, and M. Viñar).

In some people, a sort of split perception (into the possible and prohibited) was evident for a long time, along with a formal behavior that left no room for misunderstandings, which was interpreted as a high level of internalization of the messages received. Other people appeared affected by a high degree of insecurity as regards norms and codes of conduct, as if they had to permanently restructure their perception of the surrounding social medium (Fariña 1990: 153-158).

5. The Relevance of Fear as Repressive Agent

During almost twenty years, human rights organizations reported on the neglect and abuse of these rights in South America. The violation of human rights formed an integral part of the psychological warfare unleashed by the local armies against their own populations, for the purpose of impeding social reforms and trying to impose a barracks mentality on the dissident majority.

E. Lira and M. I. Castillo, in an investigation of fear in Chilean society carried out in 1988-1989, even as the military government was still in power, make the following observations: "...In the study groups these threats appeared to be registered as specific fears… Political threat is perceived by the subjects in the study as a real threat of death, of annihilation and as a threat to the process of consolidation or maintenance of their identity. A social perception of basic distrust, neglect, loss of autonomy or desperation is developed, appearing in the context of fears generated by political threat… By introducing death as a possible sanction, political repression modified the previous social rules, the collective representation of politics and the permanence of rules and laws as referential guidelines. In this sense, reformulating the codes of interpretation of reality and of representation was implied, altering the basic confidence of the subjects in reality and their own perceptions of it… The climate of terror that governed social relations is consistent with the perception of a state of indifference in the subjects of the study toward an authority perceived as omnipotent, cruel and sadistic… Silence characterized a lengthy period of social life, no one mentioned what was taking place, because doing so was prohibited..." (Lira and Castillo 1991: 236-237)[14].

Rozitchner makes reference to the psychopathology implicit in organized violence: "The terror and repression broadened the limits restricted to the individual, breaking the barrier between fantasy and reality, between illness and health. What the psychotics hallucinated, their terrors and destructive threats that caused them to live in continuous anguish and horror were confirmed as true and really existing in tortures, rapes and assassinations. The complex and surrealist constructions of psychotics, everything the terrified individual imagination fabricates as persecution, aggression and destruction, dismantling and intrusion, desecration, violation, espionage, imperative orders, obsessive repetition of a period experienced as infinite in its unfinished extent, all of this was confirmed in the historical and institu-

[14] These investigators also clarify the positive psychocultural effects, based on observations arising from their investigation, of dealing publicly with the topic of societal fear: "This perception that appears to belong exclusively at a subjective level was confirmed as a fact in reality in the Public Opinion Surveys (in samples which included 98% of the population) of the period of the study. They were able to gauge the impact and the internalization of threats and fear in society, and they provided evidence of the perception of a threatening social climate… This verification reflected a shared social perception, which in turn allowed a process of awareness about the existent threats and fear. In reducing the ambiguity in the perception of reality, its existence was confirmed, which permitted the structuring and labeling of this reality in objective and subjective terms, and acting on it" (Lira and Castillo 1991: 238-239).

tionalized reality of terror and its laboratories of horror. There was no distinction between the fabricated and the real; the historical reality itself confirmed it to be true" (cited in Lira and Castillo 1991: 29).

J. Vergara summarizes: "In contrast to the Nazi strategy, which sought to dissolve the traditional groups in order to reconstruct society on the basis of new groups, Chilean authoritarianism was able during one decade, approximately, to fragment and split society, destroying or debilitating the traditional groups and organizations of the subordinate sectors" (Vergara 1990: 178).

- Aside: Consequences of Fear in Daily Life

  In the last two decades, the majority of the population of Argentina, Chile and Uruguay experienced the effects of organized violence that was aimed at paralyzing and deactivating the social and cultural organization of opponent individuals and groups, both real and potential.

  To create experiences of terror in all facets of everyday life, physically and psychologically extreme situations were intentionally developed. In this way, all active expression of discontent or opposition and of resistance toward what was interpreted as unjust was nipped in the bud, so as to destroy the movement of the democratic culture and create the impression of a total threat. Playing dead became an automatic reflex for those who differed from the military regime. Under these conditions, many people found themselves forced to go unnoticed in an unspoken survival tactic, as a consequent way of reacting to eventual annihilation, since they could effectively become "disappeared" at any time, or tortured or assassinated. The ideological strategy of State terrorism was not only expressed in the use and abuse of power by the State apparatus, but also involved the intention of psychological intervention. It sought to openly transcend the limits of formal obedience and, through sophisticated techniques of influence (Riquelme 1990: 125-141), to penetrate the consciousness of each member of society as an instance of psychological power to create a subtle compliance ("see nothing, hear nothing, say nothing about a secret that concerns everyone").

  In general, the fact of finding oneself embroiled in a repressive event, whether directly or as a relative or friend of a tortured person or of one who was "disappeared", often developed a characteristic psychological profile in those affected, which some Chilean psychologists have characterized as possessing the following attributes:

  Feeling of vulnerability: faced with a situation of vital threat, the perception of personal weakness arises. The person recognizes himself as "identified," "pursued"; the environment of his personal life loses the possibility of privacy or intimacy. He comes to be a subject susceptible to arbitrary acts beyond his control.

  State of alert: an exacerbation of the senses is produced, without the possibility of rest due to the imminent danger and vital threat this would entail. It can be expressed in many varied symptoms.

Individual helplessness: refers to the realization that personal resources and personal strength are useless for confronting adversity. The subject feels that he doesn't have control over his own life and that the decisions about his own future are not in his hands. The abandonment in the presence of violence, the feeling of vulnerability and defenselessness are expressions of such helplessness.

Alteration of sense of reality: one of the objectives of terror is to impede all action, tearing people away from their activities by force. An attempt is made on the psychological mechanism of verification of reality. The impossibility of verifying the subjective in practice tends to dissolve the limits between the real and the possible, the fantasized and the imaginary. Reality becomes totally confused and threatening without clear limits, losing its orientative role within subjective processes (Timmerman 1987: 44).

Giberti describes the vicissitudes of living under a constant State of Exception: "During the years of the dictatorship, being careful to avoid imprisonment proved useless; ingenious strategies could be practiced, like moving to a different house or not speaking about certain topics, but everything depended on who was wielding authority. You had to flee the country or put up with whatever came. There wasn't room for anything psychopathologic or interpretive that only covered one part of reality: the psychological. In contrast, it corresponded to political lectures when it involved making decisions about ourselves or some consultants or patients… If the criteria of reality announced that "there are dangers" it was because something was happening; for some that criteria served to "not get involved" or "not wanting to know," but it proved difficult to maintain ignorance about that event..." (Giberti 1987a: 17-34).

Caetano and Rilla provide some reference points on the effects of State terrorism on everyday life in Uruguay: "The logic of repression also supposes that the repressors will never reveal definitively the object of their furies. The citizen, the subject, lives then in fear of the illicit and on the verge of transgression: his only way out is the proscription of politics, even in the minimum frame of their reproduction as a family. It was not difficult to notice that Uruguayan society had expelled politics even from family parties. More than a prohibited topic, it seemed taboo, a topic that was not even thinkable… The media, meanwhile, accompanied the repressive process with the silence that was imposed on them and that some accepted without major violence… And between the repression and concealing, the dictatorship naturally revealed itself by play of rumor and the underground: you would read between the lines, the texts were extracted, deeds were searched and inflections from dispersed intentions from dispersed intentions… The dictatorship had a parallel history, woven from the rumors emerging from terror and from the blocking of information… Education centers, amidst the general deterioration of the educational system (poor attendance, under funding, "purging" of teaching and administration), incorporated into their daily lives the horrors of the authoritarian society that they should be serving. All in all, it is probable that school and high school, despite the obsessively casuistic ordinances and regulations, were unable to transfer

neither the militarist mystique nor pro-dictatorial fervor to the children and youth" (Caetano and Rilla 1991: 147-148).

H. Faúndez defines, from a phenomenological perspective, some situations of intra-familial communication in the atmosphere of a ubiquitous fear: "The circulation of fear within a family is also marked by denial, pretending and concealing. More evident than in other communicational contexts, the phenomena of fear are tied here to the processes of blame, hostility and mutual desire for protection. The intensity and nature of the inter-familial interaction make it impossible for the pretending and the concealing to go unnoticed. Living this way (with no fear or pain) evolves from the basic communicational rule of the "shared secret," a phenomenon wherein one or some of the members play the role of the delegate of group anguish, or of scapegoat, or of "weak victim," of "invincible solver" as well as other functions which tend to maintain the dysfunctional cohesion and survival of the family. In any of the cases and their variants and summaries, there appear rigid phenomena and the inevitable tendency toward homeostasis. We have assisted families in which one of the members (generally a parent) breaks the "shared secret" at the point of no longer enduring the guilty conscience of his own pretending. Racked by this guilt, he performs a courageous act and declares his fears. In a tentative relief of his self-reproach and weakness, he also makes an intimate expiation before them: he declares himself a coward. With this he hopes to put an end to the question, bearing his own guilt and that of the others, wishing in this way to protect the family."

But it happens that these acts do not always achieve the alleviation of guilt, and the end of fears even less so. The subject is trapped and can come to reproach himself as doubly coward: one, for not having done something in agreement with his principles, and two, for not admitting the true history and determinants of his fear and guilt, which are those of being immersed in indignity and the helplessness created by authority. He begins then to rage. Hostility is added to the fear and guilt. He will rage against authority, its symbols and representatives, but it is also common for the members of his own family to suffer the irritation of a humiliated individual, fearful and filled with guilt.

The motivations of mutual inter-familial protection that run next to the dangerous desire to be consistent with their convictions has led some members of these families to very pathological interrelational interactions.

From among these, two that we have observed in parent subjects who have suffered prolonged torture and imprisonment seem worthy of emphasis: a) "I am worthless… everything I do is stupid...!" b) "Do not love me!" In the first case, this proclamation may occasionally be very explicit and well argued by the subject himself. The person intends to simultaneously explain (or justify) his vital process, his current fears and eventually to atone for the guilt of breaking under torture. In the familial context, particularly in front of the children, it may be an attempt at protection, of preventing them from following the same steps. These are for the most part an enigma, since it is rare for subjects to be able to share traumatic events and feelings from their past.

These parents negate their own image and they discount it; at the same time they compel their family to love them and feel sorry for them by placing themselves in a victimized position.

The natural confrontation and differentiation where adolescent children are concerned inevitably leads them to solutions that may be extreme: they encapsulate themselves in a bitter and solitary resignation or they react authoritatively and with hostility. Either way, however, in their life practices they again deny the ideals which give meaning to their existence.

During this whole process, fear is always acting to touch the nucleus of the traumatic experiences of terror. The members of the family perceive and share the untouchable quality of the pain. They protect, on their part, the affected by keeping themselves from opening a dialogue. The trap of anguish, pain and fear closes over them time and time again.

In the case of the imperative statement “Do not love me!", the subject is overwhelmed by the guilt of having inflicted “avoidable” pain to his family, generally following clandestine life, kidnapping, torture and prison. Even when he is able to live a life full of caution and “not get involved with anything” following their release, he lives in fear of a potential further persecution (without being paranoid: it actually happens).

As a means of preventing a great hurt to his loved ones, he protects the family by attempting to force them to not love him. They protect themselves with an apparent affective coldness, they become obstinate, unsociable, distant and self absorbed. They do not speak, and do not allow others to speak, about political contingencies or their past. They take refuge in the effort to provide materially for the family as best is possible. Expressed colloquially, the terminology of this paradoxical

paradigm is as follows:

Subject: Because of my love for you, I insist that you not love me. Because of your love for me, you have to learn to not love me. Family: Out of affection and protection for you, we will pretend as if we did not love you. Because of our love for you, we live, each of us alone, our pain in silence.

The familial relation is frozen; they accompany each other sharing the pain in silence and solitude (Faúndez 1990).

In this pathogenic context which the psychotherapeutic profession develops by support groups, in their greatest non-government organizations, under the aegis of terror in Chile, became particularly important. The following position was defined toward fear or anxiety induced by organized violence:

Fear, the subjective phenomenon, formerly private, has been transformed into a massive and perceptible psychosocial experience that simultaneously affects thousands of people in our society, forming a central element that impinges on daily life and social interaction in the Chile of today… We wish to point out with great clarity that the therapeutic objective of treatment of families living in fear is not to overcome the fear. Overcoming it would be equivalent to denying it and as such perpetuates its destructive effects within the family and society. Rather, the principal ob-

jective of psychotherapy is the confronting of fear in order to integrate it, with all its implications and contradictions, in a healthy and dialectical manner. … It is up to psychology to deepen an individual and collective analysis, assuming that fear can come to constitute a powerful motivation of social conduct in relation to social and political participation and responsibility, since it becomes necessary to reveal its impact and counterattack its effects with the intention of acceding to a democratic and participative society (Becker and Weinstein 1986).

The magnitude and significance of the effects of State terrorism, both in the personal environment and the therapeutic treatment of victims, were thematically outlined early and gave rise to a critical discussion beyond the national borders. The same occurred in the area of psychosocial health, so that it is now possible to have at one's disposal a broad base of information on the repercussions of terror on those affected, as well as information on those who provided medical and therapeutic assistance to victims.

Despite its pertinacious repressive implementation through techniques intended to evoke an attitude of submission and passive adaptation among the population, the military apparatus was unable to achieve a hegemony over consciences. Such "regimes of force" were unable to create climates of unconditional acceptance anywhere, nor were they able to ideologically consolidate their virtual epigones (R. Huhle 1991). On the contrary, the practice of organized violence served to create the basis for a form of psychosocial resistance that sought the most varied forms of public expression to draw attention to the systematic repression, in all its detail, that was being suffered (Lira, Weinstein et al. 1984). In the recent history of those South American countries, a certain simultaneity of the coercive destructive processes of state authority and the cultural and psychosocial repair from its base is observed regularly (Riquelme 1990: 9).

In our opinion, this form of psychosocial practice did not have a significant importance only for the patients and psychotherapists directly involved in it (Lira, Weinstein and Salamovich 1986: 51-57). The confronting of organized violence and the maturation of social experiences during the last twenty years represents a social and political task that must be continued with the cooperation of all social forces. The preventive character of the specific knowledge of fear and its effects on society must be accentuated, so that "never again" acquires social meaning and is transformed in a historic reality (Rojas 1990: 235-239; Aldunate 1990: 372-375).

Later in this study, we will see that doctors played a very important role in these situations. Some were specifically pursued by the repressive apparatus by virtue of their compromising attitude in societies renowned for their deep social contradictions while others, utilizing their professional capacities, came to actively participate in the formation and development of the totalitarian model of domination.

6. Human Rights and Justice in the Postdictatorial Era

The explicit consideration of the damages caused in the area of human rights constituted a fundamental characteristic of the return to a parliamentary system in the three countries.

As it is known that during each military dictatorship there was a coordinated effort against human rights, we wish to concentrate the analysis on the considerable relation between human rights and the return to legislative democracy. This is done without settling on a number affected the repression in each country.

In Argentina, where the charisma of the ex-head of State Perón has had strong support and his Justicialismo Party holds a large majority even today, the electoral triumph of Alfonsín in the first post-dictatorship elections was surprising. His election has been attributed to his choice of human rights as an issue, which he presented as a key point to the reconstitution of Argentinean society (Scholz 1990: 222) and which took up a substantial part of his time during the first part of his presidency[15].

On the initiative of president Alfonsín, the National Commission on the Disappearance of Persons (Comisión Nacional sobre la Desaparición de Personas - CONADEP: Sábato Report) was created in 1984, an entity intended to investigate the crimes committed by the military governments between 1976 and 1983. The results of the labor of this commission were documented in a work whose title has acquired a global connotation: *Never Again*, which we refer to frequently in this study.

In addition, a public trial was held of the generals responsible for the mechanism of terror, which ended with the pronouncement of strong condemnations. Nevertheless, beyond the effect of clarifying the conditions in which the multiple transgressions of human rights occurred, there hasn't been a subsequent process to sanction those responsible for crimes against humanity. On the contrary, civilian power has given way to the renewed threats of the armed forces, expressed in mul-

[15] Eight weeks after the onset of the presidency of J. Alfonsín, J. Timmerman reflected on the prevailing mood within the country: "Like a repetition in miniature of Germany in 1945, the Argentina of 1984 is trying to know and to understand. In this grueling effort, the same questions come to the surface; How was it possible for children to be tortured in front of their mothers? How was it possible for women to be raped in front of their husbands? Why were there soldiers in Argentina who kicked pregnant women to death? Why were children assassinated or given over to other families? Why were people drugged and thrown into the ocean from airplanes, or tortured corpses taken in containers and thrown from ships into the water ?" "□,□□(Timmerman 1989: 207).

tiple outbreaks of military intervention, and laws of progressive exoneration have been promulgated such as the “final point” and “due obedience,” which led to the presidential reprieve of imprisoned generals, Christmas 1989 (Fariña 1990: 203-210).

In Uruguay, the historians Caetano and Rilla characterize the death of Dr. Roslik, a doctor in the town of San Javier, occurring in April 1984 as a result of torture in army quarters, as a key moment in the deterioration of the repressive powers of the military. The military centered all their efforts on “denying the true reasons for the death and avoiding the diffusion of information about the episode.” The authors state that “the death of Dr. Roslik took place at a truly high point of events, when the dictatorship could no longer neutralize with impunity the effects of an episode with those characteristics” (Caetano and Rilla 1991: 101-102).

In that country, political prisoners were already freed in 1985 and procedures begun to be undertaken for their reintegration into society. During Christmas of 1986, a presidential proposition called “Law of expiry of the punitive intention of the State” was passed by Parliament, that not only decreed the impunity of the military with regard to politically motivated activities during the dictatorship, but also ensured the maintenance of the internal hierarchy during any intervention by the civilian government. As a form of internal compensation, the law also reinstated the officials discharged by the Military Junta owing to their loyalty to the previous democratic Constitution.

This legislative action provoked great discontent within civilian society, culminating in a referendum dealing with the law of impunity of violations against human rights, clearly recognized in Uruguayan society. Following the defeat suffered in the referendum by opponents of the amnesty law, a situation has taken form that R. Huh describes emphatically: “In Uruguay, there is no longer any possibility of those responsible of the crimes against human rights during the dictatorship being brought to justice. In fact, those military personnel who are assigned by name as torturers, continue without major difficulties in their military careers...” (Huh 1991: 79).

Although impunity as a legal body appears irreversible, it does not represent an obstacle for some Uruguayan legislators who are carrying out activities intended to pass a law concerning “Crimes Against Humanity,” wherein the crimes pertaining to this rubric are specified in detail. In addition, based on the international conventions to which Uruguay has subscribed, responsibilities are stipulated, as are forms of penal sanctions for the transgressors (Uruguayan Bar Association 1989).

In Chile, the Coalition for Democracy was created among the forces opposing the dictatorship. It was conceived of as a way to unite forces not only as opponents

of military rule, but also as a political front to govern and allow the transition to democratic ways of life after the enormous affronts to human rights during the military dictatorship (Nolte 1989: 33-46). Following its triumph in the presidential elections, it was able to initiate its government labors in 1990.

In March of 1991, the Report of the Commission of Truth and Reconciliation was presented in Santiago, Chile, one that ought: "to contribute to global elucidation of the truth over the most gravest violations to human rights committed in recent years, be it in our country or abroad, and elsewhere if they were related with the Chilean State or with the national political life..."

Serious violations are to be understood here as situations of those persons who disappeared after being arrested, who were executed, or who were tortured to death. In these situations, the moral responsibility of the state is compromised, as a result of actions by its agents or persons in its service, as well as kidnappings and attempts on the life of persons committed by private citizens for political purposes (Rettig Report: 3).

The report emphasizes the direct responsibility of the State in acts of organized violence and political crime is defined itself as sanctionable.

Owing to the conditions dictated by the Constitution of 1980, approved under the dictatorship, and to the fact that the organizational and logistical power of the military apparatus -even after the democratic exoneration of Pinochet- remained unscathed and able to exert strong pressures against any process of indictment of those responsible, a process of transition to democracy is spoken of even today.

We are confronted here with a very recent process from which it is not yet possible to reach conclusions about the future. While it is very difficult to create conditions to bring those who committed transgressions against human rights to justice, it doesn't appear as if the present situation will allow the dictation of a law of global amnesty. In fact, diverse processes currently exist to annul the law of autoamnesty decreed by the military government in 1978.

In two of the three countries of this study, an erosion of the "State punitive intention" is evident, which has culminated in the passing of amnesty laws for the criminal acts committed in the era of dictatorship. Beyond the conditions of "political pragmatism" (Realpolitik) present in each context, we are in agreement with the opinion of R. Huhle 1991: 79 in the characterization of amnesty: "It also confers legitimacy to those pardoned under amnesty. Amnesty is not related, in contrast to the pardon, with specific people but rather with events themselves… Amnesty makes explicit that the events pardoned under amnesty are not fundamentally illegitimate, but rather that they can at least be considered a virtually acceptable form of behavior. It not only signifies freedom from punishment, but also the moral rehabilitation of those benefited. It is precisely this position toward crimes

against humanity which cannot be adopted by a lawful democracy… since in fact the statute of limitations for sanctions for crimes against humanity is vetoed by the International Convention of 1968..."[16]

It is difficult to make global assessments about the social and cultural impact of the dictatorial governments in the three countries. Nonetheless, from what has been observed in the process of legislative restructuring following the return to representative democracy in each country, we can deduce that as a direct result of the experience under terror, neither an unrestricted respect for human rights nor an attitude of "Never Again" has arisen as an important part of the civic conscience.

The struggle against strong authoritarian tendencies continues within each of these societies, confirming the judgement of H. Mayer: "There exists a marvelous curative virtue of nature, but there is no curative virtue of history" (Meyer 1990).

2. Medical Practices Under the Influence of Totalitarian Domination in South America and Germany

The role and significance of physicians during the military dictatorships — which ruled for seven, sixteen and twelve years in Argentina, Chile and Uruguay respectively— have hitherto been infrequently studied, and much less so in a systematic way. The direct participation of doctors in efforts in support of, or against, the respective totalitarian regimes appear fleeting and independent in the retrospective analyses of some contemporaries, as if these activities had been carried out by isolated individuals or small groups and bore no relation to each other.

The collaboration of some doctors with the totalitarian regime and the resistance of others are each evident in numerous situations within the three countries. In this part of the documentary section of this work, an analysis of these events is developed based on documentary sources. We take a detailed look at the fundamental circumstances of the involvement of doctors in repressive activities and their col-

[16] And that all sovereign States have signed.

laboration in crimes against humanity, and at the relevant instances of other doctors' opposition to injustice and contempt for fellow humans.

The results of investigations of medical practices under Nazism will be incorporated in their investigation as a necessary historical background and with the objective of providing depth to the analysis. The influence of Nazi ideology on medical activity and the behavior of doctors toward that regime have been subjects of intense study during the last thirty years. These inquiries expressly document how medical practices became distorted under the influence of totalitarian domination and the forms of opposition that existed toward an authority conceived of as absolute and destructive.

In accordance with our own systematization, medical practices during the military dictatorships in South America's recent past and during Nazism will be discussed separately, followed by an epistemological and phenomenological comparison of these situations.

Finally, a diachronic comparison of the importance of medicine in both eras will be carried out on the basis of the documentary evidence and the fundamental notions arising from the study of these sources.

The analytical requirement to situate this investigation in an historical context will thus be fulfilled, so that the attitudes and actions of doctors during those years are not reduced to isolated incidents within a regime of terror. Rather, they can be understood within comparative contexts involving the situation of doctors under totalitarian domination

A.2 Medicine under Military Dictatorship in South America

The recent social experience of the three countries studied shows, in exemplary form, how totalitarian domination was able to fundamentally interfere in medical activity and how many ethical axioms were regularly disregarded and abused under such influence. These axioms were made to appear as expressions of good intentions, rather than as governing principles of professional conduct, known in precise form by health professionals in every country and sanctioned in many international conventions and codes[17].

[17] Concerning the participation of physicians in torture, we can make reference here to the following documents: (a) Declaration of the World Medical Association in Geneva (AMM 1948, 1968 and 1983), regarding the ethical definition of medical practice; (b) Declaration of the General Meeting of the United Nations on torture and other inhuman treatment (9-12-75); and (c) Declaration of Tokyo.

The direct participation of doctors in repressive activities of state terrorism -or in displays of opposition- gave rise to unprecedented circumstances. As often occurs with events that transcend the everyday imagination, the knowledge that exists of these areas of medical activity is anecdotal and fragmentary and seems to be the dubious province of casual observers and a handful of scholars.

The influence of that era remains perceptible in many spheres of medical endeavor and the terror experienced continues to affect people, even those individuals who do not appear to have themselves been implicated. A young female doctor from Argentina formulates the situation in the following manner: "Although at the time I was just fulfilling my scholastic obligations and abstained by whatever means possible from participating in any sort of discussions, I can say now that there are many events of which I have no recollection. It is as if many events that occurred in my immediate proximity had been simply erased from my memory" (Personal communication from Dr. E. S. during the VI Symposium *Cultural and Psychosocial Situation in Latin America*. Hamburg, 1992).

It is necessary to deal systematically with the role and significance of those doctors who decided to actively cooperate in repression, for example in torture and ill-treatment, in the three countries studied. Of similar importance is establishing how members of the medical community were able to develop both active and passive forms of opposition, and the consequences of their opposing stance toward the processes of terror.

In order to develop these thematic complexes we turned to our own classification of the specific involvement of doctors in acts of harassment or in diverse activities of resistance to totalitarian domination.

In the pages that follow, extreme situations, in which medical efforts had unusual objectives, will be described. These situations often led those affected to experience a sort of mental uncertainty. That is the description of Jacobo Timmerman, Argentinean journalist, in relating his prison encounter with a doctor he knew, appointed to participate in his mistreatment: "...he 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 it is always so painful because it affects your brain; so why can't you just talk and we can be friends'. His presence was terrible because he was the symbol that a scientific instrument is with you when you are tortured by the beasts" (Timmerman, *Doctors and Torture* interview, BBC Television, September 12, 1990).

The willingness to cooperate with a repressive system seems to exist explicitly in some members of the medical corps. The opinion of torture expressed by Dr. Guido Díaz Paci, before the Special Commission of the Department of Ethics of

the Chilean Medical Association, is of great relevance since Dr. Díaz was in charge —in his role as a military physician and for more than six years— of those detained for political reasons: ”I think, says Dr. Díaz, that torture is an extreme form of physical coercion and that physical coercion, without causing injuries, is legitimate… that coercion which only causes pain… it’s the same thing you do to your children when you pull their ears or you hit them as punishment… I think that psychological coercion should also be permitted, like impeding sleep or something of the sort...” (Rivas 1990: 128).

However, not everyone acquiesced and was passive when faced with terror. There were also attitudes of rejection with regard to perceived injustice. Dr. Martinera discusses the nascent resistance efforts within the Uruguayan Medical Association (UMA): ”Following the death by torture of Dr. Roslik, we became conscious of our ethical responsibility to society. I believe that event shook many of us deeply… after that, neither personal fear —my house was raided ‘preventively’ several times— nor labeling us as criminals were of any use to the military. Nobody could prevent us from creating, within the Medical Association, the National Commission of Medical Ethics to determine the veracity of the serious accusations against some doctors relating to ethical crimes (Personal communication from Dr. Martinera during the VI Symposium ”Cultural and Psychosocial Situation in Latin America”. Hamburg, September 1992).

Seven central themes of medical practice under totalitarian domination are dealt with in this chapter. We begin with the active participation of doctors in ”swift punishment,” continuing with professional cooperation with a highly corruptible justice system. We then focus on the treatment accorded children born in prison, the ”disappearance” of expectant mothers, and the fate of some doctors and health care institutions under dictatorship. To conclude, we first outline some little-known aspects of medical opposition. Next, we look at work conditions and the legal-social results of committees organized to clarify accusations of transgressions of professional ethics; and finally, current attitudes within the medical community toward difficult medical-ethical issues are discussed

2.1 Torture and Medical Practice

As a rule, an activity is acknowledged culturally when it begins a process of conceptual definition. The Chilean Medical Association (CMA) provides the following definition of torture related to professional activity: ”To supervise torture from a medical perspective means to evaluate periodically the victim’s capacity to withstand cruel treatment. It also entails giving medical attention to lesions caused

by torture or failing to denounce torture, thus leaving the victim at the mercy of his captors" (Stover 1987: 69).

2.1.1 Torture under Medical Supervision

Dr. Liwski describes the following situation in Argentina during the "Process of National Renovation": "Already tied up, the first voice I heard was that of someone who said he was a doctor, and he informed me of the severity of my hemorrhages and, because of this, to not attempt any resistance… In those days there is a second… intervention by Vidal which is related to a comment he makes to one of the torturers; almost verbatim: "By the fourth or fifth day of torture one has to insist, because the acetylcholine is becoming exhausted, and from that point forth we know that all possibilities of resistance are in vain." He commented… indicating knowledge of the [physiological] mechanisms intervening in the application of torture… One or two days later, with the tortures continuing, and in accordance with the information that I was going to be tortured along with my daughters, three and six years of age at the time, Ana and Julieta, Vidal is consulted by the most direct operator of torture, Superintendent Raffo, about the factors to be considered in applying torture to children. Vidal's response was very categorical, saying that beginning at 25 kilograms, the application of the cattle prod was possible" (Sábato Report, p. 28; and Statement to the Court, pp. 15-16).

Regarding Chile, the "*Truth and Reconciliation*" Report recounted what occurred in a prison in San Antonio, seemingly representative of the general situation in Chile following the coup d'état of 1973:

"One feature of this complex was that doctors, also hooded, were on hand. They supervised torture (to prevent people from being killed) and gave emergency treatment to those who were most seriously harmed by it… Normally, the prisoner who seemed unlikely to reveal new information was sent back or returned to the public jail in San Antonio, usually in pitiable shape… A report by a humanitarian organization in late 1973 and early 1974 notes the high proportion of prisoners who needed medical care in this jail —five or six times more than that of the other jails visited… [As regards] the Tejas Verdes complex, many people died there or were taken from there to meet their death; some had been sentenced by war tribunals while others were executed without due process of law, and still others were tortured to death. These latter deaths, as well as those constituted by execution without any court verdict, were either covered up by false war tribunals, or with death certificates that were -to say the least- intellectually dishonest about the cause of death (Report from the National Commission of Truth and Reconciliation, pp. 135-136).

By 1982, an Amnesty International committee (1983: 20) had irrefutably confirmed the participation of doctors in the illicit coercion of detainees. The delegation interviewed and performed clinical examinations of nineteen individuals, of whom eighteen affirmed having been tortured. The AI-report describes in full detail the circumstances surrounding the entrance of victims into the detainment-torture-imprisonment cycle established by the Chilean secret police (CNI).

The following statements relate to Uruguay: ”I was thoroughly examined by a doctor. He asked me about my family, any chronic or present illnesses, and about any parts of my body that might be delicate because of previous sickness. I thought that giving that information might reduce the torture. Hours later I realized the real reason for the doctor’s interest. I heard his voice, unmistakably, saying: ”That’s OK, you can carry on.” I felt angry and powerless. Here was an individual trained by society to save lives, dedicating himself to inflicting pain. Mostly I was angry with myself for being so naive as to believe that a doctor who worked in such a place such could possess a trace of humanity. These doctors are saving lives, but in a perverse way. The aim of torture is thwarted if the victim cannot support the interminable ordeal. The doctor is needed to prevent you from dying for your convictions (See: ”*They Condone Torture*", by César Chelala in: *World Health*, April, 1989. Cited in: Weschler 1991: 259).

This seems to have occurred in a systematic way: ”Upon admission to a detention center, each new captive was examined by a physician who then prepared a ”complete medical report.” This report was sent to the military officers responsible for that detainee. Interrogating officers often used information about preexisting health problems to draw the line when they felt it necessary to give their charges ”a pretty rough time.” If, for instance, an officer knew that a detainee had cardiac problems, immersions in ”el submarino” [the submarine] might be abbreviated or other stressful procedures withheld. In addition, officers sometimes requested medical exams during harsh questioning or torture ”to see if things had to stop,” or could continue. Concerned about being fooled by detainees not genuinely impaired, some physicians studied guerrilla manuals that gave instructions on how to fake illnesses… In the national security prisons as well, physicians performed their technical tasks of examination and diagnosis, then communicated the results to commanders without informing their patients (or weighing the consequences for their patients’ welfare). Especially notable in this regard were the psychiatrists at the Penal de Libertad” (Bloche 1987: 14-15).

Gregorio Martirena highlights the responsibility of military doctors in these activities and specifies the tasks a doctor would undertake: ”The doctor is active or passive in many ways: in the examination of the prisoner when he comes in; by noting the physical or mental weaknesses which will later be used as part of the

torturers' strategy; in his neglect of direct assistance to the sick prisoner; in the falsification of cause of death to conceal the use of torture; in direct participation in interrogations; in conducting constant psychological harassment in the prisons in order to destroy the personality of the prisoners..." (Martirena 1988: 13).

The author adds: "Among the reprehensible practices carried out by military doctors are the following: a) participation in torture; b) advising on the continuation of torture to avoid imminent risk to the life of the victim; c) concealing evidence of torture or, more commonly, covering it up; d) deliberately or unscrupulously neglecting sick or injured prisoners; e) submissively obeying the orders of the military authority, even when they are detrimental to the health of the sick or injured, or imply cruel treatments" (Martirena 1988: 22).

2.1.2 Specific Medical Tasks in Places of Detention

Medical and health care endeavors in prisons and concentration camps during the dictatorship seem to have been guided by a different set of rules than during democratic times.

A prisoner in Argentina provides evidence of this particular sentiment:

"While at La Escuelita I received medical attention on two occasions. One time during a torture session and while still blindfolded, someone listened to my heart and lungs with a stethoscope. Later, samples of my urine were collected because one of my kidneys had been injured. I felt like an animal in a laboratory experiment, with a professional taking care of my vital functions but not of me as a human being. Another prisoner told me that he knew the doctor. He had seen the doctor from underneath his blindfold and recognized him. I only remember that his last name was Germanic, and that he was a doctor in the Fifth Army Corps in Bahía Blanca". (Testimony of Carlos Sanabria, in: Stover and Nightingale 1985: 52-53).

And Francisco Tropeano made this statement before the CONADEP:

"All of us would hear when someone was taken from the principal compound to be tortured with a cattle prod. I presume there was a doctor present indicating when they should stop. On two occasions I heard, while they were torturing, something like "he's cut… he's cut." It also seemed to me that they applied injections..." (Statement of Francisco Tropeano to the CONADEP, file # 6956).

The situation within the prisons and other places of detention in Chile does not appear to have been very different: "Alberto Barraza… said in his statement to the court that a physician treated him on three occasions while he was undergoing torture. "After each thorough examination, [the physician] would say things like, 'He's okay… He's all yours… You can go on with the treatment.' It must clearly

have been the same doctor who prescribed me tablets to be taken three times a day and a sour liquid tasting of mint" (Stover1987: 27).

This form of behavior was not limited to the capital; similar events also took place in the provinces: "I.V.M., in his testimony before our department, spoke of his encounter with a physician after his arrest on August 23, 1984 in the city of Concepción. I.V.M., who is the son of an appellate court judge, said that a physician examined him before his first torture session. The following day, he said, "the same physician examined me … and gave me some pills for my heart… Later in prison I learned that they called this physician 'Quincy,' and in subsequent inquiries I found out that he was Dr. … and that he works in … There were about five torturers. The torture lasted for several hours at a time. [During one torture session] they clamped the 'plugs' on me, around the penis at the opening and in the anus. This meant that I had to urinate and defecate on the cot. They made me eat my excrement. ...[The following morning] I was reexamined by a physician. His mission was to give the green light for torture to continue. He was taking stock of my capacity to resist torture..." (Stover 1987: 70).

Amnesty International also testifies to this type of activity, even ten years after the coup d'état: "From Friday on, I was interrogated in different forms, gentle and violent. Even on the following days I was examined by two physicians who, besides checking us, marked with a pen the zones most affected by torture, to guide in that way to the torturers" (J. P. Grau testimony, in AI Index: AMR 22/29/84).

Following the return to a parliamentary system in Uruguay, Dr. Bloche was able to conduct a field study, asking many military physicians about their activities during the years of military rule and thereby obtaining firsthand accounts: "Questioned about charges that the physician at an elite military intelligence school taught methods of resuscitating prisoners after torture, one physician, Dr. Robert Scarabino, replied, "You should ask him." Scarabino then declined to reveal the physician's name, claiming it was *classified*. Several days later, a senior military source said the physician was Scarabino himself" (Bloche 1982: 11).

The Uruguayan Medical Association initiated the task of ethical clarification even amid the dictatorship. The following testimony was gathered about the activity of a doctor investigated by the UMA's Ethics Commission: "… the complainant stated that on entering the aforementioned barracks, he was made to wait and after several hours his hood was taken off, he was made to sit and he found himself before Dr. Fornos, whom the detainee knew because both had lived in Trinidad and because Fornos was a client at the bank where the complainant worked. Fornos then took his pulse, examined his chest with a stethoscope, and asked him some questions related to his health. Dr. Fornos then left and the military personnel replace the hood and apply forms of torture like the "submarino" and beatings over

his whole body… When he was first freed, Dr. Fornos saw and recognized him on the streets of the City of Trinidad… he was summoned by said military authority and was obliged to sign a paper stating that the medical attention received during his stay at said barracks had been good… The complainant stated that during his final detainment, he was examined by Dr. Fornos and subjected to extremely severe physical coercion for a period of twenty-one days. [Among others] they applied the ”submarino” to him, submerging him in water while he was tied to a board… after a very long period of immersion, from which he emerged in particularly bad shape, a jolt of electrical current was administered, and he sensed at that moment a feeling like that of something cold and metallic in his chest. Immediately after, he heard Dr. Fornos say ”he’s perfectly fine"… In another case, a complainant stated that Dr. Fornos took the blood pressure of another detainee, said it was high, and indicated ”light treatment” to the clerk”. (Martirena 1988: 52).

The debate within the UMA’s Ethics Commission on the conduct of Dr. Fornos led to his expulsion as a member of the Medical Association of the Interior (AMEDRIN), declared unanimously in August 1985. It also prompted a denouncement before the Letrado Court in the City of Trinidad[18].

Miguel Angel Estrella, world-renowned Argentinean pianist, also spent time in Uruguayan prisons. He was detained in Uruguay in December 1978 and provides this account of his experiences: ”They applied electricity under my nails, without stopping, and later they hanged me from my arms. After two days of torture I hurt all over, and had no sensation whatsoever left in my hands. I touched things and didn’t feel anything. They kept making like they were going to chop off my hands. The last time they even had an electric saw going. They’d pull on my finger and

[18]The legal denouncement was made in the following terms: ”To Doctor Nelson Fornas Vera -doctor from group number 2 (Flores)- several detainees of the military unit charge him with the co-participation in every type of torture that was suffered (submarine-holding the head under water, beatings, cattle prod), ‘assisting’ in the same through auscultation with a stethoscope. Said assistance, logically, was provided not with a curative end but rather so that tortures could continue without a threat to life. There are several possible crimes present: 1) Abuse of authority against those detained (art. 286); 2) Private violence (art. 288); 3) Personal wounds (physiological disorder from which an illness of the body or of the mind is derived...) (art. 316) specifically aggravated by the article 320, bis. In all these cases the responsibility would be at the level of _co-authorship, for cooperation directly at the time of the crimes being committed. But in other criminal acts, his responsibility would be at the level of author, as in: 4) Omission of public employees on denouncing crimes (art. 177); 5) Covering up (art. 197)” (Martirena 1988: 54-55).

ask: ”Which is the finger you use most in playing the piano?” I didn’t say anything, I was praying, and one of them says: ”Is it maybe the thumb?” They pulled on the fingers and made like they were going to slice them off with the electric saw. They said, ”We’re going to cut off your hands, one finger at a time, and then we’re going to kill you, just like with Victor Jara” (Jara, the great Chilean folk singer and guitarist, indeed had each of his fingers smashed, before he was killed, in Santiago in the days after Pinochet’s coup in 1973.) (Weschler 1991: 126).

In a pertinent comment Dr. Mandressi says to Lawrence Weschler, journalist from The New Yorker: ”You have to understand that these guys were specialists —the main torturers. They were highly trained in methods of exacting the maximum pain without leaving any significant physical traces —and, for that matter, without killing the victim in the process. There were relatively few deaths under torture in Uruguay. This was because there were usually doctors in attendance at the sessions” (Weschler 1991: 126).

2.1.3 Torture and Mistreatment Based on Medical Criterion

Doctors were not limited to merely being physically present during diverse acts of repression; some also seem to have made an effort to carry out their tasks in more sophisticated ways.

The following statement was made to the CONADEP concerning the attention paid by personnel —posted to carry out these assignments in Argentina— to maintaining high levels of preparation: ”In February and March of 1979, a group at the Superior Army School of Technicians (SAST) organized a ”Course in Anti-Subversive Combat,” to which repressive agents of various Latin American countries were invited… Each of the countries made a presentation which was recorded [about their own anti-subversive efforts]. The SAST group prepared several reports… on the most effective methods of torture, with its different stages, physical torture (diagramming the most vulnerable spots), psychological torture and isolation… (Testimony of Amalia Larralde to the CONADEP, file # 3673).

The situation is described in more specific terms: ”A ”special” torture consisted of striking the prisoners immediately after they had been subjected to the cattle prod. This method was aimed at causing a death that was unavoidable and horrific… ”María Luz” was tortured extensively with simultaneous use of the cattle prod and beatings. Those who had been imprisoned longer knew that this torment leads inevitably to death, a horrific death, since, while the muscles contract be-

cause of the passing of electricity, they relax as a consequence of the beatings with clubs..."[19]

Dr. Bloche provides an example of professional zeal in these types of activities in Uruguay: "… a former Libertad official said data from prison physicians aided in the close monitoring of inmates' "activities and attitudes." "We learned along the way. When we noticed some kind of nervous attitude, a lot of chat, too much conversation, we would take a measure to neutralize that. For instance, I gave them less recreation time, took their books away from them, changed their cells, increased their controls. All that reduces their chances of operating because they never sleep —they never rest" (Bloche 1988: 15-16).

2.1.4 Use of Non-Therapeutic Drugs and PsychologicalTechniques

The term "therapeutic arsenal" refers to the group of known techniques and means used to combat discomfort and illnesses. Here, reference is made to the development of an arsenal of this type aimed at non-therapeutic objectives.

With regard to Argentina, the testimony of the priest Orlando Vigilio Yorio to the CONADEP stands out: "Sometime after May 25, they came to give me an injection in the buttocks. I could hear this small noise, like that of a tape recorder, and then I began to fall asleep… at the end of five months, October 23 [they granted us freedom]. At around 5 in the afternoon they gave us an injection… I notice that it makes me a bit dizzy. They load us onto a pickup truck, we drove I don't know how long, they gave us another injection, and later another… and I couldn't remember more. We wanted to get ourselves together, we would fall down… we woke up when there was starting to be some light… we walked a little more than a kilometer until we found a small ranch, we knocked and a peasant answered… we asked him where we were and he said in Cañuelas..." (CONADEP, file # 6328).

And Samojedny shows in detail how daily life in prison was transformed by psychological repression: "In jail, reading was prohibited and suppressed; also writing, conversation and all attempts at communication among the political prisoners… [an attempt was made] to suppress thought with orders like, Don't reach conclusions!… Everything here has already been invented! Here, the only one who

[19] See FDDRP: *Testimonios sobre la represión y la tortura*, Number 7-8-9: 8. "In physiological terms, the most probable effect of this type of torture is a generalized miolisis** (destruction of muscle cells), with a consequent saturation of toxic substances in the blood and a subsequent hepatic-renal** insufficiency (functional incapacity of liver and kidney cleansing) which, without treatment, leads to a horrific death" (Personal communication from L. Bonaparte).

thinks is me; you do what I say! In all these cases the prohibition was accompanied by repression, and when one of my fellow inmates would dare to state ”It seems to me that...” or ”I think...,” they were reprimanded for ”talking back to the warden” or for ”lacking respect for the warden” (Samojedny 1986: 497).

In Chile there were physicians implicated in particularly relevant situations. Several reports refer to a woman anesthetist with the armed forces who has administered drugs to detainees. One account goes as follows: ”At one point they took me to a hospital...[where] I was seen by a young woman physician [her name is given]. [She] spoke to me very sweetly. She said, ‘Look, you’ve been badly beaten. Now we are going to treat you, don’t worry, we’re going to give you an injection to calm you down.’ They gave me an injection of something. Later I found out that it was a small amount of sodium pentothal. I fell immediately into a void and grew physically tired. I couldn’t answer questions. Someone asked, ‘What’s your name ..., your political name?’ Then, I fainted… The next day, or what I thought was the next day, they took me back to the same room. The same woman physician spoke to me sweetly and asked how I was feeling. I had a terrible headache. I told her. She said they were going to give me another injection. Then somebody said, ‘Give this jerk a strong dose this time. He can take it like a horse.’ They gave me another shot and it seems I had a very strong reaction because they had to tie me down… Later, I learned through another person that the sodium pentothal had made me shout and jump around a lot… (CMA Report, cited in Stover 1987: 71).

Similarly, there are statements from those who participated in these events as agents: ”Andrés Antonio Valenzuela Morales, a confessed torturer and a member of the intelligence service of the Chilean Air Force (Servicio de Inteligencia de la Fuerza Aerea, SIFA) from 1974 until he left the service and fled the country in August 1984, says he once watched a physician inject a prisoner by the name of Miguel Rodríguez Gallardo with Pentothal, the trademark for preparations of thiopental sodium which can induce hypnosis and sleep within 30 to 40 seconds of intravenous injection (Stover 1987: 28).

Three Chilean neuropsychiatrists make this comment on the progressive professional specialization in support of the repressive system: ”The incorporation of doctors, psychologists and social scientists into the group of government workers of the repressive apparatus indicates that, to the necessary perfecting of the repressive acts, experimentation with new techniques aimed at correcting previous deficiencies are added. (”Clean torture” refers to the series of experiments in the field of psychology designed to perfect techniques utilized in the treatment of phobias, various addictions and sexual disorders) (Reszczynski, Rojas and Barceló 1991: 273-274).

In a country of renowned formality like Uruguay, it is not very surprising that the police, as early as August 1970, had solicited the justice system for legislation permitting the use of Pentothal in the interrogation of political prisoners. A short time before, the Republic Senate had designated a committee to elucidate the reports of torture, which appeared to be a regular practice of the political police even prior to the coup d'état in 1973. A forensics doctor, summoned to testify before said commission, answered: "And you ask if there are tortures? You must be the only Uruguayan who doesn't know about it" (*Mañana* 1992: 133-135).

There are many indications that, during the dictatorship in Uruguay, a doctor named Dolcey Britos served as a consultant in the formulation of rules intended to inflict mental suffering. Dr. Liber Mandressi was invited by Britos to collaborate with him in data collection. He was able to examine records and "statistical charts" kept by Britos, who had examined a large number of prisoners and was trying to correlate punitive sanctions and the incidence of psychiatric problems within his subjects (Bloche 1982: 20)[20].

A prisoner who testified before an Amnesty International committee on April 11, 1982, reports on the use of neuroleptics for non-therapeutic purposes within prisons. This is corroborated by a study of the activity of military physicians in detention centers for political prisoners: "Another disturbing charge is that Libertad psychiatrists administered neuroleptics, including fluphenazine and haloperidol, to provoke extrapyramidal side effects (EPS) as a torture technique. EPS include involuntary muscle rigidity and writhing movements, often quite painful, of the victim's trunk and limbs (Bloche 1982: 22).

2.1.5 Executions Using Medical Methods

Details of the use of medical knowledge to induce the death of prisoners have been much less widespread. The information provided here refers only to Argentina, and, although we do not exclude the possibility of similar occurrences in Chile and Uruguay, there are no concrete references to such activity: "...Father Amador sent us to Monsignor Graselli, who told us the young people… were well treated… He said Videla had been the kind soul who devised the plan for not losing same intelligent people (!)... he said that psychologists and sociologists were working with the young people, that there were medical corps for health, and that

[20] It would not be unusual for these studies to have been published in some military psychology magazine under a neutral title such as "Symptomatic Incidence Under Adverse Psychological Conditions: A Casuistic Study."

for the irretrievable ones, there was ”someone pious” who could give them an injection and they would fall asleep and never wake up...” (Denouncement presented to the CONADEP concerning the disappearance of Carlos Oscar Lorenzo, file # 1560)”.

The Sábato Report contains the following statement: ”… The three vehicles entered via a dirt side road until they reached a wooded area. Dr. Bergé, the medical official, was there. The three bodies of the ex-subversives, who were alive at that point, were taken out. They threw the three of them onto the grass, the doctor applied two injections to each one, right in the heart, with a reddish liquid which was poisonous. Two died, but the doctor figured all three were dead… Then the priest, von Wernich, spoke to me specifically because of my impressions about what had happened. He told me what we had done was necessary, that it was a patriotic act, and that God knew it was for the good of the country. These were his words verbatim… (Testimony of Julio Alberto Emmed to the CONADEP, file # 683).

2.1.6 Circumstantial Malpractice Resulting in Harm

The medical treatment provided to prisoners also seems to be tainted by a disdainful attitude toward their rights as patients.

Dr. Liwski makes this comment regarding an illness he contracted during his time in prison: ”It was around day 60 or 65 of being ”disappeared,” as a consequence of very severe symptoms I had suffered because of a recurrence of typhoid fever at the time. I was brought to Vidal’s room. I was able to see him face to face and he indicated —in my presence— the appropriate medication for these cases, chloramphenicol. Everybody involved in medicine knows, that to be effective, a treatment with high doses is required… the chloramphenicol was suspended after 48 hours. As such, the effect is exactly the opposite of what is sought by the treatment” (Liwski, Statement to the Court, p. 16).

Luis Arquiza, a psychology student, corroborates this situation with this statement related to his imprisonment in Córdoba, Argentina: ”At daybreak on day 16, I was led to a washroom by the on duty official, Francisco Gontero, who, from a distance of four or five meters, loaded his .45 caliber pistol and fired three shots, of which one went through my right leg at knee level. I was left standing, losing blood for about twenty minutes; the same person then ripped my pants and hit my wound with a club, and then my finger. When various people arrived there, this official said that I had tried to disarm him and flee. I was separated from the rest of the detainees and put in a dark room and I was denied going to the washroom, having to relieve myself physically in my own pants. A doctor examined me. He gave me an injection and painkillers but didn’t supply any other type of medication, and

my leg was bandaged. This physician was the on duty forensic pathologist at the time. During day 16 I was beaten, particularly on my injured leg, and I spent two days on the ground, unable to remember any more because of the severe pain and the semiconscious state I was in" (Statement to the CONADEP, file # 3847).

The Chilean Medical Association documents the situation in Chile: "Another testimony in our possession was given by F.I.F.R, who was detained in Quillota on January 19, 1985. An official statement says that F.I.F.R. was wounded during an armed encounter. The detainee, who was shot several times, states: "I was taken to another city to a hospital, and put in a small room. A group of male and female nurses came in the room with an official, a physician. They advised [and were present during the four days of physical and psychological torture] the CNI interrogation team that carried out my torture. Sometimes they disconnected me from several life support systems which made me have spasms and vomit blood. Then, a male nurse who pretended to be a good guy would reconnect me, perhaps to gain my confidence in order to find out what I supposedly knew..." (Stover 1987: 71-72).

To overcome the perceived limitations of doctors observing other doctors, we refer to the prison experiences of Fernando Huidobro and Mauricio Rosencof in Uruguay, elaborated eloquently in their book Memories of the Dungeon. In this work, the authors provide a frugally detailed counterpoint of their experiences as "hostages" —according to the definition provided then by the Uruguayan military— during eleven and a half years, of which most were spent in isolation. We turn to the testimonial value of these "Memories" to demonstrate more vividly, if possible, situations relevant to the current study:

> "F.H.: … [our] experiences with a new medicine: each time we were taken to a barracks, it was the norm to be examined by a doctor.
>
> M.R.: They didn't want to be responsible for any of the complaints that you might have: the scrapes, the injuries, the illnesses contracted at other units. They took care of their own executioner, not that of others. One of the things they would examine was your testicles.
>
> F.H.: And the blows, bruises and scars —they would ask where they were from.
>
> M.R.: When you left too, so they could certify it.
>
> F.H.: And they would fill out a record, which followed us throughout this long journey. And they would make us sign a page indicating we had been treated well. But in the interim, when we would get sick or we needed medical assistance, they would have never heard of us before.
>
> M.R.: I recall the following anecdote… from Santa Clara. We arrived already quite worn down. And I remember that at the infirmary in Santa Clara, lying on my back, naked from the waist up and hooded, the doctor grabbed the skin from my belly and pulled it —I looked like the tent at the Sarrazani Circus— and said: "But

'che' this is an atrocity!" The unit commander was also there. They wanted to verify for themselves the condition we were arriving in. When they were about to take me away in order to bring another prisoner, they were killing some time in the washroom because there were civilians around the Plaza de Armas and we couldn't cross it yet. The commander and the doctor assumed I had already been taken, and so the doctor said to the commander: "If they're going to keep them like that, it would be better to kill them." Mengele was a humanist..." (Huidobroand Rosencof 1988: 26-27).

These men also tried to acquire serious illnesses in order to get a respite, however brief, from the cycle of horror they had been entered into by the dictatorship:

"M. R.: … We considered possibilities for means of attacking our own bodies which would produce some sickness or injury such that they would be obliged to transfer us.

F.H.: The problem was with acquiring tools.

M.R.: Sure, it wasn't easy. You had mustered up the strength, an arsenal, and one day you asked me what would happen if you swallowed a nail; you had a two-inch one, bent and rusty. I answered: "Nothing, because they'll remove it with a catheter." Later you considered the possibility of cutting your veins with a small piece of tin… I responded immediately with a peremptory strike. Discounting that, you thought of using a needle for a self-vaccination, using the mould from the toilet that hadn't been thoroughly cleaned for ages. You would extract it with your nails whenever possible; then… you self-vaccinated yourself with the needle, hoping to acquire getting a severe typhoid fever which, among other things, would have raised the fear of contagion among the guard and the command. They would have to take you somewhere to recover. The other thing we dreamed of was tuberculosis, which would take us to the Saint Bois [sanitarium].

F.H.: … my arm became inflamed and some kind of eczema formed where I had been sticking the needles. The nurse checked me. He prescribed (dipirona)" (Rosencof & Huidobro 1987:84-85).

Faced with many extreme situations in the medical practice under state terrorism, the Ethics Commission of the Chilean Medical Association took on the task of developing an adequate conceptual understanding of these circumstances, allowing them to clearly discern the situations to be resolved related to medical ethics and human rights. This would also serve as a reference for other disputed situations of guild ethics or legal disputes. Regarding this, the Commission stated: "In summary, the participation of physicians in torture takes several forms:

1. Evaluating the victim's capacity to withstand torture.
2. Supervising torture through the provision of medical treatment if complications occur.
3. Providing professional knowledge and skills to torturers.

4. Falsifying or deliberately omitting medical information when issuing health certificates or autopsy reports.
5. Providing medical assistance within the torture system without either denouncing torture or resigning from such work.
6. Administering torture by directly participating in it.
7. Remaining silent in spite of the knowledge that abuses have taken place" (CMA Report, in Stover 1987: 75).

Now that the majority of Latin American nations —including the three countries studied— have undersigned and ratified the Convention against Torture, there should not be significant obstacles for the provision stating "Torture and the practice of medicine are antagonistic and mutually exclusive" to come into effect (cf. Declaration of Tokyo, 1975). Nonetheless, it is presumably not only the display of good intentions, but rather the realization of actual transgressions which grow among doctors and the general population, so that a culture arises from the declarations where human rights are indeed a right.

2.2 Medicine and the Law

The subordination of medicine to the interests of the de facto governments in South America constitutes a recent historical landmark, of which the full ethical dimensions and scope are not well known.

There are various areas of professional activity which aroused the specific interests of each regime and where absolutely trusted individuals were kept[21]; foremost among these was forensic medicine. To continue, we address situations of ethical conflicts in which the relationship between medicine and the law remains controversial.

[21] In Argentina, on September 9 of 1981, during his inaugural speech at the National Academy of Law and Social Sciences, Dr. Mario Justo López defines himself with respect to "The doctrine of separation of powers at the present time", and he condenses into few words the attitude of the de facto regimes towards eventual alternative political positions: "The opposition may present different levels and characteristics —disagreement, limit and control, cyclic alternation of the majority— where the disagreement deserves special attention, as long as it involves an anticonstitutional opposition, this means, against the system and the regime, which raises the question of the limits" (Baruch Bertocchi 1988:49).

2.2.1 Medico-forensic Work

The functioning of the Judicial Morgue during the dictatorship in Argentina provides evidence of the professional collaboration of forensics doctors with the repressive apparatus and allows an understanding of how part of the system of ”disappearances” of people killed by the military worked. The ”disappeared” were taken to the Judicial Morgue for an autopsy and to be definitively identified, then were transferred by the military and buried in common graves as unidentified. These events were not reported to their families: ” It always happened the same way: the adjacent streets would be closed off late at night and army trucks would enter the block, stopping in front of the aforementioned building. They would drop off their cargo there. Nobody in the terrified neighborhood would dare speak aloud about what everyone came to gradually know” (A. Colombo, in: *Madres de Plaza de Mayo*, s.f., pp. 10-11).

Still during the dictatorship, toward the end of 1982, the Center for Legal and Social Studies (CLSS) voiced a denouncement of irregular events in the operation of the Judicial Morgue between 1976 and 1978, affecting 106 individuals whose corpses had been taken to the morgue by military command. The formal accusation includes the following:

In essence, the complainants felt that while the Judicial Authority decided, through the rejection of habeas corpus, that the fate of the disappeared was to be ignored, their lifeless corpses (several already identified and others without this essential formality) were in the hands of the Judicial Morgue with the knowledge of the Penal Chamber… It was alleged that said organization had carried out autopsies and effected burials of unidentified corpses without any legal intervention following the instructions of the Armed Forces thereby omitting an investigation by the High Court, in spite of its knowledge of evidence about ”violent deaths” and the absence of intervention by a competent magistrate (Sábato Report, p. 397).

In order to support this accusation, ”Files of proceedings with habeas corpus were included in which requests were rejected, by informing that the required authorities respond to this, ‘they are not detained,’ when their bodies were in fact at the Morgue of the Judicial Authority".

During the ensuing administrative investigation, the dean of the Forensic Medical Corps in 1978, Dr. Jos Daverio, declared in a report that the Penal Chamber had full knowledge of these facts. He also declared that in order to corroborate this, he had insistently requested ”the integration of a greater number of autopsy physicians, given the increase of work as a consequence of the corpses dispatched by the military authorities” (Sábato Report, p. 397).

Similar activity is evident in Chile: ”Another way in which physicians participate in covering up torture is by issuing incomplete or falsified autopsy and/or

death certificates, a practice that the Department of Ethics has confirmed in its investigations (CMA Report, in Stover 1987: 74).

A specific example is provided: ” For instance, in the case of Mr. Alvarez, the department found several irregularities in the autopsy report signed by Dr. Exequiel Jiménez Ferry… As you will recall, Mr. Alvarez was transferred from the Penitentiary Hospital to the Central Emergency Hospital in Santiago where he was immediately placed in the intensive care unit. Four physicians examined him there… All of the hospital physicians agreed that the wounds had been inflicted over a period of several days, However, in the autopsy report signed by Dr. Jiménez, a pathologist at the Medical Legal Institute, he stated: ”Wound to the cranium, sutured, small (3 x 1 cm) lumbar scrape and metacarpal scrapes on the left hand.” Dr. Jiménez described no other lesions. He went on, however, to describe the head wound as a superficial fracture of the skull that was neither depressed nor included the meninges. The head wound, he stated, was caused by a blow from a revolver when the patient was arrested by the Carabineros. Even though Dr. Jiménez did not establish the existence of brain lesions, nor cerebral edema or subdural hematoma, he concluded that the cause of death was due to ”complications from a cranial fracture".… the case raises serious questions about the extent to which improper postmortems have contributed to judicial errors (Stover 1987: 74-75).

The pressures to which medical civil servants in Uruguay were subjected are apparent in the following account:

”In the first days of December [1976], the ambulance from the encampment came to pick me up at my house. The driver and the nurse told me that a detainee had died in Bella Unión. They took me to the office of the Regiment Chief, who confirmed the fact for me. He told me that only the chiefs, and now me, knew of this death and that if the news came to public attention it would be my responsibility. At that point, I replied that the driver, nurses and soldiers all knew of the fact since many people in the barracks had already spoken about it.

That same night they transferred me to Bella Unión… The body of Dante Porta was in the barracks at Bella Unión, where an autopsy was being carried out by Dr. N., the doctor with the police… who was not a forensics doctor. The autopsy was inconclusive. I was required to draw up a death certificate. I reported the cause of death as ”myocardial polymicroinfarctions,” intending with the diagnosis to provide an indication of ”shock,” which I personally felt had been the cause -or probable cause- of Porta’s death”[22].

[22] Text of the resolution of the Medical Ethics Committee on denunciations presented against Dr. Mario Sarasúa (Non dated copy, certified by public notary). As a consequence of these events, the Medical Ethics Committee declared the expulsion of Dr. Mario Sarasúa

2.2.2 Issuance of False Death Certificates or Good Health Certificates

The intentions demonstrated in falsification of diagnoses, making false statements and wrongful assessment seem to arise not only from habit, as in the previous section, but also from the necessity of documenting a parallel line from medical activities.

An investigation carried out by the scientific team supporting the Argentinean Mothers of the Plaza de Mayo provides the names of twenty-one physicians who had issued false death certificates. These include, for example ”deaths by confrontation,’ when in fact the dead individuals had been executed (*Mothers of the Plaza de Mayo*, February 1986, p. 11).

In a specific document about this type of professional activity, the Chilean Medical Association cannot help adding a sarcastic comment: ”The Department of Ethics is aware of numerous cases in which physicians have examined victims of torture shortly before their release and failed to report the existence of torture related lesions. It almost seems as if these detainees had just been released from a rest home. They are all in good health and show no signs of physical trauma. Their examining physician issues a health certificate stating that everything is normal. The physician’s signature is almost always illegible. In addition, the physician fails to note his identification number on the certificate”.

One of the first cases of this type that we investigated was that of Federico Alvarez Santibañez who was detained by the CNI from August 15-20, 1979. On August 20, Mr. Alvarez was taken before a military prosecutor who, having found him in such a deplorable condition, ordered him taken to the Penitentiary Hospital. At the hospital, a seventh year medical student attended to Mr. Alvarez. The student noted on the patient’s chart ”multiple contusions on the cranium, thorax and extremities. Pallid, rapid and shallow breathing, pain at the sternum, multiple thoracic pains, nausea, heavy perspiration, labored breathing. Lucid and oriented. Extensive bruising around eye sockets. Multiple contusions, more than 48 hours old, on the thorax and extremities.

Because his condition worsened and because he developed haemoptysis (bleeding from the lungs), Mr. Alvarez was transferred to the Posta Central, the emer-

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as a union member. On the arguments to support the sentence, states: ”(Dr. Sarasúa) Acted lacking technical independence (fundamental for professional practice). This is evident when by himself declares, on page 18, ”They demanded that I write a death certificate...” Which, in fact, he extended and signed, establishing a false cause of decease (heart attack). It follows from here that the whole context of Mr. Porta’s decease is absolutely abnormal, which arises from Dr. Sarasúa’s statements on page 18 (order of hiding a decease, etc.)...”

gency hospital in Santiago. He died there a few hours later, despite efforts to save him. The day of Mr. Alvarez' release from detainment, he was "examined" by Dr. Luis Losada Fuenzalida in his capacity as a CNI physician. It is obvious that Dr. Losada placed the interests of the CNI before those of his patients, because the health certificate he signed reads as follows: "The undersigned physician has professionally examined Federico Renato Alvarez Santibañez, C.I. 646.500-8 of Santiago, and found him in good health and showing no wounds of any kind. Santiago, May 20, 1979." In May 1986, the Chilean Medical Association expelled Dr. Losada.

We believe, without any reservations whatsoever, that these certificates fail to comply with their intended purpose of protecting the detainee. On the contrary, they have become part of a routine that allows excesses to be committed with impunity. *Physicians who issue such certifies, therefore, become accessories to these excesses* (italics from the author). (CMA Report, in Stover 1987: 73-74).

In the case of Uruguay the death by torture of Dr. Vladimir Roslik, occurring just after his detainment in 1984, warrants particular attention. Roslik's death led to the first internal investigation by the Medical Association of the role of military physicians in violations of human rights. The investigation highlighted the basic difficulty of certain agents of military health care services in separating military and medical jurisdiction.

In his statement to the ad hoc Investigative Commission of the Interior Medical Association (AMEDRIN), Dr. Eduardo Saez Pedrini referred to his three examinations of Dr. Roslik within twenty-four hours, " on orders," as if they were routine procedure. He said that Dr. Roslik did not complain of having been tortured and that, also on orders from superiors, he had carried out the autopsy on Dr. Roslik after his death. In the official autopsy report he stated that Dr. Roslik's death was due to "cardio-respiratory failure."

Dr. Roslik's family, on advice from another physician, Dr. Burjel, requested a second autopsy. The autopsy found strong evidence of Dr. Roslik's violent death at the hands of his captors:

> "A massive liver haematoma, signs of splenic trauma, greatly diminished blood volume in major vessels, and numerous large external ecchymoses were interpreted by a team of forensic pathologists as consistent with death from internal hemorrhage secondary to blunt trauma. Moreover, fluid in Dr. Roslik's right mainstem bronchus and right middle pulmonary lobe was noted to be similar in composition to fluid in his gastric cavity, evidence of aspiration (and believed by the pathologists to be suggestive of drowning)" (Bloche 1982: 16-17).

The forensic pathologists concluded that Dr. Roslik's death had been a result of either beating or asphyxiation by drowning (the method of torture known as "el submarino"), or both, that he was subjected to during his brief imprisonment.

Dr. Saez Pedrini, the military doctor who carried out the official autopsy on Dr. Roslik, was expelled from the AMEDRIN in March of 1985. However, this in no way prevented him from being assigned, to the Uruguayan delegation of the United Nations' International Forces stationed in Sinai (Personal communication from Dr. Burjel; Bloche 1982: 17; Martirena 1988: 29-49).

2.2.3 The Semantics of Collaboration

Without entering into a discussion of conscious or unconscious collaboration, the use of certain medical euphemisms is sometimes resorted to for the purpose of covering up human rights violations.

An example that is subtle in its argumentative links is that of Dr. Mautone, the former head doctor of forensic pathology at the Military Hospital. In his reports, he listed the cause of death of patients clearly succumbed to torture as "acute edema of the lung" or "acute cardiopulmonary insufficiency," both "resulting from stress." Dr. Mautone left the decision of whether an explanation of the diagnosis of "stress" was required to the discretion of the courts.

In his statement to the Ethics Commission on the "Balbi Case," Dr. Mautone said: "On August 20 [1975], someone was brought in under similar circumstances and I had to do an autopsy. I did it, sent the material to the examining magistrate, and I also told the director that we couldn't continue with this kind of case because the responsibility of the Military Department of Health is to take care of sick people and not to perform autopsies. I am put in a position of having to give legal approval to bury the man and get him off their hands [those responsible for the death]… The Magistrate asked me to explain my conclusions with greater clarity. He asked me what "stress" was and I clarified for him that it was caused by many small things which by themselves are not a cause of death: taking away the cigarette he is smoking, playing music loudly, giving him lice, striking him. Together these produce such a disintegration of physical resistance that when they subject him to the "submarino" and he feels asphyxiated, he ceases to fight back, and for a person who has already given in this produces the acute cardiac arrest which kills him..." (Minutes of the National Commission of Medical Ethics, Montevideo, December 1, 1989. Copy authenticated by notary public).

2.2.4 Consequences of Direct Repression on Health

There are few documentary sources to date going beyond personal statements regarding the effects of imprisonment on the health of those affected.

Dr. Pedro Marín conducted a study in Chile of the health of political prisoners in the Public Prison of Santiago between January 1987 and October 1989, during which time he was also detained there and had participated in the care of other prisoners. The information provided by him can thus be considered highly reliable (see Table 1).

These figures become particularly relevant when we consider that the high rate of mortality observed is for a relatively young prison population (84.5% of inmates below 40 years of age). Also, it is relevant when we consider that cause and effect relationships can be established between the living conditions (including torture) under the repressive regime and specific pathologies. Marín specifically elaborates on depressive manifestations: ”Depressive reactions arise quite frequently after the first year of imprisonment. The political prisoner makes an assessment of his errors and weaknesses which, despite its truths, creates a feeling of blame. It is what we call ‘the first year crisis’...” (Marín1990: 152-159).

Dr. Lombardi, on the situation within Uruguayan prisons: ”[Approximately 10% suffered major psychiatric troubles, often delirium or chronic hallucinations]… Psychiatric help was provided exclusively by the military psychiatrist. The prisoner with psychiatric problems was subjected to selective harassment and persecution, along with manipulation of medication, creating dependence; on the other hand, an attempt was made to use him as a disruptive element within the prison. The aggressiveness generated among the prisoners led -in its extreme cases- to self-destructive aggression, which led nine of them to suicide. The suicide attempts were very numerous. Aggressive conduct toward others was observed less frequently...” (Lombardi, in Liwski et al. 1987: 132).

Table 1

Morbidity observed in political prisoners. Public Jail of Santiago. 1987-1989

Diagnosis	Number of cases
☒ Psychosomatic disorders:	
Tensional Headache	168
Ulcer syndrome	32
Arterial hypertension	5
Psoriasis	2
☒ Neuropsychiatric disorders:	
Anxiety symptoms	79
Depressive symptoms	58
Sleep disorders	53
Epilepsy	5
☒ Acute digestive illnesses:	
Gastritis	116
Enteritis	53
Colon infection	7
☒ Acute infections:	
Respiratory	134
Otorhinolaringologicall	41
Typhoid fever	1
Hepatitis	1
☒ Renal Litiasis	6
☒ Dermatological illnesses	71
☒ Wounds and traumatisms	138
☒ Ear, nose, throat and eye related sicknesses:	
Hypoacusis	4
Tympanic perforations	6
Vision	47
Conjunctivitis	29
☒ Peripheral circulatory illnesses	6
☒ Diabetes mellitus	2
☒ Others	108
Total observed morbidity	1,100

2.3 The Illicit Appropriation of Descendants

2.3.1 Defining the Problem

The sale of children, born in prison to "detained-disappeared" mothers, to individuals with no blood ties to them was a common occurrence in the clandestine detention centers known in Argentina as *chupaderos.* It is estimated that more than three hundred children were taken away from their birth parents in this way and illegally adopted.

In an interview with the Spanish weekly *Interview*, Ramón Camps, a high-ranking official in the Argentinean Army, spoke of this practice in almost programmatic terms: "… people were not "*disappeared*," subversives were. Personally, I did not eliminate a single child; what I did was hand some of them over to welfare agencies so they could find new parents for them. Subversive parents raise their children to be subversive. That must be impeded..." (cf. *Minutes of the Ethics Tribunal of Health against Impunity*, December 3, 1987, p. 20).

A report from the CONADEP includes the names of several physicians who directly participated in such transactions: "Once the child was born, the mother was "invited" [formally] to write a letter (which without exception would remain in official records) to her family, to whom the child was supposedly to be taken… The Director of the SAST at the time, Naval Captain Rubén Jacinto Chamorro, personally accompanied the visitors -generally high-ranking Navy officers- to show them where the pregnant prisoners were staying, boasting of the "Sardá" [the best known maternity hospital in Buenos Aires] they had set up at the encampment… We learned that at the Naval Hospital there was a list of married Navy couples who were unable to have children and who would be willing to adopt children of the disappeared. A gynecologist at the hospital was in charge of this list" (Sábato Report, p. 303).

R. Salguero details this clinical procedure: "Neither the first nor last names of these patients [pregnant disappeared-detainees] were recorded; rather, only two letters appeared on the list: N.N. [No Name] (R. Salguero, in Sábato Report, p. 313].

The statement of Adriana Calvo de Laborde to the CONADEP shows, in an exemplary way, the procedure followed by the repressive system in dealing with women in labor and children born in prisons: "On February 4, 1977, at about ten in the morning, eight or ten armed men entered the house. They were dressed as civilians… I was seven months pregnant… By the door, in front of all the neighbors, they put me into one of the cars. They threw me to the floor, blindfolded me and handcuffed my hands behind me… we reached… the Bureau of Investigations

in La Plata… I was interrogated that same night [and detained in spite of an absence of charges against me]… March 12, Inés Ortega de Fossatti, another detainee, went into labor. We made ourselves hoarse calling the ”on duty commando” [that is what he made people call him]. Hours passed without an answer. Since I was the only one with experience, I helped her however I could. She was a first-time mother and was seventeen or eighteen years old. Finally after twelve hours, and on a dirty table, blindfolded and in front of all the guards she had her baby, helped by a supposed doctor, who —all he did was yell at her while the rest of them laughed. She had a boy whom she named Leonardo. They left her in a cell with him for four or five days and then they took him, telling her that the Colonel wanted to see him… On April 15, I went into labor. After three or four hours of being on the floor with contractions —each time closer together— and thanks to the screams of the others, they put me in a squad car with two men in front and a woman in the back [whom they called Lucrecia and who participated in tortures]. We set off for Buenos Aires, but my baby girl didn’t know to wait and at the top of the crossing of Alpargatas, in front of the Abbot Laboratory, the woman yelled for them to stop the car in a ditch and Teresa was born there. Thanks to those things which are a part of nature the delivery was normal… After a lot of driving around we reached what I later learned was the Bureau of Investigations of Banfield. The same doctor who had attended to Inés Ortega de Fossatti was there. He cut the cord in the car and they took me up one or two floors, where they took out the placenta. They made me undress and, in front of the officer on guard, I had to wash the bed, the floor, my dress, pick up the placenta, and, finally, they let me wash my baby, with insults and threats throughout… The regime there in Banfield was much more strict than at the Fifth Precinct in La Plata… I was able to get them to put Patricia Huchansky de Simón with me and my baby, and she was of great help to me in those first days when the pains from puerperium would not leave me in peace. She told me that a few days earlier, she had been at the delivery of María Eloísa Castellini. Even though they yelled asking for help, the only thing they were able to accomplish was for the two of them to be allowed out in the hallway and for a knife to be brought to them from the kitchen. Right there on the floor a beautiful baby girl was born, which they took a few hours later. Finally, on April 28, and with the same guard on duty who had made me wash the floor, he received the order from La Plata to release me. It was evident that this ”gentleman” was not accustomed to freeing people because he became very nervous… He told me ”not to believe everything I had seen and heard because that was just meant to scare me a little.” That same night they dropped me off four blocks from my parents’ house with my baby in my arms, dressed in a nightshirt and sandals,

without documents and [both] plagued by lice...” (Statement of A. Calvo to the CONADEP, file # 2531).

This also occurred in regular hospitals, to which Army doctors had access: Dr. Justo H. Blanco’s statement to the Ethics Tribunal of Health against Impunity provides direct evidence of this: ”Yes, I’m a doctor, a specialist in gynecology and obstetrics. At the beginning of April 1977, when I was chief of Obstetrics at the Isidoro Iriarte Hospital, a detainee was brought in by a group of uniformed police, accompanied by a police doctor whom I recognized due to having the same specialty and having met him. His name is Jorge Antonio Bergés. At that point in time I examined the detainee, who was seven months pregnant and had gone into labor. I admitted her. The police were intending to remain in the delivery room, to which I was strictly opposed, and so the police and doctor left. And the on-duty obstetrician and I were left to attend to the detainee, last name of Valenzi. She was attended to quickly. She had a premature delivery of a female weighing about two kilos. Due to her prematurity she was immediately sent to the Neonatal Ward. Immediately after the delivery was carried out, the detainee was taken to the admissions room by me personally, and from then on a police guard who did not allow us to continue our care of her kept watch over her. Fortunately we were able to obtain information about her name and learned that she had been detained and tortured. A clinical history was written up for her which later disappeared. Her name was written in the deliveries book in my own hand and was erased a posteriori, I’ve no idea by whom. At about seven in the morning —I had remained awake because of the work involved in being on call in obstetrics— the police and Dr. Bergés returned and took this woman who had just given birth away in a private pickup truck, in the back, lying down, and we didn’t have any more news of her”. (Statement to the Ethics Tribunal of Health against Impunity, Buenos Aires, 3 December 1987).

Corroborating information to this statement is found in the Sábato Report: ”The case of Silvia Isabella Valenzi (File # 3741) is illustrative. Having been kidnapped at the well at Quilmes, she was taken to the Quilmes Hospital to give birth. This information was recorded in the hospital’s book of deliveries, as was the birth of her daughter Rosa Isabella Valenzi. The alluded to book of deliveries, of which a copy was obtained by this Commission, appears on page 156 grossly testate, where the name of the patient Silvia Isabella Valenzi is recorded, and, beside the number 82019, where the birth of Rosa Isabella Valenzi appears, the word ”died.” The nurse and midwife at the Hospital were kidnapped for the ”crime” of informing the family of Silvia Isabella Valenzi about the events described” (Sábato Report, p. 281).

2.3.2 Scientific Identification of Kidnapped Descendants

The generation gap produced by the ”disappearance” of parents was filled, as required by law to obtain access to children born in prisons, by the so-called ”Grandmothers of the Plaza de Mayo.” The ”Grandmothers” were a group of women, mothers of the ”disappeared,” who were aware of the births occurring within prison walls and took on the task of recovering their grandchildren.

The evolution of genetics as a biomedical discipline has been of inestimable importance in the identification of children illegally adopted by couples with a proclivity toward the military regime. The Grandmothers of the Plaza de Mayo undertook a wide variety of activities to establish their bloodlines to these children and claim the consequent right of the children’s return to their original families. These efforts led, among other things, to their contacting various scientific institutions in Sweden, France and the United States.

In their own words: ”At the time [1979-1981] we were starting to learn scientific concepts. Our reasoning was linear. There are gestures which are passed on: kids who raise their hand to their face in the same way their parents did, who cross their legs like their mother, who stand like their grandmother...” (Hererraand Tenembaum 1988: 94).

In 1982, the Grandmothers of the Plaza de Mayo contacted the American Association for the Advancement of Science (AAAS), headquartered in Washington, and met Dr. Fred Allen (a member of the group of investigators who achieved the transfusion of blood of children born with RH negative blood) at the Blood Center of New York. With his support an investigation was initiated, aimed specifically at the genetic identification of children presumed to have been illegally adopted. The task was to try and establish the genetic link with the grandparents (the ”grandparent” index). This verification of a blood relation can also be effected with uncles and aunts or other close relatives.

To determine the identity and parental relation of the children in question, a number of hematological studies of genetic markers are used through the following tests: a) blood groups; b) seric proteins; c) H.L. or tissue compatibility; and d) seric enzymes. The result of these exams constitutes conclusive proof of both identity and blood relation and has been incorporated in the normal procedures of the courts (Torres 1987: 137-148).

2.3.3 Psychological Consequences of Adoption Following Kidnapping

E. Giberti summarizes the symbolic burden of the practice of clandestine adoption of ”spoils of war,” for society in general and the children specifically in-

volved: ”… the myth of the stolen child ceases to be such in order for it to be incorporated as a fearsome possibility,… in contrast to adopted children, they were not abandoned by their parents; rather they were taken from their side… Any of the children of which I speak, now recovered, could recount: ”I am the child of ”*disappeared*” individuals. My grandparents rescued me because I was in the care of… It happens that my mother (and he would then narrate her story)... Because of this, I was born during her captivity, and the man who kidnapped her kept me and registered me as if I were his son… He worked for (the name of the repressive institution to which he belonged)... The same thing happened to many other children like me. But my grandmother appeared when those who had me were preparing to take me abroad with them and so I was able to return to my family"… Those who maintain professional contact with these children are prudent and cautious in their assessments; the outbursts come from those who theorize from a distance, certainly historic, maintained around this tragedy as it developed. It seems necessary, faced with this tragedy, to refine our listening and show restraint. All of these children, and only they, will be able to speak for themselves when the time comes” (Giberti 1987: 206-210).

There is a lack of concrete information concerning Chile and Uruguay, but it can be supposed that the detainment and ”disappearance” of pregnant women and the subsequent absence of references to their children did not occur only in Argentina. The extensive and systematic nature of the plundering process of ”spoils of war” -children born in prisons- in Argentina cannot lead to hiding the fact that there were similar situations in the other countries. Even today it is not known if the pregnancies were brought to full term, and if so, where, or whether future mothers were killed by torture prior to giving birth. A valuable effort to untangle the web of disinformation woven by kidnappers regarding nine pregnant women who were detained and disappeared in Chile was made by the Committee for Defense of the Rights of the People (Comité de Defensa de los Derechos del Pueblo, CODEPU). In the book: *All of Us Would Be Queens*..., this organization’s investigative team centers its efforts on evoking the presence of these women from the perspective of those who accompanied them at the time of their detainment by security or paramilitary forces, then during the period of tortures, and finally at the point where their trail is lost. Although the direct presence of physicians in this process of annihilation is not established, the study of these nine women provides proof of a delivery by at least two of them (there is even a record of the daughter of Cecilia Labrín being born on March 5, 1975, weighing 3.85 kg), and of these births taking place in military hospitals in Valparaíso and Santiago. Given that the archives of these hospitals are inaccessible, it is impossible to determine what happened to these mothers and the children. References to two of the other ”dis-

appeared" detainees lead to the Colonia Dignidad, where the potential births could have taken place outside of regular jurisdiction and the children could have grown up in an enclave unrelated to the world of their parents[23]. It was impossible to reconstruct the journeys of the remaining five pregnant women through detention sites, either known or clandestine. At most, their expected date of delivery could be specified" (CODEPU, 1990b).

As can be appreciated, there remains a "zone of silence" around the fate of many children born during the imprisonment of their mothers[24]. In Argentina, the Grandmothers of the Plaza de Mayo have a series of trails at their disposal to continue in their search for these children.

Having confirmed that in some South American countries there were physicians who participated in the fraudulent adoption of children, it is not possible to trust in the suitability of any authority. Rather, it becomes necessary to create legal and professional bodies of control in order to avoid such occurrences and to prevent new outbreaks of violations of the right to identity of each child.

2.4 Physicians and Public Health Departments

The special significance of medicine during the dictatorial governments stems from the fact that, from among its practitioners, there arose determined opponents as well as important defenders of each particular regime.

Sociological studies relating to the medical profession and the social vicissitudes in this region have yet to be carried out. The fact that many of the doctors in Chile were originally actively opposed to the government of Allende, even applauding the coup d'état as an adequate and necessary solution, and then initiated efforts of fundamental opposition to the dictatorship clearly influential in the creation of the Democratic Concertation, the opposition group responsible for the so-

[23]Colonia Dignidad is a settlement of Germans who emigrated to Chile at the beginning of the seventies. The participation of its members in acts of complicity with the military dictatorship has been demonstrated in numerous judgments, and also, internally, in the oppression of other members.

[24]Concerning the increasing medical work with those affected by State terrorism, M. Viñar 1991 expresses: "This zone of silence is, nonetheless, crucial. The unconfessable, says Maurice Blanchot, is not what is not confessed, but rather when there are not confessions or confidences revealing it. The unconfessable becomes apparent, when something urgent and conclusive makes it rise by default or by absence".

cial and partisan bases to defeat Pinochet at the polls —thus remain at a somewhat anecdotal level (Personal communication from Dr. Luis González, former president of the Chilean Medical Association).

The following corollary is in keeping with this context:

A Chilean military doctor, Dr. Augusto Schuster, penned two documents: ”The Irredeemable,” October 11, 1973, and ”The Rescuable,” October 12, 1973. In the former, he presents a classification of the ”contingent which forms part of the 44% of pro-Unidad Popular voters of March 1973” into five groups (extremists, highly dangerous and intelligent activists, ideological activists, activists from the Unidad Popular parties, Unidad Popular sympathizers), for which he proposes specific measures (irredeemable; not useful although they can be neutralized; not immediately salvageable, but possibly reliable upon reconsidering their political affiliation; can be won over through intelligent and successful politics). In the second document, reference is made to ”those citizens who suffered the Marxist persecution of the last three years” .A suggestion is also made to the military junta to adapt to the preceding classification and to take adequate measures if it wants to avoid the ”reorganization of Marxism and the progressive increase of civil resistance” (cf. Reszczynsky et al., 1979: 270).

Dr. Martín Gutiérrez, chief psychiatrist at the Penal de Libertad in Uruguay and later an adviser to the governing junta, speaks about the situation of detainees within the prisons and barracks of that country: ”The war continued inside the prison. Day after day, rule after rule, were part of a grand design to make them suffer psychologically”. (Bloche 1982: 15).

Dr. Maraboto speaks openly of the unconditional loyalty of military physicians to superiors at his institution in Uruguay: ”The function of the military doctor in any country in the world, and in any political regime, is to advise the chief from a technical point of view, but, in the end, the chief is the one responsible for what is done or is left undone in his unit. The physician is a ”chief official of the major state”; he is an adviser on medical matters”. (Statement of Dr. N. Maraboto to the National Commission of Medical Ethics, October 26, 1986. In: Martirena 1988: 69).

Nevertheless, the purposes of this chapter are to highlight the ways in which members of the medical community were the object of special forms of repression during that era, and also to delineate the inclusion of some hospitals in the repressive apparatus.

2.4.1 Arbitrary Dismissal of Opposition Doctors

Consistent with the aforementioned statement of principles of Dr. Schuster, the working conditions of many Chilean physicians is illustrated as follows: ”Three North American physicians sent to Chile in June 1974 by the Federation of American Scientists (FAS) to investigate reports of human rights violations directed against health professionals spoke to Dr. Arriagada, the National Health Service director, about this review process. He acknowledged that the military government had ordered directors of hospitals to classify all health professionals on their staffs into three categories. Health professionals in the ”A” category were considered both necessary in their posts and above political reproach. Category ”B” contained the names of those who were potential activists and militants. Those in the ”C” category were considered politically unreliable and were to be dismissed from the National Health Service, while persons on the ”B” list were to be transferred to other positions. The North Americans were shown a copy of the ”C” list which contained 1,700 names” (Sagan, Jonson and Paredes 1974. Cited in Stover 1987: 45).

2.4.2 Detention and Mistreatment

The forces of repression concentrated their efforts on particular members of the health care field. For Argentina, the following situation is illustrative: ”I am a physician at the Posadas Clinic. A few days after the coup d’état, the first Sunday after the coup to be precise, the hospital was occupied militarily by a massive movement of troops including tanks, helicopters and trucks with soldiers as if it were an assault on an armed fortress. The detentions within the hospital, which proceeded for two days, began that same day. Because of its swiftness following the coup d’état and the synchronization of this movement, there is no doubt that it had been programmed and prepared for a long time prior… These events at the Posadas involved the detainment of almost 200 health care workers amongst doctors and non-medical personnel… Nothing could be turned up for any of them, given that all of them were freed in the end (give or take a few days, imprisonment lasted just over a year)... I was freed in December [1977] and for years I wasn’t able to enter any hospital, either as an audience member or as a lecturer… Regarding the Posadas, when I returned, it was as if night had fallen, as if a cyclone had passed through. Only now is it starting to recuperate. It was a devastated hospital. It was a hospital where the wishes and plans of the military’s economic mentors to diminish the public health care budget to a minimum were evidently upheld” (cf. Statement of Dr. M. Scharier to the Court, op. cit., p. 13).

Situations of extreme severity are also described that pertain to the mistreatment of prisoners by members of the Uruguayan medical corps:

”Phony acts of terror, such as staged executions and machine-gun fire during recreation periods, further heightened tensions and uncertainty. Recalled one former prisoner, a physician: ”It could happen that you were in the yard and you heard the alarm. You were obliged to lie face down on the floor, hands behind your back, all the machine guns pointing at you from the towers and the soldiers running. This was something difficult to adapt to. You could not predict it. Sometimes we heard the guns firing. Sometimes it was impossible not to think ‘they’re going to use them sometime on me —perhaps it’s today’” (Bloche 1987: 15).

2.4.3 Direct Persecution

The harassment of health care personnel took place not only at the hands of the military: it should be emphasized that some of these incidents also occurred among colleagues, for example in Chile:

”Many physicians throughout the country were assassinated or detained on September 11, 1973… Also, from daybreak that day, other doctors participated in the search, detention, interrogations, torture and death, not only of colleagues but of hundreds of Chileans. The testimonies are numerous… There were physicians who pointed out colleagues so they would be imprisoned by the Armed Forces, as happened during the raid at the José Joaquín Aguirre Clinical Hospital on September 15, 1973. A hematologist denounced the sympathies for the government of Allende of Dr. Moisés Brodsky, sending him to prison and also causing him a long exile… Other doctors were seized by a true paranoia of foreigners, accusing any doctor who spoke with a Central American accent of being an extremist… There were physicians who took advantage of their political position to expel their colleagues from hospitals, thereby attaining prominence in teaching capacities and in the labor assistantship. In the Department of Neurology and Neurosurgery at the University of Chile’s Clinical Hospital, a doctor tried to accuse another of sabotage, knowing that in those days -after September 11- this was punishable by death. The head of services presented the false allegation from succeeding. Nonetheless, the unjustly accused doctor also had to go into exile” (cf. Rivas 1990: 8-9).

Among the military personnel who applied it, the consideration of torture as simply another technique ”in times of war” seems to have been very ubiquitous. This practice was so free of moral questioning for them that they did not hesitate to seek professional advice, even from the imprisoned physicians who themselves

were regularly victimized by this form of ”treatment,” as evident in this statement by Dr. Solimano:

In December 1973, several physicians and I who worked with the Ministry of Health under the Allende government were arrested by the military authorities. We were taken to a place called ”Tejas Verdes,” the barracks for military engineers located south of the port of San Antonio. During our stay there, we were kept in huts near the barracks and brought to one of the main buildings for interrogation and torture. Our interrogators wanted to know about what they said were certain ”irregularities” in the previous government’s health system. At one point, one of my interrogators, an army officer, asked my advice, as a physician, on how to keep detainees from dying under torture. He said they were ”losing too many people” and wanted to know from a medical perspective what could be done to keep them alive, especially when applying electric shock. The notion terrified me. Anyway, the best I could do was to frighten them. So, I told the officer that medicine could offer him and his companions no guarantees of saving the people they tortured and that they should stop (Stover 1987: 26).

The subordination of the medical practice to the repressive efforts in Uruguay is also evident in other examples: ”In the regime’s clandestine detention centers and national security prisons, soldiers regulated detainees’ access to medical personnel and routinely read clinical reports furnished by physicians, psychiatrists, and psychologists. Almost all the army clinicians interviewed admitted having disclosed information about prisoners’ medical or psychological condition to military authorities without these prisoners’ consent or knowledge” (Bloche 1987: 12).

2.4.4 ”Disappearances,” Executions…

In addition, there were radical forms of repression of health care professionals, as in Argentina: ”In the health care field we can verify the disappearance of at least 164 doctors, 35 nurses, 56 psychologists, 19 odontologists and 150 medical students in the capital and in Buenos Aires province. We can assert that more than 500 people belonging to the health care field currently retain the detained-disappeared status”. (cf. Public Prosecution Statement of Dr. Diana Kordon to the Court, op. cit., pp. 22-23).

Similar references are available for Chile: ”In the aftermath of the military coup of September 11, 1973, hundreds of health professionals went into hiding or fled the country. Of Chile’s 7,200 physicians, 109 were detained, 9 of whom were executed and 11 were made to ”disappear.” According to the American Public Health Association (APHA), 7,700 NHS health workers were dismissed from a staff of 55,000 and 880 others were forced to retire. In addition, the budget of the School

of Public Health at the University of Chile was slashed by three-quarters, and 82 faculty members out of a total of 110 were fired or imprisoned" (Stover 1987: 42).

- Aside: Abuse Within Hospitals

  Given that hospitals are public places dedicated to the promotion of health, their use for purposes antagonistic to their primary objectives would seem to be an aberration; however, there are in fact many examples of their illegitimate use. For Argentina, a report from the CONADEP provides a detailed account of the establishment of a department of repression at a clinic, subordinate to a central hospital: "At the Alejandro Posadas Clinic in Haedo there was a clandestine detention center which functioned in cooperation with the precincts in Castelar and Mor¢n, with the Superadministration of Federal Security and the Assignment Group of Aeronautics… Events occurred in full view of the employees and of people who attend the establishment, occasioning a generalized terror that prompted the silence of everyone. The victims in the majority of cases were… hospital personnel… The operation… was directed by General Bignone… it culminated with the detention, as it was called, of a group of forty individuals (see statement by Dr. Scharier). From this point forward, Colonel Dr. Abatino di Benedetto served as an administrator at the clinic, discharging all personal and forbidding them entry to the establishment. Subsequently, Colonel Dr. Julio Ricardo Estévez was appointed as interim director… Gladys Cuervo contributes some significant observations on the functioning of this clandestine detention center: "On November 25, 1976, Estévez called me to the office. There, they held me at gunpoint and put my arms behind my back. More toward nighttime, they took me in a small truck and after driving around in circles for some time, they told me I was in Campo de Mayo. However, I realized we were just behind the clinic. They undressed me and punched me, questioning me about some leaflets which I hadn't seen. Then some other people came who tortured me with a cattle prod. They tortured me for several days..." (cf. Report from the CONADEP, File # 1537, and Statement of Dr. Mauricio Scharier to the Court, op. cit., pp. 13-14).

  In the photographs accompanying the CONADEP report (p. 177), a room probably used for torture is evident. The walls in the room reduce the white asepsis of a hospital and must have served for the relaxation of the "acting personnel." Thus, a poster calls for heeding traffic signals, another shows a landscape of the south of Argentina and a third depicts a windmill form in Holland. A new form of everyday existence had been established there, and those who tortured made that space their own with their own form of cultural privacy.

  This transgression in the use of hospitals also occurred in Chile: "The case of Fernando Fuentes Ramírez permits a glimpse of the torture sessions to which the detainees were subjected. Wounded by gunfire, with various fractures and with an acute anemia due to hemorrhaging, Ramírez was admitted to the hospital and had his vital functions stabilized. He subsequently related: "… Immediately on entering this place a process of physical and psychological torture was systematically initiat-

ed, with the help of a naval lieutenant, doctor, and a team of male and female nurses...” A group of approximately ten individuals interrogated him: ”...at the same time that they hit me, they put strong pressure upon the lacerated regions: ankle, lung, jaw, etc. Several attempts on my life were made at the Naval Hospital… something which was impeded by the hospital administrator, whose sole objection was that it not be carried out there: ‘if you want to kill him, take him from here and do it somewhere else’ ” (Ibacache 1990: 146).

A similar case is that of Mauricio Arenas Bejas during his forty days at the Sótero del Río Hospital, where he was admitted to the intensive care unit with multiple bullet wounds following a ”unilateral shoot-out with clear objectives of extermination.” The victim was suspected of having participated in the assassination attempt on Pinochet in 1985: ”The first interrogation was conducted on February 25, 1987 [the sixth day of clinical development], with the detainee in very serious condition, presenting with feverish symptoms… with frequent losses of consciousness, multiple corporal pains, surgical traction in the lower extremities and significant injuries from treatment… The first interrogation was initiated by an unknown civilian, a ”specialist” on the matter, before..., the Medical Deputy Director at the hospital… The formal part of the questioning was inquisitive, threatening, with a clear intimidatory purpose… ”the man spoke rapidly, very abrasively. He would constantly be moving around my bed. It was difficult for me to follow his speech. He gesticulated, pounded the dresser threateningly, commented on the disabled state I was in. He insulted me… I felt a great sense of desperation because of my state of defenselessness, which was at his disposal. I looked at the Deputy Director of the hospital as if to beg him to stop this thing, because he is supposedly there to even things out. He has ways of seeing what is happening with the patient but he didn’t do anything. He was very servile before the Public Prosecutor. I was like a lamb, totally defenseless,… I felt very distressed"… [Between the second and fifth interrogation there was little change in the modus operandi]. With the apparent objective of looking for incriminating information, Bejas was subjected to new psychological pressures: provoked confrontations with political prisoners… ”… they brought Dr. Marín in very poor shape, deteriorated. I was sweaty, dirty, pale, unkempt. He looked nervous. But he entered the room and said loudly, ‘I am Dr. Marín.’ He examined an old injury on my leg. [He eluded the confrontation in this case] and as he left he yelled in a strained voice: ‘How can you interrogate a riddled person who is very sick?’ ” Certainly, here is relevant testimony of a doctor -also tortured- who condemned the cruel treatment of a patient in a seriously ill state” (Madariaga and Pavin 1987).

It has been deemed relevant to elaborate both on the forms in which physicians were the objects of persecution and the ways in which the function of hospitals as health care institutions was distorted. This serves to underline the personal situation of doctors subjected to repression and also to illustrate, with respect to hospitals, the thoroughness of the totalitarian regimes in their invasion and subjugation of almost all areas of daily life.

2.5 The Other Part of the Story

This essay on the practice of medicine under the military aegis in Argentina, Chile and Uruguay would be one-sided without introducing the active response against the totalitarian intentions of the State. During these years of widespread repression, the participation of doctors in ethically responsible acts can also be established; individuals who went beyond the passive abstention of collaborating with the oppressive system and gave descriptions and examples of professional ethics at the time.

2.5.1 Non-Discriminatory Treatment of Patients

The non-discriminatory treatment of patients is the cornerstone of assessing each position of professional ethics under exceptional conditions.

The following example refers to Argentina: ”… I received a call from London; an English woman I had treated [for a psychotic crisis] long ago, asked me to see a nephew who was in fact schizophrenic. Well, this nephew came. He was the son of a Minister of Proceedings, and this man also came, with the same old story: ”I didn’t want to ask you for an appointment. Rather I asked for an appointment through my sister-in-law for this boy who is seriously ill.” I treated this boy. The constitutional government was already in place. I proposed helping the boy, but with the condition of not working with the family, because it was impossible, no?” (Personal communication from a physician interviewed for this study).

The next example is from Chile: ”There were also doctors who respected the Hippocratic Oath and tried by whatever means to save the detainees and those who had been tortured, such as the doctor who snatched Carlos Lazo, president of the State Bank and dying from being tortured, away from a colleague. Or another in Copiapó who took Rubén Herrera to the city hospital because of the poor condition he was in. Or the administrator at this same hospital who later prevented Fernández Larios from taking Herrera, thereby making him one of the few survivors of the caravan of death of General Arellano Stark” (Rivas 1990: 10).

In addition, during the dictatorship itself there were a series of initiatives from both individuals and ecumenical groups who dedicated themselves, despite reprisals, to the promotion of human rights:

One of the first physicians to offer medical services to victims of torture was Dr. Pedro Castillo Yañez, a thoracic surgeon and a Fellow of the American College of Surgeons. In a wave of academic dismissals in 1975, Dr. Castillo had been fired from the chairmanship of the Department of Surgery at the University of Chile in Santiago. In 1981, he founded the non-governmental National Commission against Torture… In early May 1981, CNI agents began watching Dr. Cas-

tillo's house in Santiago. On May 23, his wife, Erica Toucher, filed a writ of preventive habeas corpus. In it, Dr. Toucher pleaded with the court to stop "the illegal surveillance of my husband" and investigate "whether an order of detainment already exists." Dr. Taucher's appeal was to no avail. Four days after it was filed, her husband was picked up at their home and taken to the CNI detention center at 1470 Borgoño Street. At around the same time, two other well-known Chilean physicians —Drs. Manuel Almeyda and Patricio Arroyo— were also detained and taken to the Borgoño Street center. Like their colleague, Drs. Almeyda and Arroyo had been attending to torture victims referred to them by human rights organizations… As soon as terrorist charges against the three physicians appeared in the [pro-regime] press, the Vicariate and the Chilean Commission on Human Rights countered with charges that the secret police were angered by the fact that the doctors were submitting complaints of torture to the Chilean courts and international human rights organizations. These testimonies contained detailed descriptions of the torture centers run by the secret police and in some cases testified to the presence of medical personnel at the centers… Three weeks after their arrests, the three physicians appeared in a public prison in Valparaíso. Eventually, the military judge handling the case granted the two North American physicians permission to see Dr. Castillo and his colleagues. Visibly shaken by the ordeal, the Chileans recounted how they had been held in solitary confinement for three weeks, most of the time with their eyes taped shut, without access to family or legal counsel. "The first thing they talked about," one of the North Americans later told the press, "was how upset they were about the publicity that defamed them. They were anguished that they had been made to appear as terrorists in the press. Their whole careers could be destroyed in an instant by having the national newspapers link them to terrorist activities."

On July 1, 1981, a military court in Valparaíso ruled that there was no evidence that the three physicians were associated with terrorist groups and that another charge of illegal political activities was not within the military's jurisdiction. The military judge referred the second charge of "illegal association" to a civil court. On July 4, that court rejected the case against the three physicians and ordered their immediate release (Stover 1987: 48-50).

The following experience pertains to Uruguay: "Following an armed confrontation between the army and the Tupamaros, I was called -in my capacity as a surgeon- to attend to the injured. I noted a bullet wound in the thorax of Mr. Z., a Tupamaro, and a minor injury of the gluteus of a military official. I asked that we urgently undertake the treatment of Mr. Z. and was told that he could wait since there was also an injured military man. I insisted that the medical priority was to

attend to the most severely injured, without other considerations prevailing, and I began to treat Mr. Z...” (Personal communication from an interviewed doctor).

2.5.2 Refusal to Obey Orders Harmful to Patients

In Argentina, a determined effort to protect a female patient in fact, one admitted in the irregular conditions of ”night and fog” is apparent in the experience of Dr. Blanco alluded to earlier.

In Uruguay, the resistance of a psychologist who refused to release information about prisoners at a detention center illustrates the conviction of health care and military personnel regarding the lack of privacy of the detainees and the betrayal of professional confidentiality:

”The psychologist, Alberto Milkewitz, refused in 1982 to obey orders to prepare reports on internees for his commanders at the Penal de Libertad. He was arrested and held incommunicado for one week. A secret order for his arrest, obtained by the author of this report, is candid about the reason: ”indicating an absolute lack of understanding about his obligations as a member of the armed forces by stating that he could not supply information about his conversations with incarcerated elements without their knowledge because his ethics as a psychologist would not permit it” (Bloche 1978: 13).

2.5.3 Everyday Practice under Dictatorship.

There are not, at the present time, any specific studies concerning professional life in the three countries during the military dictatorships and the documentary references to the matter are limited.

In Chile, three neuropsychiatrists, clearly committed to the Allende government’s process of change carried out a systematic analysis of experiences in the period immediately following the coup d’état .This study provides points of reference from that time seen from a professional perspective:

”We decided to open up a private practice. With it, we principally sought to enable a means of subsistence and to conceal and make the treatment of victims of repression possible. This type of practice led to our attending to patients who supported the dictatorship. Our medical services did not discriminate with respect to the political commitment of the individuals treated… Throughout one year we lived a contradiction at the practice, day to day, patient to patient…

When we had to treat those who backed the dictatorship and had to listen to them relate their private affairs, we were able to verify their consensus with the situation of generalized repression… We frequently heard their opinions that ”now there is order,” ”the streets are clean,” ”there is tranquillity"… These characteris-

tics of the petite bourgeoisie were greatly emphasized among those who had an imprisoned family member. The shame due to a ”tarnished honor” was one of the principal sentiments. They were unable to accept that a family member was in jail. Fear also contributed to covering up of the fact at work, keeping it from friends and sometimes from the rest of the family. They thought ”their” government was justified in detaining the enemies of order, of liberty and of justice. They reproached the detained family member for his irresponsibility in sacrificing them for ”ideas” they considered to be corrupt. All of this shame, bitterness, rage, resentment and frustration were at odds with the existent affective bonds… of sacrifice and concern for the prisoner. In treating these patients, we had to limit ourselves to a therapeutic position directed at eliminating the symptoms… thus contributing to facilitating their adaptation to the living conditions they were subjected to… Assuming this stance required us to suppress our feelings of rejection of their problems, to avoid stating political opinions to protect our safety and to acknowledge that by improving their condition we would be aiding in their adaptation to the new regime… From the outset we began to learn of the effects of another form of repression. It was that exercised on the families of the persecuted, imprisoned, dead or ”disappeared"… We saw in these people symptoms of agitation or stupor, of intense anxiety or severe depression, psychomotor restlessness with verbosity and reduced awareness, primitive affective reactions as described by Kretschmer, symptoms of premature deterioration in persons less than fifty years of age, apathy and even pseudo-catatonic manifestations…

Our contact with fellow leftists was not restricted to the practice. The tremendous secrecy was for many a sort of ”total incommunicado,” interrupted only by some family member… or by a compañero who was bringing information… Abruptly, the day of the coup, they had to go from creative and productive activities to a passive seclusion… Maintained in these conditions for months, some of them were presented in states of severe distress, with intense anxiety… Others were presented in depressive states… Other individuals became accustomed to a new daily existence, these being increasingly numerous as people learned to live this way… The most frequent type of secrecy practiced was an open secrecy… Here, the necessity to blend in demanded a constant state of alert. Recognizing the smallest indication of abnormality as potentially dangerous led, on many occasions, to interpreting banal, chance events as if they involved actual risk. Suppressing reactions of repudiation toward flagrant and arbitrary events, [protecting oneself from] one’s own emotions, passively accepting opinions with which you were not in agreement, sometimes led —despite a high-level of self-control— to having irrepressible explosive reactions, a result of powerless rages which had to be vented in private… [in some *compañeros* we saw] distressed reactions to liv-

ing, psychosomatic illness, neurotic states, reactive psychosis, a consequence of living a life of ”open secrecy” … Undertaking their treatment required us to elucidate the facilitative and obstructive mechanisms of what it is to be in the underground...” (Reszczynski1979: 28-32).

The authors reflect on the subject of torture: ”… It was at the practice that… we came face to face with evidence of the physical and psychological torture practiced extensively by the Chilean State. We listened to the first accounts with incredulity; tales of symptoms of spinal column lesions among ex-political prisoners who told us they had been left hanging from their hands and feet for hours or days… The objective neurological exams confirmed the veracity of these accounts… An embarrassment existed among most of the former prisoners about showing their remnants of torture, so that our examinations were inhibited. We did not dare ask questions and the long silences were difficult to fill. Due to our feeling of helplessness in adequately treating the distressed reaction accompanying the recollection of their experiences, we were fearful of unraveling details of those times when they had been near death… This medical practice showed us new mechanisms capable of producing sickness, pathological manifestations whose configuration was different from those of classically described syndromes. It made the ineffectiveness of our treatments in resolving them very clear… this led to our trying to get to the bottom of each question to its smallest detail. Our examination would never again be laconic and inhibited; it must be frank, direct, committed… At that time we began to conduct a detailed study, noting all elements that seemed to us to be important, effecting complementary examinations permitting the confirmation or rejection of our diagnoses. All of this material outlining the preliminary elements of a clinical methodology was left unfinished after one year of work in Chile when we ourselves were detained and imprisoned” (Reszczynski 1979: 38-40).

2.5.4 The Denouncement of Ethical Transgressions and Its Consequences

It should be noted that even after the return to parliamentary democracy the totalitarian administration has not disappeared from the political scene, and with attacks of invariable efficiency and impunity, it maintains its influence of terror in the minds of those who lived under its aegis. Within this frame of reference, gestures of opposition to the silence imposed by the organized violence, such as the following, are of great relevance: ”… I denounced Dr. XX to the hospital authorities and later before the Commission; I was one of the witnesses in the trial of the commanding officers. That earned me a bombing of my house that blew out the

whole front. My children survived —I was sleeping upstairs— but the bedroom next door was destroyed. Besides being a heavy burden on me, it was a very big blow for my family, for my children, particularly the youngest ones. Two boys and a girl. They were three, five and seven years old. In fact one still has a cut on his face from the flying glass of the explosion. My daughter, for example, still has night terrors. [Question: The denouncement of those events, was it a common practice in your line of work?] A: No, it wasn't that way. So much so that at the time there were a total of fifteen on duty professionals and none of them provided statements to the Commission, including the midwife who had been working with me —she also did not provide a statement. Summoned by the Commission, she said she did not remember anything, and the public prosecutor asked her if the event of a detainee arriving and then being taken away and of her not recalling this seemed normal to her. She did not answer. [Question: what was the attitude of your wife toward these events?] A: My wife was in total agreement with my position, even after the bomb… she could have been critical: "why did you declare this?," but she recognized the ethical aspects of what had to be said and it was said..." (Personal communication from an interviewed doctor).

As can be observed, there were also stances of active and everyday resistance among health care professionals to the situations studied. In the course of the field study we had the opportunity to interview several individuals representative of these stances who, with their anonymity intact, will be cited regularly in the empirical part of this investigation.

2.6 Internal Indictments and Proceedings by Medical Organizations: The Conditions of Legal Amnesty

There have not hitherto been any specific efforts by judicial authorities in the three countries to legally define the personal responsibilities of those participating institutionally in acts of torture, assassination or "disappearance." However, it is noteworthy that medical associations have sought ways to demonstrate the limits imposed on professional ethics by military dictatorship. With unquestionable clarity, the professional associations of two countries have declared that medical activity in support of the repressive apparatus of State cannot in any way be considered normal. The ethical judgment during this time has resonated strongly in public opinion within the three countries.

In Argentina, the legal efforts against those responsible for crimes against humanity quickly reached a limit. Following the publication of the Sábato Report, and once the proceedings against the generals of the "Proceso" had ended, there was a strong military backlash, leading to gradual concessions in the treatment of

the accused. Two bodies of law, those of the ”Punto Final” [*Full Stop*] (December 1986) and of ”Obediencia Debida” [*Due Obedience*] (July 1987), eased the concerns of the military and substantially reduced the possibilities of legal intervention against those responsible for human rights violations. Though this is not the most appropriate place to reflect on the effects of these gestures by Argentinean political sectors on the social and cultural evolution of that country, we nonetheless concur with the opinion of H. Kelman and V. Lee Hamilton: ”It may well be that the due obedience law saved Argentine democracy from another military coup. In doing so, however, it established the presumption that all but the top military officers have no choice but to follow superior orders, even when those orders call for torture and murder” (Kelman and Hamilton 1987).

Thus, the decision by a group of health care professionals to fight against the common denominator of hierarchical subordination becomes more relevant when they initiated, based on the motion of Bertrand Russell, a Health Ethics Tribunal against Impunity in the city of Buenos Aires on December 3, 1987: ”We do not represent any State authority, nor do we stipulate means to oblige those responsible for the policies giving rise to the crimes committed to appear before us on the bench of the accused… It is not possible for us to establish death sentences. I think these limitations are in fact virtues. We are free to initiate solemn and historic proceedings without being bound by reasons of State or other similar obligations”.

Three physicians were tried in absentia in that court, recognized by many former prisoners as being directly responsible for acts of torture, kidnapping of children and even assassinations. Public prosecutor Dr. Diana Kordon based her arguments on existing ethical codes. Among other references, she stated: ”Article One of the Code of Ethics, ratified by the Medical Confederation of the Republic of Argentina in 1955 states: ”In all proceedings, the physician shall care for his patients abiding by their human condition. He shall not utilize his medical knowledge against the laws of humanity"… And she based her accusation on the testimony of individuals affected by State terrorism and who had been in direct contact with the accused physicians. The public prosecutor stated: ”The repressive methodology required the participation of doctors for its implementation. They evaluated the resistance levels of the prisoners to torture. They supervised and controlled the prolongation of suffering for the purpose of obtaining a maximum of information. A sinister task, that of these professionals; rationing out torture, being a part of torture. And they also participated in the abduction of kidnapped children and those born in prisons, by assisting with the disappeared-detained pregnant women and the false certificates that existed...” (Minutes of the Ethics Tribunal of Health against Impunity. Allegation of Prosecutor).

Dr. Kordon summarized the situation of the three accused principals, from the formal perspective of Argentinean law, in the following terms:

> ”- Colonel Doctor Julio Ricardo Esteves. Head of the Clandestine Detention Center of the Posadas Hospital. Unprocessable by due obedience law.
> - Police Doctor Jorge Antonio Bergés acting in the following Clandestine Detention Centers: Pozo of Banfield, Pozo of Qilmes and Bureau of Detentions of La Plata. Convicted by the Federal Chamber for application of torture… in conditions of impunity… due obedience law.
> - Héctor Jorge Vidal. Forensic pathologist at the Bureau of San Justo and doctor at the Laferrere Children’s Hospital. Signed birth certificates of children born in prisons. There is also evidence that he forged the identity of other children kidnapped along with their parents” [25].

The Court unanimously declared the accused responsible for a severe lack of professional ethics and for crimes against humanity. In its final decision, the Court requested that universities, the academic community, medical associations, and health and community institutions deny the convicted physicians access to all types of teaching and investigative activities and to medical work.

The effect of this initiative can be directly assessed in the intense interest evoked within the country and abroad, and in the violent reaction it provoked among the implicated parties (several members of the Court have been physically assaulted). It can be seen indirectly because it constituted a landmark of ethical reference for defining professional activity in the context of the silence and forgetting imposed by decree. Dr. D. Lagos elaborates on this point: ”… In a state psychiatric hospital in the city of Buenos Aires, authorities ordered the professionals to provide psychiatric care to individuals implicated in torture. They founded these instructions on the laws of the *Punto Final* and *Due Obedience* which had withdrawn the charges against them. This instruction went against the ethical position of the group of professionals, who refused to provide said care”[26].

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[25] Ibidem. About Dr. Vidal, we have to add that, a few days after a public meeting of the Ethics Tribunal, a judge from the province of Buenos Aires ordered his capture and imprisonment. This verdict was voided by the Federal Board of San Martín, an institution that immediately left this physician free, based on the law of the ”Punto Final”.

[26] Lagos 1989:16-19. What is interesting about this proposal it that goes beyond disobedience to a treatment mandate (which by itself can be accepted if there are some reasons demonstrating some personal implication of the doctor). It can also be considered as an act

The Chilean Medical Association in 1983, just after the first association elections not interfered with by the military government, began developing procedures for clarifying ethical conflicts related to political repression. These were based on a long tradition of professional membership and legal statutes repealed by the military dictatorship in 1973. The Ethics Commission aroused a great amount of interest by calling for an internal review of medical collaborators of the dictatorship's apparatus of repression. This served the purpose of a parallel trial, which simply by its presence, highlighted the blindness of the justice system in regard to this subject and subpoenaed the repressive system based on specific cases and charges.

In their statement to the United States Congress on May 16, 1984, the CMA representatives referred to torture as follows: "Our view of the problem of torture indicates that the fact that torturers exist and that they persist in their "work" until it becomes institutionalized is a clear signal that the society is sick. It would be easy to place the problem only on the torturers as evil and psychopathic persons. This is a phobic way of easing the social culpability involved in the problem… In this context we determine the CMC's position on the torture… We observe that the torture has been used during these 10 years in Chile by the authority as an instrument… The CMC, as an important contribution against the participation of physicians in cruel treatments, inhuman and degrading, incorporated into its Ethic Code a special article, prohibiting the direct or indirect participation of physicians on those activities. Such attitude denouncing the torture allowed the initiation of the investigation of doctors participating in inhuman and degrading treatments..."

They continued: "Considering this position, it is not surprising that, in the years between 1983 and 1989, members of the CMA executive were also targeted for direct persecution by the military government and jailed as political prisoners for periods of up to several months" (Personal communication from Dr. Luis González, former president of the CMA).

The prosecutor in the trial of physicians accused of violating professional ethics provides some considerations regarding the case of a doctor implicated in torture: "… I was the public prosecutor in the first proceedings undertaken by our Association to establish the degree of participation of a doctor in torture. It is not unusual for a Chilean, even a doctor, to consider the possibility of experiencing torture. Some of my friends, regrettably, have had to go through it. More than one was unable to survive, but to consider the possibility of investigating it and establishing responsibilities was for me a remote possibility… The first concern was, how to be objective?; how to not prejudge in one way or another?… we simply wanted to determine the truth, whatever the cost… We received a lesson from Ma-

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of civil resistance toward the laws of impunity.

ría of Los Angeles, who, in providing her statement, indicated to us that she did not come here so that the guilty would be punished, but rather to try and ensure that there would be no more torture in Chile...” (Villegas 1985: 19-20).

There was a high degree of consistency in these endeavors within the legal realm in initiating trials based on the principle of the prosecution’s confirmation of accusations prior to the filing of a formal lawsuit. The accused was notified of the accusations and he or his lawyer could express an opinion on them before any type of official indictment was initiated (cf. Chilean Medical Association, 1974).

This responsibility in trying colleagues, during an era in which the regular justice system was regarded as incompetent, was in practice defined as follows: ”The Department of Ethics has often faced difficulties in obtaining information about alleged torturers and their accomplices, as their ability to cover up torture is as great as their ability to intimidate those they have tortured. … We firmly believe, however, that serious and deliberate fact-finding is paramount. To do otherwise could result in wrongly implicating a colleague, an action that could damage not only his career but also the CMA’s credibility. Our task is not to prosecute or to persecute; we only want to see the ethical norms prevail. Consequently, before beginning an investigation, we conduct a thorough review of all the available evidence. If the material is incomplete or questionable, we wait until more detailed information can be obtained before proceeding with the investigation… We have now suspended or expelled 6 CMA members for their collaboration in torture and the cases of several other physicians remain under investigation. We believe these investigations and subsequent disciplinary measures are significant when contrasted with the Chilean judiciary’s inability and, in some cases, unwillingness to prosecute those responsible for torturing and ill-treating detainees (CMA Report, 1986. In: Stover 1987: 66-67, italics in original).

In making legal accusations, one of the primary stumbling blocks pertains to the perception doctors have of themselves and their particular circumstances: ”Faced with a specific question regarding the ethical correctness of examining detainees in a secret location of the CNI, Pérez Castro responds that he cannot give his opinion. He is an army doctor and adheres strictly to military discipline, according to which an order must be carried out, and if an observation is to be voiced it is done after the order has been carried out” (Rivas 1990: 40).

In his role as secretary general of the Chilean Medical Association, Dr. Fernando Rivas was able to closely monitor the ups and downs of professional ethics under the military aegis in his country. In his presentation during an international conference on ”Physicians, Ethics and Torture” in Copenhagen in 1986, he stated: ”During the dictatorship, over 80 physicians directly or indirectly participated in acts of mistreatment, humiliation, or torture; the great majority of these physicians

belonged to the armed forces and were attached to the security agencies (Rivas 1990: 191).

Based on his experiences in trying colleagues who had transgressed professional ethics, Dr. Rivas carried out a systematization of the acts of greatest ethical relevance. The following information is excerpted from his study: ”The unusual event occurred whereby the first investigation and sanctioning of a physician involved in violations of human rights simultaneously paved the way for the continuing acquisition of knowledge and investigation of other cases… The Regional Administrative Division of the Sixth Region, whose capital is the city of Rancagua, initiated proceedings and presented an accusation against seven people, among whom was María, for infraction of the law of internal security of the State. This trial began on April 5, 1982 and was heard by Judge Juan Rivas… The document presented by María's defense —she had only been accused— in which her innocence of all charges brought against her was argued and sought her declared innocence on these charges [this was in fact the judgment]. It sought to identify and summon the doctor who, as the accused asserted, had agreed to examine her before, during and after her detainment in the CNI's secret barracks… Contrary to what normally occurred in the administration of justice at the time, the judge requested said information from the aforementioned security organization and the CNI, contravening everything worked on in the preceding years, identified the doctor by name and rank… They identified the doctor as Carlos Hernán Pérez Castro, a Major in the Army… For the first time in the nine years of dictatorship the name of a collaborating doctor with the security department was revealed… The Department of Ethics made a suggestion to the Medical Association's General Council that it should instruct a Summary of Unique Instance… [initiated on September 22,1982] and on March 26, 1983, given the denouncement against Doctor Pérez Castro, his own statements, the testimonies provided during the investigation of the charges and all the documentation verifying them, the prosecutor decided to file two serious charges constituting infractions of professional ethics. The first of these was related to examining María in a secret detention center, thereby granting an appearance of normality to the process of physical, psychological and moral mistreatment, itself constituting support for the practice of torture and a way of providing means to facilitate it… The second was ascertaining, in the brief clinical file created upon the detainee's arrival, that she was in good condition, when in fact she at least had a burn on her face… These charges were communicated to Doctor Pérez Castro ,along with the information that he had the file from the indictment at his disposal or that of the lawyer he had assigned the task of defending him against whatever charges he deemed to be necessary… Doctor Pérez Castro subsequently submitted his defense, contained within a thirty-six page notarial document signed by a law-

yer, Mr. Tulio Díaz Trincado… In it, he acknowledged having examined the detainee on orders from superiors, before and after her admission, but he states that this does not contradict any code of medical ethics. He also states that he did it because he considered it a standard practice for anyone who was to be interrogated by his captors… He denied seeing her in the interval between the two examinations and stated that he had no knowledge of María having been tortured or ill-treated… Finally, he argued that he arrived to examine the detainee just prior to her questioning and then at the time that her interrogation was completed, and that if he had known she was going to be tortured he would not have done it… And Doctor Pérez Castro protested in the document about the attempt to sanction him for prohibitions contained in a code of ethics just having been approved in 1983, whereas the events motivating the indictment had occurred earlier, in April 1982. As such, the only ethical concern that could be demanded of him at the time was to not issue false certificates… The General Council… suspended him for one year from his status as member [of the Chilean Medical Association]… Given that the profession can be practiced without an affiliation to the Association, this sanction had a strictly moral character… Doctor Pérez Castro did not appeal[27].

Since 1983, a vast number of parajudicial procedures questioning the participation of doctors in repressive activities have been undertaken. Of these, only those establishing the direct responsibility of the accused physician have been brought to public attention.

This impartial attitude in dealing with presumed transgressors of professional ethics, but also with active participants in crimes against humanity, has not been well received in a society still shaken by the organized violence of almost two decades duration. It is society which, on the one hand needs points of reference in order to restructure its sense of justice, and, on the other, needs the certainty of knowing that crimes will be paid for, and the guilty be dealt with under the law[28].

There was a similar course of events within the two medical organizations in Uruguay, the Interior Medical Federation (IMF) and the Uruguayan Medical Association (UMA). G. Martirena recalls the gestation of the National Commission of Medical Ethics:

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[27] F. Rivas 1990: 33-46. This book was a bestseller in Chile for six months in the year of its publication (personal communication from the author).

[28] In this context we must consider the killing by an extremist group in 1990 of a doctor declared guilty of passive support for repression .

”Even in Uruguayan medicine, it is a historical and irrefutable fact that there were military physicians who participated actively or passively in the torture of political prisoners, or, who in the service of superiors, violated ethical norms they should have respected. There also exists a collective responsibility for the absence of a denouncement by military doctors,… of belonging to an institution… executor of practices infringing on human rights, at a general level and with such strong evidence that no-one could have been unaware… Faced with these events, in July 1984 —the dictatorship in Uruguay still in power— the VII National Medical Convention was held… On their part, and in the presence of military physicians, there was once again a public denouncement of the systematic torture suffered by political prisoners and of violations of human rights by the dictatorial government… the National Commission of Medical Ethics was created unanimously by the delegated physicians” (Martirena 1989: 14-15).

A short time after the efforts of this commission were initiated there was a governmental resolution, signed by the then Minister of National Defense, Dr. Justo M. Alonso Leguisamo -trading the concept of Commission for that of Tribunals- in the following terms:

> ”1. It is prohibited for Military Physicians to agree to effect any type of statement to the Ethics Tribunals created by the VII National Medical Convention, requiring that the Superior be informed of any situation of the sort which might arise.
>
> 2. It will be published and communicated to the Health Department of the Armed Forces and filed” (cf. Resolution 15.057, dated August 7, 1984, published the same date in the Bulletin of the Ministry of National Defense, no. 8082).

Despite this prohibition, the ethics tribunals were able to clarify and reveal a variety of transgressions of professional ethics on the basis of denouncements confirmed by subsequent investigations (see G. Martirena 1991, Exemplary Cases, pp. 29-85).

One case, that of Dr. Mautone, tried by the Commission of Ethics and chronicled only in its archives, elaborates on the alliance between health care professionals and the military during the state of exception. Due to its exemplary nature, it is interesting to note the relevant aspects of the Commission’s accusation: ”We are not after the young military physician, needing his position to live, who harbors suspicions that detainees are tortured at the military complex where he carries out his assignments. We are after the head of the Department of Forensic Pathology of the Faculty of Medicine, a head of the same discipline with the Armed Forces… who scientifically verified the etiology of the deaths, the existence of severe torture, individualizing the victims, and who, despite this, continued unperturbed,

carrying out these condemnable functions, issuing certificates both ambiguous and concealing the truth… His conduct… of ethical infractions, all too common in the era of the dictatorship: concealing evidence of torture, or generally covering them up..." It continues as follows: "For the exposed arguments, the National Commission of Medical Ethics resolves to: I. Declare that this investigation has confirmed that the performance of Dr. José A. Mautone in the autopsies of Mr. Br. Hugo de los Santos Mendoza and Mr. Alvaro Barbi does not agree with the ethical principles which should regulate his conduct. II. Notify and communicate this decision with remission of the antecedent to the trade union organizational entities (Uruguayan Medical Association and the Medical Federation of the Interior)". (*Minutes of the National Commission of Medical Ethics, Montevideo, December 1, 1989. Copy authenticated by notary public*).

Nonetheless, not all military physicians were passive subordinates to the principles of obedience. Dr. J. Burgel took it upon himself to make a statement to the Commission of Medical Ethics and University Conduct in order to clarify the anonymous denouncements made against him:

"I would like to say that I began work at the Military Department of Health in 1960… until my retirement… 1985. I would also like to say that in 1972, when there were mass detentions in Paysandú of people belonging to the MNL, I questioned whether to stay or go because it was a novel situation for those of us who were doctors in the Military. I consulted various family members, colleagues and other individuals, and I personally assessed the situation, concluding that I should stay… I would like it to be clear that I am, and was, absolutely against the National Security Law, this law which progressively penetrated the Armed Forces and served to justify all types of action… [upon examining detainees] in each case, I produced a written record of the condition of the detainee and whether there was evidence of maltreatment or torture… when they retired me from the Army they retired me as a traitor, but I was never one. I never betrayed them, but neither did I betray the detainees" (*Minutes of the Commission of Medical Ethics*: 5, 14-15).

The Commission reacted positively to his defense, emphasizing his "ethical behavior and valiant attitude in facing the investigation which had to be carried out of the death of Dr. Vladimir Roslik during the de facto government[29]."

[29] Archives of the Faculty of Medicine, Universidad de la República (1989): Proceedings of the Report of the Committee on medical Ethics and Universitary Conduct on Dr. Jorge Burget´s personal situation.

Other military physicians have also turned to ethics commissions or civil courts to publicly elucidate the responsibility they may have had as agents of a regime which infringed on human rights (*Noticias* 52: 62; 55: 53).

The judgment by letter of convocation concerning the situation of Dr. Martín Gutiérrez, a psychiatrist whose activities at the Penal de Libertad during the dictatorship were questioned and who was exonerated of crimes during that period, had a great public impact (Personal communication from Dr. Gutiérrez).

In a country as small as Uruguay, where the anonymity of the big cities is but a literary reference, the demonstration that one is not judicially questionable seems to be important to the self-image of doctors who are upright and respectful of cultural values. This is even the case after the proclamation of the law bringing to an end the ”punitive intention of State” relating to crimes having occurred under the military dictatorship.

Considering the authority of certain parties in each of the three countries reluctant to question the dictatorial era, the actions of medical associations and entities can be viewed as unique in the social and cultural environment. However, they have not been emulated by other organizations, particularly those within the judicial system. This is not a matter of the responsibility of doctors in those countries; it simply provides a glimpse of the feebleness of ethical support in the new order of things.

2.7 Stances on Recent Issues within Medical Ethics

Owing to the fact that we consider that the dictatorial era, in addition to its dimension of fear, also meant a questioning within all areas of social work, it seems that since that time new challenges for professional ethics have arisen or made themselves evident. In this way, it can be postulated that professional sensitivity toward ethical conflicts has been heightened since that period. We wish, in this section, to outline some of the areas in which professional ethics face new cultural situations for which it is not always possible to find absolutely certain solutions. It also seems important to consider the repression experienced by many physicians in order to accentuate their sensitivity to the living conditions of persons who are detained, whatever the reason for their imprisonment.

2.7.1 Former Torturers and Their Psychotherapeutic Treatment

Although in a ”normal” war the issue of whether a military physician should or should not attend to an injured individual —a member of the enemy army— is not a cause of moral digressions, in the unprecedented situation created by the military

dictatorships in South America the psychotherapeutic treatment granted active participants in torture constitutes a highly controversial topic.

In the case of Argentina, and regarding a period prior to the ”Proceso", L. Bonaparte provides a systematic description of the interaction occurring during psychotherapy with a doctor who had been a torturer:

”The first sessions were effected in the first part of 1973. The patient had been referred by a colleague describing him as ”male, doctor, 50 years of age, married with three children and very conscious of his suffering and the suffering he was causing for his loved ones”. The present crisis has very aggressive connotations, with marked characteristics of persecution, and coincides with his oldest son’s entrance into the university"… This man’s story seemed like that of an average man, except that at age 24 he had been a doctor with the police force. He had done this for 26 years and it was no secret to anyone that the police had a division devoted to torture… The patient had participated in torture and other para-police activities as a recently graduated doctor… The patient’s problems seemed to be related to his oldest son’s new status as a student: his son was a student and many students had to withstand torture… His son became someone who not only resurrected his past, but also represented the resurrected victim who could accuse him… The therapist discovered, after two and a half years of treatment, that her professional commitment hinged on one misunderstanding: she had chosen to see a patient, whatever his pathology, and suddenly found herself before a torturer… At this point he related, with absolute clarity, his active participation as a torturer and as an agent of various repressive measures brought about by the government in power. The therapist realized that she had been trapped in a situation without a solution. Whatever the motivation for the patient to reveal his involvement, the therapist was now condemned to a situation of collaboration because of the confidentiality imposed by her profession… This case history belongs to what we can characterize as the ”craftsman” era within this sinister camp...” (Bonaparte 1985).

D. Lagos, soon after the return to democracy in Argentina, expounds on the recent clinical history of an ex-torturer. The case involves a patient with depressive and persecutory symptoms, with multiple neuropsychiatric admissions in Buenos Aires and treatment with psychopharmaceuticals and individual psychotherapy throughout a period of eight years (1978-1986). In 1986 it was decided to carry out psychotherapy along with spousal support. During the first session with the patient, the doctor assigned to conduct this therapy became aware that the man had participated actively in repression and that he felt hounded by this previous activity. However, in reviewing the man’s clinical history, he noted that until that time nobody had documented this rather important aspect of the patient’s life. Apparently, with each new psychotherapist there had been a type of renewed pact of si-

lence regarding his activities as a torturer, and as a result this had not been addressed in psychotherapy. This coincided with the attitude of the patient toward the therapist, whom he only sought to make the symptoms disappear. The physician did not assume this stance but rather the opposite, stating the following as essential: a) clarifying the social and personal significance of the acts committed; b) discussing confidential stories with the couple. Without dealing directly with these two issues, it would not be legitimate to carry out psychotherapy. The patient apparently did not accept this proposal, since psychotherapy was interrupted.

Lagos reflects on the attitudes of other therapists who, according to him, in entering into a pact of silence became accomplices of the ex-torturer, supporting his efforts to ”cancel the symptoms” and even tacitly exonerating him by maintaining him in the role of being ill without making reference to such basic elements of his biography and psychopathology in his clinical history (see Lagos 1988).

Concerning the situation in Chile, E. Pérez A. provides a casuistic description of the psychiatric advice he provided to five former military and police government employees who had participated in ill-treatment of prisoners of the military dictatorship. As a preamble, he outlines the characteristics of the authoritarian system of power, the torturer, and the latter’s training and preparation as such:

Rather than psychopaths, these individuals are obedient citizens, normal types who have adequately carried out the learning of their role… Learning of the role is progressive and gradual, both ideologically and in practice… the ”other” —the repressed, the tortured, the ill-treated— is seen as an object and not as a fellow human, with a loss of the boundary between ”what should be done” and ”what can be done"…

In the course of the five clinical histories he is able to establish a causal relationship between participation in torture and the development of specific psychopathologies. However, he does not elaborate on the treatment deemed appropriate in the specific circumstances of each patient.

At the end of his analysis, he poses two very relevant questions: should a torturer be treated if he needs care, or if he requests it, if it is known beforehand that he tortured? And, should care continue once we learn of his history as a torturer? He defines his position as follows:

”It is fundamental to position oneself before the patient in the way we believe is correct: not in a neutral or impartial manner, nor on his side. He should be helped, but placing an emphasis on the fact that we consider him to be a person in need of rehabilitation, and if at some point in time he seeks expiation of blame and a pardon, this will depend on the social group, particularly those affected by his actions. He should know that he can count on our ”technical” help, but that we at no time are, or will be, in agreement with his actions, methods or thoughts… Sub-

jects trained to exercise violence and to abuse authority can very easily come to feel above the law, almost ”beyond right and wrong.” But since they have been raised with certain basic ethical principles, general within the society to which they belong, the contradictions will sooner or later appear. Moreover, we think these are always latent in them, and if this is not so, why do they cover up their line of work? Why do they speak of their work with sentiments of shame and self-blame?...”

The author proposes as a therapeutic aim for ex-torturers -perhaps too generally- to plant in them the bases of a guilty conscience directed toward society as well as their own self-esteem (Pérez, in CODEPU: 62-73).

Regarding Uruguay, we refer to the interview conducted with a young colleague (see Empirical Section), who stresses his attitude of service and neutrality toward the damages provoked by political repression, ”in one camp or another ” (interview: Urug-07-Young).

2.7.2 Physicians and Execution

The active participation of doctors in executions is a highly topical subject insofar as lethal injection can be considered a ”more refined, even aseptic” form of execution.

The Chilean Medical Association, in a country that retains the death penalty in its Code of Civil Law, stated its opposition to any attempt at putting doctors in the role of performing executions. The example of a physician in the United States, Dr. Start, who refused to administer a lethal intravenous injection to a convict in the state of Oklahoma, served as an example for the Association in its discussions on the issue.

This led to an intense debate about professional ethics (the Hippocratic Oath prohibits the administration of lethal drugs) and the function of prison doctors. The American Medical Association, in 1982, approved a declaration stipulating that physicians could not participate in executions. The discussion ended when state authorities decided that injections would be administered by individuals without the status of a doctor. Probably due to the explicit stance of the CMA, efforts to ”import” lethal injection from the United States —into a country often in the vanguard in accepting these developments in Western culture— did not prosper.

2.7.3 Physicians and Hunger Strikes

The professional activity and ethical conflict of health care teams supporting participants in a hunger strike are central issues of discussion in Uruguay. M. de

Pena, M. Jáuregui and G. Mesa carried out a detailed analysis of their experiences, during more than twenty-five years, in this area of medical work: ”In normal medical practice, the patient is presumably ill, or in danger of being so, and wishes to regain his health or prevent the illness. In this case the patient’s interests coincide with those of the medical team. In the case of a hunger strike, it is presumed that the participant is sane and that he is willing to put his health at risk, even to the point of death, for some purpose external to him and unrelated to his health. His interests are in principle contrary to those of the medical team… Ignoring the conflict between two duties, equally valid for each of the involved groups, can result in the failure of the health care workers” (*Vida Médica* 1985, Vol. 36 (3): 75-82).

The authors enumerate possible errors in the interaction between health care personnel and hunger strike participants: ”...steadfast support for the means (”wearing the shoes” of the strikers); not believing in the effectiveness of the means (acting in an exclusively technical manner); exclusive interest in acquiring new knowledge; rigidity and omnipotence (paternalistic attitude)... The supervision of a ”regulated” hunger strike is an act of prevention of health to the extent that the responsibility of the technical team is to ensure that the participants emerge from the strike with as little damage as possible”.

In their essays they discuss their own experiences in light of the declarations of the World Medical Association (WMA) in 1991 concerning hunger strikes. They also broaden the systematic perception of conflicts produced in the area of psychiatry and within prisons, concluding that professional accompaniment of hunger strikers does not constitute a ”determination to aid in suicide” (sanctioned in Article 315 of the Uruguayan Penal Code). On the contrary, it is an integral part of medical action inasmuch as it leads to overcoming the crime of ”omitting assistance.” Furthermore, they endorse the WMA declaration stating: ”it is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them...”[30] .

2.7.4 Ethical Norms Regarding the Medical Treatment of Detainees

As has been previously expressed, the board of directors and, in general, many members of the Chilean Medical Association maintained very close contacts with the forces of opposition to the dictatorship and thus came to learn of the physical

[30] Paper presented at the First International Conference on ”Salud psicosocial: Cultura y democracia en América Latina” in Paraguay, 1992.

conditions within Chilean prisons and the arbitrariness which often prevailed in the interaction between jailers and prisoners[31]. This growing sensitivity led the CMA, in 1985, to issue a resolution regarding the medical treatment accorded detainees. The resolution was stipulated in the following subsections:

”1. The physician will not attend a person under the following conditions:

1.1 If the doctor cannot identify him/herself.

1.2 If the physician is hidden, masked, or under any form which impedes his/her physical recognition.

1.3 If the patient’s sight is blind —except for a justified medical reason— or under other condition or artifact designed to prevent the patient from seeing the doctor.

1.4 In a place of detention other than his/her house or public sites for that purpose;

1.5 Under the presence of other third persons obstructing the direct contact or altering the normal relation between doctor and patient.

2. The physician will have to identify him/herself, if requested by the patient. Under no situation should he/she deny such petition.
3. No physician should participate, not even as spectator, in interrogatory sessions; even less to inform the interrogators or other related persons about the patient’s physical or psychological capacity to withstand illegal harassment. Furthermore, he/she cannot maintain with the detainees any professional relation which may not have, as its only purpose, the benefit of the patient.
4. The physician who might have to undertake examinations or other professional actions on persons under detention, besides following the ordinances above described, will have to completely identify himself with his full name, number of registry of the Medical Board and the (national) number of identification, on all certificates or documents submitted by him, with clear and legible characters.

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[31] S. Pescio states in his essay, *Tortura y profesionales de la salud. Chile 1973-1989*: ”Since no answer from the government was received, the National Board called for a big national strike scheduled for July 2 and 3, 1986. That was violently repressed by the armed and police forces, where two young demonstrators were set on fire by a military unit… The National Board leaders were imprisoned, among them, of course, Dr. Juan Luis González and his Secretary, Dr. Francisco $Rivas, who remained in jail for 40 days and were finally released only because of the enormous international solidarity produced by these facts”.

5. The physician will proceed to the medical examination only when he has the necessary freedom to undertake it, to make a diagnosis and take note of his observations.
6. If, because of strict medical urgency or under threat, harassment or compulsion, a physician is obstructed in accomplishing in full the conditions described above, he will have to, in no more than 5 work days, inform the Regional Medical Board of this situation, who will deliver a receipt of the denounce. The National Medical Board, will treat such information with absolute discretion, if it is requested by the denouncer to do so" (cf. AI Index, AMR 22/36/86).

2.7.5 Toward Legislation of Crimes against Humanity.

In addition to the explicit promotion of human rights in specific areas of medical work, medical organizations in the three countries have also undertaken initiatives aimed at overcoming the "zones of omission and silence" still existent in the general legislation. We draw attention to a government bill from the Uruguayan Bar Association relating to crimes against humanity, wherein the areas of habitual fraud in de facto governments are specified and corresponding sanctions for each are stipulated. Although it would not be effected retroactively, on being passed as a body of law it would allow the hope that such experiences under state terrorism truly belong in the past and that doctors, among other professionals, would be unable to appeal to ignorance when charged with renewed attacks on human dignity (Uruguayan Bar Association, 1987).

2.8 Comments

On the basis of the examples of medical practice referred to here, we wish to show that the systematic presentation of medical work during that era —in terms both of violations of human rights and demonstrations of opposition— can contribute to establishing a clearer picture of medical practice under totalitarian domination. In this way it is possible to gain access to a professional sphere which has previously been more or less avoided and to provide specific knowledge to the public opinion.

The participation of physicians in crimes against humanity was an open secret in these three countries, for the attitude of some individuals toward these events seems strange, while many worked professionally in "zones of high density" of human rights violations. With respect to this, the attempt at justification of Dr. Carlos Rivero, a psychiatrist at the Penal de Libertad in Uruguay, is an exemple: "I

was confined to my function. I ignored some aspects and there were some aspects I didn't want to know about … It wasn't my purpose. I am a doctor" (Bloche 1987: 16).

Some military physicians in these countries have had to bear a great degree of responsibility for crimes against humanity. The opinion of E. Canetti seems to confirm this: "It is known that human beings, in acting under orders, are capable of the most horrible of acts. When the source of authority is removed and they are made to reconsider what they have done, they do not recognize themselves..." (Canetti 1992: vol. 2: 63).

However, totalitarian domination did not have an unlimited span of influence; rather, it often encountered individual and organizational opposition. It also does not appear common for doctors reluctant to collaborate in repression -by virtue of their Hippocratic principles- to have suffered harassment or reprisals.

There were other military physicians who abdicated their posts in order to avoid a conflict between their ethical and political principles (see interview: Urug-016-Opos.). There existed campaigns of collective resistance by doctors -even during the dictatorships- in Chile and Uruguay. These campaigns had specific objectives: to raise societal awareness of human rights violations committed by colleagues and to punish violations through internal proceedings within professional organizations.

The public accusation of doctors implicated in violations of human rights by the medical associations in these two countries is particularly interesting. They helped to ensure that torture would not be considered an "accidental phenomenon" and/or one "provoked by depraved or psychopathic beings," and that considerable efforts were made to clarify, without reservations, crimes against humanity with a medical tone. They defined the circumstances in which violations occurred and the role of participating doctors. The coordination of this action has effectively contributed to a greater degree of knowledge and social awareness of medical collaboration in measures of repression. We are in agreement with the assertions of J. P. Reemtsma: "No regime of state terrorism has arisen from nothing nor withered away to nothing. There has always been support available from people who are willing to participate… The custom of isolating episodes of extreme repression temporally, under categories of historic "exceptions," forms a part of the mechanism of personally combining the eras. To speak of repressed memories or amnesia is both popular and mistaken; rather, what is involved is a self-anesthesia through the fragmenting of experiences. The post-Nazi German who is asked, were you aware of the concentration camps?, and responds almost spontaneously, "no, but we would always say: be careful that you don't get taken to the KZ," not only demonstrates a form of awkward hypocrisy, but also the level of compromise

between the sensory system, which perceives the threat, and reason, which proposes to consider this ”life” as worthy of living” (Reemtsma 1991a: 6).

Following the dictatorial era, there will likely be a long path to walk before the postulate of Kant (1903: 52): ”Act only according to the rule that you, at the same time, could wish to become a general rule” —and not only within medical circles— is taken for granted culturally.

Learning and understanding the ways physicians participated within the system of oppression -and in opposition to it- can be useful in deepening the understanding of what that historical period was like. Perhaps it can also contribute to the prevention of recurrences, even in so-called peaceful times, of these horrific acts.

B Medical Practices under Nazism: A Historical-Cultural Approach

This investigation of the medical profession under totalitarian domination in three South American countries would be incomplete without alluding to experiences in Nazi Germany and current knowledge of the collaboration of medical professionals with the Nazi machinery, and if a diachronic comparison between the Germany of that time and South America of the recent past were not attempted; a comparison not of the atrocities committed during the two eras, but rather a search for parallels and differences in the abuse of medicine by the respective dictatorial authorities.

In order to effect a comparison of this type, a description of the situation and mentality of the medical corps prior to and during the Nazi era is required. Establishing the relationship between the distortions of ethics within medicine and the general social and cultural conditions, as well as with the human beings of that time is imperative, such that the ethical-medical crimes perpetrated during that epoch will not —for the sake of an historic reductionism— be attributed to a generic "human nature," as so often occurs.

Even if such crimes cannot be "explained," it is important to note that they were committed by men whose thought processes were otherwise rational. Similarly, the knowledge of some doctors about gestures and acts of opposition and protest against Nazi domination merits particular attention so that, at least the fatal ghost of inevitability of what occurred under state totalitarianism is questioned.

The number of studies on the relationship between medicine and State in the Third Reich have increased —in both Germany and the occupied territories, and especially in the last fifteen years— almost exponentially. Half a century after those events, these investigative endeavors facilitate a better understanding of very complex themes related to the collaboration between totalitarian authority and medicine.

Beginning with information culled from an extensive search of source materials, we seek to link three basic aspects of medical practice and theory in the Third Reich. They are: 1) "race science" and euthanasia; 2) terminal experiments with human beings; and 3) medical opposition to crimes against humanity. For each topic, extensive reference is made to quotes deemed to be both appropriate and precise, and —since this work seeks to provide a forum for victims of oppression— the explicit testimony of ex-concentration camp prisoners will also be included.

B.1 From “Race Science” (Rassenkunde) to Psychiatric Measures of Euthanasia

Inasmuch as many capital crimes against humanity found a theoretical basis in “race science” and were thus carried out in the name of a resolute medical science, the fact that these race theories came to be an important component of medical training during the Nazi era merits special attention.

The establishment of “race science” in anthropology and medicine under Nazi rule has particular characteristics that will be addressed directly: first, reference is made to the social and economic situation of physicians during the period of the Weimar Republic which precedes the Nazi regime. This is followed by an ideological and historical look at physical anthropology and its influence on the practice of medicine during the first half of this century. Finally, the concrete consequences of this “new medical vision” in the structuring of psychiatric euthanasia and plans for extermination are considered.

1.1 Physicians and Society during the 1920s

The social and economic situations of physicians during the Weimar Republic were characterized by a marked instability. H. P. Schmiedebach describes these circumstances and their effects on the conscience of doctors in the following way:

There was a serious confrontation between doctors and the Health Insurance Bureaus towards the end of 1923. The Bureaus had been late with payments to physicians since the last quarter of 1922. This was due to acute inflation and to the fee payment system, which required contractors to make quarterly payments while insured individuals paid on a weekly basis. In March 1923, Parliament accepted a law which raised the payment quotas of insured parties from 7.5% to 10% of their base salary. By July 1923 the health Bureaus were again unable to fulfill their fee payment obligations. That same month, doctors decided they would call a strike if their economic demands were not met. Although they soon received a wage increase due to the devaluation of currency and were promised weekly payment, they went ahead with the strike. The situation worsened in the latter part of the year when —with the help of a law with extraordinary powers— an emergency decree was passed which rigorously restricted aid for the ill; it obligated physicians —under penalty of law— to abide by the new guidelines on the care of the ill. Finally, it placed in the hands of the Insurance Bureaus various options for reducing the number of health doctors and, by means of the formation of medical districts in the field, it could organize medical attention according to its criteria.

Insured patients now had to assume 10% of the cost of medications and these fees could be raised by an additional 20% by the health bureaus.

After December 1, 1923, the medical strike was directed at the conditions set forth in the emergency decree. Since physicians ceased attending to patients insured by the health Bureaus, the latter reacted to the boycott by establishing out-patient services in Berlin and the Lower Weser region to provide medical services to the working populace, already adversely affected in the area of health care because of inflation. These out-patient services, of model character and physicians contracted full time were perceived by many physicians as a harbinger of the socialization of medicine and as running counter to the freedom of the medical profession, as institutions directed against the "essence of being a doctor." In spite of being objects of intense opposition, the out-patient services received official recognition from the National Ministry of Health.

The situation, already difficult because of the international economic crisis, became even more severe between 1929 and 1933. Germany's industrial production had accounted for 14.6% of the world total in 1928 but had dropped to 8.9% of the world total by 1932. That same year, the number of unemployed reached eight million and the median salary had been reduced by 47% compared to 1929. By means of various emergency decrees, crisis and welfare subsidies had been constantly reduced, patient fees were raised due to the redistribution of costs by the Insurance Bureaus, the system of district physicians continued to be reorganized and the new acceptances for Bureau doctors were reduced.

These developments produced two important consequences within the medical corps: first, it increased anti-Semitism in an ethnic-racial, National Socialist environment already widespread among physicians. The medical profession had been, among the liberal professions, one open to Jews. With the passage of time, Jewish physicians in large cities -particularly Berlin- had reached a significant number. Because of this, and now that the high unemployment rate had increased competition among doctors, there was an increased demand for the dismissal of Jewish doctors in order to hire doctors of German descent. In addition, the discussion of costs —framed above all in the context of Social Darwinism— became increasingly topical. Thus, the costs of providing help to individuals with physical and mental disabilities were assessed time and again, costs defined as losses for the ethnic nation and which could be better used to support those of "greater racial and social value." By this time, anger directed at social agencies (whose number had increased rapidly during the crisis), and the mentally ill or disabled had reached frightening proportions. The "ethics of community" (Gemeinschaftsethik) which places the interests of the nation as a whole before those of individuals and de-

mands sacrifices for the sake of the common good was now established on novel bases (Schmiedebach 1987:144-145).

The author also discusses the political implications of these circumstances: "The Nazis also intensified their efforts to attract the attention of physicians, based on the idea —as could be read in the Völkischen Beobachter of March 23, 1933— that no other profession would be "as significant as that of physicians to the greatness and future of the nation." Doctors were indeed important in establishing and propagating concepts of population politics, racial hygiene and eugenics… The Nazi Physicians Association (NPA) counted 2,786 members at the end of January 1933. This represented a relatively small portion of the almost 50,000 doctors associated with political organizations, but compared to other physician political organizations, like the Association of Socialist Physicians, with close to 1,500 members, the LGNSP was the dominant organization. By October 1933, only ten months later, the number of members had swelled to 11,000. In 1935 group membership had reached 14,500 -nearly one-third of all affiliated doctors residing in the Reich- and by 1942, it had reached 46,000. By comparison, the number of doctors in the Reich had only increased by about 20,000 or 30,000 compared to 1933 (Schmiedebach 1987: 145)".

With respect to the dismissal of physicians by decree, it is interesting to note the information summarized in Table 2.

Table 2

Decisions on medical complaints based on the ordinances from 22-IV- 1933 to 2-VI-1993.

Decisions	Physic.	Dentist	Dental Techni.
Expulsions from the Insurance's Medical Union			
A. Non-Aryan ancestors	1,030	206	79
B. Communist activities	338	37	13
C. Other reasons	9	3	3
Total	1,377	246	95
Decisions from the Reich's Labor Ministry:			
A. Total canceled professional licenses	827	174	52
B. (Canceled for demonstrated Communist activities)	[91]	[16]	[3]
C. Professional license extended for exceptional reasons	124	29	13
D. Professional license extended under non confirmed Communist activities	231	19	10

(Thom & Caregorodoev 1989:43)

1.2 Ideological Precursors of Race as a Theoretical Artifact

The concept of race is based on an ideology that can be traced back to the middle of the nineteenth century and is not limited to Germany. The first volume of the Comte de Gobineau's opus on this subject was published in 1853, amid the conservative trends in France. His Essay on the Inequality of Races (published in German in 1898) was aimed specifically against the theme of equality of the French Revolution and sought to philosophically establish a return to the previous status quo. Gobineau understood the social classes as racial groups, wherein he viewed the nobility as the purified representation of the victorious white race. He did not restrict his viewpoints to the interior composition of society, extending them also to international events and granting a leading role to nations led by members of the white race against other nations[32].

[32] Cf. A. De Gobineau (1853-1855) *Essai sur l´ínegalité des races humaines.* Paris. Its German version (1898-1908) was entitled: *Versuch über die Ungleichheit von*

E. Seidler analyzes the influence of Gobineau's conclusions in turn-of-the-century Germany and reflects critically on the effects of his ideology in France and Germany: "While the work of Gobineau was not discussed much in his own country, France, where his ideas on the superiority of Germanic Aryans naturally met with resistance, the German side used it to support the postulate that, "to a great extent, the future of humanity depends on the populations of German and Germanized blood it already possesses." (This assumption is not very far removed ideologically from the well-known words of Emanuel Giebels to the effect that the German essence could save the world: Am deutschen Wesen soll die Welt genesen). If, for Gobineau, Aryan-Germanic elements were too limited to prevent the decline of culture, the German "Gobinists" systematically inverted the race theorist's opinion. Thus, according to Schemann, Gobineau had underestimated "the mixing of populations, the extraordinarily valuable consequences of the invasion and assimilation of the most important components of the blood"… "which, fortunately, exist among us, the Germans" (Seidler, 1984: 124; here cites: L. Schemann: Gobineaus Rassenwerk. Stuttgart. I/2 and 403, 1910).

Francis Galton, a well-known English biologist, coined the term "eugenics"[33] .On the basis of limited sociological observations and the genealogical reconstruction of the direct transmission of aptitudes for specific areas of activity (for example, doctors and lawyers), he drew the following far-reaching theoretical conclusions:

1) The intelligence and physical capacity of individuals is secondary to the primacy of inheritance;

Menschenrassen, Stuggart. On the matter of the topic under discussion, C. Guillaumin states: " Gobineau, the proponent of the theory of determinant role of race in human relations gives no definition on his *Essai sur l´ínegalité des races humaines*, probably not to be cautious in his theory: essentially, he considers the existence of human races a given fact. Therefore, in order to be used, it does not need any definition or precision. A number of scientists who currently research human sciences propose that the human race is not a clearly independent concept conclusive or definite. That means that, on the contrary, it came from an evidence *per se* and it was needed more than a century before the work of conceptualization could start with an unproven notion" (Guillaumin 1991: 162).

[33] Galton formulated the objectives of eugenics in the following terms: the first would consist in controlling the birthrate of the "unfit", no matter if a large number of them are already condemned to die before they are born. A second purpose is to lead to race improvement though the promotion of the productivity of the "fit" by means of the early marriage and special attention to the healthy growth of children" (Schmiedebach : 142)

2) Aptitudes are conditioned by heredity and distributed disproportionately within a population (population is understood here as race); and,

3) The progress of civilization leads to the members of societies with the greatest (intellectual performance capacity tending to limit their reproduction, which demands that special measures be taken (Mann 1978: 101-111).

Many physicians completely identified with this "biological" conception of the theory of inheritance, conferring a scientific aspect on such prejudiced beliefs on inheritance and race, thereby aiding in its widespread acceptance.

1.3 Academic Precursors to "Race Science"

Against this epistemological backdrop, certain streams of physical anthropology strove -at the beginning of the twentieth century- to achieve a scientific naturalist basis in European universities. They aspired to establish a "natural history of the hominid" as a hegemonic alternative to the sub-disciplines of social and cultural anthropology. In Germany, this discussion was not confined to academic circles; rather its sphere of influence, with regard to issues of "race science" and "social hygiene," also encompassed politics and medicine.

In the course of establishing the Nazi State, physical anthropology was implemented with great resources as a functional ideology, to such an extent that cultural and social anthropology were all but abandoned as academic disciplines[34]. A racial theory with a presumed scientific basis was therefore created and lines of argument were provided for the acceptance and imposition of euthanasia programs by physicians.

Michael H. Kater, a professor at the University of Toronto, Canada, illustrates the evolution of this discipline —as a specialized branch of medicine under Nazi domination— by outlining the academic rise of four central figures. The text which follows will be complemented by notes from other bibliographical sources. In general, Kater's analysis of the epistemological aspects of this discipline, the process whereby it arose, and its effects on medical training and doctor-patient relationships under totalitarian domination, condenses a vast amount of information.

[34] Ethnology, study of old civilizations, a specific part of cultural anthropology in Germany, found no place as a useful science for the Nazi State, in spite of the frequent submissive offers from its academic representatives. H. Fischer 1990 attributes this fact to the lack of interest of the Nazi leaders in reactivating the German colonialism of last century.

For the purposes of this study, it is invaluable as a precise and detailed description of "race science" and its consequences for medical education.

"Race science," a specialized branch of medicine under the Nazis possessed a natural-scientific component, deriving from conventional anthropology and positivistic medicine, and an ideological component, culminating in the concept of an immutable hierarchy of blood… Within this course, a narrower path can be mapped out that led from the experimental laboratories of the late nineteenth century to the gas chambers of Auschwitz. Four men were treading that path, all of them physicians, each one starting as a genuine disciple of science and veering increasingly toward the irrational as time progressed… Their names were Theodor James Mollison, Eugen Fischer, Otmar Freiherr von Verschuer, and Josef Mengele…

… two aspects of Mollison's career are revealing: his regular natural-scientific training in medicine and anthropology and his conditioning in the abject racism observed by the German colonial masters, particularly the hypernationalistic physicians in the African territorial administration at that time… in a publication of 1923, Mollison placed the Negro just above Neanderthal man and the Australian aborigine just below, in a rank order of "lower races."

That article had been coauthored by Eugen Fischer, who was Mollison's junior by four months. Fischer, too, graduated as a physician in 1908, having studied in Freiburg, where he and Mollison could not have been strangers… In 1908, Fischer, like his friend Theodor Mollison, sailed for Africa to do "anthropological research." His resultant testimonial was the study of the "Rehoboth Bastards" (1913), a self-contained group of Dutch-Hottentot half-breeds in German southwest Africa, which for white supremacists around the world became a classic. In many respects, the book read like a manual for white man's colonial rule over native tribes: their treatment must be "good, just, stern and not pampering," for even as mongrels, which placed the Rehobothers noticeably above the indigenous natives, they could not come close to the white race, judged by the indices of intelligence, morality, or vitality[35]. In 1923, Fischer expanded on the Negro by judging

[35] On the manual *Science and Politics*, Pross and Aly analyze E. Fischer´s work. They quote a part of the last chapter of his research report of 1913, suppressed in the further editions: " The Political Importance of the Bastard, he wrote: "We still do not know very much about the mixing of races. However, we know the following with certainty: Without exception, every European people that has accepted blood from inferior races —and the fact that Negroes, „□,□□Hottentots and many others are inferior can be denied only by dreamers— has suffered an intellectual and cultural decline as a result of the acceptance of inferior elements. The book was published again in 1961 a "basic scientific work on human genetics"

condescendingly that he was "not especially intelligent in the actual sense of the word, and above all, bereft of any spiritual creativity or imagination ...yet docile and clever. Prescience and spiritual independence are little developed. Of a cheerful disposition, the Negro indulges his carefree existence day in, day out…"

Fischer would rise to fame as Germany's preeminent interpreter of Rassenkunde. In 1927, Fischer accepted the directorship of the newly founded Berlin Kaiser-Wilhelm-Institut für Anthropologie und Eugenik coupled with a full professorship in anthropology at the university…[36]

In his stratified racist world view, however, there certainly was room for Jews, as he would often show after Hitler's ascension. He admired the anti-Semitic Führer unreservedly if only because he followed a "qualitative population policy.[37]„ In 1933 the famous geneticist pronounced publicly against "international intellectualism" and in favor of "the Nordic ideal race (cultural heritage) of our Germanic forebears, and a desire to ruthlessly annihilate anything of alien race." Concurrently, he turned against the "alien spirit" of the un-völkisch and condemned the immigration into Germany of eastern Jewry. To be sure, Fischer the race scientist never neglected to advance the empirical work of the biophysicists as based on studies of twins. But he also partook in the assessment of the "Rhineland Bas-

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(See Pross 1989: 98).

[36] The area of activities of this institute were defined by him in the following way: " The tasks consists not only of studies of anthropological characteristics, but rather of reaching knowledge of the distribution of the highest possible number of favorable or negative transmissible preconditions in the German people. In doing so, the so-called eugenics or racial cleansing seeks to integrate works arising from anthropological studies and from biological heritage. This results in positive proposals on marriage and procreation, legislation on wills, and rules of other social, charitable, legal nature.

[37] Fischer clearly remarked his intellectual support for the objectives of the Nazi proposal: "It is rare and very fortunate for theoretical research to occur in a moment when the general conception of the world (*Weltanschauung*) grants it the favor of recognition, and even its practical results are immediately accepted to support state policies. When, years ago, the Nazism not only transformed the State, but also our conception of the world, the science of human inheritance already had enough maturity to offer it a basis. It is not the case that the State needed a scientific basis to be proven correct —people´s conception of the world are experienced or attacked but not hardly grounded—; but the results of the science on human inheritance were fundamental for the laws and normative precepts of the new State" (E. Fischer, cited by Bergmann A. et al 1989: 133).

tards," those unfortunate post-World War I offspring of French colonial fathers and German mothers, just before their forced sterilization, and helped to plan the evacuation of all European Jews to Poland-based slave camps.

Fischer's equal as a researcher and scholar was Otmar Freiherr von Verschuer, whose allusions to the master pervade his own work and who succeeded Fischer at Berlin in 1942, and became his lifelong friend thereafter. Baron Verschuer, scion of an aristocratic Hessian family, was born in 1896 and hence belonged to that Freikorps generation which blamed the loss of the first war on Marxists, pacifists, and Jews. A demobilized first lieutenant in 1918, Verschuer was immersed in the racist, prefascist subculture of the period in a dual capacity: as a fellow of the Verein Deutscher Studenten, long Germany's most extreme anti-Semitic fraternity, and as a member of the notorious Marburg student Freikorps that in cold blood shot dead fifteen alleged communists near Mechterstedt in 1920…

Verschuer, allowed time off for studying, majored in medicine. He graduated as a general practitioner in 1923, and was certified as an internist in 1927. That year marked his rise to dubious stardom. He also managed his "Habilitation" [academic/professional screening], specializing in genetics, and, after a noted inaugural address at Tübingen, was installed as director of the anthropological section at Fischer's Berlin institute. Here, goaded on by the scientific optimism of the day, he did a lot of biophysical experimentation, publishing prolifically.

Such work was carried into the Third Reich, and Verschuer became one of the chief protagonists of comparative twin research and a positive population policy based on whatever possibilities of genetic engineering then existed. Since this was of interest not only to Germans, the Baron traveled abroad and was quoted widely in specialized international publications. His superiors and the new authorities smiled on him, and he rose to the challenge of full professor and chief of the new Institute for Hereditary Science and Race Hygiene at Frankfurt University in 1935. Logically, he was a party member by July 1940.

But Verschuer, too, became more susceptible to irrational currents. Shaped by the racist experiences of his youth, he was soon propelled into the camp of the ideological fanatics. As Aryanization of German society proceeded, Verschuer could not help but have a hand in "scientifically" ascertaining the people's racial pedigrees. In January 1939 the baron, in a Berlin public lecture, spoke in all seriousness about the "differences in the racial traits between Germans and Jews." As he himself has reported, his institute cooperated in the training of future physicians under the auspices, and along the guidelines, of the SS[38]. His genetic in-

[38] Waffen-SS or SS: Security Service created for " special tasks", just under the command of the Nazi chiefs. Its scope of operations included everything from the "racial and

sights became instrumental in -by universal standards- criminal medicine climaxing in sterilization and "mercy killing." And his unsavory racism was even more radicalized when, in 1944, he acknowledged that Germany was waging a "racial war" against "World Jewry" and demanded as a "political priority of the present, a new, total solution to the Jewish problem..."

Of the several assistants employed by professor Verschuer in 1939, Dr. Josef Mengele was his favorite. Mengele started his career in Munich, where, in 1935, at the age of twenty-four, he received a doctorate in anthropology under Professor Mollison, who at that time was gravely concerned about the impact of what he termed the Jewish mentality on the "racially uprooted." Mengele's dissertation dealt with the jaws of four primeval groups, one of which, the Melanesians, was recognized as racially the lowest and then used as the standard against which to measure the other three, in order to rank them all according to empirically perceived differences. By formal criteria, Mengele's work was in the exact-naturwissenschaftliche vein his teacher Mollison had been schooled in, but it exhibited two disturbing elements of subjectivity that appeared to have marred the budding scientist even then. One was the certainty that "races" would be different from one another (a view that concurred with the doctrines of Mollison and Fischer) and that, as a consequence, differing qualitative value judgments would govern each of them. The other had to do with Mengele's privately motivated choice of his topic, for… he was born with a diastema between his upper central incisors, and… had upper bicuspids missing symmetrically on both sides. Was it legitimate for an objective scientist to choose as the object of his scrutiny a problem that was tied to his personal pathology?…

Mengele continued to mix the rational with the irrational after he arrived in Frankfurt to accomplish his second doctorate under Verschuer, this time in medicine, by 1938. Again, he decided to examine dental and palatal disorders of children who had been operated on in the university's surgical department, headed by

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political cleansing" of the Reich and the occupied zones, to the administration of concentration camps —massive extermination included— and forced labor for the war industry. They were expected to be the germs of a national-socialist aristocracy: "The SS is conducting the selection of a new leader class. This is done positively, through the institutions of national-political education, by means of the ordering entities (Ordenburgen) as truly academies of the incoming national-socialist aristocracy, and ending with a seminar on administrative instruction on state policies. Negatively, it is accomplished by means of the extermination of all elements of a lesser biological-racial value and the total elimination of all that impossible political opposition which would never agree to accept the basis of the national-socialist State world view and its fundamental institutions" (Hofer 1957: 108). From now on we will refer to them as SS.

Professor Victor Schmieden, between 1925 and 1935. Mengele amplified this "material" on the basis of data on persons in the Frankfurt area whom Verschuer had already registered in the demographic files of his institute. All told, Mengele examined 1,222 people, parents and their offspring, concluding that the irregularities were hereditary with the highest degree of certainty. Moreover, he found a positive correlation between those disorders and other hereditary malfunctions such as idiocy, propensity for dwarfism, and hydrocephaly. To suppose that this correlation disturbed him personally would not be wide of the mark.

Before Mengele arrived in Auschwitz in spring 1943 to continue his research with a view to Habilitation, he visited his teacher Verschuer in Berlin at the anthropological institute. There he processed data on Gypsy twins already assembled by one of Eugen Fischer's graduate students, Georg Wagner. What is significant about Mengele's subsequent Auschwitz experiments in his capacity as Verschuer's Berlin assistant is the mixture of objective science, as manifested in exact anthropometry and the methodical dissections performed by classically trained Hungarian pathologist Miklos Nyiszli, on one hand, and subjective humbug, such as injecting dark eyeballs with blue dye, on the other. In Mengele's Auschwitz work, the ultimate benefactor of which was Verschuer, the rational and the irrational congealed, only to render the end result useless, for exact science will not allow even a trace of irrationality. The new boundless opportunities for experiments on humans constituted one of the ideals of that novel breed of natural scientists that was ethically unrestricted; here Mengele made utopia reality. Mengele's use of twins as guinea pigs also manifested an extension of the overdrawn positivism in science as practiced by the originally serious and always deeply religious internist Verschuer, who touted twin methodology in his spectacular Tübingen lecture as early as 1927, and then put it to the test in Frankfurt, still without murder[39]. The fact that the Auschwitz-murdered twins were Jews and

[39] See Kater 1989, in Pross and Aly 1989: 360-364. Kater directly approaches theoretical and human consequences of the science of the race: " … it cannot be emphasized enough in what strength potential physicians were exposed to Nazi racial doctrines in the classrooms of the universities, doctrines that then infused their working knowledge, even if the doctors privately derided them. For instance, in early 1942 many, if not most, of the "younger doctors" were in accord with "euthanasia," on the terms propagated by the Nazis at that time and doubtless discussed in the nation's medical schools, whereas older doctors were more reluctant. On this subject, the b□,□□Verschuer's seminars in Frankfurt serve as further proof. The baron was broadly in charge of training medical students in "hereditary and race discipline" (Rassenpflege) and of acquainting them with applicable regime laws in that sector. Techniques in the examination of potential marriage partners for "conjugal fitness" (termed "congenital pathology") were as much a part of the Frankfurt curriculum as

Gypsies pushed an already questionable methodology into the dual realm of the falsely scientific and the irrational, for in their case, that which was to be proven, their racial insufficiency (an irrational presumption), was already preordained (a fallacy of method)[40].

1.4 The Effects of Science through the Lens of Race

This cultural and ideological background constituted an ideal climate for unrestricted extermination programs, focused on aspects of race and those of Social Darwinism. These perspectives, as stated earlier, existed before the First World War and had paved the way for legislative trends to limit life and reproduction or to exterminate those human beings who were outside the production system and/or were marginalized in society because of chronic illness or disability.

Opinions of this type gathered continually increasing acceptance within the medical corps. Parallel to attempts to legalize doctor-assisted suicide at the turn of the century, a campaign to devalue humans with limited or nonexistent mental capacities was initiated. A comparison with those "weak" and "incompetent" beings who, in the "struggle for survival" would -were it not for modern medicine- have succumbed to "natural selection" was effected for this purpose. Regarding this matter, S. Hahn says: "Ideologically prepared in this way, affected by the deaths of many healthy young men in World War I, and spurred on by their experience with social indigence —which at the time was common in institutions for the chronically ill and the physically and mentally disabled— the social con-

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were "hereditary diagnosis," "hereditary prognosis," and sterilization assessment. In "race science," discrepancies between human "races" and miscegenation were studied, such as between "Aryans" and Jews. "Population policy" —always the ultimate aim of the Nazi state— remained the wider background for all of this…" (Kater 1974: 235-236).

[40] "Among the compromises accepted by physicians on that period, there is a very special one, though habitual in many places: the application of the Nazi rules on castration. Even though this issue has not been exhaustively researched, we can talk about 400,000 castrated people under the Third Reich, non-voluntarily for the majority of them. Now, it still has not been determined how many of them were denounced after attending the doctor's office. In turn, what is known is that the denouncement represented a threat for the physician. He could easily avoid that imposition, but in doing so he conflicted with the dictatorship. Likewise it was for the patient, who, because of fear, often did not stop by the doctor's office. During the Third Reich, this factor perverted to the extreme the traditionally cultivated mutual trust among doctor and patient, hence destroying the individual right of every citizen to the human protection of his health" Kater 1989: 366.

science of physicians became inverted. It took on an inhuman and reactionary character: medicine and the State could not sacrifice healthy men in the battlefields while the lives of the weak and sick were preserved with high material and welfare costs. Medicine and the State should not take steps to counter natural selection, thereby aiding in the deterioration of the human species. Insofar as medicine and the State ostensibly could not provide adequate living conditions for all, they should have the courage to promote the lives of the healthy and socially strong, and to exterminate the 'human burdens'." These demands are formulated programmatically in a writ from the attorney K. Binding and the psychiatrist A. Hoche, published in 1920. (Hahn 1989b: 118-119).

The pamphlet referred to by Hahn is *The Sanctioning of the Destruction of Life Unworthy of Living: Its Measure and Shape*, which at the time was quite well-received. Three aspects of this work are of a central significance:

a) The description "human burden" possesses a dimension of concrete application and value insofar as the value of the individual is only considered in relation to his utility for the population as a whole, thereby losing its individual worth.
b) The criteria of costs, for example the economic aspects of caring for mental patients, are brought to the forefront of public interest. The calculation of costs relative to units of time (months, years, etc.) are considered "data" with a supposed rationality.
c) Free reign is given to arguments in support of the necessity of exterminating lives as a way to heal the "body of the nation" (Baader and Schulz 1983).

Pross and Aly analyze the content and significance of this work in Germany in that era: "A different response to Germany's defeat and the ensuing crisis was the development of racial hygiene and eugenics, a field devoted to "breeding" and fighting for general acceptability at this time. As these researchers saw it, the war had torn gaps in the ranks of the "qualified and strong," while the "weak and unqualified," and the "inferior" people had been spared. It was imperative that the scant resources not be "wasted" on people who were sick and suffering. Foremost was the philosophy of the "unimportance of the individual" and the understanding that "individuals who had become worthless defective parts," had to be "sacrificed or discarded." Alfred Hoche, a neuropathologist from Friburg, was the author of these statements. [Hoche published this pamphlet] together with Karl Binding, a lawyer who still enjoys a positive reputation today… While Binding relativized the legal side of the prohibition "Thou shalt not kill," Hoche put forward arguments that alternated between medical and economic elements. He spoke of "mentally deceased," "human burdens," "defective persons," and "one-quarter-" and

“one-eighth workers.” He continued saying that it could be clearly estimated “what a tremendous amount of capital was being withheld from the gross national product in terms of food, clothing and heat — all for an unproductive purpose.” The main criteria for killing people —Hoche estimated the number at between "20,000 and 30,000 cases"— was to be seen in a “lack of productive output,” a “state of complete helplessness” and “needing the help of others[41].”

E. Seidler refers to the political climate of the era in order to underline the significance of this document during the Weimar Republic:

“The effect of the writ was extraordinary for several years. To illustrate the environment [political and cultural] in which it occurred, it is necessary to remember that, in addition —parallel to this and within all the parties of the Weimar Republic— debate about abortion and sterilization reached new levels. Losses from the war also coincided, such that a new impetus was provided for the original reflections on eugenics. Thus, “race suicide” and the “death of the nation” were spoken of, and demands were made —each time with greater urgency— to exclude certain groups from procreation in order to conserve and improve the German nation” (Seidler 1986: 73).

On the ideological bases of these strategic reflections of Nazi thought, Mitscherlich and Mielke state:

“Hitler’s interest on ‘eugenic’ policies is located in the NSADP programatic proposals. Already in 1933, dated July 14th, the law on “Profilaxis of descendants with hereditary diseases” was passed. Gütt, Rüdin and Ruttke presented their extensive remarks on that issue by March of 1934.

With that the starting point was set for a process conducting, on one hand, necessarily to the “grace death” of insane persons with incurable diseases, and, on the other hand, to the plans of extermination for races considered inferior, such as Polish, Russian, Jewish and Gypsies, executed during the war.

Within this context must be considered the notion of “special treatment” which, even more than for the “grace death” makes salient its utilitarian purpose, in absolute contrast with a humanist ideology.

These efforts in the public health of the nation and of making sure of the “germanicity” of the population, can be summarized in three main aspects:

(1) The program of euthanasia, for incurable diseases;

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[41] Pross & Aly 1989:22. Taking as illustration a discussion titled “Can a doctor kill?” from Sajonia, in 1922, the authors show how closed the arguments are: “in that a physician from Dresden criticized the existent contradiction, where many of those who ask for the abolition of the death penalty for criminals supported the killing of the idiots”.

(2) The direct extermination of unwanted ethnic populations and unwanted sick persons, by means of "special treatment";
(3) Preparatory experimental work for massive sterilizations".

On the significance, for the specialists, of commentary from renowned academics such as Gütt, Rüdin and Ruttke, A. Thom states:

"In the years that followed, these commentaries were repeated many times and were disseminated in new publications. They formed part of the standard literature of the practice of medicine. A. Gütt represented the Ministry of the Interior's Medical Department; E. Rüddin the position of racial hygiene and applied psychiatry from the standpoint of biological inheritance; F. Ruttke, as a jurist, the positions of the normative content of the legal proceedings of the Ministry of Justice" (Thom 1989a: 87).

On applying the "final solution" to the children of gypsies ("Roma" and "Sinti," the original groups) in Auschwitz-Birkenau, an eyewitness to these events says: "The extermination of gypsy children began in April 1943. One day the concentration camp's chief doctor asked the camp commander, 'How many children do you have here?' 'Four thousand' was the reply. 'You have two thousand too many'. Send the others to the baths." The next day half of them were killed with gas[42].

1.5 Extermination and Psychiatry

Psychiatry was an important part of the manipulative reconceptualization of medical theory and practices. It was transformed with regard to the daily tasks of diagnosis, since it involved the interpretation of tendentious ideological slogans as if they were reliable psychiatric classifications. Schröder describes this situation:

Almost all therapists adhered to the vacuous "rating of the value of illness," pitting conduct that was "antisocial" or "alien to society" against "socially adaptable" conduct. The description "alien to society" was used arbitrarily within society to stigmatize —in conditions of supposed associability— all minorities that were to be marginalized or exterminated… (Schröder 1989: 298).

These slogans led to paradigmatic conclusions, including the following: "Psychotherapy constitutes a discipline "of race" and of the "ethnic nation" (völkische), and, in a process of self-purification, it shall extract all elements "alien to

[42] See: Zeugenaussage durch Herrn Werthaimer, Insasse in Ausschwitz und Bierkenau. In: *Konzentrationslager Dokument* (henceforth referred to as KLD). F 321: 190.

the race" from its conceptions and methods. Treatment with a psychotherapist "of alien race" is discouraged, since he cannot have any resonant effect whatsoever on the unconscious; this always takes place in racially specific terms" (Schröder 1989: 290).

A. Thom clarifies this process within psychiatry: "The so-called "psychiatric investigation based on biological inheritance" increased gradually after 1933. With the foundation of "biological inheritance" departments in sanitariums and clinics, a large number of psychiatrists from these institutions were incorporated into this work. New centers of investigation sprang up in the subsequent expansion" (Thom 1989b: 134).

Hitler, meanwhile, was aware of the constitutional significance of an euthanasia law and seemed to fear the consequent international reaction and the one within Germany, given that he did not —in 1939 nor after— seem willing to sign the government bills on "euthanasia" presented to him on several occasions by the council of state (Reichsausschuá). He eventually sanctioned, in the latter part of October 1939, a surreptitious practice of killing: through an Enabling Act, backdated to September 1, 1939, he empowered his personal doctor, Karl Brandt, and the Secretary of State, Philipp Bouhler, "to nominally extend to some physicians the faculty of applying the grace death to incurable patients, following a humanitarian criterion and after a critical review of the state of their disease"… (Mitscherlich and Mielke 1978: 184). This decree was not based on any existing laws and was formulated in an extremely general way, so that it could essentially be interpreted arbitrarily.

Riedesser and Verderber illustrate, on the basis of military psychiatry, the relationship between the course run by the war and the participation of professionals: "At the start of the Second World War, German military psychiatry showed itself to be quite "successful," since the dreaded mass "shell-shock neurosis" did not come to pass as it had in World War I. The "soft" functional complications observed, particularly of the digestive system, were "treated" by internists (in lazarettos or "ultrafast treatment" departments) along with the necessary disciplinary pressure to ensure that the patients returned to their units on the front or else were sent to "battalions for the weak belly." Only a relatively small percentage was declared "unfit for combat." Particularly during the last third of the war, brutal "therapeutic methods" were consciously practiced (Pansen: painful skin irritation due to galvanic electricity; Brockhausen's cure: treatment with jolts of electricity and "psychotherapy" consisting of the alternatives of returning to the front or being court martialed or sent to an euthanasia program). Finally, all health officials were obliged to raise the "morale" of the utterly exhausted German troops by means of Nazi indoctrination, supposedly to make the "final victory" possible, but

in reality to prolong the agony of the fascist state" (Riedesser and Verderber 1985: 35).

1.6 "Euthanastic Measures" Involving Children

The registration of children in euthanasia programs, of interest to the council of state, had begun in August 1939 through a secret circular from the Ministry of the Interior (from 18 August 1939). This ordinance required doctors and midwives to report those children, up to three years of age, who were "...affected from birth by the following serious ailments":

1) Idiocy, mongolism (especially those cases coupled with blind-ness or deafness).
2) Microcephaly.
3) Hydrocephaly in an advanced or serious state.
4) Deformations of all types, especially the absence of limbs and serious fissures of the cranium or spinal column.
5) Paralysis, including Little's disease" (Klee 1985: 239).

These ailments led to admitting the registered infants in "special infantile departments," where they could be exterminated without causing a stir[43]. On the organization and purpose of these euphemistically designated "new facilities," A. Thom says:

"To direct these "special infantile departments," the council of state chose active and trusted members of the NPA, instructed on their tasks by headquarters in Berlin. Hitler´s Enabling Act was used to justify the legality of the effected acts. In general, the directing physicians did not themselves effect the deaths, requiring instead that other personnel supply an overdose of Luminal or give injections of morphine. From the available documents of the proceedings against doctors and paramedical personnel carried out after 1945 —proceedings which in the first years led to harsh sentences including death— it can be inferred that those implicated invariably carried out orders given to them, providing as a principal motive their compassion for the supposed incapacity of the children to live… The number

[43] The activities of this special organization was covered with the following statement: "The purpose is, in such cases, to conduct a treatment of those children, by all possible medical means, in order to make them free of the risk of being permanent victims of their incurable illnesses" .Taken from the decree of the Minister of Internal Affairs, dated on January 18 of 1940: "Approval of medical assistance for the treatment of newborn children with incurable illnesses".

of victims of the council of state is estimated at a minimum of 5,000 children. The number of mentally retarded children and youths killed on the basis of the "elimination of lives unworthy of living" is significantly greater. An especially macabre aspect of this organized criminal activity is that, although it was based on such inhumane procedures, it coincided with the research interests of renowned scientists of the period who sought to acquire more detailed knowledge about the causes of dementia and certain other diseases, specifically through forensic work on infantile brains… In early 1941, Carl Schneider, a professor of psychiatry from Heidelberg, conceived a "plan for psychiatric research," foreseeing among other things the conversion of some of the "special infantile departments" to a council of state research departments. According to this plan, children considered "without the power to live" would be the object of rigorous physiological and psychological research prior to being killed. These results could then be compared with the morphological analysis of the brains once they were extracted… The Ministry of the Interior granted important financial support to the research program envisaged by Schneider, expected to last for fifteen years..." (Thom1989a: 143-144)

The same author concludes his account with the following reflection:

"In accordance with all the verifications heretofore effected, it can be ascertained with certitude that, from a juridical point of view, the deaths of children in the framework of the described program constitute assassinations. There can also be no justification from an ethical point of view..." (Thom1989a: 143-144).

1.7 The "T4 Project"

Beginning in 1939, in the course of immediate preparations for war, a plan was also initiated to sharply reduce the number of beds in psychiatric institutions[44].

The initial evaluations of the number of patients whose deaths were to be organized centrally, in order to "decongest" the psychiatric centers, began with the assertion that five of every ten thousand inhabitants required institutional psychiatric help. Of these, at least one qualified as a "life unworthy of living." This resulted in approximately 65,000 to 70,000 cases of this type among the population under Nazi domination.

[44] The preparation for a war addressed to expand territory and to stop communism was summarized by Hitler in 1936: (I) The German Army must be prepared in four years for action. (II) The German economy must be ready for war in four years. From "Aus Hitlers geheimer Denkschrift über den Vierjahsplan", in Hofer 1957: 86.

On the coordination and precise realization of these “special measures,” A. Thom says:

“In July 1939 a committee was formed to assess the details of the project. Members of the committee, in addition to Brack, included H. Linden —a representative of the Ministry of the Reich’s Medical Department, psychiatry professors M. de Crinis, B. Kihn, W. Heyde and C. Schneider, and a select group of institute directors. The committee established the institutional structure, procedures, and in particular the system for judgment, and, based on research by the Technical Institute of Criminology of the Reich’s Central Offices, asphyxia with carbon dioxide was chosen as the method to effect death. The following institutions -closely connected with and subordinated to the Reich Secretariat- were created to carry out the organizational tasks:

1) The “National Society of Work for Sanatoria and Treatment Centers”.
2) The “Company of Pubic Utility for the Transport of the Ill”.
3) The “Foundation of Public Utility for the Care of Establishments”.

Since the central offices for the administration of this rapidly expanding apparatus (employing more than five hundred workers in 1940) soon overwhelmed the Secretariat of the Führer, they were transferred to a villa on Tiergarten 4 street in Berlin, providing the project with its code name, “T4.”

By October 9, registration cards were sent —having been printed in the interim— to a series of sanatoria and treatment centers, along with an instruction sheet which included a circular from the Ministry of the Interior, requesting the prompt forwarding of the registration documents to the “National Society.” There was no mention of the real objective of the measures. Rather, reference was made to transfers related to necessities dictated by the war. The registration cards used in 1939 requested -in addition to personal information- information about diagnoses, a characterization of the work carried out at the institution, information about the duration of the hospital stay, and information on nationality and race” (Thom 1989a: 145).

The instruction sheet subdivided the patients into groups:

Patients should be registered who:

1) Suffer from the following ailments (or can only perform mechanical work such as disentangling wool or the like): schizophrenia, epilepsy (note if it is exogenous, evoked by a war injury or other cause), senility, refractory paralysis and other syphilitic diseases, imbecility resulting from all causes, encephalitis, Huntington’s disease or other terminal neurological conditions.
2) Have been institutionalized for at least five consecutive years.

3) Have been confined as mentally ill criminals.
4) Do not possess German nationality, or are not Germans or blood relatives of Germans (Ankerstein et al., 1985: 82).

Referring to the course of this "special project", A. Thom adds:

"The registration cards arriving at Berlin headquarters from the "Work Society" were expeditiously evaluated by trusted psychiatrists, who made the decision on whether to admit a patient to the elimination programs exclusively on the basis of the data on these cards. Transport lists were made up for patients designated for "euthanasia." They were first taken to transit establishments, and from there were led to the actual facilities where the killings took place. A previously defined modus operandi existed to inform relatives: the transit establishments announced the admission of patients it had been sent, with reference at the disposal of the "Chief of Defense of the Reich". However, when they were picked up by the "Public Utility Company for the Transport of the Ill," families were informed only that a transfer to another institution had taken place —detailed information would be communicated from there in due time. Deception of the families continued with the relaying of incorrect information about the cause, and sometimes even the date, of death. This information was compiled in registry offices -closely allied with killing institutions themselves- which sent official 'cards of condolence' " (Thom 1989a: 145-147).

The system of successive transfer of patients between transit establishments was intended to make it difficult for patients' families to contact them, particularly because stays at any one center typically did not last for very long. The intentional lack of a trail of evidence proved to be very effective. It is difficult even today to retrace the steps of a patient with any precision, beginning with initial transfer from the first clinic and ending at the facility where he was killed. There are only indirect indications of the possible deaths of patients at the psychiatric clinics themselves. For example, among the high frequency of lethal cases at the end of July 1943 among patients at a university clinic in northern Germany, records do not provide any evidence of serious physical illnesses. Without exception the patients met a sudden death, formally and simply registered as: "December 30, 1943. Exitus letalis in a high state of excitation" (Pfäfflin et al., 1989: 333).

The clarifications of A. Thom also shed light on the high level of organization at the final institutions in this chain of extermination:

"The facilities for effecting death were replete with special security measures and were located within or in the vicinity of psychiatric clinics. The institutions for effecting death by gas were camouflaged as shower rooms and there were specially located dissection rooms and crematoria, wherein the corpses of those killed could be immediately incinerated. The directorship of these estab-

lishments was entrusted to psychiatrists qualified as responsible persons, whose tasks, in addition to ensuring the organizational operation, included (Thom 1989a: 147):

- A final and swift examination of patients arriving on the transports.
- Establishing causes of death on the cards of condolence.
- Personally turning on gas to effect death.
- Certifying the death of victims.
- In special cases, particularly those involving abnormal cranial formations, the dissection of extracted brains and sending of these to the Kaiser Wilhelm Research Institute in Berlin".

A. Thom calculates the total number of victims of the "T4 project," coordinated at high political and psychiatric levels, as 70,273. He also cites an excerpt from an internal document from Hartheim:

"Until September 11, 1941, 70,273 persons were disinfected (that is, killed; A. Thom): "and to this total he adds, asserting with apparent indifference, the savings for the national economy attributable to the extermination of "lives unworthy of living."

"With daily costs averaging 3.50 RM, the daily total saved is 245,955.50 RM; an annual saving of 88,543,980.00 RM; and with a life expectancy of ten years: 885,439,800.00 RM"

This means this sum has been saved up to September 1 as a result of the "disinfection" of 70,273 people (Thom 1989a: 147).

The abuse of scientific categories arising from physical anthropology paved the way for making a diagnosis to justify the mass segregation of "foreigners." This culminated with the project called "Law on Foreigners to the Community" (Gemeinschaftsfremdengesetz) of 1940. The juridical establishment of this law was postponed until the end of the war, and yet the law was responsible for the largest mass extermination of marginalized groups (gypsies, prostitutes, individuals with tuberculosis and others) in territories occupied by the Nazis (K. H. Roth 1983).

Aside: The Nuremberg Doctors' Trial

In the juridical reconstruction of the acts of mass extermination before the Nuremberg Court, Karl Brandt mentioned an event that occurred in 1939 that may have provided the motive for Hitler's "Enabling Act." The father of a disabled boy had addressed himself to Hitler, soliciting permission for the "mercy killing" of his son. Regarding the degree of responsibility of the various physicians involved in the euthanasia program, Karl Brandt, as a witness in his own trial, stated: "Hitler ordered me then to take charge of the matter and travel immediately to Leipzig — the event had happened there— and, having arrived at the destination, to confirm

the case. There was a boy blind since birth, who seemed an idiot and who also lacked a leg and part of an arm. The position of the doctors was that to keep such a boy alive, truly, was not justified".

According to Brandt's statements at the Court, there was an evident forethought in the planning and realization of the extermination of these lives regarded as "worthless"; because, with regard to the convenience of making those decisions in times of peace, Hitler would have empowered Dr. Wagner, medical boss of the Reich: "If the war comes, he would take charge of and carry out matter of the euthanasia"; because: "According to the Führer's opinion, during the war to go ahead with such matter it would by itself be easier and free of obstacles, since the public resistance that could be expected from the ecclesiastical side, in the general conditions of the war would not have the same weight as in normal conditions" (Mitscherlich & Mielke 1978: 184)

On the specific responsibility of physicians in the program of euthanasia, as a witness at his own trial, K. Brandt expressed for the records: "Each doctor was responsible himself for the activities undertaken as part of the decisions that finally led to euthanasia. Each physician was completely responsible of the verdict resulting from his/her examination; as well however as the chief medical specialist. He had as much responsibility as the physicians from the departments for euthanasia. Under no circumstance should we think that physicians working under such program were compelled to authorize euthanasia if they did not agree is do so, according to their own opinion. On the contrary, if they were reluctant, for any reason, they were obliged to reject euthanasia. Because of that facility of making their own decisions, physicians bore a considerable responsibility. On the other hand, the case was not only that physicians had the possibility of making decisions on life or death, but also the fact that they were co-responsible of keeping an individual alive. Perhaps this should be added in order to effectively see and make a judgment of the responsibility of each person in this matter. The responsibility was in the hands of each of those who participated in it. I estimate that there were ten to fifteen; maybe up to twenty of those in charge of the examination, who executed their work after receiving the order from their medical chief specialist, with remarks and specific instructions. In my opinion, it counts, perhaps crucially, that it was the Head of the State who assigned that mission to me, and that for sure I could not expect a decree from him ordering anyone to commit a criminal act of any order. And also, later on, it became evident, to me and the others, that everywhere they were doing the same, as if everything was in order, and for us it was correct" (Mitscherlich & Mielke 1978:205-206).

The argumentative construction of this plea to the court provides evidence of a rhetorical coherence in articulating personal implication -and that of other doctors responsible- in acts of euthanasia. These explanations show the accused's conviction that there needed to be a consensus among the physicians who had participated in the act, with each doctor possessing full knowledge of what had been effected and of the responsibilities of each of his colleagues. Only voluntary participants were involved in these acts of killing. However, the structure of the argument leads

convincingly to the dilution of individual responsibility, given that from the outset emphasis was on the obligation of each physician to avoid damages for the whole of the nation "since he was in fact co-responsible for that individual remaining alive." The power to decide did not reside with any individual doctor but rather - and this is fundamental- with the community. Thus, Brandt depicts individuals who had lost their wits, having to make decisions of a scope beyond all comprehension, and attending only to the general situation. Although they were conscious of being part of a hierarchically structured chain, the orders to continue the transport to the next person and then to the final establishment, as well as that of causing death by gas, were given individually. This way, individuals were rewarded for participating with conviction (elevated motivation) and for having to constantly support a heavy burden. By means of an authoritative conclusion, the overall responsibility is transferred to the head of state: of course the Führer could not personally order the execution of criminal acts and "also it became evident to me, and to the others, that everywhere people acted like this..."

Karl Brandt frames his own views on euthanasia in the context of love for his fellow man: "On the grounds of that there is an intention of helping a human being who is not able to help himself, and who extends his existence under torturing sicknesses… Besides, the patient hopes to receive help, and their relatives do the same. And with certainty we can affirm in this context —which lately appeared on the newspapers— that the patient has been released from his suffering… Likewise, the church has frequently expressed —and I would like to make special reference to Martin Luther— that the life carried on by an idiot for sure is not pleasant to God… And he considered it as something anti-natural. If somebody wants to make a decision about the problem of euthanasia, and make a judgment on it, he should go to an asylum and stay there for a few days with the insane. After that we could ask him two questions: the first would be if he, as a human being, would like to live in that way; and the second, if he would like to have a relative, maybe his son or parents, who were obliged to extend his life under such conditions. The resultant answer is not compatible with the concept of "diabolic order" , since that will be clearly of deep gratitude for one's own health. And on the issue of the human, what is more human? To help to such a being to find a peaceful end or to keep taking care and assisting him? This answer comes out by itself, of course, though it is not openly expressed..." (Mitscherlich & Mielke 1978:206-208).

Karl Brandt was sentenced to death by the Nuremberg Court. The court responded to the previous argument as follows: "We do not doubt that Karl Brandt, as he himself expressed, truly believed that incurable patients should receive euthanasia, those whose life was a burden for themselves, causing considerable expense to the State and their families. This Court does not address the abstract question of whether euthanasia is justified in certain cases of the above mentioned categories. Nor is addressed here the question whether a State can dictate valid laws to apply euthanasia to certain categories of its citizens. Even supposing that such State has the right to do so, the international community is not obliged to recognize such leg-

islation, specially when there is evidence that it clearly legalizes the death and torture of weak and defenseless human beings of
other nationalities.

The probatory documentation is conclusive, since non German citizens were included in such a program. The negligence of the accused, Brandt, contributed to their extermination. This is enough for this Court to confirm his responsibility for such a program" (Mitscherlich & Mielke 1978: 209-210).

The Court did not address the issue of whether the State has the right to conceive and develop such programs for its own population, returning instead to the possibility of laws of this type not being observed by the international community. A direct consequence of the Nuremberg Trials was the express rejection of all types of euthanasia, contained in the eighth provision of the Professional Code of Physicians, articulated in Geneva in 1948 by the World Medical Association.

B.2 Experiments on Humans Resulting in Death

Experimentation on human beings can be defined as a series of well-defined medical interventions and test treatments carried out on humans with the objective of obtaining indispensable empirical results otherwise impossible to collect. This includes new types of curative treatments that could not be adopted without a clinical test of therapeutic effectiveness.

In the first twenty years of this century, as a direct reaction to tuberculosis bacillus experiments on children conducted in Lübeck, there arose in Germany a commendable awareness of medical responsibility for all of society.

Julius Moses, editor of Insurance Bureau Physician, had written in 1930: "Public opinion must be urgently expressed about the problem of medical experiments. The patient is not "material," nor a "case," a "sample" nor an "experimental object," but rather a human being with a will and right to make his own decisions. He does not exist owing to medicine, but rather medicine owes to him its reason for being. What happens to the patient should be justified by the physician, not to circles of specialists, but to the people. Since the experiments are carried out exclusively in public institutes for the ill, this topic concerns the public interest. The establishments are maintained by public means and as such are subject to public censure and control. The activities of physicians at these establishments are not a private matter; rather, as they were hired to practice there in the interests of the health of the community, they are subordinate to the control of public opinion" (cited in S. Hahn 1989a: 77-78).

On Criminal Experiments in Concentration Camps, Hommel and Thom state, from a retrospective historical perspective: "In the second half of the 19th century, there was considerable expansion in the use of experimental procedures

in medical research in the field of basic natural scientific investigation, such that in pathology, bacteriology and pharmacology —in addition to experiments with animals there were frequent experiments on human beings. The broadening of knowledge promoted a new conception of science, even in clinical spheres, in which the search for diagnoses and therapies with scientific bases also led to the use of experimental methods to test the effectiveness of therapeutic methods..." (Hommel and Thom 1989).

From the reciprocal influence of public opinion and legislative authority in turn-of-the-century Germany until the 30s, Hommel and Thom derived a development that, by 1931, led to a detailed elaboration of "norms for new types of curative treatments and the effecting of scientific experiments on human beings." These norms were legally sanctioned by the National Ministry of Health and the Ministries of the Interior and of Justice[45].

The authors infer: "From the turn of the century, the increasingly critical attitude of the irresponsible disposition [of some doctors] in the use of experimental methods in medical research promoted an awareness of the problem and made possible the establishment of regulatory norms for the scientific contract with human beings which would limit dubious ethical procedures..." (Hommel and Thom 1989: 386).

But they add: "Even though the basic ethic regulations and normative rules on experiments with human beings, elaborated up to the early '30s, were not questioned nor officially derogated by means of different legal ordinances, including

[45] In order to understand the situation of medical ethics just before the Nazi takeover of power and their later crimes against humanity, the next parts from that Ordinance are very important: " … (3) In the sense of the guidelines, hose interventions and forms of treatment undertaken for research purposes, without having, in every case, to serve as curative treatment, and also whose effects and consequences are still not well covered by the previous experiences, must be considered scientific experiments. (4) Every new therapy, on its implementation or its realization as well, must be in agreement with the basic principles of medical ethics, with the rules of the medical arts and sciences… It can be undertaken only if, as far it is possible, it has been previously proven on experiments with animals. (5) A form of treatment of a new type can only be applied after the persons involved, or their legal representatives, on the basis of a previous and specific explanation, declare their unequivocal agreement and approval… (7) Medical ethics prohibits the use of any kind of precarious social situation as a basis for the execution of new types of therapy… (12) … A) Conducting an experiment without previous expressed consent. B) Every experiment based on human beings must be rejected, if it can be conducted with animals. C) Experiments with children or persons younger than 18 years of age cannot take place if they involve even a minimum risk for the child or the young person" (Hommel & Thom 1989:385).

the years under the fascist dictatorship, they slowly lost along that time their validity and effectiveness" (Hommel and Thom 1989: 386).

It is important to assert in the context of this study that in Germany, prior to the Nazi rise to power, discussions of medical ethics were already very common. There existed legislative measures with the express objectives of rigorously controlling experimentation on humans and of considering the relevance of investigations in light of public opinion.

2.1 Sulfonamide Experiments

The decision to carry out sulfonamide experiments with prisoners was made in the Reich Government Offices in May 1942. Two factors seem to have led to this decision. First was the soldiers' lack of confidence in the medical assistance offered them at the battle fronts; the large number of injured and the limited capacities for treatment inflamed the fears of the troops. This feeling was reinforced by the airdrop of enemy fliers on the German fronts, which "revealed of the delivery of packets with Sulfonamide and Penicillin to the Allied soldiers in such a way that soon, on the German side, that medicine 'was talked of as a miraculous medicine which, from the beginning protected the diseased or injured against infections' "(Mitscherlich & Mielke 1978: 132).

Another important factor was the death of Reinhard Heydrich in Prague, considered a real catastrophe at Hitler's General Headquarters[46]. The fact that Heydrich had died as a result of the infection of his injuries, just fourteen days after an assassination attempt, caused widespread discussion about medical measures that might have been able to save him, but which had not been applied in his treatment. Together these factors determined the decision to initiate the experiments immediately[47]. The use of sulfonamides on individuals injured in battle was advocated by

[46] On the current situation at that time at the General Quarters, Prof. Gebhart expressed at the Nuremberg Trial: "The situation at that moment is truly unimaginable, and I was called by Hitler, who did not attend me, but rather sent me to Himmler. An the Himmler declaration was very simple, since it clarified Hitler's opinion: Heydrich was a lost battle, but of such an enormous importance, as we had never suffered" (Mitscherlich and Mielke 1978: 133).

[47] With a clear propaganda intention, a working session of Hitler, Himmler, and Wolff —an SS general—, was reported: "In principle, experiments with human beings must be allowed, when the safety of the state is involved..."; and "Nobody who is imprisoned in a concentration camp must remain untouched by the war, while the German soldiers have to

Health Services as compensation for the shortage of surgeons on the major battle fronts, since otherwise the injured would remain untreated. In this way, the High Command attempted to directly influence the persistent deterioration of combat troop morale.

The therapeutic effectiveness of sulfonamides in the treatment "of injuries similar to those incurred in war" was to be tested by Prof. Dr. Karl Gebhardt through experiments with concentration camp prisoners. Gebhardt was leading Clinical Physician of the Medical Department of the SS and the police and, in those capacities, had urgently been sent to Prague in order to treat Heydrich following the attempt on his life. However, due to a flight delay, he had been unable to participate in the emergency operation on the "Acting Protector of Bohemia-Moravia." However, it is presumed that he incurred the ire of Hitler since he had neglected to bring other German physicians to attend to the difficult case. As such, the sulfonamide experiments could have helped Gebhardt redeem himself before the Nazi command (according to his arguments in the proceedings against doctors in Nuremberg, cited in "(Mitscherlich & Mielke 1978: 132-133).

Prof. Gebhardt did not limit himself to sulfonamide experiments, participating also in others —for example, involving the transplant of bones— with concentration camp detainees. The following is excerpted from the KLD: "I completed a very thorough inspection of all the Polish women, those we called Versuchskaninchen [Guinea Pigs]. All of these women were sentenced to die; they had been used for experiments or had sustained burns in which German doctors had cultivated serums. They had also been used to extract pieces of bone for subsequent grafts. These pieces of bone were to be used in special investigations for soldiers on the battle fronts..." (see KLD, F 321:152).

Affected prisoners have described the series of sulfonamide experiments as follows: "Injuries were intentionally provoked in the subjects and then infected, for example with streptococcus, gangrene or tetanus. Blood circulation was interrupted by ligation of the blood vessels on either side of the injury to simulate a wound suffered on the battle field. The infection was aggravated by wood splinters and crushed glass put into the wounds… After this artificial infection, treatment was begun with sulfonamides in order to evaluate its effectiveness" (accusatory writ for the proceedings against doctors at Nuremberg; from A. Thom 1989a: 388).

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accomplish with the impossible, and the nation, with its women and children subjected to fire bombs made with phosphorus" (Mitscherlich & Mielke 1978: 132).

Anesthetics were not used in these experiments and the prisoners were subdivided for observation into three groups of women and three of men. Dr. Samuel Steinberg provided this information, regarding the specific course of experiments, to the investigating commission: “In Block No. 20 the Germans also effected experiments with a sulfonamide preparation, listed as B.1034 and administered to many patients. This medication had been shown to be generally effective, but there was no evidence of benefits in the treatment of phlegmons and injuries. The investigation into the curative effects of B.1034 was continued with a large number of patients in Surgical Block 21, but there were no positive results for the treatment of serious injuries or suppurations. Despite being treated with this medication, several cases of septicemia proved to be fatal” (KLD, F 321:142).

In spite of all the systematic precision and the complete disregard for the well-being of the prisoners -at risk of serious illness or death- these experiments entail, in retrospect, a profound irony. This disgraceful medical work was in fact a product of tremendous ignorance, considering that “since 1940 there existed sufficient and certain knowledge of the utility of sulfonamides in the treatment of infected wounds” (Hommel and Thom 1989: 388).

From the standpoint of publicity, it was nevertheless important to make the preliminary results known. This was done in May 1943, during the “Third Session of the Advisory Physicians of the Army’s East Division” in Berlin. Dr. Fischer, representing Dr. Gebhardt, led a conference on “Special Experiments on the Effects of Sulfonamides.” Fischer, before the Nuremberg Court, stated the following regarding the conditions surrounding this presentation: “In the presentations effected by Dr. Gebhardt and myself, the fact that experiments had been conducted with concentration camp prisoners was stated with absolute clarity. Prof. Gebhardt began with the following words: “I assume all human, surgical and political responsibility for these experiments” (cited in Pross and Aly 1989: 377).

Mitscherlich and Mielke add: “Around two hundred medical counselors of the Army participated in this meeting. Prof. Gebhart made the introduction of Dr. Fischer’s presentation. In that he revealed that the experiments had been ordered by the highest State authorities and that the subjects had been selected among people sentenced to death —who had been promised pardon. From his preamble, it was not inferred that he was talking about political prisoners or women. The place of the experiments was not mentioned. From Dr. Fischer’s presentation it was possible to infer the number of subjects, their distribution and the general method of the experiments. Furthermore, that they have had three fatal cases. During the general conference that day, no objection was heard against the method of experimenting on human beings undertaken by Drs. Gebhardt and Fischer” (Mitscherlich & Mielke 1978: 151).

The Nuremberg Trials provided the opportunity to openly clarify the nature of this research on human subjects. Following the public prosecutor's questioning of Dr. Fischer, Fischer said: "First, and as a doctor, I regret that destiny made me break the fundamental law, *nihil nocere*, and that human beings have come in front of me to testify, not that I have helped them, but rather that I have injured them. And I regret even more that they are women. I have learned, nonetheless, that an act —when committed and later on judged— must be considered on the grounds of the reasons and circumstances that originated it. The practice —that caused me to be taken in front of this Court— had the basic and exclusive reason of helping people injured on the war. Special help had to be provided in such specially difficult times, when the injured were counted by millions. And the acts were committed by me as an obedient member of the German Armed Forces. The trust and confidence in the legal right of the authority, the State and the Führer —that was what I believed by then— provided legal frame and justification; and, as I was repeatedly told, it relieved me of individual responsibility. In those times of a life or death struggle of my people, at a time when a final decision was involved, I believed —since I was not a member of a resistance group— that the State had a reason to make decisions that go beyond the horizon and the capacity of understanding of an individual being… The State, with its duty of obedience and military structure and, on the other hand, a medical personality such as Gebhardt, were the motivations that gave me the alternative of choosing between disobedience during a state of war, or compliance. And then I considered as the worse offense disobedience, rebellion during the war" (Mitscherlich & Mielke 1978: 149-150).

During the proceedings against Dr. Karl Gebhardt in the Nuremberg Court, his specific explanations of the course of experimentation were brought to light, but there was no attempt by Gebhardt to justify his actions. The Court stated its position as follows: "We do not see admissible the principle of superior order as a defense against the charges contained in the accusatory text. This principle could never be applied in a case where who receives the order is free to accept or reject it. That was the situation in the case of Gebhardt. The probatory evidence shows, in unequivocal way, that he was not ordered to conduct the experiments, but rather than he sought the opportunity to execute them. This is particularly valid in the case of the experiments with sulfonamides: actually, Gebhardt directed the experiments to Grawitz, in order to show that certain surgical procedures —recommended by him beside the bed of the dying Dr. Heydrich— were superior to those of Dr. Morell, Hitler's personal physician, both in scientific and medical terms" (Mitscherlich & Mielke 1978: 158-159).

Prof. Karl Gebhardt was sentenced to death and Dr. Fischer to life imprisonment. The juridical basis of the verdicts involved the fact that the individuals sub-

jected to the experiments were foreigners. The text outlining this argument states: "Another argument contained in the defense's statement seeks support for the controversial idea that, for the sake of the general interest in mitigating human suffering, a State can order the execution of experiments with prisoners sentenced to death, even without their consent and no matter that these experiments might provoke serious suffering or death. Whatever would be the right of a State over its own citizens, it is an unquestionable fact that such legislation cannot be made applicable to foreign citizens, who become subject to those experiments under the worst form of slavery, against their will and under the most horrendous and irrational conditions" (Mitscherlich & Mielke 1978: 158-159).

2.2 Phlegmon Experiments

Similar to the sulfonamide experiments, the formation and treatment of phlegmons among prisoners was to be systematically studied using concentration camp prisoners. Phlegmons were artificially induced in order to scientifically verify the effectiveness of various medications in treating them.

Dr. Samuel Steinberg, a prisoner doctor at the time, reported to the International Military Court of Nuremberg's committee of inquiry on the experiments on humans at Auschwitz: "In room 15 of Block 28 there were thirty prisoners, divided into three groups with eight to twelve people in each. The first group of these guinea pigs received injections of 2 cc to 3 cc of petroleum. Eight days later, purulent phlegmons appeared; they were lanced and the secretions from the wounds were collected in closed and sterilized test tubes which were sent to the Breslau Institute.

Other experiments, consisting of irritating the skin by means of diverse chemical substances, were carried out with the second group of ten men. Some of them were treated with a solution of argil with 8% acetic acid (Barowsch solution). The treatments were effected for a week, every day: on the shoulders, on the legs, always in the same place. When the week had passed, severe irritations were evident on the skin and in some cases ulcers had formed. These irritations were produced on two levels (one superficial and the other deep) [and their material] was put into sterilized tubes, which were also sent to Breslau for a histopathological study. The ulcers did not heal very readily. In the case of a Jewish prisoner from Hungary, he healed only after seven months… The experiments lasted from August 22 to October 25, 1944" (KLD, F 321: 144-145).

According to the investigations of Mitscherlich and Mielke, many people died as a result of these experimental infections. The effectiveness of allopathic and homeopathic medications was tested in these experiments, leading Mitscherlich

and Mielke to state: “The SS members, mentioned in relation to these experiments, are dead or missing. Only the accused Dr. Gebhardt, who was aware of the experiments, declared that he had submitted to Himmler a protest against these experiments. However, Himmler, in his attempt to “discover ancient traditional medications, already forgotten, had been convinced of the right and necessity of conducting such experiments” (Mitscherlich & Mielke 1978: 165).

2.3 Typhus Experiments

Typhus is transmitted to human beings by clothes lice and often evokes large-scale epidemics in situations of war, hunger and misery. This disease was rampant among members of the army in the occupied territories of the USSR and in the POW camps. For technical reasons, the then-used Weigl vaccine could only be produced in small quantities and certainly not in quantities sufficient to put a stop to the outbreak of epidemics. Appealing to the military’s medical necessities in conditions of war, new methods of prevention and treatment of infectious diseases were tested on concentration camp prisoners. Hommel and Thom report on this situation and its consequences for these prisoners:

“In order to quickly test the effectiveness of the new therapeutic vaccines and medications offered by industry, and upon the insistence of the High Commissioner for Hygiene of the SS, Prof. Dr. Joachim Mrugowsky, and following several meetings of representatives from the Department of Medicine of the Ministry of the Reich, the Reich’s Health Services and renowned physicians, a Division for the Investigation of Viruses and Typhoid Fever was created in the concentration camp at Buchenwald. Such tests of effectiveness were conducted with human beings, under the direction of Dr. Ding-Schuler, a doctor in the SS, beginning in the first part of 1942. A work report from Dr. Ding-Schuler, addressed to Mrugowsky, provides a precise look at the type and scope of experiments realized in that Division in 1943. Among other experiments, the following were carried out:

- 1 December, 1942 to March 20, 1943: Experiments on 20 individuals involving vaccination with typhoid fever from the Behring Laboratories.
- 20 January, 1943 to February 20, 1943: Experiments on 47 individuals involving therapeutic medications for typhoid fever.
- 10 January, 1943 to May 17, 1943: Tests of typhoid fever vaccines on 435 individuals.
- In this one year alone, 848 individuals had been used in the work carried out by the Division. In addition, therapeutic vaccines and medications to combat diphtheria, typhus and cholera were also tested” (Hommel and Thom 1989: 390).

Professor Dr. Robert Waiz, then a prisoner in Buchenwald and formerly a member of the School of Medicine in Strassburg, reported to a committee of inquiry on the conditions in Buchenwald:

There existed in Buchenwald a large center of investigations of typhoid fever, dependent on the Hygiene Institute of the SS in Berlin, whose director was a Head Doctor in the SS. This center of investigations was in Block 46 and was equipped with the latest innovations and luxuries. It included a diagnostics center, the laboratory, and quarters for preparation of the vaccine (for the German Army). Since it is all but impossible to culture typhus bacteria in test tubes, as is done with the majority of microbes, they were cultured in living persons. Each individual was a living typhus microbe culture (KLD, F 321: 140).

The following description by Mitscherlich and Mielke, excerpted from the Nuremberg Trials, proves however that the realization of such experiments on humans was not totally devoid of difficulties for the physicians involved and that some of them tried to maintain the appearance of a basic ethical position: “Professor Gerhard Rose was then the director of the department of tropical medicine at the Robert Koch Institute of Infectious Diseases in Berlin and a doctor and general in the Air Force, but he did not belong to the Health Services of the SS. In spite of his public stance against experimentation on humans, he shortly thereafter joined the investigation team and actively participated in experiments in which typhoid fever vaccines were tested”.

Hommel and Thom add: “Although Rose had initially declared himself wary of experiments with humans, and especially of the inclusion of concentration camp prisoners, he later decided on an active collaboration. The importance to the military of the results sought in these experiments played a major role in this decision, as did the argument that the individuals involved were delinquents and as such could be sacrificed for the common good. The fact that the majority of people interned in the concentration camps by the fascist terrorist regime had been persecuted because of political resistance, for racial motives and as a consequence of an arbitrary application of ordinances related to the unlimited protection of security was not even considered...” (Hommel and Thom 1989: 391).

An ex-concentration camp prisoner, Alfred Belachowsky, a doctor in natural sciences who had been the director of a laboratory at the Pasteur Institute, describes experimental practices in words audibly tinged by the working conditions in the camp: “The camp received vaccines from the Krakau Wigl Institute and from Italy, which had to be tested and improved. As experimental subjects, prisoners from the green category (criminals) had to be chosen. However, since the Chief selected them, anyone was susceptible of being sent to Block 46. For that reason, some French political prisoners were also sent there, members of the resistance.

People who had to be eliminated were sent there" (Mitscherlich & Mielke 1978: 110).

The Nuremberg Court, having proved that Prof. Rose had designed a series of experiments which resulted in four deaths, sentenced him to life imprisonment. On the finding of such verdict they expressed:

"Certainly it is possible that at the beginning Rose had put forward many objections to the program of experiments executed in concentration camps. However, he finally abandoned his doubts about it and participated in the program in full awareness, in an active and cooperative form. He attempts to justify his actions with the argument that a State can legally order experiments on persons condemned to death, even in the case that they denied their consent to make themselves available as objects of experiment. Such defense does never apply in any way to the central point under discussion. As we have already argued in the Gebhardt case, whatever the legal context would be, related to medical experiments realized for/by a State with its own citizens, such type of act is not recognized by international law when is carried out on citizens or subjects of an occupied territory.

We have maturely weighted every assumption in favor of the accused, but his position lacks any support in the face of the considerable evidence against him. This Court decides that the accused Rose was a main offender and accomplice, ordered, gave support, gave consent and was involved in plans and actions that led to medical experiments with non German citizens, without their consent, and during the course of them homicides, brutalities, cruelty, torture, atrocities and other inhuman actions were committed. Although these actions did not represent war crimes, they indeed constituted crimes against humanity" (Mitscherlich & Mielke 1978: 102-103).

The experiences and knowledge of experimentation on humans under the Nazi regime, compiled and evaluated during the proceedings in Nuremberg, supplied the medical and legal ethical bases for the code of ethics relating to this type of experiment, articulated by the World Medical Association on August 20, 1947 in Nuremberg. The Nuremberg Code establishes, as a sine qua non condition for these experiments, the voluntary consent of the human subject and the cautious responsibility of the physicians who carry out the experiments. The Declaration of Helsinki (1964) complements these basic conditions with, among other things, reference to the necessity for mutual controls among investigators and their obligations to protect the privacy of the experimental subject and to the abandonment of experiments if the risk involved is incalculable.

2.4 Collection of Anatomical Material

The absolute control over the life and death of prisoners in concentration camps induced physicians who participated in Nazi domination to consider these prisoners as "human material" that was at their disposal and to use them with a total lack of consideration.

The anatomical study of human corpses has stirred emotions since its introduction in the classes of Vesalio (1514-1564) at the University of Padua. The robbing of cadavers for the teaching of anatomy was popular in romantic literature. Nevertheless, events in the concentration camps can be considered unique in the extent of their premeditation and treachery.

Johannes Paul Kremer, a professor of anatomy at the University of Munster, asked to be transferred —in his position as a doctor with the SS— to Auschwitz for some months in 1942 and there continued to write his personal journal on events occurring around him[48]. In his statements before the Krakow Court in 1947, he had to take a stance on the contents of these daily notes. He related that he had mentally accompanied each of those prisoners whom the on duty doctors in the concentration camps had set aside to be killed, justified by the general diagnosis "physically weak." He stated to the court that if any of the condemned individuals evoked a particular interest in him, he would "order the nurse, reserve him for me." These people were taken to Kremer to be interrogated one last time. Kremer would write up a clinical history for each of them with up-to-date information about weight, illnesses incurred and treatments received. He complemented his statement to the court with this information: "After I obtained this data, a health official would come and kill the patient by means of an injection in the vicinity of the heart." Later, Kremer would effect a methodical analysis of the corpse and prepare the so-called "fresh materials" in alcohol: the liver, the spleen and parts of

[48] Hommel and Thom make a comment on the story of this man and give information on the conclusions of the process of Krakower: "The journal of J. P. Kremer constitutes a contemporary document, which is especially interesting as it covers spheres of family and professional life. It shows the lack of character of a person who, on the one hand, held two degrees of doctor, had an outstanding career, displaying some scientific distinction, but still was lacking conscience and capacity to make a moral judgment. For the crimes committed in Auschwitz he was sentenced to death in 1947, but ultimately, due to his age, he was released by the Polish Government. Later on, in the Federal Republic of Germany, he was sentenced to 10 years in prison. The University of Munster canceled his two degrees" (Hommel &. Thom 1989: 400).

the stomach were sent to Munster where Kremer studied it in detail on returning from his stay at the concentration camp (cf. Bezwinka and Czech 1981).

Joseph Tyl, a former professor and catholic priest at the Pasteur Clinic, on his experiences as a prisoner doctor in the laboratory in Auschwitz, related: "Toward the end of October 1943, our pathology department received an order to send, as quickly as possible, very good anatomical preparations to the most important German universities. At the same time, a special station for tuberculosis was founded similar to the "histology" station, which had received an order to undertake the study of all forms of tuberculosis based on histological preparations. Parallel to this, a complete collection of preparations of healthy organs -consisting of more than 2,000 preparations- had to be sent to the University of Innsbruck. These preparations were valuable because they were from people, completely healthy, who had been either hanged or sent to the crematoria" (KLD, F 321: 141-142).

August Hirt, longtime professor of anatomy at the University of Strassburg, distinguished himself as the author of Deaths for Scientific Interest. He urged the collection of skeletons of "Jewish-Bolshevik Commissars" for his "anthropological" investigations in Auschwitz[49]. He received important support for this work, on the direct recommendation of Himmler, from Wolfram Sievers, director of the Society for the Investigation and Study of Genealogical Inheritance Foundation of the SS. Prof. Hirt also carried out experiments on the effects of corrosive substances (such as yperite and phosgene) on prisoners for this organization, as he wanted to test, "in a direct way," the practical utility of a "prophylaxis with vitamins" that he had devised[50].

The Nuremberg Court concerned itself with these events as they related to Wolfram Sievers, who was sentenced to death. In the fundamental verdict it is said: "Sievers received direct orders from Himmler to undertake research work for the Genealogist Heritage, whom he also directly informed of the experiments. Sievers devoted his activities to obtaining money, means and instruments needed by the researchers. The material obtained by him also included those prisoners who had to serve as subjects. In this context, Sievers necessarily had to use his

[49] According to the statement of the witness Henry Henrypierres, who worked for the Institute of Anatomy until the occupation of Estraburg by the Allies, in this action 86 persons were involved, men and women, who "did not die by natural causes" (Mitscherlich and Mielke 1978:178).

[50] Regarding his situation, the authors say: "Prof. Hirt is missing, he is considered dead" (Mitscherlich and Mielke 1978: 180)

own, independent, judgment to maintain a level of free initiative with respect to the details involved on these orders..." (Mitscherlich and Mielke 1978: 181).

2.5 Psychological Experiments

Some of the "experiments" conducted with prisoners hardly merit being designated as such, since either it is impossible to evaluate the relevance of the sought-after knowledge, or else the methodology displays disdain for humankind. As a complement to the infractions of medical ethics under Nazism already discussed, two examples from the field of psychology are included:

Professor Chr. Champy, a member of the Faculty of Medicine at the University of Paris and also a prisoner in Struhof, wrote -at the request of legal government workers- a scientific report based on his experiences. There he states: "A professor of histology from Berlin had the shamelessness to publish, in a German scientific magazine, observations made on hemorrhages provoked in women as a result of their being informed of terrible news. These experiments were done with women with normal menstrual cycles, informed that they were to be executed. This provoked internal hemorrhaging which this doctor studied" (KLD, F 321: 147).

Dr. Steinberg from Paris reports on his experiences in Auschwitz:

"One Sunday four convalescent individuals were brought in. Each had to drink a glass of sleep-inducing liquid, whose lethal dose was to be determined. These medications had been sent to Auschwitz by the Bayer factories so that experiments could be done with them. Two of these guinea pigs drank a vomitive mixed with the poison. All four guinea pigs were taken to Block 19, where a physician observed the effects of the medication. Two of them vomited and survived after going into a deep sleep for eleven hours. The two others died that same afternoon. The two survivors, along with two new guinea pigs (who had replaced the two dead from the first experiment) were used the following day for a new experiment. They were given a new mixture to drink; two vomited and the other two died" (KLD, F 321: 143).

Aside: Ethical Problems of Prisoner-Doctors in Concentration Camps

There were a large number of individuals in the concentration camps who had previously worked as medical professionals.

L. Löwenthal, in "*The Individual and Terror*," highlights the causal relation between mass arrests and the intent of annulling the personal histories of the victims of totalitarian terror:

The mass arrests typical of the first phase of totalitarian terror, the overcrowding in the concentration camps of people with a most varied origin and ideology of religion, served, for a variety of reasons, precisely to erase individual differences

and rights before the authoritative apparatus. The qualitative difference which normally exists between tried and convicted prisoners and the rest of the population was absent between the victims of terror in the concentration camps and individuals on the outside. The principle of selection in mass arrests, seemingly so irrational, is in fact based on a terrorist calculation. The question of individual culpability is as irrelevant as the hope of temporary punishment is useless (Löwenthal 1988: 16).

Regarding the ethical-professional situation of prisoner-doctors and their inclusion in the machinery of murder, Lifton states:

"For prisoner-doctors to remain healers was profoundly heroic and equally paradoxical: heroic in combating the overwhelming Auschwitz current of murder; paradoxical in having to depend upon those who had abandoned healing for killing —the Nazi doctors… But the problem then was, as Dr. Jacob R. put it, "becoming part of the system— this was the most troubling thing." Dedicated to trying to help people, he told me with characteristic sadness and honesty of "the practice that haunts me all the time which I have never spoken about… the practice of selection of… prisoners… unable to work." He went on to describe how certain patients would be very weak and show no improvement after days of hospitalization: "So sooner or later they would be [recognized as] unable to work, —and we were unable to help. So they went off… to the gas chambers— controlled [selected] by the SS doctors. And we had to decide who he [the SS doctor] would see" (Lifton 1988: 221-227).

To diminish the degree of responsibility of SS doctors in infractions of medical ethics, prisoner-doctors were often forced to participate in criminal activities. This report from Dr. M. Scheckter about his time in Auschwitz reads like an initiation ritual for a secret guild: "A week after my arrival at the camp, myself and Dr. K., a Slovakian prisoner who worked with me, were called by Dr. G., chief of cells, Polish, but certified as a "German of the Reich." He led us to his office, where the SS squadron's second in command, Corporal K., who asked me if I knew how to give injections, was sitting on top of a table. Before I could answer in the affirmative, a doctor dressed in a white smock —who was also a prisoner and whose nationality I don't know— said to me: "I'll show you what you have to do. This is a 5 cc injection and a syringe for lumbar punctures. You have to put 5 cc of this liquid into the syringe. Be careful that it doesn't shoot out into your eyes because a single drop would be enough to blind you. It was phenol. He filled the syringe as he said this and then he made two naked prisoners, who were nonetheless carrying belts and holding bread in their hands, come in. The doctor then said to me: "Look, take the reference points: You have to put the index finger of your left hand on the nipple and the middle finger on the left side of the sternum and you have to pinch downward and from left to right, because, contrary to what you think, the heart is on the right side. You have to remove some blood to verify that you are exactly in the heart cavity, and then you inject the liquid." And he did as he had said. The man, seated in a chair, fell dead immediately" (KLD, F 321: 124-125).

Lifton describes almost unimaginable extreme situations in which prisoner-doctors were led to kill: "There were at least three kinds of situation in which pris-

oner-doctors felt it necessary to participate in killing. First, the killing in medical blocks of capos who murdered and beat other prisoners… Such killing saved numerous lives —but was killing nonetheless… someone had to do the killing, usually a cooperative effort between a prisoner doctor and other inmates working on the medical block.

Second, there were situations in which prisoner-doctors felt certain patients had to be killed. Dr. Elie Cohen, in a book whose subtitle is "A Confession," tells how, when he was in charge of a "lunatics' room," one of them escaped into the camp and caused a disturbance, leading the SS commandant to issue a warning that such things had better not happen again. Cohen's reaction, which he shared with a prisoner friend who worked with him, was that if they could not keep things quiet on the ward "we'll all be for the gas chamber." Since this mental patient was extremely difficult to control, the friend responded by questioning his "sacrificing 600 people for one lunatic!" The two men cooperated in the killing by injecting an overdose of insulin… there was a third form of killing that certain prisoner-doctors engaged in: abortions performed during various stages of pregnancy, and the killing of newborn children after secret deliveries. These abortions and killing of newborn children were done because women (especially Jewish women) discovered to be pregnant or to have given birth to an infant were killed by the SS..." (Lifton1989: 223-224).

Dr. Lequeu, imprisoned doctor, reports on this latter subject at the camp in Buchenwald: "That constituted a difficult problem and a deep conflict of conscience for prisoner-doctors. If the child died at birth, the mother's life was saved. Could one sacrifice the child in order to save the mother? That was done several times to save the mother and the truth might be shocking to many people: the mothers accepted the sacrificing of their children quite readily, since that was a means of preserving their own lives. The physical and moral suffering we experienced, the concentration camp atmosphere in which we lived, had perhaps transformed the state of mind" (KLD, F 321, pp. 130-131).

The decision concerning the life or death of prisoners frequently had to be made by prisoner-doctors or other members of the internal administration of the prisoners. The record of proceedings in Nuremberg indicates that this cannot always be attributed solely to the victim. In the record of proceedings, under the heading "on whether, and under what conditions, an act of sabotage is appropriate, not to justify, but rather excuse the participation of the collaborator in acts of killing, from the perspective of criminal law and the conflict of duties," the following legal issues, among others, are considered: 1) The collaborator must be confronted with a truly unavoidable situation for the decision; that is, there is no other humanly possible alternative for saving the lives of some of those who are in danger, other than sacrificing the lives of the remainder.… 4) the collaborator must have acted with the verifiable intention of avoiding a greater loss… (Mitscherlich and Mielke, 1978: 228).

This takes into consideration the fact that the doctors involved could not influence the conditions within the concentration camps and, as such, were more victims than executioners.

2.6 Experiments in the Area of War Medicine

Dr. Sigmund Rascher is considered the originator of experiments involving the effects of low atmospheric pressure and freezing on humans (with temperatures close to the freezing point), judged to be very important military experimentation projects. They were carried out on direct orders from Himmler in the concentration camp at Dachau beginning in 1942[51].

In investigations of high-altitude flight, effects on humans at altitudes as high as 12,000 meters -and faced with a sudden loss of atmospheric pressure- were studied using damaged airplanes.

Dr. Rascher had begun his career in the Air Force and, as is evident in his correspondence with Himmler, had made a great effort to participate in investigative projects related to military medicine. He was soon presented with an opportunity and, full of confidence, wrote the following on May 15, 1941: "Most respected Reichsfuhrer: ...I have been assigned to the 7th Aerial Command in Munich for a special doctor's course. During this course, in which the investigation of high altitude flights plays a very important role -owing to the rather high maximum altitudes reached by the British fighter planes- we considered, with great concern, the misfortune of not having had conducted experiments with humans, since these are very dangerous and, furthermore, no volunteers present themselves… I posed a serious question to the others: would it not be possible to provide one, two, or three professional criminals for these experiments? The experiments are to be effected at the "Control Station on Firm Ground for the Investigation of Altitude" in Munich. The experiments, in which, logically, the subjects may die, are to be carried out with my collaboration. They are critically important to the investigation of

[51] Rascher is described as a particularly ambitious and reckless person, who would have used his personal relation with Himmler —even before the war started in 1939— to obtain permission to incorporate prisoners from concentration camps in the research works on the blood composition of patients with carcinoma that he was undertaking (Baader 1985:43).

flights at high altitude… (mentally disabled individuals could also be used as subject matter)"[52].

The experiments, as outlined, were undertaken by Rascher in February 1942 in Dachau using a pressure chamber provided by the Air Force. He also obtained financial support from the "Society for the Study of Genealogical Inheritance," which was created by the SS in 1935. He had considerable freedom in the methods he used. (Kater 1974)

Hommel and Thom summarize the course of these investigations and their results: "Close to two hundred people from the concentration camp at Dachau, who were neither condemned to death nor were voluntary participants, were subjected to extremely difficult physical conditions, with experimentally invoked sudden drops in pressure and suppression of oxygen. Between seventy and eighty prisoners died during or immediately following these experiments. These activities, indefensible from an ethical standpoint, were compromised -in the experiments of Rascher- by a considerable lack of scientific method, as Rascher simply described externally verifiable reactions and symptoms and carried out invalid dissections of the dead. It was therefore impossible to acquire any new and valid knowledge of the existing physiological conditions and the protective reactions of subjects. Some representatives from the centers investigating flight medicine, who had initially collaborated in the project, distanced themselves from it after Rascher's preliminary observations and refused to continue these experiments, though sanctions were brought against them".

The authors add: "The range of possible decisions in the individual choice of methodology for completing the secret scientific work was so broad, even during the final years of the war, that extremely inhumane practices could be overlooked" (Hommel and Thom 1989: 389).

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[52] In this letter of Dr. Rascher, written in a very personal form to Himmler, some inaccuracies can be observed. The Air Force had just experimented with volunteers (researchers and assistants) with high-altitude flights, with a maximum limit of 12.500 meters. Dr. Rascher did not have any sympathy with the direction of this section, therefore no type of agreement had been reached. Despite all these discrepancies. Dr. Brandt, Himmler's personal secretary, transmitted to Rascher the approval of his superior to undertake experiments with human beings in high pressure chambers: "I can tell you with real pleasure, that quite soon prisoners for the experiment with high-altitude flights will be given to you. I have informed the Security Police Chief about the respective approval from the Reischsführer-SS and I have requested him to instruct the employee in charge to make contact with you" (Mitscherlich and Mielke 1978: 21, 283).

Minutes were kept for all experiments, and films and anatomical preparations were made, all included in the reports sent to the Reichsfüh-rer. Himmler followed the progress of experiments personally and made frequent written suggestions in order to clarify issues deemed problematic from his perspective. These letters, like the correspondence of Dr. Rascher, reflect the Nazi Chief Himmler's disregard for the value of life[53].

The effects of near-freezing temperatures on warm-blooded beings should have been confirmed by the results of a series of experiments initiated in Kiel by Prof. Ernst Holzlöhner and later continued in experiments with humans beings by a working group in "Maritime Urgency" flight medicine. Rascher also joined this group with the decisive support of Himmler[54]. This working group carried out experiments with prisoners in Dachau from August 1942 until December 1943. The first phase, from August 15 to October 10, 1942, included about fifty people, of whom fifteen died from ill-treatment (Baader 1986: 46).

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[53] This can be appreciated in the letters addressed by Dr. Rascher to Dr. Brandt, Himmler's personal secretary, with the purpose of defining specifically an important point on the treatment of the prisoners: "I request to clarify as soon a possible with the Reichsführer the following case: In the RF-SS document dated by 18-IV-1942, Paragraph 3, it is ordered that, if the prisoners sentenced to death in Dachau survive experiments with mortal risk, they must be pardoned. Since to the present time, I have received only some Polish and Russian, among them also some sentenced to death, it is not clear for me if the Paragraph 3, above mentioned, can be applied to those as well; and if for the same people, after resisting the strongest experiments, we might commute the sentence for a life term in prison in the concentration camp..." .The detailed answer of the 21-X-1942, expresses: "To the SS Obersturmbannführer Schnitzler, Munich. Please, inform to SS-Untersturmführer Dr. Rascher, with regard to his written inquiry, that the ordinance submitted at the time by the Reichsführer-SS on the pardon for persons surviving experiments, is not valid for Polish and Russians" (Mitscherlich & Mielke 1978:25-26).

[54] Himmler expressed his opinion on the treatment that should apply to other people, as follows: "If other people live in conditions of prosperity or they are starving, they only interest me inasmuch we may need them as slaves for our culture; otherwise, it does not interest me at all. If to dig trenches for tanks it is required that 100,000 Russian females fall down exhausted, it only interests me as far the trench goes we well for Germans or not. If not necessary, we will never be brutal and soulless; it is clear. We Germans, the only people with a decent attitude toward animals, will also have a decent attitude toward those human beasts; but it is a crime against our own blood, to take care of them and to consider them ideals in such a way that our children and grandchildren have bigger difficulties with them" 1□,□□(Hofer 1957:113).

Hommel and Thom provide the following commentary on the methods and ulterior motives of these experiments:

Concerning the particularly brutal methods for which Rascher was responsible, an accusatory writ at Nuremberg Doctors Trial says: “In one series of experiments, people were forced to remain in a tub of cold water for up to three hours. In another series of experiments, people were kept nude in the outdoors for several hours, with temperatures well below freezing. The victims would scream from the pain caused by parts of their bodies freezing.” The testing of methods for reheating the body also constituted an integral part of this program of investigations. These ranged from full-body hot baths to the transmission of animal heat from bodies of animals or women. The total number of victims of this program, deceased during the “freezings” or soon afterward, has not been precisely determined. In any case, it probably approaches one third of the three hundred individuals involved (Hommel and Thom 1989: 390).

The experiments of Dr. Rascher were handled in the Nuremberg Trials in his absence. Mitscherlich and Mielke were able to deduce his fate from the minutes: “In 1944 Rascher and his wife had been imprisoned for illegal trafficking in children. [Rascher] would have been executed in Dachau prior to the arrival of the United States Army and his wife hanged on orders from Himmler in Ravensbruck or Berlin” (Mitscherlich and Mielke 1978: 71).

The authors comment on the breadth of experiments carried out on human beings by Rascher: “As far as the documented evidence allows us to assess, it seems that the experiments proposed and conducted by Dr. Rascher in Dachau are the first experiments in a special category with human beings: “terminal experiments” —as they were called by Dr. Rascher— .That is, the death of the experimental subject was an inherent part of the intent of the experiment” (Mitscherlich and Mielke 1978: 20).

Taking Dr. Rascher as an example, Mitscherlich and Mielke focus on the question that arises repeatedly throughout the course of the proceedings at Nuremberg: “Does killing lose its contemptible character if it has been committed because of a superior’s order? Postulating this argument can surely be understood only in the context of war. It is precisely war which lends itself optimally to be defined as killing by superior order. The direct responsibility must be sought in that Rascher was the initiator of these “lethal experiments” and had only sought the approval of Himmler” (Mitscherlich and Mielke 1978: 46).

2.7 Selection of Candidates for Extermination

Individual prisoners in the concentration camps were regularly selected to be sent in groups to the gas chambers. This took place on the descending ramps of the trains on the arrival of new groups of prisoners from the Reich or the occupied territories, and, in the camp itself among the prisoners who had been detained for an extended time. Although these procedures do not constitute experimentation on human beings, they will be discussed since they represent part of a process of extermination concerned even with the most minor of details, a process, furthermore, effected by physicians at every stage.

The selections on the ramps took place in a matter of seconds: “They separated you and then lined up everybody in fives,… and there were two men standing.… On one side, was the doctor, one was Mengele,… and on the other side was the… Arbeitsführer, which was the… man in charge of the work Kommando. And it was,… “You go, you go by truck. You walk, you go by truck."… A pattern pretty soon developed that you could see, under about fourteen and over thirty-five were assigned to the trucks. And not until we actually marched into the camps did you know exactly where the trucks had gone,… and this was done, I mean, very fast, very efficiently” (Lifton 1986:163-164, quoting an Auschwitz survivor).

Dr. Scheckter, commenting on the modes of selection overseen by doctors: “Every 14 days, the doctor from the SS came to conduct what was termed “selection.” The sick were undressed by the Polish chief of hospital rooms; they had to be standing, whatever their state of health, and they would wait like that for hours and hours for the arrival of the doctor. He would barely look at them and would then take some clinical papers with him. Two days later, the people whose sheets the doctor had taken were led to a place and we didn’t know their fate, but the head doctor would order us to fill out other sheets, dated and with whatever cause of death: Mr. X died of… the… The cause of death was left to the discretion of the person filling out the sheet” (KLD, F 321, p. 185).

A Doctor of Theology reports on Buchenwald, from his perspective as a victim there: “The examinations were a pure formality because the doctor completed an examination in a minute. One walked in front of him completely naked and with outstretched hands; the doctor would take one glimpse at you and say: “Fine.” We were asked about our profession. I answered “university professor” and I was declared “transportable.” I also said that I had had infantile paralysis. On my card was simply written “childhood illness.” On the basis of this inspection, many of my people were sent to the transports (KLD, F 321: 114).

Lifton turns to the statements of a former prisoner to examine the conduct of Nazi doctors in these activities more closely. The former prisoner states: “They [the Nazis] were psychologically very [well] prepared for every situation,” so that

at times "the doctor was very friendly to the people,… asking, 'How are you?' and, 'What occupation [do] you have?'" When an arriving inmate mentioned illness, looked weak, or was too young or too old, the same doctor made the decision to send him or her to the gas chambers… [The former prisoner] went on to list the series of steps in SS doctors' involvement in the killing: first, the chief doctor's assignments to his subordinates concerning duty schedules and immediate selection policies; second, the individual doctor's service on the ramp, performing selection "in a very noble [seemingly kind] manner"; third, the doctor riding in the ambulance or Red Cross car to the crematoria; fourth, the doctor ordering "how many [pellets] of gas should be thrown in… these holes from the ceilings, according to the number of people, and who should do it.… There were three or four Desinfektoren"; fifth, "He observed through the hole how the people are dying"; sixth, "When the people were dead,… he gave the order to ventilate,… to open the gas chamber, and he came… with a gas mask into the chamber"; seventh, "He signed a [form] that the people were dead… and how long it took"; and eighth, "he… observed… the teeth… extraction [from] the corpses." This was the survivor who concluded that "the killing program was led by doctors —from the beginning to the end" (Lifton 1978: 166).

B.3 Crimes against Humanity and Medical Opposition to Them

The role of doctors within the Nazi regime has been investigated to this point with the priority of clarifying the structure of medicine by Nazi domination or the participation of individual doctors in crimes against humanity. The topic of ethical conflicts, which must certainly have been an issue for the majority of doctors at the time, has hence become secondary to an analysis of medical activity as a system and to demonstrating the de facto implication of certain individuals. This creates the impression of an unavoidable subordination of medicine to the State and an inescapable obedience by doctors to Nazism[55]. Since events probably did not take place in such an absolute form, and broadening the scope of typical discus-

[55] In epistemological terms we can talk about a process of "social scotomization" on the perception of what the opposition to Nazism was; that is, the creation of zones of perceptive omission for the specific issue, and an area of conceptual emptiness and lack of analysis by those who should confront the matter (See Riquelme 1995c: 131).

sion is of tremendous personal interest to the author, both active and passive forms of protest will be discussed.

3.1 Isolated Opponents

An excellent example of the tendencies to submission and of having been "the lone voice in the woods" can be found with respect to experimentation involving the freezing of prisoners. The vast majority of doctors who were informed of the results of the experiments between 1942 and 1943 showed no objection to, and did not protest against, these clearly criminal procedures. Only Franz Büchner, a pathologist in Freiburg and then employed as an Air Force health inspector, who himself conducted freezing experiments with animals, reported afterward that, at a meeting of Armed Forces doctors in the latter part of 1942 dealing with the effects of cold, he and another colleague had protested against the "moral abjection" involved in the experiments carried out at Dachau and criticized their "scientific senselessness" (Büchner 1961: 151). He had directed his criticism at the completely superficial procedures of Rascher, who again in this case appeared to follow a strategy devoted exclusively to the observation of random results and, as such, could not establish significant physiological antecedents.

3.2 Systematic Blocking of Opposition

It is an unquestionable fact that it was difficult for doctors to offer resistance to the totalitarian regime, inasmuch as the principles of "national renovation" had garnered a high level of acceptance within all German social circles, including among doctors. Based on doctors' attempts at resistance to the "program of extermination," Mitscherlich and Mielke put forth an exemplary framework of the situation of the time, in which the personal commitment of the participants and the involvement in execution of the dispositions is put forth with all intensity:

"The procedures which, from beginning to end and through mass murder had a place in the action of euthanasia, provide evidence of the oppressive burden that doctors who were opposed to it, but who had decided to remain at their posts in order to save at least a few of the ill, had to bear. They were faced with multiple constraints and a high lack of understanding:

"1) Dictated in the "ordinance of the Führer." Thus Prof. Creutz, for example, during several months of work, had been able to elaborate a plan to completely impede the carrying out of activities in Renania province, in conjunction with the directors of provincial sanitariums and care centers subordinate to him. On February 12, 1941, a commission from the offices of the provincial executive

head, who had also been converted to the plan of blocking, arrived. It was composed of Prof. Heyde, director of the Reich's Work Society, and by leaders of the Tillman and Vorberg Company for the Transportations of the Ill. The provincial head, his deputies Dr. Kitz and Prof. Creutz, as regional chiefs of the Health Service, revealed their reasons in great detail for rejecting the activities. Prof. Heyde immediately produced a document from his pocket and passed it to the provincial head, leading him aside for him to read it. The provincial head read it, his face changed color, he was silent for a short time and finally he declared: "I didn't realize; under these circumstances, I cannot refuse to turn over the patients." It is a virtual certainty that the document was a photocopy of the Führer's decree of September 1, 1939. To that effect, the Tribunal states: "The exterior form of the decree: paper like that of a private letter, signature without indicating the legal position of state authority, absence of supporting signature of the responsible minister and the unofficial publication contradict the regular use of such legislative acts. This manifestation of Hitler's will, against all formal regulations, was itself not legitimized by any legal authority." But the automatic submission shown toward authority of State ostensibly annulled all calm reflection, all possibility of distancing oneself, even among government workers who possessed experience in legal matters. Hence, the agents of euthanasia did not have major difficulties in meetings, like that cited here for example: "The thin partition which… Dr. Creutz had been able to raise during long months of work between thousands of defenseless patients and the inflexible instigators in Berlin, supported by all the circles of power of an authoritarian state system, had been torn down in a few minutes on first contact with the brutal authority that ended with the name Adolf Hitler" (Tribunal of Juries, Coblenza, July 1950, 9/5 KLs 41/48).

This set of factors clarifies why it is easier, in principle, to investigate the degree of ideological collaboration and direct implication of individuals and institutions in the course of such special actions than it is to locate opponents who at the time were, naturally, like "flies in the ointment," and therefore were part of a sphere of camouflage and silence.

Accordingly, there is a vast quantity of source material on, for example, how the Nazi Physicians Association was able to coordinate the "unification" of the medical associations. Using a strong propaganda campaign and the apparatus of terror of the Nazi regime, the NPA was able to incorporate a large number of physicians in its first six years of existence, expanding membership from fifty, when it was founded in 1929 to 15,500 by January 1935. Parallel to this, members of those organizations who had remained in opposition, such as the Association of Socialist Physicians, were forced into exile en masse by means of racial or political persecution (Pearle, 1984).

Nevertheless, there were doctors who opposed and resisted the trends toward assimilation promoted by the Nazi regime. These individuals and their acts of defiance will be discussed here, since their side of the story is not often discussed in works of this type[56].

3.3 Thematically Centered Investigation

S. Fahrenbach 1989 has, with great dedication, studied the "forgotten" topic of opposition by physicians to the Nazi regime. Although some of the categories she uses -as well as her interpretations- are in the customary investigative style of the ex-RDA, the results of her investigation are concrete and rich in conclusions. On the consequences of acts of opposition by physicians during the Nazi reign, she states:

"We know of isolated activities wherein doctors officially in the service of the fascist State expressed themselves, for humanitarian reasons, against actions devised by government authorities. Dr. Wilhelm Hagen, medical functionary in Varsow and district director of the tuberculosis committee in General Ministry of [occupied Polish territories], in a December 7, 1942 letter addressed to Hitler, declared himself against the planned execution of 70,000 Poles. The danger involved for the individual in an act of this type is evident in the fact that the SS-Reichsführer Himmler wished to "enter" Dr. Hagen into a concentration camp because of his ideas, which placed the State in danger; he apparently desisted on the recommendation of Dr. Conti. Nonetheless, this should not obscure the fact that doctors who demonstrated these opposing attitudes were otherwise and without doubt established as part of the system, and generally -as evident in numerous examples- did not have to fear sanctions placing their lives in danger" (Fahrenbach 1989: 455).

In order to characterize the different forms of active and passive opposition among doctors to the Nazi regime, Fahrenbach differentiates between an antifascist opposition and a pro-humanist attitude. She distinguishes among three groups: "The first group comprised physicians who followed humanistic norms of conduct

[56] With regard to the passive complicity in actions that should aim toward the release of the military enlistment records, Riedesser and Verdeber propose: "We could not find any source from that time from which it could be inferred that the military physicians presented resistance to such orders. Nonetheless, probably there were hidden medical activities, whose stories are yet to be written. Thus, for example, it can be seen in the Peter Bamm novel, "Die Unsichtabare Flagge" (The Invisible Flag) that some physicians 'closed an eye' in cases of self-mutilation" (Riedesser and Verdeber, 1985:34).

and thus came to oppose the dominant political authority. Pro-humanist dispositions of doctors encompassed all types of actions directed against specific rules or legal decrees of the fascist state, above all those pertinent to the medical field. This might involve attitudes of partial rejection, like of the killing of mental patients, protests against racial legislation and other Nazi programs, refusal to participate in medical crimes, taking in and protecting politically or racially persecuted individuals, etc. The motivation for these acts, so worthy of recognition, was generally based on a commitment to bourgeois ideals of humanism, on religious convictions or on adherence to traditional norms of medical ethics; that is, on the preservation of the prevailing scale of values destroyed by the fascist regime. This precise or partial opposition consisted of a criticism of details, not of the system…

A second group was equally imbued with humanistic ideals, but also with a conscious liberal bourgeois way of thinking. More comprehensive forms of action are evident within this group, owing to a level of organization which was not possible with the first group. The Berlin group Uncle Emil [Onkel Emil] can be mentioned as an example of this type of opposition…

The third group was characterized, along with a medical ethos, by a political view of the causes and content of fascism. The clearest expression of this opposition is found in the participation of physicians in organized groups of antifascist resistance..."

The author also refers to the blurred boundaries of this classification:

"A division of this type should not be understood as being rigid. In actual historical events, transitions from the first group to the second, and from the second to the third group, are dominant" (Fahrenbach 1989: 46).

In the course of her investigation, the author encounters physicians whose behavior is contradictory. They appeared to be in a situation which they could no escape because for many physicians it seemed perfectly compatible to maintain a supportive personal stance toward individuals persecuted by the Nazi regime and yet be loyal to the German nation (as she herself felt during the Nazi era):

"An exemplary case of the difficulty involved in assessing this apparent contradiction is that of Dr. Schede, a professor of orthopedics at the Faculty of Medicine in Leipzig since October 1, 1923, and head of the department at the same university since 1929. During the process of denazification, the Special Commission of the antifascist Group of Saxony confirmed, on 24 September 1946, that he had obstructed the deliberate sterilization of individuals born with a dislocated hip or club foot. When, in 1935, in the context of the "Law for the Reestablishment of the Statute of Professional Government Workers" (according to which the first order of 1933 had been temporarily nullified), the chief physician at the clinic, Professor Dr. Ernst Bettman lost his license to practice and to work as an

educator at the university. Professor Schede helped Bettman to reestablish himself in New York. Bettman emigrated from Germany in 1937, owing to his Jewish roots. Such stances, worthy of recognition, were nonetheless combined with Prof. Schede's —as with many renowned university professors of medicine in Germany— statements of support for fascist policies of "national renovation," issued by him as the president of the German Orthopedic Society" (Fahrenbach 1989: 438).

In addition, the author depicts other opponents whose forms of opposition had a clearer structure: "Professor Rainer Fetscher conducted himself differently after being suspended from his teaching position at the Pedagogical Institute of Dresden in 1933. In 1934, he opened a practice where, on the one hand, he treated antifascists who had been prisoners in concentration camps, and, on the other, had the audacity -extraordinary for those times- to certify the injuries incurred by a former concentration camp prisoner in Hohnstein and Königstein-Halbestein" (Fahrenbach 1989: 438).

The author dedicates a large space to specific groups wherein opposition was developed based on a clear definition of tasks: "But there were individual physicians who helped out the racially persecuted. This was the most important area of activities by the opponents of Nazism at the First Division of Internal Medicine of the Hospital of Moabit, organized there in the middle of the 30s. Georg Groscurth, an assistant doctor who arrived at the clinic in December 1934, was one of the individuals. Initially, this small group set out tasks for themselves of an exclusively humanitarian nature. It concerned itself with people with Jewish beliefs, whom it hid. It obtained nourishment for them and supplied them with falsified "Aryan" passports in order to facilitate their escape from Germany. The group members frequently used the clinic as a place of safety… they also maintained contact with the Circle of Antifascist and Mutual Confidence of the Neurology Department of the Clinic of Moabit, where Chief Doctor Max Burger in particular, and assistant physician Dr. Hermann Hillerhaus, acted as obstructors for forced sterilization, altering diagnoses (leading to forced sterilization) in their medical reports, those of "demented from birth" or "epileptic from birth" made by doctors on duty. They classified the illnesses as acquired, thereby helping many evade that inhumane intervention (Fahrenbach 1989: 339-340).

S. Fahrenbach's investigation shows how conduct in accordance with religious convictions sometimes crosses the boundaries of "interior opposition" toward "passive resistance." This is evident in the history of the White Rose [Weisse Rose] resistance group of Munich, consisting of the Scholl brothers (one of them, Hans, was a medical student), the medical students Willi Graf, Christof Probst and Alexander Schmorell, and Kurt Huber, a professor of psychology and philosophy:

"The fliers written by the Munich group beginning in 1942, particularly by H. Scholl and A. Schmorell, evoked quite a sensation. In these, the students criticized not only fascism and its war policies, but also called for resistance… The results of these activities of the Munich students, of whom Hans and Sophie Scholl and Christof Probst were executed on 22 February 1923 (A. Schmorell and K. Huber were killed shortly thereafter) also reached Saarbrucken and Freiburg (through W. Gras), Berlin and Hamburg (through the chemistry students Hans Liepelt and Traute Lafrenz). The January 1943 pamphlet entitled "Summoning All Germans" had a significant effect, encompassing an area much greater than Munich. For example, it impressed the members of the Berlin group Uncle Emil so profoundly that they copied and distributed it, writing it out by hand… The Uncle Emil group also demonstrates how humanism based on religion could, in such an anti-human environment, lead to activities and methods that far exceeded a simple protest… Ruth Andreas Fischer… in her diary entry dated 16 April 1945, expressed the main motives for the activities of herself and her friends: "None of us ever belonged to any political party. We just always wanted to be human beings. The motive for the association of those with similar sentiments (in Uncle Emil) was provided by the events and consequences of the so-called "Reichskristallnacht" of November 9 and 10, 1938. Thus, the first acts were in support of individuals in hiding because of racial reasons… The doctors belonging to the group helped by simulating the existence of illnesses or issuing medical certificates with false diagnoses to many arms industry workers. They also sabotaged obligatory labor such as service in the militia and military service, by means of the necessary and inherent exemption from work of those affected…" (Fahrenbach, 1989: 441-442).

The author also draws attention to the negation or omission of the quiet forms of opposition of some physicians. This evident "scotomatization" of resistant stances to the Nazi regime leads, even today, to the creation of zones of perceptive omission for classifying and understanding clandestine resistance in that period: "Along with these physicians who acted in groups, there also existed a large number of doctors —who certainly have not been sufficiently considered— who, without maintaining close ties to those with similar thoughts, tried to remain loyal to their medical oath and their humanitarian sentiments. For this reason, they frequently adopted a position of "internal emigration" and direct action. For the most part their activities were temporally limited and often related only to a specific part of the fascist authoritative apparatus. Toward the end of the war, the re-

sistance of these physicians to the 'orders to tolerate, to destroy and to devastate senselessly' became increasingly fortified" (Fahrenbach 1989: 445)[57].

3.4 Hidden Resistance

Taking as an example the "*Extermination of Lives without Value*" program, Mitscherlich and Mielke document the opposing position of doctors who remained in the shadows:

"The resistance by conviction of the majority of psychiatrists toward such a 'cornerstone on the progress of Psychiatry' and their attempts to stop the transfer of inpatients, after the conduct of the personnel from the Company of Public Utility for Transport —formed almost entirely by people closely related to the SS— had motivated their lack of confidence, is clearly inferred from an official French document. This report was the product of six months of investigation and summarizes the events that took place in Wurtemberg and Baden. It reads: 'This evil plan is synonymous with hypocrisy and untruth. Consistently they tried to mask it, while at the same time relatives of those inpatients and physicians were treated as silly persons. When there was no doubt about the nature of these transfers, a great commotion in psychiatric circles started to arise. The hospital doctors resorted to different places, hoping to get support. But the universities remained silent, the zone directors transformed by means of threatens, keeping the secret as an obligation, and the courts of justice showed themselves impotent. Only sectors of the church and the Army tried to act directly, seeking to dominate the growing anxiety of the population of these provinces, where fear spread largely. We are aware of the struggle initiated in different universities against this new doctrine. Personalities with great scientific prestige are continuously expelled and disappear into anonymity, and that way they are neutralized" (Mitscherlich and Mielke 1978: 204)

The authors provide some examples of this public rejection and establish the abrupt end of the measures for the "Extermination of Lives Unworthy of Living":

"Professor Buchner, from Freiburg, addressed the topic of medical ethics in a presentation delivered at the School of Popular Education, in Freiburg of Breisgau, in 18-XI-1941, strongly rejecting the idea of euthanasia.

Some psychiatrists, Prof. Kurt Schneider among them, refused to release new publications on his discipline.

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[57] See also Riquelme, H. (1993): "Human Rights and Zone of Omission in the Perception of the Child."

Hitler stepped back in the light of pressure of this public opinion, emerged in an unexpected way, ordering verbally, from his general headquarters in August 1941, the instructions to Karl Brandt, to make him in turn, order 'to stop the actions of euthanasia". Karl Brandt transmitted by telephone the order to Philipp Bouhler. No written document with this order was ever found, and it seems that it never existed. From the testimony of different witnesses it can be inferred that, in realty, in the Fall of 1941 (in the institutions mentioned before) the death of insane people by means of gas was halted" (Mitscherlich and Mielke 1978: 204-205).

This example illustrates the basic need of the Nazi regime for competent professionals, who enjoyed social recognition: there could have been crimes committed unchecked that could only be committed while the legitimacy of the regime remained unquestioned.

From a current perspective, it might seem bold to imagine what would have occurred if there had existed less blind obedience and more ethical autonomy among physicians. Nonetheless, what has been pointed out with respect to medical opposition should show that, even in the unavoidable conditions of the Nazi regime, there were individuals who did not hesitate to express "epur si muove", actively opposing totalitarian terror.

B.4 Comments

During Nazism, as never before, medicine served as an acquiescent instrument of a global strategy.

In medical circles, arguments with a presumed scientific value were used to legitimize the extermination of "lives without value" and experiments were conducted on humans on the basis of a "rationality for the end of the world." In both respects, physicians involved seemed to be freed from all principles of medical ethics. A well-defined structure of terror arose, taking concrete form in concentration camps with "terminal experiments," intended to cause the death of patients, and in which doctors participated in the systematic administration of the art of killing.

Given the broad range of crimes against humanity committed during the Nazi reign, the normal categories for ethically judging medical and scientific activities lose their meaning. It is not only the concrete examples of this involvement —with their total disdain for humans— which surpass the imagination and make "*Dante's Inferno* itself seem like a comedy"[58]; in the same way, the consideration of "criti-

[58] Related by Kremer's journal, by the 2-IX-1942. Cited in Pross & Aly 1989: 298.

cal situations" such as the renowned "total war" seem out of place with respect to the conduct of implicated physicians and scientists, since activities of relevant position and functional structures were made available until the end.

For this study of medical practices under Nazi domination, it was imperative to be guided by the questions, "what happened and how did it come to pass?" It is thus sufficient to confirm that physicians and scientists put their knowledge and aptitudes at the disposal of an authoritative apparatus viewed as transcendental and, that in doing so, they broke all ethical conventions.

As suggested by Dan Diner (1991:65-76), taking the perspective of the victims makes the direct description of such experiments and arbitrary acts toward human beings invaluable: when reality exceeds one's worst nightmares, learning of that reality in a serious and direct way becomes critical.

In general, it can be asserted that this "medicine without humanity" has profoundly influenced our current views. Knowledge of experiments on humans in concentration camps and of the extermination of "human burdens" has altered the perception of what is "unimaginable" in medical practice and investigations. Although today these incidents seem difficult to reconcile and fully understand, they nonetheless represent a decisive part of the history of medicine. Only learning of these occurrences in a systematic way can help to ensure that the possibility of such acts being repeated does not increase because of sheer ignorance.

B.5 Towards a Comparative Diachronic Summary

In the previous chapters, a summarized and systematic description was developed of medical practice in Nazi Germany and under the military dictatorships in South America. The thematic interest of this presentation was focused on demonstrating how medicine became an instrument of these regimes. Also, however, for ethical reasons, there were attitudes and expressions of medical active opposition, singular and collective, in both contexts.

The information presented allows us to affirm that many of the violations - with medical support- of human rights in South America, like the structural subordination of the medical sciences to nazism in Germany, do not constitute isolated phenomena[59].

[59] This investigation did not have the intention, neither could it check, for doctors of South America, the validity of the theory expounded by Lifton 1988/1990, about a presumed development of dual personality in doctors from Nazi Germany, responsible for crimes against humanity. Although in Latin America there was no medical investigation of ideological tendencies, one could distinguish similar attitudes in the doctors of these two

To continue, a comparative analysis is outlined, of events at the intersection of human rights and medical ethics during the Nazi regime and under the military dictatorships. Although the extent of current knowledge about each of these times is unequal, there are nevertheless some general themes which reveal both parallels and differences between the eras and those who experienced them.

To begin with, certain events and fundamental acts of interest coincide in this comparison, which, without dismissing the basic uniqueness of each era, call attention to latent similarities. For example, in each situation there are phenomenologically intelligible similarities in the areas of physician crimes and in the forms of resistance practiced.

Transgressions of Medical Ethics

The principal activities of physicians implicated in the Nazi regime comprised the theoretical support and practical execution of:

a) Experimentation on human beings without any regard for the well-being or the lives of the prisoners affected, nor for the existing precepts of medical ethics. In this capacity, doctors were concerned only with establishing experimental results and were responsible for innumerable deaths.

b) A euthanasia and eugenics policy based on racial criteria and those of "social utility," specifying strict criteria for medical practices (for example, family doctors and medical government workers) regarding registration, in order to control and officially inform on groups of suspicious individuals. In this way, medical efforts were of inestimable significance in support of the regime.

c) The fortification of the internal and external front in the "total war." This position was manifest in the restructuring of a war economy for the health system and in studies, by medical experts, aimed at overcoming the "demoralization of the military spirit," personified by soldiers who were out of combat for psychosomatic reasons.

In the South American countries studied, the following medical practices relevant to maintaining totalitarian domination can be revealed:

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times however. In the interviews (empiric section) of physicians strongly in favor of the military dictatorship one could discern serious degrees of collaboration (e.g.: in the relativization of violations to the human rights). However the virtual separation between social function and private life that Lifton denotes as characteristic of the medical Nazi transgressions was not verified.

a) Participation in torture in a broad range of respects, from being present during torture in order to avoid “complications,” to personal implication in the act itself by abusing medical knowledge.
b) Writing false reports relating to the cause of death on death certificates, and false reports and documentation of the health conditions of prisoners in order to cover up physical mistreatment, using either outright lies or euphemisms.
c) Gynecological assistance to women in labor —already secretly condemned to death (“disappeared")— so that the newborn children could be taken as spoils of war and adopted by families of officials or regime supporters who did not have children and wished to have them.

Physicians in Nazi Germany and those of the recent past in South America — in becoming a part of practices promoting the deterioration of the human condition— have in common attitudes of unconditional obedience to the totalitarian authority and considering this authority as unquestionable with regard to matters of medical ethics. As such, they did not offer any objections to the ill-treatment accorded victims. External events such as World War II or the “war against subversion” served, in Germany and South America respectively, as a form of justification for the implicated parties.

Opposition by Physicians

Comparisons can also be made related to the resistance offered by some physicians.

In the Nazi era there were, above all, forms of individual opposition that went against the “vacuum of reaction” fostered by mass propaganda. They were the following:

a) Refusal to participate in investigations and/or acts of “selection” and “extermination", as ordered by superiors. This required taking a direct stance, though these were nonetheless rarely punished by the regime.
b) Certification of false diagnoses in order to prevent problems for patients. This represented an indirect form of expression and possibly occurred with greater frequency than has been previously supposed.

There was also medical and ethical opposition by professionals in South America. This activity often consisted of —in a spirit of ecumenical cooperation— informing the public about ethical transgressions. This resistance began with treatment directed expressly at the victims of torture and their relatives within the country and abroad, and provided knowledge, through case reports, about violations of human rights carried out by the forces of repression.

Thus, the different forms of collaboration of medical and psychological specialists in the practices of terror were demonstrated from very early in the dictatorship and were kept active in the awareness of an informed public.

Distinctive traits appear in the recent history of South America. First, crimes against humanity perpetrated by physicians were met with resistance within the medical corps itself, and second, questions raised within medical organizations about the participation of doctors in human rights violations sometimes led to interior indictments and trials within these organizations and against implicated professionals, with trials before the regular justice system sometimes arising from these. In addition, the fact that some of these procedures within the medical organizations had already taken place even during the military regimes allowed for this type of crime to be judged socially in determinant form.

These opposing stances by physicians under totalitarian domination, diachronically comprehensible in both epochs, have in common the explicit recognition of the abuse of medicine and protesting against the absolutism of the authoritative apparatus.

Ideological Background

Regarding ideological foundations for transgressions of medical ethics, a comparison would show the following:

Medicine seems to have been a fundamental pillar in the system of the Third Reich. References, first and foremost, are to the following:

a) A “social hygiene” based on “race science,” which attempted, in the name of the common good, to reach a maximal eugenic purification, to carry out mass sterilizations and to effect the death of “marginal humans.”

b) An attitude toward experimentation with humans strongly imbued with the intention of Nazi domination, favoring and aiding in the covering up of inhumane abuse within prisons and concentration camps (of prisoners of war and members of persecuted minorities). This conception of medicine conferred on some doctors an identity as “biological soldiers” and a function in the “therapy through genocide” (Lifton, 1988). Himmler, in a speech in October 1942 on “Experiments with animal heat and human beings,” argued ideologically: “The people who today oppose those experiments on human beings, and would prefer that brave soldiers die owing to freezing, are guilty of high treason and of betraying the fatherland, and I will not hesitate to provide the names of those gentlemen to the appropriate authorities (Hofer 1957: 114).

The Nazi ideology, overloaded with resentment, Social Darwinism and racial arrogance, consequently seems to have influenced many physicians, in the extermination of “beings of other species” and in their being conceded the role of “precursors” in the transcendentally important policy called “national renovation”.

The involvement of doctors in totalitarian domination in South America seems to have occurred only in the sense of technical assistance in repression. In the documents and materials discussed here, there is no evidence of a comprehensive ideology nor of the systematic completion of specific experiments with human beings. Collaboration with the apparatus of repression was, by and large, carried out by low-ranking military physicians who did not occupy positions of high responsibility within a hierarchically structured military system. As a result, it is difficult to imagine how they could have advanced their own investigative projects. Given this context, it is significant that the Uruguayan Minister of Health -a physician and official- on the eve of the return to democracy, seems to have made a tremendous effort to legislate forced retirement and prohibition of any statements by military physicians before ethics commissions. It is impossible to find a programmatic integration of medical investigation and education in the processes of social reorganization advocated by the military in these three countries.

Investigations of Each Era

The investigation of medical practices under Nazism makes evident, in accordance with the lengthier passage of time, a considerable advantage relative to corresponding work on medical practices under military dictatorship in South America. On the basis of a presumed relationship in the nature of both forms of totalitarian domination, it can be postulated that new knowledge of the collaboration of doctors in the Third Reich has a fundamental relevance to the study of medical ethics in South America.

The diachronic incorporation of the history of medicine under Nazism permits a deeper understanding of what occurred within the medical corps under the military dictatorships. This effect can be compared metaphorically to that of the dark chamber in the microscopic camera inasmuch as some life forms, for example treponema pallidum, can only be observed by shunning direct light and in contrast to a dark background. The recognition and analysis of medical transgressions simply from a specific and systematic phenomenological perspective seems unfeasible (since the observer’s attention is frequently drawn to specific aspects). Available knowledge of the attitudes and conduct of physicians during Nazi rule

forms a historical backdrop, allowing a more detailed and precise look at what is possible in the medical field under totalitarian domination.

Similarly, the study of medical practices under Nazi domination helps in overcoming the "epistemological obstacle" arising from a totalitarian power and its inherent destructive potential (Bachelard 1974), thereby impeding any objective definition by the observer, since the "reluctance to investigate all of the implications of terror, without any precautions, is in itself a sublimated symptom of terror (Löwenthal 1988).

This observation and interpretation, diachronically delineated, of criminal acts and forms of opposition by doctors in the context of dictatorship and terror, can be understood as an historic-medical definition of totalitarian domination. Investigation is conducted in terms of continuity, but also in terms of defining differences, between Nazism and the military dictatorships of South America in the area of medical ethics.

In order to understand the implications of such a perspective, it is worthwhile to turn to the Greek metaphor of the struggle between Mnemosyne and Lethe. Mnemosyne, as goddess of memory and mother of the Muses (founders of all the arts), dedicated herself completely to life and was responsible before the goddesses as a witness and preserver of "everything that has been, is and will be". In contrast, Lethe was viewed as the patron saint of forgetfulness and as inhabiting the halls of death, so that his efforts are directed at erasing traits from memory.

The mythical struggle between Mnemosyne and Lethe also has a symbolic significance in present-day South America, since there is still a great deal of resistance to the elucidation of the role of medicine during the military dictatorships and the ethical transparency in the practice of medicine is in no way culturally implicit.

As painful as it may be, it seems that it is only possible to acquire a solid ethical stance within medicine through an actualization and analysis of one's own history.

Part II

Empirical Research

Professional Ethics and Physicians during Dictatorships in South America

C. Methodology and Main Results of the Empirical Study

C.1 Theoretical background

I began this cross-cultural research into the impacts of totalitarian regimes on doctors and their medical-ethical decisions in three South American countries in the second half of the eighties. At the time, the link between human rights and medical ethics was just coming under scrutiny using forms of scientific analysis that would go beyond direct accusations, impossible to overlook, of crimes against humanity by medical personnel (Cruz-Coke 1978: 144-145).

By the early eighties in all three countries different bodies had already carried out several studies in the fields of medicine and psychotherapy,[60] which assigned enormous importance to documenting events then taking place during the dictatorships. Elsewhere, prestigious research institutes in Belgium, Denmark, France and the United States[61] were embarking on efforts to demonstrate torture's consequences to the scientific community,[62] along with the participation of some doctors in human rights violations.[63]

During the better part of a decade, an academic exchange between colleagues in Europe and Latin America, for whom the topic of human rights had become cen-

[60] Representatives should be mentioned here: for Argentina, CELS (Centro de Estudios Legales y Sociales); for Chile, FASIC (Fundación de Ayuda Social de las Iglesias Cristianas) and for Uruguay, SERSOC (Servicio Ecuménico de Rehabilitación y de Reinserción Social).

[61] We should also mention as representatives the University of Leuwen in Belgium, the Universities of Copenhagen and Aarhus in Denmark, the INSERM (Institute Nationale Superieure de Etudes et Recherche Medicale, Paris) and the AAAS (American Association for the Advancement of Science, Washington).

[62] A pioneering effort worthy of recognition in this area is the incorporation of the work of M. Viñar and M. Ulriksen 1989: "*Troubles psychologiques et psychiatriques induits par la torture*," as a specialized medical contribution, in the French encyclopedia Encyclopaedie Medico-Chirurgicale.

[63] See extensive publications from the AAAS, USA.

tral to their activities began to give rise to the basic design of this research project. Throughout these preparations, I was driven by the idea that only a qualitative research methodology examining the life of doctors under totalitarian regimes could offer new insights —for example of this era's implications for medical ethics. Similarly, I gave preference to using inductive methods from anthropology for this purpose, as the key to understanding the period and the main people involved.

From 1990 to 1992, I carried out preparatory documentation activities, which culminated in the annual symposium "*Culture and Psychosocial Conditions in Latin America*," at the University of Hamburg's Medical School, thanks to the support of assistant researcher, Enzo La Mura, who gathered texts and materials in the three countries under study toward the end of 1991.

From late 1992 through early 1993, I did field research in Argentina, Chile and Uruguay, obtaining information directly from witnesses of the era (by interviewing physicians) and the relevant supporting documents and other materials. Afterward in Hamburg, I started to process field research results, which led to additional questions for the doctors interviewed, this time in the form of an in-depth questionnaire based on statements made during the interviews.

1.1 Contextualization of the study

This research into the repercussions of totalitarian regimes on the lives of doctors and their ethical-professional judgments immediately following an era of despotism is unprecedented in scientific literature.

In 1947, the documentation included in "*The Trial of Doctors in Nuremberg*"… completed by Mitscherlich and Mielke, provided a horrifying chronicle of the improper use of medicine under Nazism. This kind of chronology is unsurpassed in terms of the rigor and precision of the treatment of trial documentation. These reporters, however, do not seem to have had the chance to contact the accused directly, either during or after the trials. Something similar must have occurred with the doctors who, at the end of 1949, attended the trail of Japanese doctors accused of preparing bacteriological weapons and using them on Chinese prisoners. (See *Prozeámaterialen in der Stafsache gegen ehemalige Angeh"rige der Japanischen Armee wegen Vorbereitung und Anwendung der Bakterienwaffe*. Moscow, 1950).

The pioneering interviews of Lifton (an American psychiatrist involved in the era of National Socialism through the Jewish culture) with Nazi doctors and survivors of the Shoa took place later, with certain chronological lapses.[64] Scientific

[64] Lifton himself, in the foreword to his book *The Nazi Doctors*, writes: "Soon after I completed my earlier study of the atomic bomb survivors, a rabbi friend visited me and in

analysis of medicine's role under the Third Reich didn't start until the late seventies, in the then-divided Germany, and has basically taken the form of dealing with certain themes and historical evaluation.

Since then, however, medical organizations have become increasingly sensitive to the issues involved. In 1986, the British Medical Association held a working meeting in London, and then met again in Paris in 1989, during the International Conference "Medicine at Risk: the Health Professional as Abuser and Victim (AI, 1989; Marange, 1991). The British Medical Association held its last meeting to review the issues of medical conflicts and human rights, including possible legal actions, in 1992 (BMA, 1992). These procedures all involved a common search to define uniform criteria for identifying human rights violations committed by and against doctors, and encouraging a legal position on them. The proposal of creating an international tribunal to publicly deal with crimes of this nature seems to be gaining more recognition and support (Grodin et al. 1993: 8-12).

My study is based expressly on these fundamental works. I am, however, unaware of any empirical study in the literature on the consequences of totalitarian regimes that specifically deals with doctors.

This work examines the link between two fundamental and epistemologically important themes in the post-dictatorial era: human rights and medical ethics.[65] I have already analyzed the human rights situation in the three countries and the point of intersection between medicine and human rights under the Nazi regime and military dictatorships in South America in the section presenting documentation. Here, therefore, I will focus on examining medical ethics in Germany, the United States and South America, in order to identify common traits and significant differences.

Medical ethics is a recent discipline, concerned with evaluating technology's consequences and identifying the moral limits that should govern all areas of medical action and activity.

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the course of our conversation declared: "Hiroshima is your path, as a Jew, to the Holocaust." The comment made me uneasy, and I thought it a bit pontifical, even for a rabbi. Yet from that time (the late 1960s) I had my own strong sense that I would, before too long, attempt some form of study of Nazi genocide. All of the work… seemed to point, professionally and personally, to such a study."

[65] We differentiate conceptually between ethics in medicine and bioethics; bioethics falls within the domain of technological-medical conflicts, and as such do not seem relevant to the objectives of this work.

In the Federal Republic of Germany, medical ethics became a separate discipline only recently, in the mid-eighties. The specific efforts of small working groups and some educators played a decisive role, as they worked to identify fragile points in medical research and practice, and to promote greater sensitivity to areas of conflict in both academic and political spheres. In 1986, this effort resulted in a call for everyone from "the Ministry of Health and the senators from the federal states to medical school commissions, to use their influence with the aim that questions of medical ethics may have major access and attention in the general pedagogical curriculum and in the courses of areas of concentration and specialization," (Heister & Seidler 1989: 13-23). The Academy of Medical Ethics was born in 1986 and with it a platform for interdisciplinary work considered essential. The associated magazine *Ethik in der Medizin*, started to publish in 1989.

The Bochum Center for Medical Ethics has been particularly outstanding in its efforts to distribute relevant information on this issue in the form of working papers, which examine the medical-ethical and judicial issues involved in doctor-patient relations, available to interested individuals (cf. in particular R. Kielstein, H.M. Saas and H. Viefhues).

Since 1993, a German magazine called *Zeitschrift für Medizinische Ethik* has dealt with medical-ethical principles, succeeding *Arzt und Christ*, founded in 1954.

A glance at publications in Germany to date leaves the impression that the debate about medical ethics has primarily functioned as an educational and theoretical discussion, with the successful integration of a multi-disciplinary perspective, thanks to the participation of representatives of many scientific and humanistic disciplines.

Recently, F. J. Illhardt defined the main areas of ethical problems within medicine as involving: a) the need to generate a consensus around ethical questions involving medical techniques, professional training and specialization; b) different modes of decision-making; c) the identification of new practical challenges in the development of medicine, and d) the perception of contrasting experiences in medical practice (Illhardt 1989: 24-35).

With the exception of work by Heisler and Seidler (1987), which examined the development of medical ethics through surveys, to date there have been few empirical studies published that deal with topics in medical ethics (Bostelar 1993, Dresel 1993, Gaestschenberger 1993, Geust & Swchoen 1993, Mendler 1993, among others).

In fact, it can be argued that until 1993, medical ethics in Germany were dealt with strictly through discourse. This is the method used to carry out basic deductive work assessing the consequences of technology in medicine and consequent

changes in the boundaries of the medical world. However, more recently, it is precisely the "human factor" that has triggered an examination of attitudes as identified by looking at empirical data, forms of action and the motives of medical personnel. E. Seidler observes that: "Ethics in medicine… is a science to use in the course of the clinical decision and in the conception of research… For the immediate situation in Germany… it can be said that after a long period of an essentially theoretical treatment of ethical problems in medicine, a strong need to go beyond daily ethical situations has now become apparent … Here, new forms of thought and communication are required, which must also facilitate the perception of conflicts involving values and objectives and include these in the convenient decision" (Seidler 1994: 13).

In the United States, medical ethics has formed part of the curriculum for candidates seeking to specialize in internal medicine (cf. *American Board of Internal Medicine* 1983: 720-724) since 1983. Special research institutes such as the Hasting Center in New York and the Kennedy Institute of Ethics in Washington, dedicated to basic research and publications on ethics in medicine and their implications for society, started up in the late sixties and early seventies. The literature available in English presents a rich tradition of dealing with topics involved in medical ethics using social science methods (inquiries based on questionnaires, catamnesis), studies, standardized interviews with specific professionals), which attempt to determine physicians' opinions about current conflicts within medical ethics (for example, confidentiality, treatment of AIDS patients, euthanasia, contracts with representatives of pharmaceutical laboratories, genetic consultations, treatment with placebos, etc.) (cf. Anderson & Cadells 1993, Brotzman & Mark 1993, Hyward & Weissfeld 1993, Lynöe et al. 1993, Resnick et al. 1992, and Wertz & Fletcher 1988).

Similarly, in the Federal Republic of Germany teaching medical ethics occupies an important place in the specialized literature of the English-speaking population.[66] The authors quoted here are self-critical: given that research into medical ethics must deal with extraordinarily complex structures of judgments of a normative nature affecting professional activity in daily and individual life, qualitative research techniques (participatory observation, semi-structured interviews, etc.) are essential to bring into focus the developing opinions of patients and medical

[66] See work on this topic, in J. Andre, 1992; D. Sulmasy, 1990; and C. Strong, 1992.

personnel. Similarly, studies of the ethical-professional attitudes of medical personnel in other cultural milieus are urgently needed.[67]

In South American countries such as Argentina, Chile and Uruguay, medical ethics are highly complex and represented by three main areas of interest or debate: a) bioethics, given that concern about the consequences of technology and the constant extension of medical boundaries (organ transplants, biotechnologies, human reproduction) is considerable throughout the region; b) social-medical concerns, given that today, as before, a significant percentage of the population lives in poverty, considered a source of structural violence that accumulates, taking the form of specific illnesses and conditions in which medical attention is inaccessible to many;[68] and c) human rights issues, because the era of military dictatorships continues to weigh on the present, with direct consequences in terms of organized violence affecting individuals and society slowly manifesting itself (cf. the documentary part of this work). These three dimensions are expressed in autonomous structures: participation in the international discussion of bioethics is carried out by the "J.M. Mainetti Foundation for Medical Progress" in La Plata, Argentina and its publication divisions (Pis 1994: 34-44), among others. Research into and the planning of social medicine, which enjoys a long tradition in South America, was reintroduced in the universities of Argentina, Chile and Uruguay following the return to democratic government (Durán 1991: 53-54). Also, as mentioned above, the area of human rights has increasingly found its way into specialized medical journals.[69] These three areas of effort in medical ethics in South America show little interconnection. If interest in Deontology (ethics as a doctrine of moral obligation) within medicine is currently at a peak as it appears to be in both the academic and professional worlds (in Uruguay in 1992, two volumes on standards, codes and medical clarifications for students and professionals were published simultaneously). Nonetheless, until now, there has been no attempt by academics

[67] "More studies using a qualitative approach are needed to validate our results and to illuminate inconsistent responses and the ethical principles which lie behind particular judgments." See N. Lyne et al., 1993: 767).

[68] According to UNICEF, 18,000 children die in Argentina in their first year of life each year and two-thirds of these deaths are avoidable. "La Mortalidad Infantil Neonatal", in: *Salud, Problema y Debate*, Vol. No. 7: 41-43. See also Fica & Abello 1992: 276-283.

[69] See studies cited in the bibliography by D. Kordon, G. Martirena, and G. Seelman in: *The Journal of Medical Ethics*.

in the three countries to synthesize these three areas within medical ethics. I can perhaps assume that events occurring during these military dictatorships raised sensitivity about the ethical fragility of being a doctor, but fear generated by them still weigh on public debate, even among individuals holding only slightly different opinions regarding medical ethics in the social sphere.

1.2 Methodological Considerations

In this empirical section, I will use an inductive approach to examine the thinking and behavior of doctors in the three South American countries during the post-dictatorial era. To do so, I will explore field observations step-by-step, as gathered, thereby providing a record of the preparation, implementation and results of field research, in order to develop a discussion of the tendencies observed at the end.

Four fundamental questions about doctors' situation during the dictatorships in Argentina, Chile and Uruguay arose during the preparatory stages of my research:

(i) What was daily life and medical practice like during this period?

(ii) What did interviewees know about doctors' participation in human rights violations, for example, torture?

(iii) What do physicians think today about that period?

(iv) Is there any relationship between sensitivity to issues involving professional ethics and life experience acquired during totalitarian regimes?

The material gathered during field research underwent a three-fold evaluation:

(1) An analytical discussion of interview content in which the main lines of argument of the doctors interviewed are systematically documented in depth, with regard to the many themes involved in interactions between totalitarian regimes and medicine, and based on their own position and experiences. Structural analysis of each specific question provides for a qualitative analysis of replies.

(2) A quantitative analysis of the questionnaires to establish numerical correlations between answers regarding the five issue areas and the political position of those surveyed.

(3) A general evaluation, synthesizing the qualitative and quantitative results of the study, followed by a general discussion of interviewees' arguments regarding the new challenges to medical ethics as well as their explicit attitudes toward the dictatorship.

The field research sought to establish the subjective dimension of participating doctors (passive adaptation or forms of protest) with regard to the totalitarian regimes and medicine in the three countries. I also hypothesized that there might be some link between doctors' present sensitivity toward relevant conflicts from the point of view of medical ethics, such as organ transplants, genetic modifications,

testing of new medications, etc., and their collective and individual experiences during the preceding era.

The main concern of this study was to identify the subjective situation of doctors during totalitarian regimes. Medical professionals were treated as actors during a prolonged State of Exception and were asked to offer their interpretations of that period and the corresponding personal consequences.[70] Based on these considerations, I opted for a qualitative analytical method that would allow me to approach both the local situation and an understanding of it.

In field research based on a qualitative method —in this case oral history— it is imperative to explicitly state the researchers' theoretical conjectures and generative hypotheses.[71] Researchers' skills can be decisive, providing greater detail and more understanding of the area being researched, and influencing their approach, as well as conditioning the circumstances of the field study.

a) The Relevance of Comprehensive Hypotheses

"If we wanted home truths, we should have stayed at home" (Geertz 1984: 276).

My field research was preceded by some years of general inquiry into the topic (Riquelme 1990, 1994) and by a systematic processing of specific materials throughout almost a year. In the course of this theoretical preparation, I elaborated three guiding hypotheses related to the socio-historic context, participants' mental state, and cultural aspects of medical ethics.

First of all, in order to deal with the social-historical context, H. Arendt's concept of "totalitarian domination" proved useful, since it permitted the theoretical separation of the general system, based on a goal of hegemony on the part of participants and/or those affected.[72] It was thus possible to consider the effects of the

[70] Clifford Geertz' statement is extremely applicable here: Individuals' histories define their characteristics, because for all the apparent homogeneity of a particular social situation when viewed from the outside, the diversity of individual conduct only becomes evident when we study it in-depth (See: Geertz 1992: 80).

[71] See L. Niethammer 1985, and R. Habermas 1992.

[72] The concept is defined as follows by H. Arendt: "In this sense, the crux of the totalitarian regime lies in terror which, nevertheless, is not exercised arbitrarily, nor is it based on the thirst for power of an individual (as with tyranny), but rather in conjunction with superhuman processes and with its natural and historical limits. As such, terror replaces the frame of law, within which people can function freely, for a strong tie that limits people in

military regimes in the three societies from a certain distance and in contrast to historical experiences already decanted. This also allowed me to resolve the question —so frequently encountered— of the degree of responsibility directly attributable to individuals (the study's subjects), as an aspect pertaining to the context of field research.[73]

Secondly, in terms of the players' psychological makeup, the concept of mental health as a dynamic characterization rather than a reductionist one proved advantageous.[74] Mental health is understood here to be the capacity of individuals and social groups to tolerate long-term situations and relationships of conflict, directing their efforts toward constructively overcoming such conditions and integrating those conflicts into their psychosocial conscience. Understood in this way, mental health performed a very useful conceptual function, providing a phenomenological frame of reference, rather than serving as an explanatory instance, for the intensity, often beyond anything imaginable, of the overwhelming experiences of those living under dictatorial regimes, thus offering an observing participant environment. Thirdly, understanding ethics as a cultural process affecting those involved, and therefore tied to people's self-perception in their respective societies, allowed me to respond less with postulates of general validity affecting the normative aspects of medical ethics and more to the specific arguments offered by each. This allowed me to keep my mind clear and open to questions within medical ethics considered to be conflictive (this is reminiscent of Piaget's model for the genetic structuralization of morals and Habermas' theory of ethical discourse, both very influential in this work).

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such a way, which excludes any free, unexpected action. In this way terror becomes, to put it thusly, the "law" which cannot be infringed. This fear-induced immobilization, supposedly is expected to serve to the freedom of the history or the nature in motion. Discussing freedom with supporters of totalitarian movements constitutes an extraordinarily difficult undertaking, because they not only have little interest in human freedom, that is, for the freedom of human action, but rather they consider it dangerous for the free articulation of natural or historical processes" (Arendt, 1991: 711).

[73] Although the military dictatorships in South America, based ideologically on the "Doctrine of National Security," were not planned as "thousand-year Reichs," they nonetheless acquired characteristics comparable to those of the Nazi era with respect to how they exercised power and the magnitude of their structural influence on all aspects of society.

[74] See Weinstein 1975, and Riquelme 1988.

In recognition of the enormous sensitivity of the topic and the fact that there has not been any similar research in South America, I used only qualitative methods for collecting data for my main research effort. I focused on systematically developing questions, identifying suitable interview subjects, and personal interactions during the interview itself. My rejection of common methods for compiling data, such as multiple choice questionnaires, observation schemes, etc., proved to be advantageous from two points of view. First, it permitted a true inquiry into biographical differences and differences in opinions without using exclusive structures of thought and action. Second, it made it possible to interact directly with the interviewee in each particular meeting, thus generating a mutually satisfying form of personal contact, which encouraged further exploration, since the subjects themselves also felt they were obtaining some personal benefit.

Field research took place in Argentina, Chile and Uruguay between October 1992 and January 1993. Except for Christmas and New Year's holidays, this time of year is part of the regular work period in the region, so finding suitable interviewees was not difficult. During that stretch, I was able to interview forty-eight doctors about their experiences during the military dictatorship and question them on their stance toward topics within medical ethics.

b) The Set of Questions.

While the author was born and lived in the geographical region relevant to this research and should thus have general knowledge of the circumstances to be researched, I am unfamiliar with current conditions and can therefore be most aptly described as a participant-observer. In many instances, I am also quite cautious.[75] Central to this methodology were the guidelines included in the interview questionnaire, which deserve some theoretical commentary.

I assumed that that the group of doctors involved in the research would share some common characteristics —such as professional socialization, social status and career perspectives— but that by virtue of personal evolution in the concrete socio-historical context, would differ greatly at the individual level. It was thus necessary to identify the themes to be dealt with during the interviews in direct questions, in such a way as to ensure they were clearly understood by everybody and could be responded to on the basis of each individual's personal experiences and ethical opinions.

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[75] Berger 1980 considers that a researcher with these characteristics provides good conditions for the realization of "participative social research".

In the first place, the questions should indicate impartiality on the part of the interviewer. Even when questions revealed a specific cognitive interest, interviewees should feel confident that their personal opinion had been requested with seriousness and sincerity and that it would not be used to prove a preconceived hypothesis. "The open character of what is asked is essential in order to avoid predetermining the response. Personal convictions must be suspended, so that contrary positions can balance each other. All questions complete their state of being in transition by their suspense, which becomes an open-ended question. Every authentic question pretends that truthful character" (Gadamer 1960: 345).

In recognition of the fact that the three countries share common social and historical traits, for example language, as well as similar social structures and economic conditions, while also possessing strong local differences, I emphasized the use of concise, unequivocal language in interviews, thereby overcoming the risk of different interpretations by the doctors interviewed.[76]

Even though I can speak with hindsight of the cooperative conduct of all those interviewed, when formulating questions I organized the thematic order of the interview very carefully. Through thematic contexts, I worked to generate a dialogue that would offer the interviewee the chance to express her or his opinions directly.[77] Previous conversations with friends and acquaintances from the three countries were important in this respect, allowing the researcher to test the validity of the "generative themes" considered.[78] A basic questionnaire was developed for the interviews in accordance with these criteria, and it was applied without deviating from content in all of the interviews during field research in the three countries. This basic questionnaire deals in-depth with the following five thematic are-

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[76] "The act of questioning presupposes an opening but also a limitation. It involves explicitly establishing conditions, conditions that are fixed and from which the uncertainty arises, which remains in suspense" (Gadamer 1969: 346).

[77] "The mayeutic productivity of the Socratic dialogue, its art of word's midwife, refers to human beings -interlocutors of the conversation-; yet, on the other hand, it abides by the opinion emitted by them and whose imminent objective consequences are revealed during the conversation" (Gadamer 1969: 350).

[78] According to Paulo Freire, the "generating themes" constitute a cultural gain, developed in "borderline situations" by the implicated social group, in that its members examine the situation according to social and cultural antecedents, and they create their own concepts and possibilities for appropriate action (Freire 1969: 75-104).

as: I. personal profile; II. opinions, based on experiences, about a) violence in everyday life, b) the historical-social phase of military rule; III. opinions about current situations of conflict within medical ethics (gene manipulation, organ transplants, surrogate motherhood); IV. opinions about the social contract (a) with the victims of the military dictatorship, b) regarding possible violations of medical ethics under "extraordinary conditions"; V. mental representation of five situations of risk within medical ethics with an opinion and exposition of its own argumentative basis.

The questions included in the questionnaire appear below as part of the qualitative evaluation.

c) Interviewees

During my stay in the three countries, my first task consisted of contacting the potential interviewees. Given the sensitivity of the topic of professional ethics and doctors under totalitarian regimes, I expected to encounter considerable resistance, particularly given that many aspects of doctors' responsibilities for human rights violations are judged very severely by public opinion.

Nonertheless, my lengthy preparations proved very useful: through activities promoting human rights within the academic community and in international organizations, I was able to rely on a broad network of friends and colleagues in the three countries, which helped me to quickly locate individuals appropriate for the interviews.

When selecting the doctors to be interviewed, I gave priority to those who remained in the country during most of the dictatorial period and to those that belonged to one of the following three categories With regard to the totalitarian regime: "Pro," "Neutral," or "Opposition".[79]

I included a fourth group, "Young Physicians," to complete the sample, but without aspiring to establish a specific category, so I also interviewed young doctors, who graduated toward the end of the dictatorship or soon after its demise. These interviews were very valuable in documenting their personal opinions, but were not included in group comparisons because they lack internal homogeneity.

The communicative network of friends and colleagues mentioned earlier was of tremendous importance in identifying and accessing the individuals from the four groups being researched. Having arrived in the respective countries, my initial

[79] This form of categorization was often discussed with the interviewed doctors after the interview (it was accepted as quasi-evident), and in general aroused a significant interest among the participants in the results of the research.ì

contacts with interviewees were almost always via telephone. I typically called the doctors at work and asked if they would be interested in participating in a research project on medical ethics in South America, based at the University of Hamburg. They were told that the interviews would deal with, for instance, aspects of professional activity during the past twenty years on the one hand, and with personal opinions on present problems within medical ethics on the other, where they would be asked to take a stand. To accomplish this I wanted to complete a narrative interview, semi-structured, for which they should be available for a minimum of two hours.

In all but two cases, I was favorably received and quickly received consent to the interview.[80] There were some individual doubts about whether the person being questioned knew enough about the concepts involved to deal with the topic, but I handled this by referring to physicians' constant need to make ethical decisions during daily practice, emphasizing that for the purposes of my research, it was precisely their personal opinions regarding different conflicts that were important, since I was not attempting to arrive at some hypothetical ideal ethical position, but rather to gain access to the specific ways that doctors respond to regular questions of ethics.[81]

In general, it was possible to arrange a meeting for the interview following the telephone conversation in a location familiar to interviewees, usually a hospital or their private office. Contrary to expectations, only three individuals refused to participate during the initial conversation. The vast majority of interviewees contacted by telephone proved to agree with the information provided about the meaning

[80] These two negative responses occurred in Argentina and Uruguay. Each involved a long series of previous telephone contacts, punctually completed by the interviewer, until the individuals declined a personal conversation definitively, citing a lack of time.

[81] There were, naturally, other personal questions. For example: why was he/she specifically recruited?; who supplied their address or telephone number?, etc. The responses emphasized the necessity —given the type of qualitative research— of including the widest possible range of participants and pointed to the telephone information services for obtaining telephone numbers. In general, the question of the interviewer's nationality was irrelevant: despite his Chilean accent, usage was atypical. Thus the physicians from the three countries seemed to consider the interviewer basically as a foreign researcher with whom, as expressed frequently during the course of the interviews, they had minimal communications problems.Ö□□□

and purpose of the research and showed a willing disposition toward the interviews.[82]

The fact that I conducted interviews in environments familiar to the doctors reduced their inhibitions and allowed them to determine the course of the interview to their liking. This also allowed me to form an opinion of interviewees' place of work or living conditions. Furthermore, since they found themselves on familiar ground and could thus influence the progress of the interview, I was able to form an opinion about their work or living conditions and submit their responses to verification. Interviewees themselves often explicitly encouraged this form of participatory observation and pointed out specific aspects of their medical practice to me or included documents of various types in the conversation in order to support their declarations.

The interviews had a highly ritualized beginning, consisting of the explanation of content and intentions and the preparation of tape recorder and microphone. This gave me several minutes that encouraged mutual acquaintance, during which no in-depth questions were asked and the nervous tension of the situation faded.[83]

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[82] The negative responses all occurred in Uruguay and were very formal. First, a change of opinion was offered as a motive. When questioned further, it was found that there were concerns about "very private opinions being published without any reservations," or with the possibility of "hierarchical principles being destroyed by the statements of a single member of the military corps." The interviewer's question concerning previous experiences in this respect was responded to in a vague way, and the assurance of strict anonymity for all of the interviews also did not help in these cases.

[83] This introductory exercise included a general explanation of the specific objectives and purposes of the interview, and of the research in general, and proceeded as follows: This study is being carried out in Argentina, Chile and Uruguay and is motivated by the desire to explore, from the perspectives of those involved, how personal experiences during the States of Exception were integrated as an important part of personal histories and how these shaped attitudes and ethical concepts. The purpose of this interview was to explore physicians' attitudes about current topics involving medical ethics, and to examine their impact on interviewees' personal histories and vice versa. I conducted semi-structured narrative interviews with the technical aid of a tape recorder and guaranteed the anonymity of the materials obtained.

This interval was also useful for clarifying any potential misunderstandings and to clearly establish the absolutely voluntary nature of the interview, which the subject could terminate at any time.[84]

My own attitude was that of a sympathetic questioner, not only because this research arose from personal interest in the topic and depended on a certain freedom for the realization of its design and conceptual development, but also because interviews were very friendly and cooperative. In general, I was very impressed by this "little journey" through the biographies of witnesses of recent history and initial attempts at interpretation.

In analyzing and evaluating the compiled materials and experiences from the field study, the interviewer explicitly sought to avoid any sense of being a prosecuting attorney investigating the events of the dictatorial era. This was so independently of personal opinions about events occurring during totalitarian regimes. For the purposes of this research, it is nonetheless of fundamental importance to submit information about participants' personal and scientific knowledge.

The questions dealing with social topics and doctors posed in the interview proved to be understandable and relevant to participants, and their responses were direct and marked by their personal experiences.[85]

Basic biographical data of the interviewees. To continue, we summarize some general social aspects regarding physicians interviewed. These include general details to help characterize the group of interviewees:

- **Generational group during military rule**. Forty of the doctors could be considered as adults at the onset of the military regime. At the time of the study each was more than 45 years old. Eight interviewees belonged to the "Young Physicians" group, with current ages ranging from 25 to 35 years. The "Young Physicians" category was later used to define this group's attitude toward the military

[84] With regard to this, Aaron Cicourel says: "To guard against overlooking differential perception and interpretation of questions by the respondent, the opening questions should be broad characterizations of the intended interest of the researcher. This allows for the respondent's definition of the situation to occur before committing him to specific meanings via fixed items of which he may not be aware. This ensures that the subject is not making choices or decisions about questions or subjects he does not fully understand, merely to satisfy the interviewer and 'successfully' end the interview" (Cicourel 1973: 102).

[85] A document containing the full texts of eighteen interviews will be published next.

regime and covers those who were still studying during the period of military government and only completed their training afterward.[86]

- **Nationality**. During the course of my research, we interviewed fourteen Argentine doctors, eighteen Chileans and sixteen Uruguayans, with approximately equal numbers from the capital and regional cities.
- **Attitude toward the military government**. Twelve individuals demonstrated their agreement with the military regime in their country and are referred to in the course of this evaluation as "Pro": during military rule, they occupied important posts in governmental offices not directly associated with human rights violations or in academic organizations. Eight belonged to the "Neutral" category: they typically remained removed from political activities, dedicating themselves exclusively to professional activities. Twenty of those interviewed had actively opposed the military regime. Some had been arrested or went into temporary exile. These individuals are designated as members of the "Opposition" group. Eight individuals comprised the aforementioned "Young Physicians" group.
- **Sex**. The sample included six women and forty-two men. Despite the fact that I made a concerted effort to include more women in the interviews, I was not able to obtain more female participants.
- **Place of childhood**. For this research what was important was not the officially registered place of birth, but rather where doctors spent their childhood. This information was used to verify if the interviewee had been raised in a small town (maximum population of 5,000), a larger city, or the capital. Six individuals (12.5%) had been raised in small towns, seventeen in a larger city, and twenty-five in the capital (87.5% in larger cities). Given the relatively small number of subjects, the high number of individuals raised in urban settings is noteworthy in itself, all the more so when one considers that the total urban population of thirty years ago does not at all correspond to these figures. At the time, less than 60% of the three countries' population lived in urban areas. The high proportion of individuals in the sample raised in urban areas (the capital or other large cities) confirms the thesis that the place of residence significantly influences possibilities for education; that is, that students who grow up and live in cities have a greater probability of undertaking university studies (Vasconi 1971).

[86] As a result, an existential attribute more than an ideological position is implied. It is important to this research to make such a statement, given that the attitudes of members of that generation, having graduated after the military era, cannot be interpreted using the usual categories of "before" and "after" the military government, but rather independently.

- **Location of university studies**. Thirty-nine doctors had undertaken their studies at a university in the capital, nine in universities outside the capital. This reflects, on a small scale, the traditional concentration of major universities in the capital cities of the three countries.
- **Family religion**. Respondents' replies indicated that one-third of my subjects (sixteen individuals) had a Catholic upbringing, three had Jewish backgrounds, one didn't say anything about the matter, and twenty-eight expressed the feeling that this was private and therefore not appropriate for comment.[87]
- **School**. Twenty-nine individuals had been educated in regular public schools, twelve attended private religious schools, five went to public religious schools, one was educated by his or her mother, and one by a governess.[88]
- **Mother's occupation**. The mothers of thirty-five of the interviewees were housewives. Those of eight others (one sixth of the sample) had independent occupations in business and five worked as domestic employees.
- **Father's occupation**. The fathers of thirty-one of the interviewees had independent occupations or were businessmen. Another fifteen had fathers who worked in daily life as employees or workers. Two people did not provide any information about their father.

Concerning the occupational situation of interviewees' parents, most of the fathers had economically independent jobs or professions and a small number of mothers had remunerated occupations. This also confirms the thesis that, in that period and in those countries, a career in medicine was available to everybody only in theory, since it is not possible to speak of equal participation by all social groups.[89]

- **Motives for studying medicine**. For thirteen of the interviewees, the decision to study medicine resulted from family-related factors. Eleven cited the wish to

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[87] In a country like Uruguay, this question could be interpreted as an invasion of privacy (Personal communication from M. Viñar).

[88] This form of education was apparently still fully recognized forty years ago as corresponding to primary school, upon successfully completing a general examination.

[89] Interestingly, the economic or social status of the parents of one third of the members of the "Pro" and "Opposition" groups proved not to be determining factors. During the political conflicts, these people did not take the corresponding stance ("of class"), but rather aligned themselves with the contrary position and maintained their views during the whole of the period.

help.[90] Eight considered the study of medicine to be an intellectual challenge. Of the remainder, eight provided personal reasons, five motives that were difficult to define, and three pointed to their attitudes as humanists.

d) Formal Characteristics of the Material

In addition to texts broadly documenting the practice of medicine during the military period in each of the three countries, we also accumulated recordings of the interviews conducted and field notes, all of which were subjected to an in-depth evaluation.

First I listened to all of the interviews, without exception, complementing the material they contained with information from the field study. This general overview from my field research gave rise to some initial reflections, for example, on the formal steps for the anonymous handling of the interviews, and also on the researcher's degree of personal involvement during fieldwork. I behaved with care and sympathy toward everyone and did not respond emotionally to interviewees' statements. In this first phase of dealing with the research materials, a contradiction inherent to this kind of research thus became evident: the difficulty of paying undivided attention to "inconceivable" life experiences and attitudes on the one hand, while simultaneously guaranteeing an omnipresent position of impartiality, combined with beginning to consciously deal with this contradiction, according to the researcher.

A second reading of the interviews allowed me to develop guidelines identifying basic types of responses to serve as models, while retaining some elements of individual opinion. Using the diverse positions and commentaries on each topic as my starting point, it was possible to: a) establish a logical systematization of possible alternative responses with very specific content, in the sense that each response is itself conclusive and different from the others;[91] b) initially process the

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[90] Having a "vocation to serve" corresponds, in the Spanish spoken in South America, to two expressions which, if not clarified, can lead to misunderstandings: wanting to "serve fellow man" and "be of use to others."

[91] In agreement with Cicourel, who, regarding the method of formation of a 'generative semantics' on daily life materials, wrote: "The analogy between judges and linguists is central to my argument because in each case the features or particulars which serve as empirical displays… are always idealized accounts, whose "legality" is decided by the judge or linguist by consulting a rule structure he has imposed on the ambiguity and looseness of everyday language" μ□,□□(Cicourel, 1964: 102).

topics being researched in order to do a qualitative evaluation and analyze the contents of all interviews (Mayring 1988).

Listening to the interviews along with reading the field notes allowed me to choose sixteen interviews for their representative character and according to criteria of conceptual soundness, content, and personal involvement.[92] Interviews were then transcribed, preserving their anonymity.

Interview transcripts were prepared using normal methods (exact transcriptions of complete sentences, three dots in parentheses to indicate ambiguities, etc.) and was completed by a Spanish-speaking professional transcriber with a doctorate in applied linguistics (Mayring 1988: 44). Final editing of the interviews was accomplished with some reference to the original recorded materials.[93]

For the German version of this work, an individual born in Bremen, who nonetheless spent a significant part of childhood and adolescence (including primary and secondary school) in Argentina translated interviews from South American Spanish to German. She has also developed a heightened sensibility to both cultural and idiomatic areas during her university studies in Germany, through research work in the area of social sciences dealing with South America.[94]

e) The Questionnaire

Following the initial evaluation of the interviews and based on a thematic ordering of responses, we developed a questionnaire that specified the possible alterna-

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[92] With regard to the criteria of authenticity, so difficult to define, readers can form their own opinions. Having completed a meticulous study of each and every one of the interviews, the researcher feels that this subset of interviews (one-third of the total) is representative and covers the spectrum of opinions. In fact the researcher is of the opinion that in an empirical study of ethics respect for each statement is essential as is the utmost fidelity to original texts.

[93] The fact that the transcribed interviews often contain long explanations —sometimes interspersed with loosely associated ideas but generally well articulated— is indicative, in our opinion, of satisfactory interview conditions: Interviews were free of external pressures (for example lack of time) and took place in a relaxed environment.

[94] She is the principal translator of the three volumes which have so far appeared in German from the Seminar on Transcultural Psychiatry, with its Symposium “Culture and Psychosocial Situation in Latin America” from the University of Hamburg, published in their Spanish version by Editorial Nueva Sociedad, Caracas (Riquelme 1993).

tive responses to each question (in general, five options), and which, taken together, constituted a synthesis of problem content as expressed by the interviewee. With regard to this, Gadamer 1960:358 states: “In the work of Aristotle, the term ‘problem’ designates questions that present themselves as open alternatives, because within them there exist many types of arguments in favor of both positions. It doesn’t seem possible for me to decide by means of unequivocal reasons, because they are questions that encompass a lot. As such, ‘problems’ aren’t really questions… but rather alternatives of opinion which we can only let be and that, as a consequence, can only be treated dialectically.”

In order to submit this qualitative instrument to a direct test involving participants, and also to maintain contact with interviewees, the questionnaire was sent to all of the individuals interviewed in each of the three countries. Despite the difficulties of transcontinental postal service, about one-third of the doctors participating responded to this new written inquiry.

Inasmuch as the questionnaire received a good response from participants, and replies coincided with the range of opinions expressed verbally during the field study, a certain compatibility can be assumed to exist between interviewees’ opinions and attitudes and the alternative responses extracted by the researcher in preparing the questionnaire. This allows me to conclude that both the interview and the questionnaire developed on the basis of field research were basically compatible and similar in their content. Mayring 1988 states the following about this quality criterion as it relates specifically to content analysis: “The basic idea here is to discursively elaborate a unification or conciliation of the results of an analysis between the researcher and what is being researched.” Such a process has its “sense of irrevocable necessity especially where the theoretical interpretations of the declarations, particularly all of the personal profile, have the function of preparing and structuring a common practice with the interviewees” (Mayring 1988: 96). For the purposes of this study, this meant encouraging an interest in the progress of the study among interviewees that went beyond the preliminary interview.

Based on the replies during this new round of contacts with the interviewees and the opinions contained in interviews, we created a database for my study that is described in more detail in part two of this section (quantitative evaluation of the questionnaires).

The primary data from field research is therefore composed of interviews as documented by transcripts and tape recordings, and material obtained from questionnaire responses, ready and suitable for the quantitative analysis carried out during the second stage of evaluation.

C.2 Qualitative Evaluation of Semi-Structured Narrative Interviews

The central hypothesis of this study holds that, in order to understand the military era and its implications for medical-ethical issues, it is tremendously important to conduct an in-depth study of the everyday professional life of the doctors of that era. It is also important to consider the impact of the times on their personal stories and individual processes of psychosocial maturation. We therefore completed semi-structured narrative interviews with doctors in the three countries under study in order to verify this hypothesis. My evaluation of interview material follows.

Overall, the collection of interviews can be said to satisfy Habermas' stipulated conditions for "normal" verbal communication,[95] which in turn made it possible to methodically organize and access lines of argument regarding the topics under discussion.

With regard to interview conditions, an initial reading revealed that in general the interviewee was someone who always uses the language well (Schatzmann & Strauss 1975). In this situation, he or she shows interest in a structured discussion

[95] These conditions can be summarized as follows: a) in an undisrupted communicative episode, there is a congruence among the three levels of communication: those opinions symbolized linguistically, those represented in actions and those materializing in gestures do not contradict each other, but rather complement one another metacommunicatively… b) The normal colloquial communication is directed by rules validated intersubjectively: it is public. The communicated significances are basically identical for all members of the linguistic community. Verbal opinions are constructed in accordance with the system of valid grammatical rules and are utilized depending on the specific context… c) In a normal conversation, the speakers are conscious of the difference of categories between subject and object. They establish a difference between external and internal discourse and separate the private world from the public world… d) In normal colloquial communication, intersubjectivity is formed and conserved as a guarantee of identity, of the relationship between individuals who mutually accept each other … What is specific of linguistic intersubjectivity is that individuals communicate on the basis of that. In the reflexive use of language we exhibit, in inevitably general categories, which are inalienably individual, in such a way that to a certain point we revoke Úmetacommunicatively (and we certify with reservations) the direct participation, to indirectly express the non identical with the Ego. This does not mix with the general determinations in every case but that, nonetheless, can only be represented by means of them. The analytical linguistic usage is immersed in the reflexive, since the intersubjectivity of colloquial comprehension cannot be maintained without the mutual self-representation of the speaker subjects..." (Habermas 1975: 91-92).

in the form of an interview with an unfamiliar colleague. If doubts of any sort arose, the interviewer directly requested clarification.[96]

Given the range of experiences and opinions expressed by doctors during the course of the interviews, two aspects key to the evaluation must be kept in mind. The first involves the careful handling of contributed opinions, given the necessity of preserving the anonymity of the interviewed subjects: additional information (taken from field study notes) had to be selected and presented from this perspective. The second involves the breadth of the evaluation; preference is given here to a discursive analysis and development of the argumentative tendencies (based on the comprehensive hypotheses). For example, an individual psychological study or semantic of materials or other forms of approximation to the texts will not be undertaken, since this goes beyond the limits of the present study.[97]

With regard to personal biographies' obvious interdependency on the respective socio-historical context, very much in evidence in the interviews, it is wise to recall the following methodological consideration outlined by R. J. Grele: "In an oral history interview, three types of relations are fundamentally effective, one internal and two external. The first of these relations guarantees the reciprocal involvement of the elements, words and signals present in the interview it involves the words themselves to create an all sociocultural involvement facing the horizon of significance between both the interviewees interviewed… The second group of relations is a product of the involvement between the interviewer and the interviewee… Those aspects of the interview that can be designated as performance are also included in this type... the participation of a listener and the personal encounter of two individuals… The third group of active relations in an interview is not only more abstract, but has also been the subject of less research and is consequently more difficult to define… In an interview, the interviewee doesn't simply speak for himself and for the interviewer but, through the interviewer, he speaks also to the cultural community at large and to its history, such as he perceives it" (Grele 1985: 205-206, italics mine).[98]

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[96] It was possible to overcome misunderstandings by exercising the outsider's prerogative to inquire directly about matters that were apparently culturally implicit.

[97] Gadamer writes of the limitless range of significance in the following terms: In the finite history of our existence resides our conscious awareness of the fact that, after us, others will always understand in a different way (Gadamer 1960: 355).

[98] On this point, three interviews varied substantially from the others. One Uruguayan interviewee, formerly a military doctor, who had previously read texts of interviews con-

2.1 Presentation and Analysis of Interview Statements

The qualitative evaluation and analysis of interview content are based on the following methodological premises:

(i) Initial questions involved a clarification of the concepts involved, while those that followed were formulated with few complementary clarifications.

(ii) For each particular question, textual responses are presented *in extensis*, representing the diverse stances of the interviewees.

(iii) Each question-response unit ends with an analysis —based on the different lines of argument and depth of the information provided — permitting an initial inductive systematization of positions and tendencies regarding the four fundamental questions.[99]

(iv) For the purpose of quotations, I have identified interview texts by country of origin and position (for example, Arg-035-Pro: Country: Argentina; Number: 035; Position: pro-military during the period of the dictatorship; or Chi-08-Young: Country: Chile; Number: 08; Position: Young during military rule) and, for reasons of consistency, they are presented in the order: "Pro," "Neutral," "Opposition," "Young Physicians". Finally, it is important to point out that sometimes a single declaration is insufficient to cover the range of opinions within a group, in which case two (or more) statements from members of the same group are presented.

With regard to the method used to select texts, through several readings the interviews to be evaluated were subjected to a qualitative analysis that examined personal participation, relevance to the topic, and coherency of content, with the objective being that they should function not only as "ideal response models," but should also consistently allude to the respondent.

From a stylistic perspective, some readers may find the anonymity of the multiple stances taken on each question irritating, since it creates the impression of a sort of darkened stage, where different actors take turns speaking, with no recognition possible other than of their voice (characteristics).

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taining views contrary to his own, avoided concrete questions; the other two interviewees, one from Chile and the other from Uruguay, offered valuable firsthand testimony, so I explored their opinions more deeply, through complementary questions dealing with several issues.

[99] To further clarify the spectrum of opinions, notes from the field study are added here.

This procedure was chosen in order to avoid identifying references while at the same time providing a broad selection of responses. Thus, my starting position is perhaps somewhat awkward and, for a more detailed study, we must postpone publication of the complete interviews to a later date.

In favor of this procedure, we should stress that the narrative method elicits a range of opinions in response to each question, opinions that are, moreover, replete with personal nuances. This qualitative evaluation also seeks to process relevant – from the point of view of content—opinions, and not remain mired in stereotypical responses.

With this in mind, we examined each group's responses to each specific question, choosing particular opinion(s) representing a more in-depth response, while not ignoring the role of the individual. Though most opinions from members of the four groups demonstrated a marked argumentative coherence, it is nonetheless essential to bear in mind that no interviewee replied solely as a member of a predetermined group. On the contrary, every interview included moments of argumentative fragility. Particularly complex situations of either an ethical or biographical nature gave subject's responses an unmistakably personal character.

This procedure made it possible to present, graphically and clearly, the structural differences within groups, while still preserving the personal characteristics of interviewees.

Part One (Overview):

- *Personal Profile. Should be reliable and center on the development of the interviewee (family, education, professional training), without posing specific questions, thus allowing the subject to elaborate his or her position freely and without haste.*

Chi-040-Pro: My family is of German origin. We come from the group of immigrants who arrived in Chile in 1850. They distributed themselves throughout the southern part of Chile and my family settled in XX, where I was involved in farm work. My first schooling was at home, my mother and a governess being formative influences. Later I moved to Santiago, where I attended two Catholic schools; one, XX, of English origin, and then a religious school YY. I completed my training in the humanities in military school, where I graduated, and from there I entered university to study medicine. Why did I study medicine? Perhaps the most direct reason was that I had, in my family, a sister who suffered from diabetes from a very young age, and who ultimately died very young from all the inherent complications of diabetes. And perhaps my feeling of helplessness stirred something inside me that, without having had any professionals or doctors in my family, led me to

medicine. My family is Roman Catholic and as such had a Chilean-British environment; I would say that I was raised with somewhat Saxon morals, not Lutheran. My father was a Protestant and he gave it up, becoming a Roman Catholic in order to marry. My family was small: I had two sisters, later I had one. The fact that I was the only man and the only male in my grandfather's family gave me a certain responsibility to go to school, to be a responsible person. The years in military school were formative from the point of view of discipline, responsibility, honorability, solidarity, camaraderie and knowing an institution from the inside, which absolutely cannot be attained if you are not immersed in that environment… I think I was very lucky because I chose an appropriate path, but I could have chosen a crooked one. Now then, I think that you, as a psychiatrist or someone involved in the area of psychiatry, know that there is something genetic, that is to say, that there is a predisposition toward something which, at a given time, propels you, if the conditions arise in one sense or another, that is, it is not only environmental conditions that generate problems, there is also an underlying genetic makeup.

Arg-010-Neutral: I was born in the federal capital, in Buenos Aires, in 1946. I come from a typical family of this country: two people willing to raise a family through sacrifice and hard work. There were no professionals in my family. My father was a blue-collar worker. My mother was also a blue-collar worker and after a period of sacrifice, when I was about seven or eight years old, she essentially dedicated herself to looking after my father's shop while he attended to the daily chores… Well, I chose medicine for an internal pleasure that is difficult to explain; it's as if the idea was, more or less, something more for me than for everybody else. It is not for society that I am who I am, but rather I did it for myself, for me, because I felt good, I thought that I would feel good doing this… My parents always encouraged certain values basic to mankind: the idea of the willingness to sacrifice, of reward and punishment, of what is right and wrong; in practice, not only verbally, but in practice. I really think that I've been a good disciple of theirs and I think that I attempt to do the same with my son; perhaps not as well because I lack the innocence with which they developed this education…

Urug-016-Opposition: I was born in Montevideo, right in the city center. I come from a very humble family of Spanish immigrants who came here to work, to survive. My father was a train conductor, my mother a nurse. This somehow generated a bond with the subject of health through my mother, and presumably an almost instinctive wish to do good and to do what is best for my fellow man. I can define my inclination toward medicine as clearly vocational, very much a matter of cause and effect —that is, trying to resolve problems for the betterment of my fellow man. I went to public school, public high school, public elementary school,

I went to medical school. I was a pretty average student until med school, where, perhaps due to maturity, perhaps due to improvement in my studying skills, or perhaps because I'd really found my calling: my progress was brilliant, excellent. I graduated with the highest marks and was appointed to a very important position through internal selection processes. Once I'd graduated, I specialized in the field of intensive care where I have worked since 1970. That is a summary until the present.

Arg-019-Young: Well, I belong to a middle-class household that at one time was very large: of Jewish origin, which gives you certain characteristics, generally a great affinity for business or intellectual endeavors. As a result, being a university student was part of education, taken for granted; just as you went to primary school and to secondary school, you had to be a university student. I was born in Buenos Aires, in the city center. I've lived here and completed all my education while living in the city center, always in public schools…

Additional comments: The personal profile of the participants focused, as expected, on the reasons for choosing medicine and the moral aspects of interviewees' upbringing. In terms of motives for studying medicine, responses varied from the wish to repair a stroke of misfortune to the family after the fact (a sister who died very young of diabetes), personal satisfaction (making the person feel good), an attitude of service to others, to continuing a family tradition (university training as a normal part of education). With regard to morals there are, above all, references to primary socialization within the family and the implicit value of parental guidance. One of the interviewees speaks directly of the importance of an institution governed by strict rules, the army, and, in a short digression, elaborates on topics such as environmental and genetic factors.

Part Two (General): Overall Aspects (Opinions on Violence in a Social and Historical Context).

The topic was raised in very general terms, insofar as, since the fifties, the media has covered the general issue of violence within the region (see Lira and Castillo, 1991, particularly Chapter 3). The question referred to Latin America in general in order to remove the interviewees from a local context and provide a broader perspective for their answers.

- *Question 1. It is said that in Latin America violence constitutes a part of daily life, considering the diversity of forms it assumes. Do you agree with this opinion?*

Question 2. Do you recall any violent incidents from your childhood or adolescence?

Chi-019-Pro: I know a fair bit about Latin America and, through my positions, I've had to visit and attend meetings with colleagues through the Pan-American Health Organization and the truth is that, without being too proud because I could be wrong, I think that Chile doesn't belong in this realm. Perhaps we have a strong German influence, particularly among the people from southern Chile, and we know, don't we, something about what happens in Argentina, where the Italian ancestry is so strong and Italians have quite a temperament… environmental conditions are probably important too. We Chileans are referred to as the British of the Americas. The truth is that I have a perception about that, which can be expressed in an anecdote about reactions toward conflictive situations. I think it goes like this: there is a bridge over which only a single person can cross. When two Englishmen must cross it, they greet each other and remain there in conversation until they resolve the problem. Two Italians scream at each other until one of them gives up. There is no exchange of words among the two Spaniards: they immediately come to blows... We undoubtedly have Spanish blood, but despite that I would say that, all in all, nothing would happen between us.

Chi-013-Neutral: Life in the provinces is very bucolic. What I've seen here, the terrorism and everything: nothing to do with that. I recall that in 1954, 1955, there was a demonstration because they had raised bus fares, against Ibañez. They knocked down a couple of posts over on Alameda. Those are the only memories I have of violence.

Arg-022-Opposition: Yes, I have two strong impressions of violence from childhood. The first was the day of the coup in which General Perón was overthrown, July 1955. Of all the violent incidents, I have an almost photographic recollection of the sequence of events that day, beginning with the terrible anguish of the people in the neighborhood, crying in the streets, hugging each other; my father who was working downtown; my mother taking us downtown to look for my father; the people coming out of the subway entrance with blood on their heads and bodies; those who were coming from the bombings at Plaza de Mayo. It was a situation of combined violence, where violence was expressed in physical aggression. In this case it was bombs and a sense of moral dispossession that I experienced the following morning in the small plaza around the corner from my house. It was a very small neighborhood plaza, triangular, with some playground apparatus, some benches, and there was also a sign on the apparatus, along with a bust of Eva Perón, that read "The only privileged ones are the children." The morning after the coup, amidst the confusion, people still speaking in hushed tones, I remember an incident where a tank was chained to the sign and the same chain being

used to tie it to the bust, and then the tank ripped them both off and paraded them through the whole neighborhood.

Urug-07-Young: I've played rugby since age 13. I don't know if you're familiar with it, it is a game that is particularly violent, but it's a sport, with a level of violence that is, let's say, social or street-level. Seen, yes, yes I've seen it, but in the street because of car problems, or around the period when I began university, because of internal problems, at the university at a time when there was still a dictatorship in this country, but I didn't come to experience it at any time where there was a fight, let's say a street brawl or a fight of some kind...

Additional comments: In three of the interviews, respondents deny the explicit or disguised presence of violence in everyday life, with one, in fact, referring to the almost bucolic nature of daily life in South America. Another refers to racial and national stereotypes associated with specific countries and their citizens; and the third relies on the mention of many minor incidents ("at a time when there was still a dictatorship in this country") that nonetheless were not of major significance for him as a spectator. A socio-historical event replete with signs of violence was only dealt with in one statement.

Participants were also asked at the outset about recollections of their own encounters with violent situations, to keep these accounts uncontaminated by responses to specific questions.

- *Please describe the reflections that have been evoked by the violent situations you observed.*

Arg-040-Pro: My feeling is that, every time violence or organizations have been used in an attempt to effect solutions —even with the idea of accelerating processes, because we haven't had any luck in that respect— we've gone more backward than forward. The largest expression of violence here in Argentina was the subversion that produced, at every level, much more harm and regression than the slow process of a society undergoing a great transformation. There is an issue for me here. I'm referring to the subversion that began in Argentina during the 1960s, that had two main branches, the leftist Peronist guerrillas and the leftist Trotskyist revolutionaries, who were the guerrillas (and the PRT-ERP). The subject of the Tupamaros in Uruguay and the subject of subversion in Chile, which you would know better than I…

Urug-046-Neutral: Me, no I haven't experienced violence, but there has been violence in the cities. Well, I can tell you that I've had a very peaceful life. Really, I've dedicated myself to my profession, to my family. I have several children; nowadays, double the number because they're all married. I can't say that I've experienced violence, I have no problem with telling you that during the period of

what we would call the revolution or the citizens' guerrillas – 1971, 1972 – almost everyone was a revolutionary and my students were very fond of me. I was very close to them and had a good relationship with all of them. I always had the students' vote, but that didn't stop them from kidnapping me one day. One day they kidnapped me: I arrived at the hospital and they already knew me, they needed transportation. I arrived at the hospital in my car, I'm about to get out and they threaten me with a weapon. No, pardon me, first they ask me to go see a patient with one of them, who was I don't know where and I said no, no, I've come for a class, I don't have time and they shut my door and threatened me with a weapon. They made me drive and later took me quite far from here. They made me get out of the car and walk with two others, with their friend and another one who pointed a gun at me from thirty meters back and we walked this way for hours, and they took my car to do one of those robberies that they did. And then they called me that night, saying that the organization would pay for everything, if there was any damage, and that my car was at a certain place, although it wasn't there, but it was close by. I didn't find the car in the dark, but I did afterward, and it was just fine. The police came —I had reported the event because they themselves had told me to report it— and they found a cargo of bullets and determined that someone had been transported in the car... I wasn't even scared at all because these were the same kids I would see sitting in the classroom. I didn't know them, they were from other departments, but were from the period and the dialogue with them was more or less the same as with them in class. I disagreed with them, because I respect the country's history and the position I had attained without significant economic support. I thought that we had to look after our country and, well, that sort of thing. So then, we understood each other very well… So much so that we ended up at a café. They invited me because I was tired of walking. They invited me to sit at the café, and we continued to chat there until we separated… In those days, there were many doctors who had that happen to them because of their cars. They would choose an ordinary car, my car was in no way special. That's how they explained it to me when I got out, when they made me get out. It may seem incredible, but I didn't feel upset. It seemed to me that it was just the time we were living in, that nothing was going to happen to me, even though at one point I made some sort of gesture and they threatened me thinking that I was armed. It was evident that there was some tension for them —sure, they were armed. They were Tupamaros.

Arg-04-Opposition: I think there was a steady shift toward violence. It is hard to say when it started but, for me, I think the first thing that really struck me as a violent event was when the *Proceso* was established, or perhaps a bit before, because things were set to begin in 1975, not before. In my youth I would go with groups of friends to nearby towns and sometimes we would walk back if the cars

broke down. I mean, you didn't have a feeling of imminent danger like you do now. Often when you go out at night you have that feeling of danger now. From the time the State institutionalizes violence you can see it because, in addition, an increase is almost produced and I experienced it while finishing my residence in XX and XX was an area of great violence. I had classmates and they would disappear suddenly and it was known that they had been murdered, because medicine was one of the specialties that found itself involved because of its humanistic tendency. So, that was perhaps the first contact with institutionalized violence.

Chi-049-Young: I would say, in fact, that it dates back more to my university days, because I vaguely remember chaotic situations around 1973.I was around eight or nine years old, and I have very little recollection of that time. But then I experienced my university years and the period of transition, which was quite an unusual era in which there were large demonstrations and the university would be closed. But really, the period I experienced was short and the subsequent period has been more or less calm, organized.

Additional comments: Apparently there's no way that violence in the three countries can be erased from the perceptual horizon. While the first person characterizes it as a social blight, identifying it with insurgency, the second speaks of having been kidnapped by the Tupamaros (the Uruguayan revolutionary movement), a situation rife with threats and yet essentially occurring in a friendly atmosphere. The last two people refer directly to organized violence; one recalls the progressive institutionalization of violence in all aspects of life and contrasts this with a worry-free youth, while the other reflects back on a time at university totally clouded by ongoing violence. As the generations changed, so did her life, becoming normal for her only in recent years.

As a way of ending this brief excursion into opinions about violence in a social and historical context, the following question was posed to the interviewees (the intent was to research the extent to which stereotyped assertions are accepted and used even today, without the context in which the statement is framed being important):

- *If you hear the phrase "Violence is the midwife of history," does it evoke a specific association for you?*

Chi-040-Pro: I think that the human species has, within its ancestral psychological composition, a primitivism, and I think that what civilization has done is stop that primitivism, forcing the human species to act in keeping with certain norms. Those are absolutely personal thoughts, that is, it's the feeling you get from reading about anthropology and knowing what happened in prehistoric times, when

man acted on instinct and survival entailed being more aggressive, whether to defend himself from others or to acquire food.

Urug-046-Neutral: Violence, the midwife… Yes, of course, if it refers to public works done for violent purposes, because they remain afterward. I think they're right if it refers to the fact that the biggest projects in this country were completed in military times, the biggest public works projects: highways or bridges or dams. Maybe it is that way… When the biggest dam that we have here within the country was built, it was built by a dictator, who was a nonviolent dictator, so much so that the period was labeled the soft dictatorship rather than the harsh dictatorship or "hardship" of Gabriel Terra. He was a bloody warrior. And once he came to power, he declared himself dictator and he built the dam. When he was, shall we say, distanced from power, there were people from the parties that had been ostracized who proposed blowing up the dam, for no reason other than that it had been built by the dictator, and that's not exactly doing a service to the country. That's spite, right? I'm a nationalist, can't you tell? Whatever comes and goes, the important thing is the country.

Chi-07-Opposition: Well, I am opposed to the oversimplification of the lives of human beings, such as thinking, as the Marxists say, that all of history is a class struggle. I think it's an extreme oversimplification, and I also think that stating that violence is the midwife of history, it appears to me to be an extreme simplification. It works, I'm in agreement with that. I know Herodotus said it, but it is an extreme oversimplification. The fact that it was said by Herodotus is like thinking that everything written by Miguel de Cervantes is stupendous, I mean, Miguel de Cervantes wrote Quixote, fantastic, marvelous, but he also wrote other things that weren't transcendent.

Urug-016-Opposition: Well, violence impregnates societies. I suppose that phrase refers more to a more categorical landmark than to everyday violence. All violent events undoubtedly leave a society transformed. Even when that violence develops at very limited levels, as would happen, let's say, when an effort was made to change some social reality, a residue always remains. I'm not passing judgment on whether it is better or worse, but a residue remains that indicates change. All of Latin America experienced it during a decade of a pro-violent view of social change, which after a very bitter stage that was very painful to all of Latin America left behind an undeniable change in political reality. It changed the opinion of those of us committed to change, we are now committed to another more civilized, more democratic, way. The suffering derived from the violence related to the action and reaction process has been worthwhile for us. It was a vitally beneficial experience as it left us with the understanding that it is very difficult to modify reality through violence, for example a guerrilla movement. A chaotic plan

like what is taking place now in Peru. You even find yourself surprised about what is happening, but if we begin to analyze, it happened in Argentina, it happened in Uruguay, it happened in Chile; with differences in chronology it happened in all of Latin America. You were saying to me that the situations weren't comparable, that they were all different; no doubt, but that there was a violent climate throughout all of Latin America, whatever the qualitative and quantitative differences, yes there was.

Chi-049-Young: Really, I think that violence is generated when situations arise that people haven't been able to resolve in other ways, and they simply explode, and so changes are produced —abrupt, immediate, a result of violence. But I don't think it's the right way, that it is violence that produces historical changes.

Additional comments: This hypothesis of violence as a social catalyst evoked very diverse reactions among the subjects. The first interviewee emphasized the potential for aggression, which in principle exists in the human species, and tried to back up his opinion with anthropological arguments. The second spoke at length about the public works projects built under repressive social conditions, and did not hide his appreciation of these gains. The third was visibly angry because of such an "extreme oversimplification," and the fourth made reference to the effects of violence on society as a whole (violence across societies) and deduced consequences for his personal understanding of history (it is very difficult to modify reality through violence). The final opinion acknowledged violence as a possible catalyst in conflicts that cannot be resolved in another way. Only the angered third interviewee and the representative of the Young Physician group refused to accept that violence acts as "the midwife of history"; the other three didn't object in the least.

Part Three (Special): The following set of questions seeks to establish interviewees' personal stance regarding the social situation during military rule.

- *You remember the period when the military assumed leadership of the country. How did you perceive the military intervention then?*

Chi-019-Pro: Okay, I'll start before that. If at some time I witnessed violence and it worried me enormously, it was precisely during the government of President Allende. I don't think he was a colleague of ours, or that it was a governmental policy, but rather that it resulted from the introduction of some very strong foreign influences, very revolutionary ones that generated tremendous fear in this region, so that laborers would come, good people because I knew them previously, and they would be poisoned. They occupied the streets downtown and their *slogans*

were *blood and guns*. There were phrases, attitudes of violence that were taking shape, and this produced enormous polarization within the people. And because of that, in 1971, the group that was called the Democrats had the first majority victory of the time, against what was then the Unidad Popular, which advocated a dictatorship of the proletariat, since that was the course of events. So these were very poorly educated authorities, there was a risk. Therefore, I have the very clear and objective feeling that the military takeover was not an event that originated from the military government in Chile: it was requested by the masses, it was said by 80% of the population. At the time I was already a doctor in the armed forces, and I know that the people threw wheat and corn at them, because they were unable to stop that, and in the military uprising there is something that is different from a coup, which involves a thirst for power. Those who don't recognize this, it's like they don't have a clear perception of what was happening.

Arg-040-Pro: I would say that the only important issue to be discerned from this has been the issue of the struggle against subversion now being called state terrorism. In my mind, if Argentina had not declared this war, there would have been a state of dissolution. I'm not making a value judgment, nor do I intend to make a value judgment of the illicit acts committed by the military government, nor provide an alternative of how to eradicate this problem within society. I would have probably liked a different strategy, I don't know what. Well, I have the recollection that just over 95% of society supported the calm that was recovered in social life. That is, attacks declined substantially, deaths declined substantially, kidnappings… I have the feeling that Argentine society knew in advance about the military takeover of the government before it was initiated. I don't know if it was one year or a year and a half before this; it began, I would say, with the unexpressed declaration of war against the guerrillas by Perón when he threw them out of the Plaza de Mayo, and then the dirty war began…

Arg-010-Neutral: Let's say that the preceding period was almost —my experience could not have been different from that of average Argentines—that it was almost like an opposition to hope. We're talking about 1976, that a new revolution could change everything. Sure I was younger and I also interpreted this; when the revolution came, I think it was an extremely high percentage of the population, myself included, who thought that we would find some sort of path because, moreover, other military governments were present in the region, and as is almost common in Latin America, we pass from periods of democracy to periods of de facto governments, but almost all were present during that period and all at the same time.

Urug-046-Neutral: Yes, I recall, I recall that there was skepticism, a deterioration of everything, true. We all reached a low point, we all protested against eve-

ryone, and the only ones who remained strong were the two groups that prevailed. The military on the one hand said: this has to be done and they did well initially, and afterward, when they had established themselves in power, they lost their way and what they should have done was leave and allow the return of civilian rule. The military intervention was necessary, I think it was necessary, I don't know… the things that happen afterward, when force is unleashed, I can't be responsible for that. I did believe in one thing: I saw an orderly country and I said, that is the way the country should be, but that didn't last for long. I've seen many things with a good birth and a bad death…

Urug-016-Opposition: It was a suffocating environment. I don't know specifically what it is you're referring to. How did I perceive it? As if society had been polarized, society had no options, it had to be on one side or the other. That is the general perception. All of us felt we were taking part in some way, very much committed to reality. That is, either you were for social change or else you were against social change. There weren't many other options. I think society was greatly torn apart. In fact it was evident later in the way repressive practices were exercised; it was very hard, very bloody, very terrible. There was a strong undercurrent of anxiety mixed with this, as if it was evident that violence would be with us for many years, because it was either the bombing of a colleague's home from the right, or it was the bomb from the left at the home of a minister, a military man, or a machine-gun attack attempt. There was a lot of coexistence with violence; it was really terrible and, in addition, you could see the military presence coming in crescendo, sort of surrounding and encroaching on the parliament buildings. I mean, you could see the coup coming and the coup was a landmark. We were opposed to the coup even though some left organizations had attitudes a little bit against the principles, because they had to commit to defending democracy. Nevertheless, in some way they suggested that they supported the military regime, because the military arrived with a very progressive discourse. By the left I am referring to the *Frente Amplio*, which later on was subject to self-criticism, of a quite critical review of the position taken by the *Frente Amplio.*

Chi-016-Opposition: The military coup… affected me, in 1973, in a very direct way and from then on there was tremendous change, well, to begin with… I was arrested. I was a university instructor, eight hours a day, working exclusively at the University. At Hospital XX, a very big crisis was experienced because of the physicians' strike in 1973 [in opposition to Allende's government, prior to the coup], which produced a frightening, tremendous polarization. The result of this was that, [following the coup], there were many detainees. What I can tabulate precisely is that eight of us were arrested —doctors, auxiliaries and students— five of whom turned up dead, among them the chief of personnel, who was a

priest. Two of them disappeared, one a medical student and the other an orderly, and I am the survivor… That's a summary, there must have been more, but that is a summary of Hospital XZ; things were very violent there, there was a lot of hate… It wasn't just a political thing, rather it had something to do with the fact that some doctors didn't cope well with the idea of other doctors not going on strike… I think there was something there in the medical thing, something that should be researched more thoroughly, because the medical guild became divided and they persecuted us tremendously… Our true persecutors were the doctors, more so than the military; that is, the military were only the executors. It was an actual persecution, in the sense of arrest followed by being fired. For example, the hospital director undoubtedly allowed them to enter the hospital, and he permitted the handing over of names… One of the arguments I raised with the officer who arrested me—the personal dynamics are quite special— was that I felt no resentment toward him, since my name must have been given to him by a civilian and those in power were civilians, something which made him very uneasy, and, I think it was one of the factors – all things considered – in their not executing me… I was at a detention site for a day. It was a vacant lot, in a place where, in theory, they had taken me to be executed. I was saved because the officer took a liking to me, in summary – because it is such a long story – but nobody else returned from there, only me, which is not very pleasant, well it's pleasant and it's not pleasant; it undoubtedly leaves an impression. They went to get me personally at the laboratory where I worked, at three in the afternoon. At the lot I met other people, including the two detainees who disappeared. I think that one of them has recently appeared and been identified, just recently this week, a student. I belonged to YZ, it was a leftist party. Those of us in it supported Allende, and my political activity, my fundamental activity at the Hospital, was work really of an educational and assisting type, very intense. I would say that the political stuff within the Hospital involved an intense struggle against the medical strike, and leading a group of doctors, paramedic professionals, orderlies and students, who were very few. We worked together to make the hospital function, something we achieved in the auxiliary aspects and the teaching aspect, and that generated a hate that was frightening… That was my fundamental motive. There was no other type of activity at the Hospital; everything that was said about the clandestine hospital, about "plan Z," everything was absolutely false.

Urug-07-Young: I was 11 years old. I remember my mother waking me up and telling me there was a coup. I didn't understand what it was. I didn't go to school for a month, then I didn't have classes for two months, or contact with [any consequences] of the coup.

Additional comments: The first question concerning events during military rule offered the opportunity to speak of experiences that apparently rouse interest in people to this day. The first response places social violence and the resulting conflicts in the era preceding that of the military and concludes that this is the definitive explanation of the "military uprising". Because they faced terribly poor governments during that time (prior to the coup), the military had no other choice. In the second response, a similar line of reasoning is evident, although no reference is made to social processes; rather, disparate social elements are mentioned (insurrection, state terrorism, dirty war), without noting the historical relationships between them, and reference is made to a specific end: achieving "social peace." The third respondent shields himself behind the average Argentine, who, in his opinion, nurtured the hope that "a new revolution could change everything," and points to a certain naturalness in alternating military interventions and democratic eras. For the fourth participant, military intervention represented the triumph of the strongest, establishing the government of the time, and one had to adapt to it since "the military intervention was necessary." The fifth interview refers to the polarization of society, the presence of violence everywhere, and the general confusion these circumstances provoked; the military repression that arose from these factors is described as extremely strong. The sixth interviewee describes her personal involvement in the days following the coup, basing her perceptions on having been the only survivor from a group of eight people who were handed over to the military by their own colleagues as dangerous elements, because of their effort (during the democratic government) to continue to provide medical attention during the physicians' strike; the military killed everyone but her. Even today, twenty years after the fact, she has to deal with the consequences of those days. She understands her survival as being the result of mere chance ("I was saved because the officer took a liking to me"). The seventh declaration belongs to a person of the next generation, who at that time didn't understand what was happening and whose parents protected him and kept him away from any direct effect of the dictatorship.

- *What impressions did you have of the first years of military rule?*

Chi-019-Pro: Well, first there was an atmosphere of civil war, not so much here provincially, but in Santiago. My brother-in-law was a colonel in the armed forces, at that time he was a captain. Really, there were some worrisome times; there was knowledge of a significant contingent of Cuban militia, for example, with snipers. There was a state of war. I think, unfortunately, that as a result of that atmosphere, situations occurred that we have since come to know about, which are very unfortunate from the human rights point of view, and I repeat that I don't intend to justi-

fy them. It's because you see how the Americans act in Vietnam, the Cubans and right now in Yugoslavia, and incredible things when living in that environment of war. It's such that in that first era, I repeat, without justification, I can explain many excesses to myself.

Chi-013-Neutral: I'd say I knew that there were deaths from the outset because there were shootings from both sides; I heard it, I had to come downtown and I saw it: you had to live with snipers firing, something of a civil war in the first months. There was one, for two months. But there was a declaration of the principles of the military junta, beautiful. An English friend who was here at the time said that the declaration had been discussed in the British parliament. Well, it was drafted by Jaime Guzmán.

Chi-016-Opposition: Well, the deaths were immediate [following the coup]. The first period was essentially one of death; that is, the people didn't return or they would be found and then disappear, and the period of torture began a little while later.

Chi-07-Opposition: I began work, I had been chosen through an internal selection process, and precisely at the time of the military coup I was working as an intern on call at the Military Hospital. I also experienced a very special situation [at the hospital]. Soldiers would arrive there telling of their experiences. They would arrive wounded, I mean, the whole environment was one of war. I was only familiar with that through the movies, through storybooks, but I had never imagined an experience of that magnitude and, on the other hand, what shocked me —because I oppose violence in any form, I don't even know how to fire a water pistol— I am absolutely opposed to violence, I don't support violence of any type. Thus, I somehow found myself being a student and working in an institution that was directly involved with the military coup and, on the other hand, not accepting violence since the moment I was conceived. Similarly, on several occasions when I passed the CC [River], I saw corpses floating, and obviously those corpses somehow died from gunshots from somewhere. Well, we more or less know where they came from.

Urug-07-Young: My family was indeed worried. I lived around the corner from the home of the Vice-President of the Republic. For example, a contact with violence: we had to be careful because we were close friends with the policeman who kept watch and we would lend him magazines, and I remember a moment when – it wasn't a direct attack, let's say there was an incident – he was beaten up by a group of guys that arrived, it was probably a movement that was organized at that moment, and they were passing out pamphlets. That was one of my first contacts with a reality that I wasn't familiar with except through hearsay. That's why I say that, since I was small, I was interested in informing myself —I was always in-

formed—, but that was one of the first incidents of direct contact because of the policeman that was my friend and who had been beaten.

Additional comments: Regarding the first stage of military rule, all of the interviewees provide evidence of the perception of major events. The first describes situations like those of a civil war ("there was knowledge of a significant contingent of Cuban militia"). However, this is based not on personal experience but on hearsay, and, using this as support, he attempts to justify "situations… which are very unfortunate from the human rights point of view"; to complement this idea he refers to other war scenes (Vietnam, Cuba, Yugoslavia) to suggest that "many excesses" are understandable. The second remained cautious during that period and would only verify the frequent shoot-outs, but, in principle, he was in agreement with the declaration of intent of the Military Junta "beautiful... it was drafted by Jaime Guzmán". The third person experienced killings directly in his or her immediate surroundings. The fourth participant found himself, as a doctor at the military hospital, facing a situation that was for him inconceivable in its violence, and the fifth experienced that era from a broader perspective involving his family, and through the repercussions of the omnipresent violence in his neighborhood.

- *Were the accounts of torture, deaths and "disappearances" that circulated valid? When did you become aware that this was going on?*

Urug-025-Pro: Torture? Allegedly, yes; but nothing proven. I'm of the conviction that, in war, people resort to absolutely vile methods. I wouldn't be able to do it but I don't know if in a war, in combat, I wouldn't have done it, me or any other person. I mean I wouldn't be able to do it, but I don't think because of this that there was no torture; only that we don't have evidence other than what the patients themselves relate to us. Likewise, it cannot be proven before a judge, beyond the report or experience.

Chi-019-Pro: A state of war was perceived then and, disappearances, yes, much was said from the outset about disappearances. But there is a problem there that is difficult to explain, because it has come out that during that whole period there were extremely revolutionary leftist groups wherein all the members had their identity papers altered, so that sometimes so-and-so would die in some confrontation; it was him yet it wasn't him, and so a situation that is very difficult to evaluate was produced. The same thing happened with people who left and fled the country: they disappeared for the obvious reason that they didn't tell anybody they were leaving. And so, in interpreting events, it was said that they disappeared, becoming fugitives. Thus it was hard to tell what the reality of the situation had been afterward. I would say that it became evident later that there had been, but at the

beginning all of them were [victims of the confusion], if the truth be told… At the beginning of 1974, I was listening to the news on Radio Moscow and they identified me, they dedicated a program to me, saying I had signed the death certificates of those who had been executed and that I supervised torture at the fort the marines have there… and the truth is that I never signed any death certificates and, if anything, I was concerned with the well-being of those detained there. Many times I did things for colleagues of mine, out of concerned for their health, etc., I even helped some to get out of certain places. There are colleagues who are now living here peacefully and who were very involved at that time. They were detained at XX, and then after I don't know how many years, they got out. Besides, I didn't know about that place YY. And so it was absolute slander. That was it. They accuse me of that to this day, and it is slander. If they're slandering me, I thought, well, they can probably slander others and then I had another painful experience. I was already the regional head of health. These accusations of torture by the military government also irritated me, since all detainees had to be examined by a doctor when they were arrested and afterward when they were taken to jail.

Arg-010-Neutral: The truth remains unknown and the objectives less so… No, about there being torture, no. Yes, about detainees who were questioned in attempts to research their connections. But my personal experience in that respect shows that all of the people who were detained were in some way connected to other people who could have held questionable views. It is clear, I don't blame one or the other: the military had the power and they decided who was and who wasn't. There was a kind of forced order, to explain it in some way: someone establishes an order and force, puts mechanisms in place for the order to be carried out. Not the order that has been established as a code for everybody…

Chi-013-Neutral: Sometime in 1974, at the beginning, I'd say when the DINA (Dirección de Inteligencia Nacional) was formed, we began to receive reports that were a bit strange, incongruent. What would happen was someone would be taken away under cover, in the midst of gunshots, false confrontations, and then we would hear, someone learned they had been tortured. It was only then that we begin to suspect that things were being taken to an unacceptable extreme. For me, the decisive event in turning me into an opponent, at least I wrote against the regime, was the case of Dr. Cassidy, a very difficult story. It was in 1975 and it led England to withdraw its ambassador. The English are very practical, very much the merchant, not like the Germans. If the English withdrew their ambassador it was because things were not right. From that point on, I had to treat patients; I had personal experiences.

Arg-022-Opposition: Three and a half months, almost four, I experienced it in the flesh. Yes, all of that has already been documented. I was with the San Justo

squad, the police of Buenos Aires province. They said the same things about the place that one could read on the outside: that you have disappeared, this is just a hole in the ground —that type of statement. Well, everything was such that it was understood to be a situation with no escape. Question: Were there specific forms of psychological duress? Answer: Yes, the psychological duress was very difficult during those three and a half, almost four, months. Because, among other things, they often made use of the fact that I was uncertain of whether my daughters had been taken prisoner and they, of course, worked constantly to demonstrate to me that my daughters had in fact been kidnapped. Well, that type of psychological strain isn't easy to bear for so long a period of time and, logically, until I was able to reunite with my family for the first time, I lived with the uncertainty that my daughters may have been kidnapped. I think there must be few levels of psychological stress and torture stronger than this.

Chi-07-Opposition: The work I was involved with as head of specialization at Hospital XY exposed me to an incident of enormous violence – I don't know if you heard about it. This was the case of Sebastián Acevedo. I treated Sebastián Acevedo at Hospital XY. I was in charge of the shift, it was sometime around 1983: I believe I was the first to see Sebastián Acevedo and he told me —he was completely burned when he arrived but he was very lucid— and he told me on that occasion. He said: "Examine me, first". His initial reaction was a sort of rejection because he thought I was just like the people he was protesting against. And so I said: "Look, I'm a doctor, what interests me is your health, I want you to confide in me." So he told me, he said: "I did this because my two children, my daughter and my son, are prisoners of the CNI (*Central Nacional de Inteligencia*)." And he described the place to me, in front of PP, and told me: "They are jailed there and what I want is to protest, because nobody wants to listen to me and I performed this act to make them free my children." He never thought of killing himself, nor did I tell him that he would die, because the truth is that he had suffered burns to over 90 percent of his body and that was incompatible with living. He provided me with a tremendous testimonial, saying that what he did, he did for his children and, well, that reflected a world unfamiliar to most of the population; for example, that there were political prisoners at secret locations, in places nobody knew about, in places where prisoners were ordinarily kept. This was evidence of a situation of violence that was unknown to the vast majority of Chileans. I even took some pictures of Sebastián Acevedo and immediately sent a letter, which I still have, to the then president of the College of Physicians, Doctor XX.

Arg-019-Young: I would cite an example from 1977, almost a year after the coup, 10 months, and the disappearance of a group of very young people, very close to me; friends, among them a cousin. We were first cousins. We were per-

fectly aware of what it was all about, that they were unlawfully imprisoned. We still hadn't conceptualized that there were concentration camps, but we knew they were in some encampment somewhere, we knew they had been tortured and that this would never be acknowledged. We also supposed, and felt quite strongly, that these people would be killed, that these people would not return, and this was extremely difficult; for example, passing on this information to the families of these kids. I'm speaking of a group of people from 17 to 20 years old. On the other hand, if we approached them to provide some of this information, we would come to be suspected of subversion, because people – the parents who shared the principles of the disappeared were the exceptions. Thus, there was a barrier there, in this case between the ideological and the generational… Or with regard to another group. When the people of one group began to disappear – I knew them all – so I worried about warning those that were still there, and I remember a 16-year-old girl [whom I called]. I warned her again the next day. The girl stayed at home anyway. I called her on the third day. By now her parents didn't trust me so I communicated to them that such and such a thing was happening and that she had to leave the house right away, that it was just a matter of time, and the girl told me she was at home, sick in bed with the 'flu, I don't remember what else, and that she couldn't leave because what would she tell her mother? After that, I didn't call again and that girl remains among the disappeared to this day. If you think about it, the extent of that girl's involvement in political activity might have been to attend a meeting to speak, or more likely just to listen, or having received a newspaper…

Additional comments: Faced with the question of the extent of their personal awareness of human rights violations during the military regime, none of the interviewees denied they occurred, in principle. Nonetheless, responses are marked by multiple interpretations of events. For example, the first respondent views torture as a possibility, but considers that evidence of its existence is based only on the testimony of those affected, and as such, should be excluded from "objective" evaluation. The second declaration tangentially acknowledges that people disappeared and introduces the argument that due to people using presumably false identification disappearance could be understood: "A state of war was perceived." The third interviewee doesn't take a stance, since the definitive truth remains in the shadows. He nevertheless has evidence of the use of "lightning-swift punishment" during that time: that is, only to uncover the truth about the connections among suspicious detainees; he doesn't make any accusations because the fundamental thing is to know with certainty who holds power. The fourth participant lost his equanimity at a specific moment in 1974 or 1975 ("if the English remove their ambassador...") and shortly thereafter as a doctor came into contact with vic-

tims of persecution. While he was “disappeared”, the fifth subject was forced to live though many stages of desperation and a resurgence in hope. His comments, often very moderate, vividly evokes those experiences and he testifies to the atrocities affecting him directly. In the course of working as a medical professional, the sixth interviewee came into contact with one of the parents scarred by the dictatorship, after a father committed an act of desperation (he set himself on fire), and this way the physician hear about events that had led to this decision. To the representative of the young group, the question of the possibility of human rights violations under the military regime gave way to a series of vividly detailed descriptions of specific acts that occurred within his immediate peer group; the subject also deals with the general silence surrounding those events in society (what should not be, must not be) and demonstrates, via a series of examples, the consequences of denying the realities of that era for people who were directly affected.

- *What was your attitude to daily life?*

Urug-037-Pro: Daily life? The same as before. I continued working at hospital YY as an RR doctor. I was chief of the XX department and then came the intervention. I was working much of the time, but it didn’t seem that way. One or two nights a week, that’s when I would try to entertain colleagues. It was difficult and I’ll confess something to you: never did I utter as many cross words as I did in that era. When a doctor would come by, he was always looking for a personal favor and trying to gain some advantage. It was very difficult for me to grant personal favors, and so we could only chat about lost cows… about soccer…

Chi-040-Pro: It was obviously an unusual time, but the objective was normality —that is, building toward normalcy. That was the feeling I had. Well, at a specific point in time the change in government arose [1973] and all of us offered our help from the technical perspective; working groups were formed and we began to work, each in our own area. Then, at some point, the group we formed took responsibility for the Ministry —as I said, something of great interest as an experience, demanding complete dedication. I left the university, I sacrificed my private life and there were some very difficult economic times, but there was a purpose, the nation; that is to say, we were working for Chile without asking ourselves who, or how much, or how. There had to be assistance for the people who didn’t have as much. The mechanisms that would allow the country to grow had to be found so that people with more limited resources would have the basic means… The military government, by applying drastic measures in certain aspects, perhaps forced the country to function with a certain order which, I think, if one were able to maintain that order operating smoothly within a normal regime, it would be ideal. But things don’t happen that way because of human nature, because all forms of

regulation are relaxed. I think the military government can perhaps be summarized by the fact that there was a common denominator to their thinking: technical teams studied a problem, decided on a solution and applied it; no one within the team disagreed or ceased to agree once the decision had been made. It was decided based on the technical aspects and that was the direction things went in; the country was our only interest. There weren't groups pressuring to profit from the country, be it personal, local or for a group. Everything went, well, according to plan. The person who didn't function within that order had to leave…

Chi-013-Neutral: I would say that there were cycles: 1973, 1974, there was an irregular, abnormal situation of being in an occupied country. I think that for most Chileans, it was as if we weren't really affected. The doctor's office functioned normally; the hospital functioned normally. Then came 1975, 1976, with persecutions, threats, disappearances, and then a very serious thing afterward: the boom of 1979 arrived, with the oil money. I missed out on it, but I was around at the beginning and at the end, and the attacks on human rights almost disappeared. From 1983 onward, no, because there were all those uprisings, social repression and general repression returned… insecurity again. At that point I began to participate more actively in this thing through the press: they published me as an independent then. My family was committed to Pinochet's ideas… I wrote against.

Arg-010-Neutral: During the period of military rule I was a college student and I didn't experience any inconvenience. I studied comfortably at the university, and I would say more comfortably than when the democratic government was in power: classes weren't interrupted, there weren't constant political disturbances and, well, there was a certain order that was more conducive to development.

Arg-04-Opposition: Yes, the violence was felt; the fact of having to permanently have your documentation with you and knowing that someone or other had experienced some problem because of his/her record, or for having long hair, or for having a beard. It involved a certain level of oppression that you could compare later to other democracies and you realized that lack of freedom.

Chi-049-Young: Well, actually, at the time that I began there was a fairly significant amount of repression at the University. The people who had different opinions were reprimanded but, little by little, this began to change, and I would say a favorable result of this was that, little by little, people began to dialogue, even having very different opinions, and, fortunately, toward the end of my seven years of study at the University a compatibility between the different opinions was achieved and the university was opened to people who held differing opinions. I refer to the University of Chile, which was one of the most combative.

Urug-07-Young: As an example, in the neighborhood where I lived there was a bowling alley where there was an explosion, and two or three women employed at

the alley died, and two of the guys who planted the bomb died. Bowling is a sport. It was an alley in a neighborhood considered to be very elite, and it was the target of a bomb attack that destroyed it completely, along with the two youths who had gone to plant the bomb and the bomb went off prematurely. It was very much a homemade type of device. The two died, and the two employees, two cleaning women, who were inside. This must have been in 1971. I was nine years old, but I remember that I felt the impact because it was three blocks from my house. Windows were shattered all around the block. I went to look, to see what had happened, but as something totally not involving me.

Additional comments: Daily life varied during military rule, depending on which side the interviewee was on. The first interviewee portrays continuity in his work (including his own appointment as part of the military intervention of the Medical Association), which would have required a strong organizational commitment from him; it appears that the most problematic aspects of this activity involved dealing with other doctors, who would constantly turn to him for help. The second subject provided a general report on those difficult times, in which, though lacking evidence, he perceived events to be leading toward normalcy; in his opinion the main efforts during this period focused above all on formulating, executing and evaluating programs, with people being secondary to the grand venture. Everyone had to act together to ensure the programs advanced. The third interviewee explains how conditions shifted over the years in a cyclical fashion, with the situation starting out at first as normal, then becoming less normal, and later downright difficult. By then, his patience was exhausted and he became an active opponent. The fourth reveals a clear willingness to subordinate himself to authoritarian structures of order: one could learn more readily this way (no more distractions), and development in general was easier. For the fifth interviewee, a climate of insecurity was evident everywhere. Moreover, the multiple factors deemed to be suspicious that marked people like him represented an enormous restriction on freedom. The fifth statement begins with a description of how divergent opinions and attitudes were repressed, and how this later relaxed until eventually there was widespread acceptance of other ideas. The sixth frequently witnessed, with little interest, acts of violence in his midst. He perceived these acts as only involving others.

- *How did you view the relationship between society and the media during military rule?*

Arg-040-Pro: I don't think the military ever managed information efficiently. This doesn't mean they didn't send out messages, but for me there seems to have been an incoherence to those messages.

Chi-019-Pro: Without major conflicts.

Chi-013-Neutral: A complementary question: did you believe in the value of the written word? I think so. You know, I wrote a lot in the press, a lot about human rights, on some aspects of hierarchical obedience (*obediencia debida*) within the line of command, opposing the death penalty, exile… they are all topics I dealt with in articles. I published in *El Mercurio*; I had a friend there and they would publish them for me. I came to have something of a fan club of people who read my work. I think I was quite helpful because there were people who thought that although the military intervention had been justified for historical reasons – they would say – we can't accept this thing or this other thing and they didn't have anyone to guide them. The choice was only: either I was for Pinochet, or I was a communist. I think I provided the viewpoint of an independent observer, based on principles and not on interests, which may somehow have served a purpose.

Chi-016-Opposition: It was all a farce because what one read, what one heard, was one thing, and the reality one lived on a daily basis was something altogether different. I mean, lies had been institutionalized. I think that has had consequences even among us, the people on the left. The country got used to lies, to a series of things: tremendous individualism, everyone for themselves, and I think we have all bought into that to some extent. Changes were produced, changes that in some ways are irreversible.

Chi-07-Opposition: There were channels via the Church, like *Mensaje* magazine. I still remember the time I read an article in the Catholic Church's *Mensaje* magazine —I don't remember whether it was in 1982 or 1983, thereabouts— and it included an extraordinary interview with an ex-CNI member, who said "I tortured," I remember, his surname was Valenzuela. He recounted all the crimes and raids —because at the time there were a lot of raids— about which they would say that a series of individuals had died in confrontations, and what would happen was that the confrontations had been staged. They were crimes of a more or less organized sort and that was documented in a magazine with a moral solidity like that of the Catholic Church. Because the Catholic Church was not about to embark on some adventure: what it had to say was very powerful and, since it wasn't refuted, people would obviously read it, and the magazine circulated and any materials that in some way hinted at opposition were read voraciously by people. I think the

magazines with the largest circulation were the opposition magazines. The government magazines were read by practically no one, or by very few people.

Arg-019-Young: Well, it was very clear to us that what was published was absolutely false, lies. Also, because we belonged to certain circles, which had contact with leftist political groups and social organizations, we had access to information. We knew considerably more about things than people in general. It was difficult to tell people what was going on. The feeling was, well, that there was a total manipulation of the media, absolutely. I remember when they gave the Nobel Prize to Pérez Esquivel —it must have been around 1980 or 1981— a small gathering formed at the Plaza de Mayo. The information in the newspapers took up three centimeters. On the news, on television, they mentioned it in five short lines. At the march which took place with Pérez Esquivel, where we applauded him, I don't know if there were even 500 of us and, of course, people didn't know who Pérez Esquivel was. Obviously, the feeling was one of living in a place where information was completely under surveillance and it was quite difficult to inform people of something different because, in addition, if you did inform them of something, you were viewed as a subversive. This was the drama.

Additional comments: The question of the interaction between society and the media during military rule led to contradictory opinions. The first statement indicates that the military were inefficient in controlling and manipulating information. There were no problems in this area for the second interviewee. The third interviewee adopted a position of rejection at that time, consistent with the human rights violations committed by the military. The fourth person reflects on life in an environment replete with falsehoods, which have left an indelible mark on society at large. The fifth emphasizes the importance of alternative channels of information, which apparently were broadly distributed and widely accepted. The representative of the Young group provides an example of what being opposed to the general information blackout of the period involved, and what it was like to function when public opinion was essentially kept ignorant.

- *What differences are evident between the previous military government and the present civilian government?*

Chi-019-Pro:...President Aylwin said it just the other day, which makes me very happy: that the state of prosperity and progress Chile is experiencing was sown by the military government and is being harvested by the democratic government.

Urug-025-Pro: At a personal level, I'm presently in a very ostracizing mood. I don't want to do anything, I'm not interested in any type of publicity, I don't want

to know about anything other than my specific professional activity, nothing. Nothing interests me. At an economic level, with ups and downs, my income is somewhat lower than it was ten years ago, but then I've also retired from two jobs. I've retired from professional association activities, holding on to certain activities, and I've begun some new ones. I mean, I'm not doing badly economically, but I think I'm suffering the same way the country in general is suffering. I think I made more money before.

Chi-013-Neutral: The most important thing is being in a land of democracy, where laws are respected… with many unfinished things, but feeling that you have someone to appeal to, that the legal system works, that it is clear, that there is a parliament, that you aren't going to be threatened. They used to threaten me on the phone and there was a rough period, 1985, —on account of my articles they began to threaten me, and that feeling is indescribable.

Urug-046-Neutral: When democratic government resumed, old customs returned: of the committee; of the political recommendations; the fact that if you have good people to recommend you, you can get more. Those things. Well, to live with my family in peace, I see them all happy now. I'm not one to question, I don't matter, but I'm content with my family life and with the tranquility and peace we have. I'm satisfied, sure.

Chi-016-Opposition: It's hard to adapt. There are different values, there is a total crisis of values, very shocking… When democracy came, I returned to working as a public employee, something I always wished for…

Chi-049-Young: I would say that presently there is freedom of expression, that people can freely express their thoughts without fear. That's something I feel is priceless, and you also get the feeling people are more at peace, they enjoy their work more. You get the feeling that the country, in some way, has room for all viewpoints, and before it was like there were a lot of people who were on the outside.

Additional comments: In comparing life under military rule and under a parliamentary democracy, opinions are again divided. The first considers continuity to be guaranteed (which the current president had confirmed, *expresis verbis*) and this fills him with satisfaction. The second openly expresses disinterest in current politics, appearing to be concerned only with financial matters, and here he doesn't see much of a difference between himself and the rest of the country in general: in any case it was better before. For the third respondent, the important fact is that now one can demand respect for civil liberties: life is easier if one is not continually threatened. The fourth interviewee appears to be basically disillusioned, because people continue to be the same as before the dictatorship (they

appear to be little affected by the massive disciplinary attack); for him, for others, history continues onward ("I'm not one to question"). For the fifth person, the wounds opened by the dictatorship remain appreciable and it is difficult to become accustomed to the new era. The statement from the Young Physician group is full of positive descriptions of the period following the dictatorship, to such a degree that the question posed could probably best be answered by inverting it.

- *Did situations of real danger directly threaten you or members of your family prior to or during military rule?*

Urug-037-Pro: I think there was fear in the streets, of an attack, because you didn't know what you might be faced with at any moment, caught in the middle of one of those problems. You would receive telephoned threats, especially around the time I led the XX; there were several conflicts and at that time there were threats. I think that to avoid that is the best way. I can't fight against a telephoned threat; what I had to do was more important. If you go crazy, they achieve what they set out to do so now maybe it's true and you lose…

Chi-019-Pro:...because I was an armed forces doctor I often had to examine detainees, and we had to fill out a form. On one occasion, they called me in the morning from department ZZ to examine a detainee who had been captured the previous day, and who had spent the night at an encampment and was being brought to justice for a political act. There was, at the time, a generation of youths who declared themselves to be advocates of violence for political reasons. Nowadays there is terrorism and I don't understand it having a political basis. So I went with my white medical suit and my identification, and I arrived at the camp for the examination. An officer made me enter, along with my assistant, and I was able to question the gentleman. I asked this gentleman if he had been harassed, if he had been mistreated. He shook my hand and denied it. And so I said: in any case, sir, even though you've told me this, I'm going to examine you. Kindly remove your clothes. Along with the assistant, I examined him in private. I even examined his genitals, because it was said to be important, even though I don't understand that it's so. I found absolutely nothing. Do you agree? I asked the patient. Yes, doctor. Good, if you would be so kind as to sign what I have written here: the person examined does not present signs of injuries. I recall perfectly, I signed my part, handed it in, and that night a friend of mine arrived, very worried. He wanted to speak with me. Yes, tell me, what happened? You know, my kid who's at the university had the following experience: there was a commotion at the university buildings… about 400 students complaining about something just then, I don't remember what, and a gentlemen asked if he could say a few words and he said

something like: “Friends, I am not a university student but a neighbor, and I was arrested yesterday. I was mistreated, I was hit… and this morning, when they released me, a doctor with last name XX came by, didn’t even examine me, and forced me to sign a document saying that I didn’t have any injuries.” And 400 students heard that, many of whom were my students at the university. Without denying that there were excesses, I am much more cautious than most regarding the truth of any report. When one has had an experience like that in the flesh. Because this is an example. I don’t know what you think. Meanwhile, I try to stick with the truth and information, that keeps being necessary.

Arg-010-Neutral: My experience, I say that because my experience is sometimes different from others’. My friends didn’t experience it either, and not because we all had the same political views, because there were people that were pro-military and people who thought that democratic governments were sensitive, and I was still like a cork, with politics not much of an issue for me.

Urug-046-Neutral: Not for me. I was in med school at the time, I was in the medical students’ union. Nobody bothered me because of my ideas and I worked better in those years, I worked better. It didn’t bother me in the least, but I realize there were people who were troubled greatly and, I don’t know to what extent, that had to leave the country. I have relatives who have left the country and have remained in Sweden for example. Does that mean I don’t have any feelings for my relatives? No, no way. I think that each person chooses his own path in life.

Chi-07-Opposition: I was very lucid, I always maintained a lot of lucidity. The only thing I can recall for you is that there were times when I was very scared, yes. They called me relatively often, they called me at particular times of the night, they would call me at my office, well… Impossible. I could not identify them. They would say: “We’re going to wait for you outside your office; we’re going to beat the shit out of you, you so-and-so.” Always aggressive statements, very incoherent, but I had the convictions of being a non-violent opponent, a position in which I was completely isolated from violence.

Arg-019-Young: Yes. In the first place, what struck closest to my family was the disappearance of this cousin, and secondly the disappearance of a second cousin, with his wife and a baby girl, whom they later returned. One was on my mother’s side and the other on my father’s. There was also enormous concern amongst my family because I had been politically active during secondary school, even though I didn’t belong to any party during my university years, but there was information from before. There was a feeling of generalized fear within the family, of worry for this family member. Yes, I think there was the gamut of feelings and reactions that we studied afterward. For example, blaming one’s parents for the fear, wondering whether to do something or not, whether the search for political or

military contacts —which were almost always fruitless— would improve or worsen the situation of the detainee. The general atmosphere was very troubled, one wondered whether or not it would be better to emigrate from the country, all those kinds of things.

Urug-07-Young: Directly with me, no. A vague fear, sure. For example, one night I was returning from the stadium from a soccer game. I must have been 12 or 13 years old. I fell asleep on the bus and woke up at the terminal, and a commando stopped me. I was walking alone in a dark area. They treated me, I wouldn't say badly, they didn't do anything to me, but I felt afraid, particularly of someone supposed to be an authority but, as I say, it was very vague. I didn't experience it up close… My first contact at university happened because of having to sign a letter... it was an antidemocratic letter, where one had to swear a kind of oath, agreeing to a number of things that went against my principles... I often questioned myself about whether I should have signed that card so that I could go to university. Ultimately I signed it. It was a bit difficult for me to sign, but everybody who entered the university had to sign it…

Additional comments: For this question, the experience of being personally threatened in the period prior to the dictatorship was equally important. In this way, an attempt was made to focus attention on the period in which military rule commenced and (if necessary) to leave the door open for other statements about the period following the dictatorship. The first interviewee experienced a feeling of constant threat prior to the military coup, his personal space was continually violated, especially through telephoned threats. The second remains weighed down, even today, by what he perceives to be an unjust accusation of having committed torture as an armed forces doctor. He says that the fact that he was accused from the shadows during the dictatorship leads him to question the truth of reports of human rights violations, because if he was so labeled, the same thing had probably happened to others facing similar accusations. The third provides a brief explanation of his strategy for survival: one can get by more readily if one doesn't have any commitments. For the fourth respondent, there was no imminent danger and he was able to work well throughout the whole period. The fifth found himself threatened, even though he supported non-violence. For the first representative of the Young Physician group, the fear of persecution and of disappearing that haunted him throughout military rule remains relevant even in the present. The second representative of the group didn't see himself personally threatened, but there was something threatening in the air that affected him only indirectly. For example, he had to sign a "Declaration of Democratic Faith," which implied support for the military government's ideological objectives, in order to get into college.

- *Were you or any members of your family affected by states of temporary or long-term mental breakdown, such as extreme anxiety, losing contact with reality, depression or delirium?*

Chi-040-Pro: No, each of us was settled in his area and his field and his responsibility, each of us knew we had to assume a function. As such, our concern was with health.

Urug-025-Pro: Breakdowns, no. Worries about money; I didn't have enough money, but no, nothing very noticeable either.

Chi-013-Neutral: No, no breakdown, but in 1985 we had a very difficult time because of threats, the doubts about leaving or not leaving, and then family concerns. I love my family very much, my wife loves hers very much, and they're all, all of the family members were supporters of the government and they didn't see the errors. It's not that they're Nazis or anything, but simply that they were for the right. Allende's government expropriated everything from them and they experienced chaos. They were always involved in business enterprises, which were free [in the military era]. They weren't removed from the country, they didn't feel the effects of the dictatorship. The dictatorship didn't affect commerce, the business world; it was evident elsewhere. It was evident at the university. Regarding the family, it became very painful, and it has been difficult.

Urug-016-Opposition: Well, yes… My wife is a very optimistic person, it is difficult for her to get depressed, and I am someone with a depressive tendency, so that small external incidents can accentuate those depressive tendencies. Yes, I experienced depressive states during that time. There were also very distressing situations that caused feelings of rebelliousness to build up, that found some outlet of expression, to demonstrate on May 1, with a banner for the first time. Well, you had to get rid of it, it was very necessary at the time… I said farewell here, at this very institution, to four or five colleagues who, having been on call, had had their houses raided and had become aware of it. Also, by chance, I bid them farewell when they left the country. They confided in me that they were leaving that night. They didn't tell me how they would leave the country, because of political problems, people that I love very much. I mean, I don't recall now the exact connection between that depressive profile and that circumstance, but I do remember the nostalgia, the heartbreak of losing a friend, of not being able to be with him anymore. I suppose all of that was contributing to my psychological condition: I don't remember if my depressions were linked with those episodes, but everything probably contributed… I was helped tremendously at those times by the cultivation of my literary inclinations, and I devoted myself, in times of great anguish, to short stories, to poetry. I put all my energy into very concrete stories, I don't like fantasy. I didn't publish those things. I only published one story, it was prior to the dic-

tatorship, a political story. In general, everything I produced remained for me; I didn't continue to publish, nor will I publish again. I performed a self-criticism and I reached the conclusion that it wasn't worth the effort in terms of aesthetics, and it was like I wasn't really saying anything. It wasn't worth the effort to communicate that to people.

Chi-016-Oposition: I was traumatized by the arrest… On the other hand, we never lacked food, or means to live. In other words, compared to the situations experienced by other people, it's almost absurd to complain about economic matters. But there was also a tremendous amount of bitterness, about so much suffering and so much injustice and one was so powerless to solve problems. I worked, for example, with a group of people; I dealt with average people, I mean, not the poorest, those needing welfare, but rather public employees, from the center, who paid with coupons from FONASA [national health insurance program], and really, their problems were tremendous. To some extent they still are, but at least now without the fear…

Urug-07-Young: No.

Additional comments: How psychological demands of that extreme period were experienced and integrated continues to be an important question. Here, responses should only be considered to reflect personal nuances though perhaps we can make some general observations. The first interviewee denied any possibility of inner conflict, since, if everybody knew their place and their obligations, there could be no misunderstandings. For the second, the problem resided in money, always insufficient. For the third interviewee, his unequivocal opinions against human rights violations placed a strain on the harmony of family relations, since almost all of his relatives were in favor of the military and couldn't understand his point of view. The first representative of the Opposition group experienced clearly depressive phases, attributable to particular events occurring within his circle of friends. Similarly his literary output is portrayed as an attempt to sublimate those experiences. The second person from the Opposition group was left marked by the arrest and murder of her colleagues immediately following the coup, but she compares her own situation with the more severe situations of other victims and she attempts to resign herself to this. The representative of the Young Physician group responded to the possibility of having suffered psychologically at the time with a peremptory "no".

- *What were the attitudes of your relatives, friends and colleagues toward your activities during military rule?*

Chi-019-Pro: They supported me.

Arg-010-Neutral: They didn't comment.

Arg-022-Opposition:...it was my mother who was the most relevant; when this whole situation of disappearances occurred, she became involved with the human rights organizations —she had a very important role throughout the four years. María Luisa is not a woman who is taken by surprise by this situation, nor is her reaction a surprise. She's not a woman who can be said to have gone from the kitchen to the plaza; she is a woman who, as she was personally formed within the family, developed social commitment, was very creative. She was an authority on art, painting, and she did something I found out about only a short time ago, after her death: my mother died last year and I found a copy of a letter she had sent to the minister of the interior, when I was still disappeared. The letter was an honorable mother's expression, making him responsible for her son's life, even though he doesn't have a heart, because only a man without a heart would permit the disappearance of people under his jurisdiction. She reminds him that Argentina is full of women with hearts, and that they will rescue their children. When I read it, I thought back to that time, because she wrote it and now I can read it and think about it with calm, but at the time everything was uncertain, foundering. She played the role of a mother very well, she strengthened other mothers, she was a friend to other women.

Chi-016-Opposition: We stayed in Chile the whole time; we didn't leave; we made many economic sacrifices… For example, we have never traveled. We were able to help our children to get ahead. My husband… is a lawyer and it was also very difficult for him to adapt to the "informal system" [working outside the formal employment sector]. We aren't people who were able to easily adjust to the "informal system" part and we were able to keep our family afloat. We were able to have our parents die with dignity and to accompany them, but it was a bad time, very bad, really bad… We preferred to stay and I think it was a good decision, but life passed us by —there is no doubt about that. I mean, we had years when we had things go very badly. I was recalling this past Christmas, for example; there were years when thinking of going to buy more wrapping paper or more decorative ribbon or a few cards I needed was a problem…

Arg-019-Young: One of rejection, I think in the first place because of the fear that something would happen to me, and secondly because of ideological differences. They may not have shared my views but the main thing was rejection and fear of the danger this might imply for me… Yes, the most critical situation occurred when I decided to leave my parents' home, which is where I lived. I decided to leave because every time there was a peak in repression, people close to you would disappear, and you would try, with whatever means available, to analyze politically what was happening, who they were looking for, which political group

they were attacking, and which force was intervening, because the forces of repression had a certain autonomy. And so you would try to sort of characterize this, to determine if you were directly involved or could get away. At first, things were very mixed up and very large-scale, so you would say: "Let's take some precautionary measures; we have to be careful". When I decided [to leave home], this scared my family even more. They opposed my leaving and I said I'm going. I was very young, 18 years old. The fact that they couldn't keep an eye on me scared them very much because I was also leaving in accordance with the security measures: I wouldn't say where I was going. I told them: I'll call every night or every so often, but you aren't going to know where I am, or who I'm with, but I'll be fine. I was very young but I was well prepared. That's how it was for several months, especially during 1977, and this resulted in a fairly violent confrontation. They worried a great deal, and well, the danger passed and I gradually made my way back. But it was a very difficult situation for them to understand, because they still weren't convinced of what was happening. They thought for a very long time, for example, that my cousin would return. Then you had to choose, with its possible consequences, because I obviously wasn't a grown-up, I was a kid, an adolescent. And so this was for me also a very difficult struggle.

Additional comments: During that extraordinary period, the emotional environment was unquestionably very important. The first interviewee could depend on his family. The second did not comment on the matter. The mother of the Opposition group representative was a very important figure: as a founder of the "Mothers of the Plaza de Mayo," she contributed decisively to drawing public attention to the situation of her son, and to that of others who were "disappeared" (perhaps contributing to saving many of their lives). The representative of the Young Physician group calls attention to a dividing line between his parents' generation and youth, in terms of how they perceived the danger originating in military rule, which made it difficult to establish a close bond.

Opinions on Current Ethical-Medical Issues

To continue, we are requesting your opinion on medical matters that could involve ethical conflicts. We would like you to respond in one of three ways: in favor of, against or abstain, and also to provide support for your choice.

- *1. In case of contagious diseases such as mucoviscidosis and hemophilia, is operation on embryonic genes acceptable? If so, who should make the decision?*

Chi-019-Pro: Absolutely not. In this case I'm very close to a relative whose daughter has mucoviscidosis, I know about her tremendous scares at night. I went to see her in Santiago, a month ago, when her daughter had to be operated on, just after birth, because of an obstruction produced by the illness…

Arg-040-Pro: [The systematic analysis of the genome] seems to me to be a very interesting project, also tremendously important. It appears to me to be, at this time, I would say the biggest research project in the world. Like every big transformation project, I think the experimental phase should be done first. Its realization will take a long time, the experimental part longer still. What I mean by this is that it seems to me that technology is advancing [more rapidly than ethics] and, as such, when you ask me that first question and I give you a definitive response, I am giving it according to a time lag I see, between access to an imperfect technology still in development, and the application of this technology in accordance with ethical principles.

Chi-013-Neutral: I'm not familiar enough [with the topic]. What I would not agree with is the abortion of a child, not giving it a chance, but if it were possible to intervene so it would not have hemophilia, by all means. No doubt about it. For that intervention, not for another one.

Urug-046-Neutral: You're referring to performing a genetic prophylaxis to prevent the appearance of mucoviscidosis or hemophilia. I never thought about that. I am Roman Catholic; I think the decision belongs to the parents. The right to avoid an illness cannot be denied the parents, even though this goes against Catholic doctrine.

Chi-07-Opposition: I think so. I think it should exist. All those illnesses that are hereditary, which include diabetes for example, the ideal would be to find the gene or the chemical element causing this in order to change it, no doubt about it.

Arg-04-Opposition: I agree. I mean, I consider that medical therapeutics can act prior to the birth, can precede birth, and this doesn't invalidate anything, that is —recognizing that not all cases are the same—, for example, in RH incompatibility, the use of intrauterine blood transfusions is almost common. It is perfectly valid, but what happens is that genetic engineering stirs opinions, and religious concepts may also be involved, a subject that I don't know much about at the moment. No, it's not that I believe in the creation of a superman; I think these are human decisions concerning a specific event or pathology. I think the parents have to be the main catalysts in a decision, seeking the help of professionals. Human beings are their own masters.

Chi-049-Young: I find it absolutely a good thing if it is going to bring a benefit. It seems to me that if technology can achieve it and can prevent a child from having a disease in the future. It's a difficult question, because one would be making

the assumption that the parents can make decisions for that being, but given the fact that the being doesn't have the capacity to decide for himself at that time, one would have to be guided by the benefit. I think the cost-benefit there is paramount, in the sense that, if the child is going to have an illness in the future, we are producing a good for him without it representing a risk or bringing any harm to him. It is acceptable.

Arg-019-Young: I have no opinion on the matter.

Additional comments: With regard to the theoretical possibility of genetic intervention, the responses, for the most part, appear to be sufficiently well-informed. The first respondent was opposed, based on personal experience: an illness of that nature affected a member of his family (here, religious points of view are very important). The second interviewee treated the question as an abstraction, referring to the dichotomy inherent in technical development within the *de facto* possibilities and medical ethics, which would always trail a bit behind, and he doesn't hide his evident sympathy for technology.

The first representative of the Neutral group agrees with an intervention limited exclusively to these illnesses, which to him seems always preferable to an induced abortion. The second representative of the Neutral group puts himself on the side of the parents, even though he is a Roman Catholic and as such should oppose intervention. Nonetheless, he thinks the parents should make the decision. The first representative of the Opposition group has a strong and absolute faith in progress. The second representative of the group cites regular procedures (intrauterine blood transfusion to a fetus at risk of getting RH-) to support his argument in favor of the technique: human beings are their own masters. The representative of the Young Physician group performs a costs-benefit analysis with a positive result, but she still considers the question of whether parents can make a decision for the fetus to be worthy of discussion.

- *2. Given the absence of unanimity regarding organ transplants from persons deceased in accidents and not identifiable, is the use of transplanted organs legitimate and who should be responsible for determining whether or not to transplant?*

Chi-040-Pro: You have touched on a very sensitive issue for me, because it happens that we drew up the first laws dealing with transplants in Chile and it was a very interesting experience, because it forced us to do an in-depth study of the topic, inform ourselves about what was happening in other countries, and work out a law that was compatible with our Western-Christian culture. In terms of progressive advancement, we didn't intend to reach maximum perfection, because it is difficult to incorporate the concept of transplants. It was in 1984, I think, the

transplant law, and obviously we tried to perfect as it became necessary to apply it. First of all, I think organ transplants are absolutely lawful. I think it is a generous way of prolonging life or of providing life for other people. I think if it involves a person who has died in an accident, and there is no identification by the family, well, according to my recollection, I think it was the judge who determined authorization and who delegated the authority to use organs at the time of transplant to the director of the Medical-Legal Institute (morgue).

Urug-037-Pro: In Uruguay there is an organization under the Faculty of Medicine and the Ministry of Public Health; it is headed by Dr. MM and is called the Center for Organ Transplants. I think that considering the benefits to be obtained from organ transplants, it is totally justifiable to do them. The decision has to go to the national organ bank and they look for a suitable recipient.

Arg-010-Neutral: We have a serious problem in our country. My personal opinion regarding this is that there should be a law establishing that all corpses are able to donate organs, and in all cases of individuals in a vegetative state, authorization should not be required, but rather the situation should be pre-established. If a person decides not to donate organs – Donation should be the norm and instead, people who think otherwise should have to establish they will not donate. That is, a person should have to establish not that they will donate, but rather that they don't want to donate, and so the decision, well, it's established: the person who doesn't want to donate his organs has established it as such, and therefore, I guess, there could be a central archive where the information is kept. If the person cannot be identified, then the organs should be donated, that is, the organs should be extracted from him. The decision should be made quickly, by the doctor or medical team and a legal entity, who could be a judge, together.

Chi-013-Neutral: I think so. I think that in the case of organ transplants, if every precaution is taken so that they won't get hereditary illnesses, there is no problem in removing the organs of a recently deceased individual under any circumstances.

Chi-07-Opposition: Well, this whole situation with transplants, unfortunately, in our country there is a great deficiency, because there is no legislation. I think the whole situation should be legislated with the input on ethics, technical input from doctors, legal input from judges or lawyers, but it must be legislated. I'm a supporter of — where the appropriate legislation exists, to protect against situations where abuse might arise— I would allow transplants, provided they were covered by legislation. The present conditions, I fear, lend themselves to abuses, because you know when we somehow allow organs to be removed from an unknown person, many people can be transformed into an unknown person, so it

seems to me that we could enter into an escalating anarchy in which many abuses in this respect could arise. I would be opposed, while there was no legislation.

Arg-022-Opposition: I think the answer to the dilemma posed is [to address the issue of] who assumes the responsibility and whether or not it is right to transplant from people who are unknown or unidentified. It seems to me that these are the potential risks that arise when these types of decisions are advanced. I would not promote the use of organs transplanted from unidentified cadavers, even acknowledging that there may be a life in the balance, taking into consideration the seriousness of generating permissive criteria in a society that allows for organ transplants from unidentified cadavers. As such, I lean more toward the adoption of new legal norms, by which it would be possible, well ahead of time, to create a condition where a voluntary declaration allows for organ transplants following death.

Chi-049-Young: I think prior legislation is fundamental there, and there isn't any, but yes, I support the use of organs. I think that if there is a person who has the possibility of living —I think there, there is a discordant point with people of a certain faith, who might think otherwise in this respect, it would be almost criminal, a sin, not to take advantage of an [available] organ. Well, I think there is an alternative there: you say an unidentified person. I think there you would simply have to go in favor of the use of that organ, the person who will be receiving it, and the doctor who can grant it to them.

Additional comments: Since organ transplants have represented a viable alternative for treatment in Latin American countries for more than a decade, this question deals with a topic of greater clarity than that of genetic manipulation. The first interviewee referred in detail to the formulation of a law to regulate organ transplants in Chile, offering a detailed review of said law and its applications, and then responded to the question using the draft law for support. For the second interviewee, this simply represents a formal question, which can also be responded to formally. The third expresses the opinion that, with something as valuable as an organ transplant (which aims to help a living person), a negative restriction should be introduced: those who do not wish for their organs to be used in transplants after their death should establish this in writing. Otherwise, their organs are deemed available for currently necessary medical procedures. The fourth sees no problem with removing the organs of a recently deceased and unidentified person when there is no hereditary disease. Both representatives of the Opposition group (from Argentina and Chile) define the legal situation to be nonexistent and requiring urgent clarification (thus, the new legislation is more or less unknown in Chile); they also display considerable wariness of possible abuses in the use of organs from bodies of unidentified persons killed in accidents, and conclude: no laws, no

transplants. The woman from the Young Physician group also sees the need for clear legal regulations, but —in weighing the imperative of life against respect for the deceased— the need to take medical action becomes the unequivocal priority: it would be almost criminal to not use the organs.

◆ *3. Regarding surrogate motherhood, beginning with a fertilized embryo from a couple where the woman cannot have children because of some severe illness in the uterus; is this option legitimate and who should make the decision?*

Chi-040-Pro: This is a more complex issue, one that I don't have a really clear idea about in either the negative or positive sense. Nonetheless, if you were to put me in a corner and ask my opinion, I would say that, in principle, I disagree, and I think the way to resolve the problem is adoption… I think life is the big university, nothing can present things to you in a better way than your own life, your own experience, and I experienced that situation in my family, and thus, I am very conscious of this. One of my daughters became RH sensitive and was able to have only one child. She later had one by Caesarean section and then a premature child who died, and the birth resulted in the end of her childbearing capacity. The impact of finding out she was infertile was so strong, that as soon as she recovered from her last operation, I called her and said: "adopt a child." She did so and today they have two adopted children, two daughters, one who is eight years old and the other four, and they have made her life full. I think it has been an extraordinarily beneficial solution.

Urug-046-Neutral: The use of another uterus can be justified, if there is an agreement among the parties. I don't think there is anything more to the issue if the parties are in agreement; the husband, the wife, and the surrogate. Yes sir, it has to be very well done.

Chi-016-Opposition: I think it is legitimate to want a child and there are couples who want one desperately. If there is an agreement, and there is nothing financial intervening, I think that yes, it would be understandable and acceptable.

Chi-049-Young: Actually, I have a contrary position on this issue and my position is concerned more with the child who is going to be born. I think situations of great conflict could arise between the surrogate mother of the child and the future adoptive parents and this could be damaging to the child…

Additional comments: On one hand, it became evident in posing this question that in Argentina there had already been an experiment along those lines (in the mother of a woman with a uterine illness). On the other hand, a South American television series had tackled the topic with a great deal of emotion just prior to the field study. The topic was therefore familiar. The first interviewee is opposed to surrogate motherhood, based on his own experience, and offers the adoption as an

alternative, which has had positive results in his own family. The second sees the process as unfolding smoothly if there is careful preparation. The third person puts himself in the position of the parents and supports the possibility from that perspective. The representative of the Young Physician group places herself in the situation of the child who is entering into the world, and imagining some very specific conflicting circumstances, decides in opposition.

- Opinions on the General Social Situation of Victims of Dictatorships and Violations of Professional Ethics by Doctors under Martial Law.

- *1. We would like your opinion, both contextual and specific, related to two relevant social matters for the profession: has the treatment subsequently provided the victims of the military government been suitable and sufficient?*

Chi-040-Pro: Well, here we get into a problem of generalization. If, in fact, they have been unjustly treated, they have rights. I think some mechanism of compensation has to be found for them. The problem is how to discriminate, and there would probably be those people who, not having rights, would still make use of something. That's simply a defect in human systems, because they're never perfect. I think that at a particular point in time exile took place, many people left the country because they disagreed, many people were sent out, some probably with good reason and others without reason, as always happens. Now the doors have been opened and everyone was able to come back. I think returning is difficult, because wherever one goes you generate roots, you live your life, and then a second transplant is produced that is difficult for everybody, for anybody. I think society defends itself a little bit against people who come from the outside for natural reasons.

Arg-040-Pro: I think that, since in all these phenomena there are two sides, there have been interests produced, I would say, since the cause is a just one —that of human rights—, one always has a predisposition in favor of the victim. I would say that treatment is always insufficient for a victim, and perhaps for his family. Perhaps many families have used this as an independent personal realization. What do I mean by this? I mean to say that: to my mind, the damage to the victim has to be repaired, an irreparable damage. It seems to me that this also includes the damage that is produced in some families. But I see that in this process they have (...) enemies and supporters of these two ideas who have profited and gained as protagonists. I would say this was more, first, I'm not sure about the figure of thirty thousand [disappeared]. Secondly, that (...) society has permitted the presence of subversion, and condemned it without acting against it. When the repression began, society noticed it and condemned it without acting against it…

But I would say that society divided the two risks: the risk of subversion and the risk of state terrorism as a phenomenon of the functioning of society.

Arg-010-Neutral: No. I think that wherever political effects of this nature exist, there is, fundamentally, no possible repair because the objective is the destruction of the political opponent, and so possible reparation doesn't exist.

Urug-046-Neutral: Well, in the few cases I'm familiar with, yes… I know of other cases, sure, in which the damage they did is irreparable. To have a person imprisoned for eight years, even though they give him US $200,000 after… Who can give back those eight years and the frustration they evoked for a fifth-year medical student? One who, when he is released, can't bring himself to return to med school, and after eight years hasn't returned to his studies and winds up as a blue collar worker. No matter if they give him the $200,000 … Ah no, that is wrong. It is fixed with money, with cash, but I think the moral suffering and the irreparable damage caused by the halting of a person's life for so many years — nobody can repay that.

Chi-016-Opposition: I think there is a lot of pain in this country that hasn't been dealt with. The big things have been dealt with, the serious things. But the small hurts, the little ones, the humiliation of people are not perceived beside the big things and one is even somewhat ashamed to speak of them. For example… I don't think it's a secret, the truth is that when one of my students and an orderly disappeared, we agreed with their relatives to keep quiet about it during the years of the dictatorship because, to begin with, it was obvious we wouldn't achieve anything by denouncing it and I was in no condition to do something heroic, politically, to agitate. I wasn't really in that kind of mood, and now, because of the Rettig report, I went to make a statement and that led to judicial processes starting up. Now I'm at the stage of going to make statements to the courts. I've gone three times and I also went to *Investigaciones* [civilian police detectives] once. The truth is that it was never a secret to me, I always had contact. I think there was no trust before, there was fear and I wouldn't go to them to make statements, no way, even if they had gone through some charade of justice. But upon democracy being reestablished, I truly became trusting, even though there was still a little bit of fear anyway. But it really is an odd situation, it's like you say, that your trust would emerge from one day to the next, but it seems it has to be done. There is still a bit of fear anyway, and I imagine there must be a lot more fear for people dealing with things that are a lot more important than mine, mine is not that serious and what I can state isn't much, that I saw them. I think the most transcendent event would be to find them, I mean, if somehow – for these people the most unthinkable suffering is not knowing where their loved ones are…

Urug-07-Young: I've had the opportunity to treat people at the psychiatric clinic. The experience of treatment, I've received patients who have been on both sides. I've had patients who have been punished or who have suffered great repression during the dictatorship or even from those responsible for repression, or torturers, and my experience is that in general it has marked everyone, at least among the people I have received. And the question I often ask myself and my colleagues when we see that type of disorder or people with that type of disorder is: what type of personality did they have before, to be able to get involved in the struggle? Psychopaths in general, people with personalities or very marked personality traits, no matter the side, that appear to be psycho-pathological…

Additional comments: The question about how society treats the victims of the military dictatorship did not contain allusions to any financial compensation, yet that possibility was the only one taken into consideration by the representatives of the Pro group, who also showed themselves to be very interested in setting the most unambiguous limits to demands for benefits of this kind, which could afford claimants possible privileges. The central point to be clarified is who has the right to indemnity and who takes advantage of a law of this nature. People are shaped by their own experience and it is worth noting that everyone is seen as seeking advantages. Assuming this perspective, it is easy to see how so many people may consider themselves to have sustained injuries from State terrorism; similarly it would appear that the estimated number of potential victims is very high. A representative of the Neutral group expresses himself dogmatically: the survivors should be grateful they weren't annihilated. The second representative of the Neutral group evaluates the damages caused as impossible to measure and, therefore, impossible to compensate. The person from the Opposition group poses three new questions: How to measure the suffering of each individual? How have the victims dealt with illegality under the dictatorship? What forms of social compensation are important in this situation? She clarifies within them her position on the search for justice during and after the military dictatorship. The representative of the Young Physician group brings up his experiences with patients from both sides, a leveling of positions intended to give the impression of impartiality. Nonetheless, by reducing his experiences to psychopathological categories, he seemed to express more insecurity than a sufficient reflection, because when the interviewer probed further, he became quite uncertain: "These patients come for a consultation because either they have illnesses of an endogenous nature or for current problems. I treat them all equally and I only ask them very occasionally about their experiences under the State of Exception."

- *2. The following question has two parts, a general one where we ask your overall opinion of the topic and another where, if the response to the first part is affirmative, we are interested in the actual consequences for each particular case.*

- *2.1. The general question is: do you feel it is necessary to punish particular doctors who have transgressed regular ethical norms during the States of Exception?*

Urug-025-Pro: Yes, of course, on the one hand and on the other. Why not? But not only a doctor… any person, that is, torture, yes, of course, absolutely.

Urug-046-Neutral: Sure. The doctor is forced to do that by his hierarchy. He who accepts, who runs that risk, is proceeding wrongly, it is questionable at such a time. There is an obvious contradiction there because I told you at the beginning that I was content with the order, with what they had done on the outside. But what they did in the prisons… it doesn't mean that this was at all right in any way. Do you understand? And what they did and if one of my colleagues did that or if they lied or made a false affirmation of something, that is something else altogether for which there is no excuse…

Urug-016-Opposition: Yes, we had a struggle. I thought you were coming to interview me about that. Because I was the head of XX when we —against the opinion of the whole country, in fact— we were summoned by the parliament. We had public debates on the radio, on television, with politicians defending our position in defense of medical ethics—we conducted an international seminar where we invited Europeans, people from the Philippines, Latin Americans, which was held at XX. The Ministry of Education and Culture even threatened to cancel our legal status as a medical association. We continued to defend doctors' right to analyze military physicians' conduct during the *de facto* period and to sanction those doctors who had participated in activities violating normal ethics. We got a great deal of pressure from the media, not direct threats to my person, but through the press there were threats, there was questioning. My situation as an ex-military doctor was even put forth as invalidating me from participation in medical assemblies, which were the most numerous in the history of the medical union. There were some personal insults but no threats. I was very fearful… I even had a meeting with the army commander-in-chief. It was very relaxed, even though the subject we were tackling was very sensitive for the country. Don't forget that at the time they were voting on a law to legally extinguish liability and possible action against the State. The commander-in-chief… He had some conceptual errors, thinking that we, solely for being ex-military doctors, were excluded from a public debate on ethics. I explained to him what our position was, and he understood it, but he didn't support it. He understood it in that little meeting, but not in the media.

Chi-049-Young: I think an attempt has been made to hide the matter in order to forget it, but no attempt has been made to punish the people who committed those excesses. I don't think one can let that happen, independently of the political position one holds. All of those acts of violence should be punished. I don't think there are time periods after which responsibility for unethical acts is extinguished.

Additional comments: This general question regarding doctors' responsibility for human rights violations gave rise to a categorical response from the first interviewee: all those who participated should be indicted. The second develops an argument distinguishing areas of competence: the military doctor is in a position where he must obey orders depending on his position in a hierarchy, and that is a tragedy from which there is no escape. For that reason, doctors who work in the prisons perhaps have no option (other than violating human rights). He personally does not agree, nor did he practice violations, although he very much liked the order imposed by these methods. The representative of the Opposition group describes the situation of conflict during the period, when the continuous human rights violation caused many doctors to get involved and organize resistance. The person from the Young Physician group expresses indignation toward those who wish to cover up the facts, demanding full clarification of all such events.

- *2.2. Should the following situations be defined as punishable or not, and, if yes, what kind of punishment do you consider appropriate?*
A. Medical examination of blindfolded persons in military or police custody.

Chi-040-Pro: Well, we are analyzing extraordinary situations in the sense that, at a particular time there exists a mechanism of self-preservation; to live in a State of Exception involves a risk to life… Parenthetically, I went to see a movie yesterday, a premiere called "A Few Good Men" which was the story of a trial at an American base in Guantánamo Bay, Cuba, rooted in a circumstantial event, but there the commander of the unit explains things quite a bit. He says: "Right now there are 4,000 Cubans surrounding the base, who are training to kill me, so it's possible that I will have to do things that wouldn't have to be done in a normal life because they aren't justified." I think that sort of happens at a certain time, for self-preservation. I think he has an absolute right to protect himself while serving the function corresponding to him as a professional.

Urug-037-Pro: I think it is more than a transgression, it is stupid…

Arg-010-Neutral: The doctor is either a military doctor, or he's from the security forces, or he is a civilian doctor. For me it is important, because if he works in a certain sphere he functions according to particular rules, which can only be opposed by the individual's own morals within his profession. I interpret there to be only one medicine, but an individual who practices that medicine does so within

these spheres and the acceptance of each of these spheres is up to each individual. It is in this regard that a civilian doctor cannot present himself to a supposed patient, whom he cannot identify in the first place, and even less so when his eyes are covered. The eyes are something very important within semiology and the interpretation of signs. What I mean to say by this is that depending on the conditions in which one meets the patient, we could accept seeing him from only a partial point of view, given that he is in a sphere with norms that go beyond those of his profession.

Chi-07-Opposition: I think it depends on the circumstances, because they may take some individual and they're carrying machine guns and they tell him "You have to do this or else I'll kill you." In the absence of coercion, I think it is absolutely punishable. The sanction is that if the individual is unable to acknowledge what he has done publicly, or through the courts, that individual should be punished by being suspended from his profession, that is with the suspension of his activity.

Urug-07-Young: If to complete the medical examination it is appropriate, remove the blindfold. If not, I can't examine him. Because you can't examine a person you can't see. To see is also one of your rights. Yes, it is punishable. It depends on the situation. In principle, merely for that fact, it wouldn't be professional. I wouldn't do it, but I don't see it as something serious.

Additional comments: Completing a medical examination of a blindfolded person is something that would occur very rarely in an everyday medical practice. Nonetheless, the question on this matter evoked clear associations in the interviewees. The first presented a justification, that these are extraordinary situations in enemy territory. For the second representative of the Pro group the possibility isn't conceivable if dealing with a doctor who is behaving *lege artis*. The representative of the Neutral group maintained the opinion that there are diverse areas of medical activity, each with its own rules. Depending on the practice opted for (military or civilian), the doctor will have to satisfy different criteria and so his treatment of patients is different. The representative of the Opposition group considered the possibility that the requirement to complete such an examination could occur in a situation where the life of the doctor in question was in danger. The representative of the Young Physician group feels that semiology demands certain rights, but the event itself was classified as being minor.

- *B. Issuing false health or death certificates for people who are in military or police custody.*

Chi-040-Pro: Well, I would say that any false certificate that one signs is condemnable, that is, if you put your signature on something you are assuring that at a particular moment in time, a, b or c is true.

Chi-013-Neutral: Absolutely punishable and also a license suspension.

Urug-016-Opposition: A very serious lack of ethics.

Urug-07-Young: It is punishable, but not only for people who are in military or police custody, for anybody who makes false certificates.

Additional comments: Here, the legal situation was clearly defined for all the participants, while possible punishments varied.

- *C. Professional help to transfer children, born during the imprisonment of their parents, to third parties.*

Chi-019-Pro: It is difficult to generalize, but I think there are situations where it is perfectly acceptable. I am going to put forth my own example. I helped to take a child away from his mother because he was maltreated and I had him in my medical care at the hospital when he was a few months old. He had a fractured spine, with a complete paraplegia and I let it all be known, with all the legal procedures of the case. She was a mother who already had a criminal record. Her right to custody was taken away by the judge. That boy is the adopted son of a colleague, he has a marvelous life and, as a paraplegic, I have treated him. He is now 22 years old and I think that it is legitimate in those conditions, no?… Oh, no, not by abduction. I'm not aware of any colleagues here in Chile who have participated in such proceedings.

Arg-010-Neutral: There could be some sort of very specific situation, but in general, the interpretation should be that if one is interested in giving the child the best future, from his own point of view, for the child, this should not be established by hiding it, but rather through a decision basically taken by the entire family.

Chi-07-Opposition: Unspeakable. That must be punished, their right to practice medicine must be revoked and there should be legal punishment. This is not mere an ethical obligation, but also a crime punishable by society through the legal system. It is a misappropriation. To put it bluntly: with a human being, in addition to a moral sanction, there must be legal punishment.

Urug-07-Young: It is punishable.

Additional comments: This question wasn't dealt with in the same way in the three countries; it appears that in Chile there was no knowledge of the handing

over of children whose mothers were beforehand considered as "disappeared," and the interviewer could only communicate his personal experience with problematic stories of adoption. In Argentina, on the other hand, it was very familiar, and the interviewee made reference to the value of a decision involving the whole family. The next interviewee, also from Chile, appeared in responding to be quite dismayed, and the representative of the Young Physician group limited himself to declaring that such an act is punishable.

- *D. Professional participation in torture and/or cruel treatments.*

Chi-019-Pro: Oh, no, absolutely condemnable. There is no justification for torture at any time, not even in police proceedings. I state with pride that I am the son of an officer who reached the rank of general in the Chilean armed forces. He was my father, whom I admire and try to emulate and, knowing the institution from the inside, as an institutional policy, nothing like that ever existed. Now, there are people within it… I think that even within the code of military justice, which is much more severe, it is punished. It is not permitted, so that a person who is proven to have proceeded in what is called the abuse of authority or the illegitimate use of means disproportionate in relation to, etc.… there is a series of circumstances in which it figures. It is punishable in a legal form, it is legally punishable and morally also.

Arg-010-Neutral: I don't think that has anything to do with being a doctor or not. Torture is a personal act totally outside of what it means to be doctor or not. The individual should be punished, not because he is a doctor, or white or blond or whatever.

Chi-016-Opposition: I think a doctor who participates in torture… I imagine that apart from the College of Physicians and legal punishment, he himself should undergo psychiatric evaluation or something like that, because this is like denying the very essence of being a doctor. A person who does something of this sort is worthy of pity, of support and of psychotherapeutic support. I think they are beings who go against everything they have thought of doing in their lives. I don't understand them. I know of some of them. I know about the documented case of a man, a known torturer, and I was able to meet him in a medical center, on a normal work day, and it seems incredible to me. He was an extremely pleasant person and really you don't know what could happen for a doctor to do that and at the same

time you see him as a normal being. There must be things that psychiatrists know more about than I do.

Arg-019-Young: It seems to me to be most serious. In fact, it is where the sense of the medical profession is most altered. I think the sanction has to be professional disqualification for life, disqualification from any activity involving medicine, for example teaching classes, not only attending, but also teaching classes or belonging to medical or scientific groups. It seems to me this requires important condemnation. I can't say how many years, but important prison sentences because they are extremely serious crimes.

Additional comments: Given that the active presence of doctors during torture is no longer a secret, a clear statement of positions on this question was expected. The first interviewee endorsed the unconditional punishment of torturers, particularly those in the armed forces (whose penal code apparently entails stricter penalties for those crimes). The researcher wonders why the indignation and the insistence on punishment arise now and not in the period when doctors' participation in torture was the order of the day. The representative of the Neutral group responded in a very general manner: anyone alleged to have participated in torture should, according to him, be banned from practicing medicine. The interviewee from the Opposition group knows some doctors who have been accused of torture before the courts and she can't understand them (one of them seems to be a very pleasant person in interactions with colleagues); she resists thinking that they could be normal and recommends psychotherapeutic help for the individuals of that group. For the representative of the Young Physician group, the emphasis is on possible punishment, which he examines in detail.

- *E. Technical assistance in executions in those countries where the death penalty is legal.*

Chi-040-Pro: I think he is performing the role of a priest, in the sense that he is really practicing his profession, lessening pain, tension… It's my understanding that in the case of execution, I don't know, in the United States, where they use an injection… It's a complicated question. I hadn't placed myself in that situation. What happens there? If the person is given the death penalty and electricity is used, and if you are the one to lower or raise the switch, or to give the injection, then you are the instrument that carries out the sentence. So, it seems the person there is an instrument from the technical point of view. I have no further comment to make.

Arg-010-Neutral: I think we have yet to interpret the difference, the difference between what the profession of an individual is and the person. One conditions the other. There is a sort of very deep mix. There is also a difference where conditions

are extreme, and in the limit governing whether an individual thinks he can practice his profession in an atmosphere where these situations can be produced. Well, to be very frank: not everyone can be a surgeon, not everyone can be a hemotherapist. Nonetheless, one can still be a doctor. No, because if an individual accepts the rules of the game and if this is legal, if we are trained to cure and not to kill, then there are situations wherein society is really demanding something that goes beyond what an individual could interpret on his own…

Arg-022-Opposition: Where the death penalty is already part of the legal code, its realization ceases to be a human rights violation, given that the legal code permits the situation. In that case, it is a question of conscience. As such, I would dare to say that the ideal would be for doctors to push for the elimination of the death penalty using the usual methods for this purpose. For example, global international organizations can very well put pressure on governments to suspend the practice of capital punishment. This is unacceptable conduct.

Arg-019-Young: The thing is, I do not agree with the death penalty in any case; that is the problem. I consider execution in those countries where it is legal to be more serious. I think there it would be interesting to have sanctions of a type… that have to do with attitudes of civil disobedience, for example: expulsion from the College of Physicians, the refusal to hire that professional at institutions, for the knowledge of who he is to be disseminated in the media, and for the population to have nothing to do with him. I mean, in all those types of things, I think it is in the hands of the community to go beyond what is stated by law.

Additional comments: Since the death penalty is still legal, for example in Chile (in Argentina there is public debate about reintroducing it), this question is somewhat urgent. The first interviewee considers the physician to be acting as a sort of priest at the execution, helping the individual condemned to death to deal with the pain and anguish. He later changes this, probably noticing that the opinion is too bold, and reduces the role of the doctor to an instrument "from a technical point of view". Nonetheless, he basically accepts the possibility of this course of action. The second addresses this question from a metaphysical perspective: some can (and should) do it, others not; in any case, it is not for individuals to judge. The final two interviewees are in favor of fighting the death penalty and they describe possible courses of action to achieve this.

◆ *To continue, sample situations will be described, containing questionable actions and attitudes involving critical moments in professional ethics. We want you to imagine yourself in each situation and to tell us what you would do if faced with this specific situation and why*

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1. Your medical chief is operating, with you as assistant, on a patient of a normal, middle class background. Suddenly, he interrupts, asking you to continue the operation, and without another word he leaves the operating room: an important patient has arrived at the hospital for a routine examination. What is your attitude toward him and why?

Urug-025-Pro: I finish the operation, yes, of course. I hope I wouldn't have to do it without knowing how; I trust that the chief surgeon wouldn't pass it over to me. I would be careful to do it well, supposing I knew how to do it, if my boss tells me and he makes a mistake and I can't treat him… I would assume the responsibility for finishing.

Chi-013-Neutral: As a surgeon I would do what I am required to do, continuing the operation. I would reproach him in private and I would let him know at that time that I disagreed with what he had done.

Arg-04-Opposition: Well, first I would look after the patient and, once the problem was solved, I would confront this doctor, the chief, and I would ask for an explanation of this discriminatory attitude to people of another economic class. If the response weren't satisfactory, I would ask the ethical bodies for sanctions. That doesn't happen commonly here, because first of all, this situation doesn't exist, that is, the very poor person goes to the hospital; there are no different levels. Secondly, only in the really hierarchical hospitals does the chief of service perform part of the operation and then pass it on to his subordinates. In the situation described, I think if it arises, I wouldn't consider organizing the operation this way to be suitable. I mean, the responsibility for an operation is from beginning to end.

Chi-049-Young: How should I put it? In medicine you can't make distinctions of any type. Undoubtedly, if the colleague is asking me to… —but if he left, he left for a reason— later, probably, I would find out if he left for another reason. I'd continue, I'd finish looking after the patient as well as possible, and if I find out later that the colleague left because the son of the president arrived needing attention, I would seek a moral sanction from the College of Physicians from an ethical point of view, because that isn't right.

Additional comments: There was unanimity on one point in the responses to this question: the operation must be completed. For the representative of the pro group the situation doesn't represent a problem: he would finish it and, in any case, the responsibility for the operation's outcome depends on the chief surgeon, who should be fully aware of the assistant's competence beforehand. The second interviewee would go after a private conversation with the chief in the future. The third expresses dismay at this attitude on the part of the chief surgeon and would

demand an explanation for his conduct. The representative of the Young Physician group considers the action to be incorrect, but she doesn't know of any authority she could turn to in order to present an accusation.

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2. You are notified by the public health authorities that you have been chosen to cooperate with a pharmacological research project of great importance. You are not told if your patients will belong to the group receiving a powerful medication or to the control group, who are treated with a proven medication you are familiar with. You are asked to maintain secrecy about the study, which is administered solely by the people working for the laboratory. To compensate you for your efforts you have been offered the chance to conduct seminars discussing the results, to be held at a posh resort after the research.
What is your reaction to this and why?

Chi-019-Pro: I see only one: if the research doesn't entail risks for the person, I would cooperate without any personal interest beyond the hope of confirming or discarding the benefit of the given medication. If I am certain that the medication could be damaging, I would emphatically refuse, even though I have everything to lose and nobody can force me… I would only participate if I were certain there were no risks involved for anybody. I think I would. As I was discussing with regard to AIDS, the problem of not having an animal model is very negative. Knowing with a hundred percent certainty that AIDS is fatal, physicians started using AZT to treat people. I think they are damaging drugs and all, but weighing the benefit versus the risk, I think you could collaborate… But as you related it to me, no, unless people are informed of and accept the treatment, then yes. The preceding consent is a *sine qua non* condition.

Arg-010-Neutral: Well, in the first place I couldn't involve myself in that type of study, or test, without really knowing what the objective of the study is, I mean, that sort of work would not include me. I don't accept the use of any type of pharmaceutical, or any type of treatment on a human being, if I don't know exactly what it is and, of course, even less so without knowing what the drug is too. Whether I am in working the group on which the drug is being used, or the placebo… I don't have problems with the placebo, I could see about the other group, but if I don't know which group I'm working with, then no.

Chi-07-Opposition: I wouldn't accept it, because I can't. It is at odds with my position as a doctor to use my patients as guinea pigs and that is what I would be doing. Not knowing what damage could be provoked in their body by that medication or pharmaceutical product is all the more reason for not using it. So there is no way I would accept it.

Urug-07-Young: In pharmacological studies, the patient's acceptance of what you are going to do and the patient's knowledge of his or her inclusion in this kind of study is fundamental. I have participated in pharmacological studies where they are told that they will receive one of two medications, but I don't know which, but I tell them, the patient must know exactly what is going on and accept it. I wouldn't participate in this if the patient can't be informed.

Additional comments: The expressed request to not discuss the study precludes the involved patients from being informed. The first interviewee shows himself to be open to this undertaking if the possible risks to his patients are clarified for him. He begins with a positive evaluation of risks and costs, but nonetheless insists on informed consent from patients. In a rather confused statement, the second expressed an aversion to not being informed. For the representative of the Opposition group, it was not acceptable for patients to be treated as guinea pigs. The representative of the Young Physician group considered a request for the patient's approval an essential prerequisite.

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3. The Supreme Court asks for your cooperation, as a doctor, to deal with a lengthy hunger strike, which is said to be placing the lives of the participants in danger. The Court would like you to carry out intravenous treatment providing nutritional serums to interrupt the hunger strike.
What is your position regarding this and why?

Chi-019-Pro: If we begin with the premise that life is the main right enjoyed by an individual, I would make a major effort to make the person on the hunger strike aware of the real risks faced and how unnatural and immoral is his or her attitude. Viewed from the perspective of my upbringing, it is immoral and a deliberate suicide… Now, in the case of this person's attitude being absolutely negative and thinking that, so long as he or she remains in this state they are in no physical or mental condition to make this sort of decision, such as would occur with a child, I would cooperate in treating these people.

Urug-037-Pro: I'm a doctor, I think I have to act like a doctor, but fundamentally, to act like a doctor I need the consent of the patient. I mean, if the patient accepts it, I would do it. If he says no and he is in a position to make the decision for himself, I wouldn't do it.

Chi-016-Opposition: To begin with, I wouldn't do anything with the Supreme Court, I mean, I wouldn't cooperate on anything with the Supreme Court of Chile. I've participated in hunger strikes, in groups who supported the strikers, and the strikers' decision was not to consume nutrients or accept anything. A tremendous anxiety was produced in doctors; for me there were sometimes critical situations when the days would pass. At the outset it was very easy to attend to them, but as the days passed we all became very nervous and, happily, I didn't have to face a situation of that type. In any case, I think the decision there is not mine. On the one hand, I think that life is fundamental, but on the other, the person's own will is also important. I think, in that case, the ideal would have been for someone other than the relatives of the disappeared detainees, or whoever was involved, if it wasn't them who had to give way, but rather that something were granted to make them desist. I was rather closely involved in that situation and I haven't resolved it. It is very hard. It's not really clear to me, but I think the ideal would be that other institutions give in and not the hunger strikers. On the other hand, I think life is also something fundamental: I cannot perform a medical act that harms my patient.

Urug-07-Young: I'm a psychiatrist and, as a psychiatrist, I would reach a diagnosis from my practice in order to evaluate what is involved. If I were to grasp that there was a psychiatric pathology, I would naturally treat the alleged patient. If this were not the situation, at least not *a priori*, then it would be very difficult to do it. So I abstain from answering the question directly.

Additional comments: On this question, only the authorities defined the conditions of the participants in a hunger strike as being at risk of dying. The first interviewee considered life as an abstract entity. He was totally opposed to hunger strikes and he would participate in the "treatment of those people". For the second representative of the Pro group, the absence of consent from the "patient" precludes all medical activity. The representative of the Opposition group refused to comply with the orders of the legal authorities and he provided an impressive description —based on his own experience— of the moral conflicts facing doctors who act in solidarity with the participants in a hunger strike. The representative of the Young Physician group maintained a distance providing an answer that apparently could not be clearly reduced to psychiatric categories.

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4. You are chosen, as a doctor, to participate in a very important exploration of the Antarctic, which will bring you social recognition and a significant increase in your income (six times your regular salary). Absolute discretion concerning the project and a complete loyalty to the head of the expedition is requested of you. What is your position regarding this and why?

Chi-040-Pro: An experience in the Antarctic. If I were young it would strike me as interesting and challenging. I would see it as an adventure more than anything, and I think that, if my personal health would allow it, I would accept. Obviously, I would have to agree with the project itself, I mean, I wouldn't go and participate in a project without being completely familiar with it and without agreeing with the things to be done, in terms of my upbringing, so that would be a prior condition… and discretion, obviously, if there is a need for a measure of that sort and I agree to help, I'd do it.

Urug-046-Neutral: I would have to know the objectives of this mission. To participate in a secret mission, in principle, no, I wouldn't go. Did you hear them offering me (on the telephone) a trip to the United States and did you hear what I told them? Because I'm not going to travel any more.

Arg-04-Opposition: No, I wouldn't accept it because it would put limits on my opinion, because I might not agree with some of the attitudes involved in this research. So I couldn't commit myself to that, or to secrecy because the research could involve something that the public needs to know. I consider that my loyalty has to be to the human race, and I keep it within a structure that has certain limits. When something makes me overlook this, I cannot remain completely loyal. My loyalties are relative.

Arg-019-Young: To me, everything demanding absolute secrecy, in normal conditions, is suspicious on principle. I don't know if there is something, perhaps there is, that cannot be known by all people. So, in principal, the demand for absolute secrecy would strike me poorly. It seems to me to be totally ridiculous because there would be two demands: the absolute secrecy that I would relate to reasons of State applied to do something that is then not acknowledged… Well, we have a lot of experience with the issue. And the other thing about absolute loyalty is that it sounds like believing, obeying and fighting for your own stomach, because it nullifies the factor of personal reasoning so, in principle, I wouldn't enter into the game.

Additional comments: In this question about willingness to blindly follow orders and accept orders from superiors without reservations, the first interviewee offered a circular argument to explain his participation in this project. The second developed immediate suspicions and was against any secret activity. The situation for the third participant was very clear: he wouldn't ever want to compromise his discretion, because his loyalties were relative and were in the service of people and not hierarchies. The representative of the Young Physician group qualifies himself as suspicious due to experience, and would in no way participate.

5. During an assembly of parents and teachers, the principal of the school, where your children are students, announces publicly that a parent of one of the students has AIDS and asks you to confirm the diagnosis since he knows you are their family doctor. What is your position regarding this and why?

Urug-037-Pro: I think this involves a very important issue, which is the confidential relationship between physician and patient. That is, professional confidentiality. I can make a decision, communicating it to the family, but could never state a medical diagnosis at a parents' assembly.

Chi-019-Pro: First I'd say: if I don't know it, if I don't have knowledge, I can't say it without the previous authorization of the person. Categorically, medical confidentiality has in this field a very special meaning. And I think I'm getting into a very complex issue here and I think medical confidentiality should be maintained until the point in time where, all efforts having been exhausted, the position of the person becomes dangerous for third parties. At that time I feel free, as a doctor, to protect third parties by revealing confidential information.

Urug-025-Pro: I would arrange a private meeting with the principal to tell him to not be so stupid as to report a case of AIDS in public. That makes no sense, and, of course, I wouldn't confirm it.

Arg-022-Opposition: I would raise the issue of the right to privacy of the patient and of the family. I would show the audience at the meeting that such a statement in no way contributes to improving the situation for their children and for themselves, but rather creates a situation of unveiling private family situations. A measure like this does nothing but create mechanisms of discrimination. In turn, it is possible to create preventive mechanisms, so it would not be necessary to report this in the way sought by the principal. Because that has the effect of marginalization.

Chi-049-Young: I wouldn't be able to assume that right, which depends on the person. It is a medical confidence and only if the parent consents or grants me the authority would I be able to divulge their condition.

Additional comments: The need for the doctor to respect the confidential relationship with the patient prevails clearly and unequivocally (all of the interviewees mentioned it), unless: a) other people are at risk; b) the patient's family should be informed; c) the patient consents to the information being made public. Only one

interviewee deals with the possibility – latent in the question – of actual discrimination against the patient.

2.2 Synthesis of the Qualitative Evaluation

So far, the qualitative evaluation has been based on textual versions of the interviews and its purpose was to define interviewees' line of reasoning with regard to a range of attitudes to each country's recent military government, as well as revealing the range of opinion among individuals.

As part of the evaluation, we also analyzed the range of opinions on each topic in order to integrate them into general contexts of argumentation and historical development. The following discussion offers more in-depth observations regarding the content underlying the interviews.

1. The mention of organized violence had different connotations for the representatives of the four groups. Considering that even today the use of force by the State remains a significant factor in the three countries, it is not surprising that almost all the interviewees — rather indirectly at first, but then very concretely — mentioned social violence initiated by the State. It is also understandable that the two main adversaries, that is, interviewees defined as Pro (pro-military regime) and Opposition (anti-military regime), specifically insert this idea within the context of a confrontation that actually took place, and from their respective points of view refer to the reasons for the violence. ("The largest expression of violence here in Argentina has been the subversion" [Arg-040-Pro]) or to its negative consequences for society ("You have that feeling of danger now. Starting from the moment the State institutionalizes violence you can see it, because also an escalation is almost produced..." [Arg-04-Opposition]).

Within the Neutral group, meanwhile, there are signs of a broader range of attitudes that differ more clearly among themselves. In some cases, there was evidence of active approval of the material results ("The biggest dam that we have here within the country was built by a dictator…" [Urug-046-Neutral]) and even open enthusiasm ("Let's say that the previous period [the military government, H.R.] was almost —my existence could not have been different from that of the average Argentine, that it was almost like an affront against hope. We're talking about 1976, (the hope) that a new revolution could change everything..." [Arg-010-Neutral]). In turn, others played an active role in defending human rights ("You know, I wrote a lot in the press about human rights, on some aspects of obedience within the chain of command, for example, speaking about the fallacy of the death penalty, exile..." [Chi-013-Neutral]). The Young Physician group gives the impression that violence has acquired a wide range of meanings at the individual level ("My family was indeed worried." [Urug-07-Young]). "Actually, I

think that violence is generated when situations arise that peoples haven't been able to resolve in other ways and they simply explode." [Chi-049-Young]. "We knew they had been tortured and that this would never be acknowledged," [Arg-019-Young]. Members of the Neutral group also expressed, with great clarity, the permanence of violence. For one member of the group, the institutionalization of organized violence has even acquired an openly annihilative character ("Fundamentally, there is no possible reparation because the objective is the destruction of the political opponent, and so there doesn't exist a possible reparation." [Arg-010-Neutral]).

2. Regarding the process of transition to democratic government, we note consensus among all the groups. The range of positions offers evidence of satisfaction with the economic gains from the dictatorship ("the state of prosperity and progress Chile is experiencing was sown by the military government and is being harvested by the civilian government" [Chi-019-Pro]); of satisfaction with current respect for human rights ("The most important thing is to be in a land where the laws are respected... feeling that you have someone to appeal to, that there is a judicial system that works, that is clear, that there is a parliament, that you aren't going to be threatened..." [Chi-013-Neutral]); of mild disillusionment with the return of old customs ("the committees, the political recommendations, the fact that if you have good connections you can get more, those things" [Urug-046-Neutral]); of deepening of habitual problems ("There is a total crisis of values, very shocking..." [Chi-016-Opposition]); or of general optimism ("That people can freely express their thoughts without fear: that's something I feel is priceless... you get the feeling that the country, in some way, has room for people with different skills, and before it was as if there were a lot of people who were on the outside" [Chi-049-Young]). Different opinions also appear to coexist regarding how the military dictatorships' victims should be treated, even though interviewees sometimes express sincere approval of the authoritarian power structures ("Nobody bothered me because of my ideas and I worked better in those years, I worked better. It didn't bother me in the least" [Urug-046-Neutral]. Nonetheless, none of the interviewees expressed general support for a return to *de facto* government.

3. Interviewees treated the issue of manipulating genes as something possible, but more in terms of finding a method for treating hereditary illnesses in the near future, and it seemed to enjoy widespread acceptance. Although one member of the Pro group explicitly praised progress ("The systematic analysis of the genome seems to me to be a very interesting project. It appears to me to be, at this time, I would say the biggest research project in the world" [Arg-040-Pro]), it should be stressed that the attitude of members of the Pro group with regard to this and other questions of medical ethics (for example surrogate motherhood) was

typically reluctant. Although far from being out-and-out conservatives, members of this group were noticeably cautious in their opinions about recent technological advances.

For every group we found that — when manifesting scruples in the face of transgressions of medical ethics — interviewees' arguments included religious nuances. In general, the optimistic opinion that human beings will be able to dominate nature in future — with no significant elements of conflict— predominates ("It's not that I believe in the creation of a superman. I think these are human decisions about a specific event or pathology"[Arg-04-Opposition]).

4. The *Nil nocere* as a fundamental basis for medical practice appears fragile, given that some physicians' participation in human rights violations during totalitarian regimes was *vox populi*. For some physicians, acknowledgement of the precariousness of professional ethics was overwhelming: in their interviews they tried to come to grips with tactical considerations ("To live in a State of Exception involves a risk to life… I think [the doctor] has an absolute right to protect himself while playing the role [examining blindfolded patients] corresponding to him as a professional" [Chi-040-Pro]); or based on principle ("The doctor is either a military doctor, a member of security forces, or a civilian doctor. For me it is important, because if he works in a certain sphere he functions according to particular rules..." [Arg-010-Neutral]). For others it seems to have produced a profound dismay ("I think a doctor who participates in torture… is pitiful, I think they are beings who go against everything they have thought of doing in their lives. I don't understand them..." [Chi-016-Opposition]). Nonetheless, the confirmation of crimes against humanity and transgressions of professional ethics not only provoked reactions of dismay or of partial approval, but was also the basis of a frank opposition ("We continue to defend the right of doctors to analyze the conduct of military doctors during the de facto period and to sanction those doctors who have participated [in repression] in disagreement with normal ethics.' [Urug-016-Opposition]). Of great importance is the fact that there is still today, evident in the arguments of the interviewees, a major debate revealing everything from latent conformity with the lack of professional ethics to strict opposition to the attempted domination and utilization of medicine by totalitarian regimes.

5. Respect for doctor-patient confidentiality appears to be firmly entrenched and to constitute a solid ethical-cultural heritage, even when dealing with a threatening illness such as AIDS. The opinions cited here pertain to the legal rights of the patient: ("I wouldn't be able to assume that right; that depends on the person. It is confidential" [Chi-049-Young]); the well-being of the general public ("I think doctor-patient confidentiality should be maintained until the point in time when, all efforts having been exhausted, the person's position becomes dangerous

for third parties. At that time I would feel free, as a doctor, to protect third parties by revealing confidential information" [Chi-019-Pro]); or as a fundamental right ("I would raise the issue of the patient's and family's right to privacy… A measure of that sort [announcing a parent's possible illness in a school assembly] does nothing but create mechanisms of discrimination" [Arg-022-Opposition]). Among the contributions from all groups to this question, the common denominator was the categorical respect for the physician's duty to respect doctor-patient confidentiality.

C.3 Quantitative Results: Group Comparison

I will now discuss the quantitative evaluation that forms part of this study, which provides new insight into the empirical material and a complementary heuristic for the overall evaluation.

The quantitative analysis of the field study was carried out according to criteria for group comparisons. The data used came from the questionnaire (with basic response alternatives); directly, in the case of questionnaire responses received by mail, and indirectly from the answers and opinions contained within the interviews.[100] With this as my basis, a statistical evaluation was calculated,[101] illustrated by the tables below. This evaluation of the data found that the division of interviewees into "Pro," "Neutral" and "Opposition" groups proved consistent and that each group differed significantly from the others on most points. The use of quantitative evaluation methods offered new ways of accessing relevant data from a professional social sector like the group interviewed. Moreover, it effectively complements the qualitative evaluation, in the sense that along with examining individuals and their personal statements in interviews (independently of how detailed they were), it also looks at thematic and group connections existing among interviewees.

[100] In evaluating the standardized questionnaires, only those multiple-choice responses that appeared to be consistent with the interview were taken into consideration. If a response was not provided this fact was not included in the data bank and was indicated in the tables as "No Answer" (N. A.).

[101] For each possible response to the standardized questionnaire a binary number was registered in the data bank.

3.1 Synoptic Tables

Faced with a large amount of information from almost two dozen synoptic tables, we will focus on a selection of interesting questions. The tables will present responses to specific issues involving medical ethics or opinions about the respective military government. For the figures, each unit represents an interviewee; here we display the information based on responses to twelve of the twenty-three questions posed by the researcher. Such questions are already familiar from the previous section, so the tables present the selection made by the members of the three groups (Pro, Neutral, Opposition). Alternatives offered for each question are included below each synoptic chart. The data for each question is discussed under comments. Finally, after presenting these tables an overall summary of the quantitative information is provided.

Table 1

How did you perceive the military intervention?

Attitude / Response	A	B	C	D	E
Pro	1	8	3	0	0
Neutral	0	3	4	1	0
Opposition	0	1	4	13	2
Total	1	12	11	14	2

N: 40 N.A.: 0

Basic responses:

A) It was the country's response to violent foreign influences.
B) It was a necessary intervention, considering evident social deterioration, economic chaos and/or political violence and/or moral corruption.
C) It was a foreseeable consequence of the polarization resulting from political and social struggles.
D) It was an arbitrary act of violence, with no judicial or moral basis.
E) An all-embracing movement for social transformation was violently interrupted.

◆Table 1 Comments. Table 1 reveals the differences in current attitudes about the extent to which military intervention in the three countries was welcome. These statements serve to support or condemn the intervention, but also to establish a significant correspondence among members of the three groups around a somewhat neutral position. As would be expected, most supporters of military intervention appear in the Pro group. Nevertheless, the Neutral group also shows a latent affinity with that line of reasoning. Similarly foreseeable was the vast number of members of the Opposition group who condemned the military intervention. There

is a significant number of responses, distributed among all groups, corresponding to C) "consequence of the polarization".

Table 2

Do you believe what was said about torture, deaths, and disappearances?

Attitude / Response	A	B	C	D	E
Pro	2	6	2	2	0
Neutral	1	1	2	2	2
Opposition	0	0	1	10	8
Total	3	7	5	14	10

N:40 N.A.: 1

Basic responses:

A) The press greatly exaggerated everything related to torture, deaths and disappearances. Yes, there were excesses and I knew of them, but I considered them as such.

B) Yes, this was true from the outset, but for both sides, because there were acts of harassment, killings of prisoners of war, kidnappings and "disappearances" of enemies during an irregular situation, of war.

C) It was acknowledged and spoken about only amongst special interest groups.

D) The opposition was persecuted in every possible form, from the beginning of military rule; the terror that torture produces, assassinations and "disappearances" was exploited.

E) The practice of torture, deaths, false executions and "disappearances" was from the beginning the rule and had an affect on many people in my personal environment/on myself.

◆Table 2 Comments. The question deals with general awareness of human rights violations. The distribution of answers corresponds to typical assertions. Thus, half of the Pro group sees violations of the legal system as being widely acknowledged, but argues that they occurred within a context of an "irregular war," while others downplay violations as isolated incidents that were exaggerated by the media. In the Opposition group, half refer to the terror as being systematic; a considerable number of them experienced direct threats. This table reveals that recognition of human rights violations was quite widespread among interviewees (the No Answer reply came from a member of the Opposition group, who most likely was aware of them). All interviewees formed their own opinions. More than half of the interviewees, including members of the Pro group, acknowledge the existence of terror; a considerable number views it as being systematic; and a minority limit the scope of such events to a small group of conspirators in the armed forces or the resistance.

Table 3

Should sanctions be brought against those physicians who transgressed basic medical ethics during the states of emergency?

Attitude / Response	A	B	C	D	E
Pro	2	1	1	5	3
Neutral	0	1	1	2	3
Opposition	0	0	0	3	17
Total	2	2	2	10	23

N:40 N.A.: 1

Basic responses:

A) I don't forgive anyone, but I can understand some of the excesses in the heat of the battle during states of emergency …

B) No, because we can't fairly evaluate how things were at the time and there are extreme situations which lend themselves to bad interpretations.

C) Doctors should not be treated any differently from other members of society.

D) Yes, but considering every situation individually, and the possible pressures the doctor implicated may have experienced.

E) Yes, unconditionally and under any circumstances.

◆Table 3 Comments. The question explores how doctors who collaborated with the military dictatorship should be treated. Based on preceding information, it could be supposed that doctors' participation in crimes against humanity during military rule was public knowledge. Here we hoped to discover interviewees' personal position on this topic, including their possible interpretations in both general terms and with regard to concrete situations. The interviewees' opinions about violations of professional ethics committed during the state of exception that are legally punishable converges on the idea of general condemnation. Nonetheless, while the vast majority of the Opposition group insists on clarification and unconditional punishment —and in this case are seconded by a considerable number of members of the Pro group— these last make an effort to establish criteria to define mitigating circumstances, which is, again, supported by members of the Neutral and Opposition groups.

Furthermore, despite generally condemning human rights violations committed by doctors, there are still some opinions within the Pro group that treat violations as being the result of "the heat of the battle." Violations are also viewed as relative, given "extreme situations, which lend themselves to misinterpretation (a point also stressed by a member of the Neutral group).

It can be concluded from this table that interviewees were generally aware of doctors' participation in crimes against humanity (only one member of the Neutral

group did not respond to the question). During the course of the interviews nobody said he or she had been unaware of these doings.

Table 4

Were there situations of real danger for yourself or members of your family prior to or during military rule?

Attitude / Response	YES	NO
Pro	2	10
Neutral	3	4
Opposition	18	2
Total	23	16

N:40 N.A.: 1

◆Table 4 Comments. The table explores subjective feelings of being at risk during military rule. Given a historical period characterized by increased levels of violence, we were clearly interested in finding out if each interviewee had felt threatened in any way before or during military rule. Their description of that threat was also important.

Most interviewees stated that they experienced contact with threatened violence. Somewhat unusual is the high number of personal experiences in the Neutral group, while answers from the Pro group (little sense of being at risk) and the Opposition (most group members felt threatened) were both to be expected.

Table 5

Specify the type of threats you experienced

Alternative / Group	PRO	NEUTRAL	OPPOS.	TOTAL
Harassment by phone	1	1	3	5
Direct threat	1	1	3	5
Direct persecution	0	0	3	3
Temporary exile	0	1	4	5
Prison	0	0	5	5
Accusations of torture	2	0	0	2
None	8	5	2	15

◆Table 5 Comments. The kind of threats is clearly apparent. Telephone threats had as much impact as direct threats in almost every group and left vivid memories. Only the Opposition group experienced direct persecution and imprisonment. People in the Neutral group and the Opposition group had to bear temporary exile. On the other hand, two members of the Pro group were accused of participating in torture, and although they were not directly threatened, they became the objects of massive social pressures.

From the statements represented in this table, it can be inferred that the State of Exception left an indelible imprint on all those involved. Many of the members of the Opposition group lived in situations of danger that can be readily verified (the group was collectively exposed). In spite of everything, members of the Neutral group were similarly affected, while two members of the Pro group experienced telephone harassment or direct threats. In general, those in the Pro group say very little about threats, though they emphasize the latent threat resulting from their being accused of involvement in torture

Table 6

Were you or members of your family affected by mental imbalance?

Attitude / Response	YES	NO
Pro	1	11
Neutral	0	7
Opposition	4	15
Total	5	33

N:40 N.A.: 2

◆Table 6 Comments. We seek to establish interviewees' mental state during the states of exception. Since it can be assumed that the social environment during the three military dictatorships also affected participants mentally, we wanted them to express more details about this in their own words. A total of five of the forty interviewees, from Opposition and Pro groups reported considerable psychological suffering during that period.

Table 7

Specify the type of mental imbalance you experienced

Symptoms / Groups	Pro	Neutral	Opposition	Total
None	11	8	7	26
Hypervigilance	0	0	4	4
Depressive syndrome	0	0	4	4
Panic attacks	0	0	1	1
Anxiety states	0	0	1	1
Action vs. Fear*	0	0	3	3
Without references	1	0	0	1

(*) This refers to behavior to attenuate anxiety and fear by channeling activity into very specific goals, however modest (for example "maintaining contact with colleagues and friends despite the waves of terror they invaded us with." (Personal communication from an interviewed doctor).

◆Table 7 Comments. Taking into consideration the specific forms of mental suffering during these dictatorships, a discrepancy is revealed between the responses in Table 7 and those of the preceding table. While only five people spoke of mental breakdowns in the question analyzed in Table 6, the number citing specific kinds of mental instability is thirteen.

However, this disparity can be explained by taking into account that interviewees considered only the depressive syndromes and anxiety attacks to be psycho-

pathological problems. Inasmuch as they saw the other symptoms as due to the exceptional conditions prevailing in the country, experienced only temporarily (for example during a wave of arrests or the loss of someone close), participants considered them to be worth mentioning, but did not treat them as clinical signs of mental illness.

When directly questioned, interviewees saw hypervigilance, active compensation for anxiety (action versus fear) and brief panic attacks as mental reactions to emotional tension, but did not treat them as being particularly disturbing – and in no way pathological events – to the individual's general psychological constitution. As for the rest, most members of the Opposition group experienced periods of persecution, with no confirmation or denial of this phenomenon, since it was part of everyday life under the military. The evidence from this table reveals conditions of extreme emotional stress for members of the Opposition group during military rule: almost two-thirds of opposition doctors experienced significant mental changes in this period.

Table 8

What would you do if the head of your surgical team leaves an operation, for minor reasons?

Attitude / Response	A	B	C	D	E
Pro	4	3	4	1	0
Neutral	0	4	2	0	1
Opposition	16	4	0	0	0
Total	20	11	6	1	1

N:40 N.A.: 1

Basic responses:

A: I would continue the operation as far as my technical abilities allow. I would question the conduct of the chief, personally, and before the ethics committee or relevant authorities.

B: I would continue the operation as far as my technical abilities allow. I would tell the chief I thought his behavior was incorrect.

C: I would continue the operation as far as my technical abilities allow. I wouldn't make a major issue of the situation.

D: I would ask another experienced surgeon for help in order to finish the operation.

E: I would not continue with the operation.

◆Table 8 Comments. This question explored interviewees' acceptance of arbitrary attitudes in a superior arising exclusively from their hierarchical position. Most of the Opposition group rejected this attitude, as did many of those in the Pro group, while half the Neutral group and a noteworthy number of Pro group members favored clarifying the incident privately. A considerable number of Pro and Neutral group members were willing to accept the situation without speaking out. One per-

son from the Pro group reduced the situation to technical aspects and a member of the Neutral group would not continue with the operation.

This table shows that the vast majority of the interviewees would proceed with the operation; half would lodge a formal complaint against the superior; and more than a quarter would attempt to clarify the situation in a private meeting. Almost a fifth of the participants would accept the situation, that is, they would accept their superior's attitude despite this infraction of rules (responses C and D).

Table 9

Should doctors participate in executions in those countries where the death penalty is legal?

Attitude / Response	A	B	C	D	E
Pro	1	1	3	2	5
Neutral	3	0	0	1	3
Opposition	3	0	0	7	9
Total	7	1	3	10	17

N:40 N.A.: 2

Basic responses:

A): It's not punishable, since the law permits it, and society accepts it. In addition, the doctor may try to humanize the execution.

B): It's not punishable, because it is the custom of the respective country and one can't form opinions from the outside.

C): I don't have an opinion on the matter.

D): The doctor's duty is to protect life and therefore s/he should reject all pressures that threaten it, regardless of origin.

E): It is punishable, because this is not appropriate to a doctor's work, although I don't know what punishment could be.

◆Table 9 Comments: The question refers to the direct participation of doctors in executions. With regard to the death penalty, the purpose of this question was to explore whether a doctor could act as an executioner, by simply following orders from the State. The answers reveal an extraordinary divergence of opinions, together with a lack of conceptual clarity, since almost half of the members of all groups express the opinion: "It is not a medical act." One-fourth of interviewees center their response on the Hippocratic Oath, assuming under any circumstance the defense of the human life. This is particularly true of those in the Opposition group, with the oath being cited in isolated cases in both the Pro and Neutral groups too. One interesting result is that almost one-fifth of the interviewees considers the possibility of reducing suffering as a factor legitimizing execution by doctors. This came up most in the answers of doctors in the Neutral group, and on occasion in those of both the Opposition and Pro groups.

Table 10

Would you interfere medically in a hunger strike?

Attitude / Response	A	B	C	D	E
Pro	3	1	0	5	3
Neutral	3	0	0	1	4
Opposition	10	0	0	8	1
Total	16	1	0	14	8

N:40 N.A.: 1

Basic responses:

A): A hunger strike is a political act legitimized by custom, and the participants are citizens with full awareness of the risks involved in a hunger strike and the effects on public opinion. I wouldn't do anything without their direct authorization.

B): A hunger strike is a political act. As a doctor, my services must be requested. I would not let any institution use me as an instrument.

C): I refuse to take a position.

D): A hunger strike is a political act. I would speak to the strikers to determine the level of risk they actually face. If I find their lives to be genuinely at risk, I would treat them as people with suicidal tendencies and would do a transfusion, because the doctor's duty is to preserve life.

E): My intervention is sought as a doctor faced with people assumed to be would-be suicides, and as such I would gauge the level of risk for those involved and proceed as necessary.

◆Table 10 Comments. The medical interruption of a hunger strike was dealt with here. The necessity of a personal decision when faced with an intervention of this nature seems to have made a deep impression on the interviewees. The set of factors (hunger strike with possible threat to life, an order from a higher legal body, a forced medical act) seemed to strike them more as a question of faith than of medical ethics and this was true for all groups. The right to a hunger strike and the issue of a suicidal component in strikers' conduct was openly discussed.

Thus, the assumed risk of death was treated as fact and many members from Pro and Opposition groups, and a few from the Neutral group, proposed a specific preventive treatment.

A similar line of argument was evident in the consideration of strikers as virtually suicidal, or at least as requiring treatment. This was the position of half the Neutral group, a noteworthy number of the Pro group, and a few isolated members within the Opposition group.

The legal and moral right to a hunger strike was similarly widely considered by half the Opposition group and a significant number of members of both the Neutral and Pro groups.

Table 11

Do you consider organ transplants from accident victims or unidentifiable persons to be a legitimate practice?

Attitude / Response	A	B	C	D	E
Pro	1	9	0	2	0
Neutral	3	5	0	0	0
Opposition	3	8	6	2	1
Total	7	22	6	4	1

N:40 N.A.: 0

Basic responses:

A): It is legitimate, because medicine should tend to the well-being of the ill and this involves maintaining the lives of people in danger.

B): It is legitimate, because it is necessary in medical and judicial terms.

C): It is not legitimate, because the precise moment of an individual's physical death is often uncertain, and this could lend itself to abuses of unidentified people (for example in asylums or mental hospitals).

D): It is not legitimate, because it could run counter to the beliefs of the deceased and their families (for example Jehovah's Witnesses).

E): I choose not to respond because the topic is somewhat unfamiliar to me and I don't know enough about the technical and ethical aspects.

◆Table 11 Comments. This table displays the level of agreement with using the organs of deceased and unidentified individuals in transplants. An active approach to getting organs from unidentified deceased persons (A and B) was especially noticeable in the Neutral and Pro groups and was also significantly frequent for the Opposition group.

An interesting result is the fact that only Opposition group members made explicit references to possible abuses. Pro and Opposition group members also mention the danger of contravening religious principles.

The content of Table 11 represents, on the one hand, a high level of willingness to use the organs of unidentified deceased persons, and on the other, an underlying fear of generating avenues for abuse of power and arbitrariness that would affect those who cannot defend themselves.[102]

[102] This cautious attitude may be related to a recent situation in Argentina: in the period between 1986 and 1992, a large number of patients (the figures vary between several hundred and more than a thousand) "disappeared" from the Montes de Oca Psychiatric Hospital in Buenos Aires province. An investigative commission organized later found, in anonymous common graves, indisputable proof that organs had been removed from people

Table 12

Do you consider surrogate pregnancies to be legitimate?

Attitude / Response	A	B	C	D	E	F
Pro	2	1	4	4	1	0
Neutral	1	5	0	1	0	1
Opposition	6	5	6	1	1	0
Total	9	11	10	6	2	1

N:40 N.A.: 1

Basic Responses:

A): It is legitimate, provided there is a sort of moral and legal agreement between the parties involved to do the most possible for the well-being of the child (for example, to allow the newborn child to stay with the host woman for a period of time).

B): It is legitimate, because parents have the right to have a child of their own with the help of medicine and a third person.

C): It is not legitimate, because there would be a tremendous responsibility facing both the unborn child and the surrogate mother and —without creating adverse conditions for the wished-for child— one can become a parent via adoption also.

D): It is not legitimate, because in vitro fertilization is questionable on religious and/or cultural grounds.

E): I choose not to respond because the topic is somewhat unfamiliar to me and I don't know enough about the technical aspects.

F): I choose not to respond because the topic is somewhat unfamiliar to me and I don't know enough about the ethical aspects.

◆Table 12 Comments. The table defines interviewees' positions on the possible gestation of an embryo in a third party's uterus. Considering the basic tenor of replies, a positive position on the matter is apparent among members of the Neutral and Opposition groups (responses A and B), where the majority holds this position. However, the Neutral group expressed concern about the concrete feasibility of intervention and the Opposition group more often mentions judicial and moral aspects. Within the Pro group, a fundamentally negative position clearly predominates (C and D) with a third of this group offering alternative solutions (adoption) or forming arguments against in vitro fertilization based on moral and religious principals.

buried there (especially corneas). This form of trafficking in organs is not only illegal: it also constitutes a paradigmatic example of disdainful and inhumane treatment of patients dependent on medical guardianship, together with an absolute certainty of the impunity of these acts. Although other people also "disappeared" in unclear circumstances, there have not been any formal accusations made to date (see detailed reports in *Clarín*, Buenos Aires, 23 February, 1992; and *Le Monde Diplomatique*, Paris, August 1992).

This table shows that the interviewees as a whole evaluated the probability of medical intervention as rather high. This is reflected in the clarity of the arguments put forth in the responses, indicating they explicitly recognize the consequences of intervention.

3.2 Synthesis of Group Comparison

An in-depth analysis of the preceding tables leads us to make the following observations:

a) There is a tendency to objectify social-historical events. The quantitative perception of the origins of military intervention polarizes opinions, many of which seem very abstract: whether or not military intervention was the foreseeable consequence of the polarization of social and political conflicts proved to be a point of convergence for members of all groups. Initially, this "objectification" appears to stem from personal caution learned during the dictatorship, which involved never revealing one's own political position. Furthermore, it gives the impression of being the result of reviewing choices made and interpretations of social processes, in light of a clearer perception of the social conflicts of that period. The range of meaning and interpretations masked by the homogeneity of responses becomes apparent only with the help of the texts included in the qualitative part of my study.

b) There has been a great deal of publicity around human rights violations during these military dictatorships. The question directly exploring the extent of personal awareness of these violations offers insight into a relevant feature of the military dictatorships in South America: how effective was the distribution of information about these events. Only one person did not provide an opinion on this matter. The responses given illustrate a range of perceptions regarding these events and, as a general rule, interviewees offered their arguments clearly. In fact, when rights violations were described as "excesses," interviewees clearly understood what they were referring to.

c) The fact that physicians committed crimes against humanity is public knowledge. Here it is important to consider the usual approaches (focused on a specific struggle or an individual context, not currently understandable) or the prevailing condemnation of these actions. However, it is also important to notice the many different forms a fundamental ethical-judicial position can take, for example in this case, one that holds that although crimes against humanity should be condemned, all mitigating factors in individual scenarios should be considered. Diverse lines of argument appear to converge here and result in a paradox, because while for some an interest in justice and condemnation follows inherent principles

and must take into consideration individual details, others stress the need to reduce culpability in general. This would promote a feeling of amnesty amongst public opinion (the emphasis on expiation through feelings of remorse, heard frequently in interviews, could point in the same argumentative direction: "If society is aware of all that happened, we can leave those poor guys alone").

d) Harassment through terror left indelible marks on the interviewees. In relation to the danger they experienced, the most serious circumstances (persecution, exile, imprisonment) especially affect members of the Opposition group, although one member of the Neutral group also had to leave the country temporarily. The impression that the terror of the past still casts a shadow over the present is born out by the interviewee who continues to suffer from the accusation that he participated in torture, which seems to hang like a Sword of Damocles over the head of the accused.

e) Depression and stress reactions are psychopathological corollaries of the era. The fact that interviewees referred directly to this kind of emotional response to situations full of anxiety and tension (in the interview, the characterization of unusual psychological experiences was left to the interviewee) is significant. While depressive syndromes, including states of anxiety, have a clear psychopathological value in the eyes of the interviewees, stress reactions such as hypervigilance and hyperactivity (action versus fear) were not interpreted as pathologically perturbing. Reszczynski et al. 1991 established a high frequency of this syndrome of stress reactions in the period following the military coup in Chile and described the assimilation of anxiety as a hyperfunction of the psychological process. Here there is evidence only that the stress reaction, as a permanent condition, left very clear mnemonic imprints on those affected.

f) Doctors still show considerable potential for submissiveness. The low level of acceptance of an obvious abuse of power in the operating room reaches a climax in the dismayed response of one participant ("interrupting an operation for personal motives is equivalent to violating part of the definition of being a doctor"). Nevertheless, seven physicians would go ahead with the operation without any complaints, showing a tendency to obey authority figures unquestioningly.

g) Execution as a medical act was partially condemned. The fact that a significant number of interviewees from all groups accepted a physician's participation in the application of the death sentence, in my opinion, merits more research. For now, one needs only to be aware of the opinion of some subjects who view the doctor as "serving the function of a priest" (Interview Chi-040-Pro).

h) The physicians perceive hunger strikers to be potentially suicidal. The hunger strike as a political act seems to be deeply influential in the area of medical duties and skills. The question on the topic gives the impression of having ap-

pealed to strong, latent fears in the interviewees. The large number of members of the Neutral group who would proceed professionally as with a potentially suicidal person can be explained by the fear of being accused of malpractice, that is, neglecting those in need of medical attention. Regarding this issue, physicians don't seem to be aware of their rights as citizens and professionals (the large number of responses rejecting any medical intervention opposed by the strikers themselves underscores the fact that a doctor cannot be forced to intervene in any of the three countries). In general, we observe that faith in the reliability of State institutions —as for example, the Supreme Court— is relatively unquestioned, and, overall, physicians were willing to abide by its decisions without hesitation.

i) A dead person cannot lay claim to personal rights. Interviewees showed a high degree of acceptance of the idea of using the organs of unidentified deceased persons, considering this a legitimate practice. Clarifying whether this results solely from pragmatic consideration or from an unconditional approval of life would require additional research to this end. The main question to be answered, from the perspective of the interviewees, would be if individual rights (for example the right to physical integrity) become less valid at the time of death and therefore should be legally repealed. Or if the principle of preserving life supersedes all else and, as a result, makes action even against the rights of unidentified deceased individuals permissible, with no reservations. These interpretative alternatives hide the different connotations arising from perceptions about the value and dignity of an unidentified deceased person (see note 43, on the incidents at Montes de Oca Hospital).

D Global Evaluation of the Empirical Research

In this section, we review the main results of the empirical study, beginning with a note on methodology, followed by a summary of partial and general observations, and a comparison between the basic questions and results. This section ends with a summary of specific and general observations and a final commentary.

D.1 The Scope of the Study

1.1 Overview

As the title of this book, *Medical Ethics in Times of Crisis*, indicates, within its pages I have sought to bring together issues involving professional ethics and human rights as they affect physicians' professional activities and in light of recent history in South America. To define the context, this book resorts to the Greek meaning of *crisis*: most crucial moment of decision in a process.

Medical ethics experienced periods of crisis during the military governments that ruled South American countries, with doctors' reactions oscillating between the poles of total obedience and consistent opposition.

The basic interest of this study was to access physicians' personal environments on both a personal, individual level and as part of their function as witnesses to a given historical period.

Although many of the doctors interviewed during this study are representative of the recent past, because of their professional activities within military governments, in the academic sphere or within the opposition to regimes and/or in solidarity with dictatorships' victims, our focus was not upon that condition per se, as a source of novel insights. Rather, we focused on interviewees in the context of their own lives, as individuals with their own biographies and their own forms of thinking.

Respecting interviewees' anonymity was necessary for many reasons. First, the treatment of the relationship between medical ethics and human rights during states of political and legislative exception remains a source of deep controversy in these three countries. Secondly, this book does not intend to judge or condemn, but rather to systematically explore the events of that period, going beyond the nature of circumstantial anecdotes to define areas of specific responsibility, leaving it to readers to draw their own conclusions.

1.2 The Source: Physicians as Social Agents

As explored above, during the course of this study, I interviewed physicians about their experiences and interpretations of their own situations. Motivated by an interest in understanding people as direct participants in social events, I underlined Gramsci's comment: "Every man… employs a certain intellectual activity, that is to say, is a "philosopher," an artist, a man of good taste; he participates from a conception of the world, has a moral line of conduct, and for that reason, he

contributes to sustaining or modifying a conception of the world and to raising a new way of thinking."

Doctors, teachers and priests are considered to be the formal leaders of civil society. Aside from the special respect accorded to them, they are expected to fulfill specific roles as part of social and cultural interactions. Gramsci's observation highlights the value of how one forms a personal opinion and vision of the world, as long as the philosophical process of questioning and understanding is defined in the daily environment. Hence, one can take the approach that a doctor enjoys certain attributes of social authority and therefore it is worth asking this professional group some questions about recent history. Although during the interview, typically professional issues were addressed, this was done explicitly as they related to the historical and social context.

1.3 Basic Conceptualization

Faced with a genuine avalanche of neologisms (consumer ethics, media ethics, environmental ethics, etc.) and multiple interpretations of ethics themselves, for the purpose of this study Max Weber's distinction between *ethics of conviction* and *ethics of responsibility* seemed particularly relevant. Using these concepts, he tries to describe the basic difference between attitudes of heteronymous or autonomous decision-making in clearly defined situations.

For the *ethics of conviction*, one should consider an argumentative basis that moves the individual involved to make decisions that —for the individual— are transcendental, as long as they are based on principles considered to be unmoving. In a situation of conflict, this attitude is expressed as a blind acceptance of authority and in forms of ideologization and/or negation of specific issues.

In contrast, for the *ethics of responsibility* one should start from an argumentative basis, examining what motivates people to make certain decisions that – for the individual – are grounded in rational thinking, arise from personal experience, and are focused on an interaction involving open discourse.

Thus, while the ethics of conviction involve an external and/or immutable instance ideally invoked in order to make a decision regarding certain ethical professional issues, in the ethics of responsibility a critical approach to normative instances of discipline and individual duty is usually taken, which also involves clearly defining the question of "who is responsible and for what reason".

Using this semantic distinction, we wish to make the process of reaching an ethical decision into just another human action, that is, a result, comprehensible on its own and in the context of its implications. In doing this, we also seek to demystify

the relationship between theory and practice in ethics as a cultural effort, removing it from its metaphysical pedestal and overcoming the arguments, a priori, that distance such a relationship from our regular daily reasoning.

Thus, the elements that form part of the discussion that follows don't seek to be simple and all-encompassing. Instead, they aim to recreate the extremely varied universe of possible decisions within this study, giving rise to an argumentative transparency —in the interaction between book and reader— that in turn seeks to affirm that human gift and cultural privilege essential to democratic societies that we know as sovereign, personal opinion.

The next section will briefly restate the different areas included in this study.

1.4 Questions and Hypotheses

The main line of inquiry in this study dealt with the following questions:

1. What was daily life and medical practice like during the period?
2. What was known about physicians' participation in human rights violations, such as torture?
3. What is doctors' current attitude to that period?
4. Is there any relationship between sensibility to questions of professional ethics and life experience acquired under totalitarian regimes?

The theoretical assumptions behind this study can be stated as follows:

a) Military dictatorships profoundly influenced every aspect of their respective societies.
b) The psychological effects of State terrorism on those affected can only be observed in their personal dimension.
c) The understanding of the relationship between professional ethics and human rights is linked to the self-perception of the actors in their respective society.

The main hypotheses regarding this line of inquiry were as follows:

1. Military intervention represented a breakdown for physicians, which personally affected everyone, forcing them to adjust their life plans to the events of the period.
2. Human rights violations (even on the part of doctors) during the respective military dictatorships were widely known and nowadays —unlike what hap-

pened after the Nazi regime in Germany— are not the subject of denial or cognitive taboos.

3. The moral-professional consciences of doctors interviewed are in line with their social self-definition, in light of recent history. There is, therefore, a correlation between personal perceptions of situations of conflict in medical ethics and attitudes in this respect, according to the biographical background of each one of the participant doctors.

The empirical study provided information about the opinions and attitudes of doctors who lived through states of political and social exception in all three countries.

Using the sociological method of “theoretical sampling", we sought contact with doctors representative of typical attitudes to the military regimes, sorting them into groups that were “Pro,” “Neutral”, “Opposition”, and “Young Physicians”, that is, those who were studying at the time. As part of a fieldwork methodology based on participant observation, we carried out semi-structured interviews with them.

D.2 Some Reflections on Medical Ethics and Human Rights in South America

In this section we will present an overview of relevant events that took place as part of the interaction between medical ethics and human rights in South America. No references are included, as they can be found in previous chapters.

2.1 Introduction

In the so-called developing nations of South America, such as Argentina, Chile, and Uruguay, the state of medical ethics is a complex matter, basically expressed in three coexisting currents explicitly based on ethical approaches to thinking and acting:

a) A bioethical dimension, concerned with analyzing the consequences of technology and shifting medical boundaries (involved, for example, in organ transplants, biotechnology, human reproduction);

b) A socio-medical dimension, concerned specifically with the toll that poverty still takes in the form of structural violence (insufficient facilities and treatment) affecting the majority of the population;

c) A human rights dimension, as the military period continues to exercise latent effects, and the consequences of the systematic use of violence for individuals and society are slowly becoming visible.

These three dimensions of ethics in medicine in South America are embedded in independent structures and develop parallel to one another. Deontology in medicine (ethics as a required course) is admittedly witnessing a revival at the present, both academically and professionally (in 1992 in Uruguay, for instance, two volumes of medical-ethical standards, codes, and explanations for students and working people were published). No academic authorities in the countries of this study have, however, seen themselves in a position to introduce a synthesis of these three approaches. Events during military dictatorships probably heightened awareness of the ethical fragility of medical practice. It is also likely that the nonconfrontational attitude that arose at that time still affects even the representatives of quite similar views of ethics in medicine.

Social experience over the past twenty years in South America reveals how deeply totalitarian rule influenced medical practice. It also reveals that many ethical principles were regularly broken in the process, as if they were merely declarations of good intentions, rather than principles fundamental to professional ethics. These principles are well known to those working in the health sector of the three countries, and they have been ratified in many international conventions and codices.

Thus, the spirit of the Nuremberg Code is no longer a distant model for emulation when examining the interaction between medicine and human rights under military dictatorships in Argentina, Chile, and Uruguay (1973-1989). To clarify this further, we will deal with seven questions central to medical practice under military regimes, in three blocks, as follows:

First Section:

1) Can the direct participation of doctors in torture be proved?
2) Did doctors collaborate with the military regime?
3) Did they participate in giving away the infants of disappeared mothers?
4) Were doctors simply docile fellow travelers of the regimes of terror?

Second Section:

1) Did doctors resist human rights violations?
2) Are the findings of commissions set up to investigate ethics within the profession reliable?

Third Section:

7) What (new) attitudes towards recent areas of conflict in medical ethics have arisen from these events?

I will analyze events in South America using a new approach designed especially for the source material. Some events can only be understood using data supplied by Amnesty International. Despite government officials' denials, this data has proven to be conscientious and verifiable *a posteriori*.

Doctors' direct participation in repressive acts of state terrorism (but also in forms of resistance) has led to historically new situations. As is often the case in situations that are hard to imagine in everyday terms, knowledge of these fields of medical activity has remained somewhat fragmentary and anecdotal and seems to be the dubious privilege of chance witnesses and a select number of researchers.

2.2 Towards Unquestioning Obedience

Several members of the medical profession have explicitly stated their willingness to submit to a repressive system. Dr. Guido Diaz Paci's opinion on torture, expressed to the special commission of the department of ethics of the Chilean College of Physicians (*Colegio Médico de Chile*, doctors' national association, referred to from now on as CMC), is especially relevant as he was responsible for political prisoners for over six years as a military doctor

"I believe," said Dr. Diaz, "that torture represents an extreme form of physical duress and that this physical duress is legitimate when it does not cause any harm… the duress that only causes pain… is the same as children experience when their ears are boxed or they are spanked … I believe that psychological duress, such as sleep deprivation or the like, can be allowed…"

(i) Torture and Medical Practice

Normally, an activity is culturally recognized as such when it is named accordingly. The CMC offers the following definition in this regard: "The supervision of torture from the medical viewpoint includes the ongoing analysis of the victim's ability to bear abuse. It also includes treating wounds caused by the torture, as well as ensuring that the torture not be made public, so that the victim remains in the hands of the torturers."

a) Torture under medical supervision.

In Argentina, Dr. Liwski describes the following situation, which took place during the "national restructuring trials":

"Already chained, the first voice that I heard was from someone telling me that he was a doctor and informing me about the severity of the bleeding and that I should therefore not attempt to resist… Back then there was a second… comment by (this Dr.) Vidal about a comment that he had made to one of the torturers, almost literally: "On the third or fourth day of the torture, it must be intensified, because by then the acetylcholine starts running out and we know that any attempt to resist at this point is pointless… This comment… referred to knowledge of the (physiological) mechanisms that occur in the course of the application of torture… One or two days later, after the torture had been continued, and I was informed that I would be tortured together with my then three- and six-year-old daughters, Ana and Julieta, Vidal was consulted by the main torturer, commissioner Raffo, about the conditions that must be taken into consideration when torturing children. Vidal's answer was very categorical; he said that electric shocks could be used for body weights of 25 kilograms and up."

Chile's "Truth and Reconciliation" report delivers a lot of detailed information about events around the town of San Antonio, in Chile, which can be considered representative of the general situation after the 1973 coup: "Typically… the doctor is present, also wearing a hood, to watch over the torture (to avoid fatalities) and treat the worst victims in case of emergency… The report by a humanitarian organization at the end of 1973 and the beginning of 1974 shows a high rate of medical intervention practiced on detainees; the rate was five to six times higher than in another prison visited..."

In Uruguay, prisoners' possible resistance was medically monitored: "Upon being interned in a prison camp, each new inmate was examined by doctor who then drew up a "complete medical report", which was handed over to the officers responsible for the prisoner. The officers responsible for the interrogation often used this information about existing health problems to determine the limits of the torture. When the officer knew, for instance, that a prisoner had heart problems, the time spent submerged in the "submarine" had to be shortened or replaced by another method. Moreover, officers sometimes required medical examinations during torture, to decide whether it should be discontinued..."

b) Specific medical tasks in the prison camps.

During these dictatorships, medical tasks in prisons and concentration camps seem to be governed by very different criteria from those in effect during democracy:

In Argentina, this particular attitude towards medicine can be reconstructed using the following statement: "While I was in La Escuelita, I received medical treatment twice. Once, during torture, when I was still blindfolded, someone examined my heart and lungs with a stethoscope. Then urine samples were taken be-

cause one of my kidneys had been damaged. I felt like an animal in a laboratory experiment, with a doctor who examined my vital functions, but did not look upon me as a human being. Another prisoner told me he knew the doctor. He could see the doctor under his blindfold and had recognized him. I only remember that his last name was German and that he was a doctor with the first division of the marines in Bahía Blanca."

Conditions in prisons and camps in Chile seem to have been similar. Alberto Barraza stated in his declaration before the tribunal that a doctor had examined him three times during torture. "After each examination the doctor said, 'Everything seems fine, you can continue the treatment.' It was obviously the same doctor who gave pills three times a day and a bitter drink that tasted of peppermint."

Dr. Mandressi briefly recounted these events in Uruguay to L. Weschief, a journalist for the New Yorker: "You must understand that these guys were experts. They were very well trained in the application of methods that caused great pain without leaving behind any physical trace or killing the victim. There were relatively few deaths due to torture in Uruguay. That's because normally doctors took part in the interrogations."

c) Torture and inhumane treatment on a medical basis.

Doctors were not only physically present during various repressive activities, but also seem to have made efforts to perfect their professional services. Dr. Bloche gives us an example of professional ambition of this kind in Uruguay:

"A former employee at the Libertad prison says that doctors' reports helped to keep an eye on prisoners' "activities" and behavior. "We have learned a lot in the recent past. When we observed very nervous behavior, a lot of talking, too many conversations, we took measures to neutralize (the inmates)... We gave them, for instance, less free time, changed their cells, took away their books, and tightened security. All that reduced their activity because they could never sleep well or rest.''

d) The use of non-therapeutic drugs and psychological techniques.

In daily parlance, we use the term "therapeutic arsenal" to refer to well-known and common techniques and medication used to treat disturbances and illnesses. Here, we are concerned with the development of such an arsenal that was not designed for therapeutic goals.

In Chile, there are several reports based on statements by a military anesthesiologist who had given drugs to the prisoners. One reads: "They took me into a hospital once where a young doctor called … examined me. She spoke reassuringly: 'They have punished you severely. We will take care of you now, don't worry.

We're just going to give you a shot to calm you down.' They gave me a shot of sodium pentothal, as I later found out..."

In a country as formal as Uruguay, it is not surprising that the police asked the courts for permission to use sodium pentothal during interrogations of prisoners, even when this happened in August 1970. Shortly before, the country's senate had established a commission to investigate accusations of torture, which apparently formed part of normal police practices even before the 1973 coup. A court doctor, who was a witness for the commission, stated: "And you want to know whether torture was used? You must be the only Uruguayan who doesn't know that."

e) Killings by medical means: The use of medical knowledge in the killing of prisoners was much less widespread.

The information for this study only looks at Argentina (in Chile and Uruguay, such practices cannot be ruled out, but there is little solid evidence at present). The "*Nunca Jamás*" report supplies the following account: "The three vehicles drove along an unpaved side street and up to the gate in front of the tree-covered square where officer Dr. Bergé was waiting. The bodies of the three former rebels, who were still alive at this point, were taken out of the vehicles and thrown on the lawn. The doctor gave each two shots of a poisonous red liquid directly into the heart. Two died, but the doctor declared them all dead. The priest, von Wernich, spoke to me about the impression that this event had made on him; he said that what we had done had been necessary, that it had been a patriotic act and that God knew that it was the best thing for the country. Those were his own words…

f) Harm caused by unpreventable neglect: Prisoners' experiences with medical treatment also seem to have been affected by disrespect for their rights as patients.

Dr. Liwski explains what happened when he fell ill as a prisoner: "About 60 or 65 days after I had disappeared, I caught typhoid fever. (Dr.) Vidal was brought into my cell. I could see him directly, and he informed me that the best medicine for this illness was chloramphenicol. Everyone who works in health care knows that (for typhoid fever) long-term treatment with high doses is necessary if the treatment is to be effective… after 48 hours, the chloramphenicol was discontinued. There was hardly any effect (though there was the risk that the bacteria would become resistant to the medicine)."

◆Medical-ethical reflections: Now that the majority of Latin American countries, including the three discussed here, have signed and ratified the Convention against Torture, there should no longer be any obstacles to the implementation of the principle that "torture and medical practice are contradictory and rule one another

out.'' It can be assumed, however, that mere statements of good intentions are not enough to raise awareness among doctors and the general public: open debate about what actually happened will be necessary to build a human rights culture out of mere regulations.

(ii) Medicine and the Law: a Dubious Relationship

Several areas of medical activity have attracted the interest of authoritarian regimes, which have only allowed those it trusted to work. Judicial medicine has had a key role to play here. The following sections provide situations involving ethical conflicts, which illustrate areas where the interaction between medicine and the law seems problematic.

a) Autopsies and the practice of 'making people disappear'.

The way the coroner's office in Buenos Aires operated during the Argentine dictatorship sheds light on the forms of collaboration between legal medical bodies and the repressive system, allowing us to understand how one part of the military mechanism for 'making the dead disappear' worked. The dead were brought into the coroner's office, identified, and then taken away by the military and buried anonymously without informing family members: "It was always the same procedure: the neighboring streets were cordoned off during the night, and army trucks came to the complex and stopped in front of the building. The cargo was dropped off there. Everyone in the neighborhood was too afraid to talk openly about what everyone eventually knew."

b) False health reports or death certificates.

The intention behind diagnostic changes, false explanations, or incorrect estimations seems to have served not only the purposes of secrecy, as above, but also those of a second, parallel field of activity, which has remained unpunished.

In Chile, doctors' cooperation in state terrorism has been documented as follows: "Doctors' participation in keeping torture secret also took the form of filling out false autopsy reports and/or death certificates, a practice that has been confirmed by research carried out by the ethics department."

The death of the Uruguayan doctor Vladimir Roslik, shortly after his arrest in 1984, deserves special attention. This death led to the first study by the doctors' association of the military physicians' responsibility in cases of human rights violations in Uruguay. It became clear that several doctors who worked for the mili-

tary had fundamental difficulties when it came to distinguishing between medical and military tasks.

In his statement to an ad hoc committee of the *Asociación Médica del Interior* (AMEDRIN), Dr. Eduardo Saiz Pedrini mentioned that the order to carry out three examinations of Dr. Roslik within 24 hours was routine. He claimed not to have heard Dr. Roslik complaining about torture and said that he had also been ordered to carry out an autopsy on Dr. Roslik after his death. In his official autopsy report, Saiz Pedrini claimed that death had been caused by "the cessation of breathing and heartbeat."

With the help of another physician, Dr. Burjel, Dr. Roslik's family managed to get a second autopsy done, which produced clear evidence that he had suffered a violent death at the hands of his tormentors. The military physician Dr. Saiz Pedrini, who had directed the official autopsy of Dr. Roslik, was later expelled from the doctors' association, in March 1985. This, however, did not prevent him from being sent to Sinai the same year, as part of Uruguay's contingent within the UN's international peacekeeping mission.

c) Semantics of collaboration.

Without wanting to go into conscious or unconscious collaboration, I would like to demonstrate how medical euphemisms are useful in hiding human rights violations. One example of a subtle argumentative strategy is given by Dr. Mautone, then head doctor of anatomic pathology at a military hospital, who gave as causes of death in his reports "acute edema of the lungs" or "acute insufficiency of the lungs and the heart," both of which were "caused by stress" in patients who had obviously died as a consequence of their being tortured. As he put it himself, he left the further definition of the diagnostic word "stress" up to the discretion of the courts.

◆Medical-ethical reflections. The unquestioning obedience and cooperation of medical examiners with regimes of terror deserves special attention, all the more so because many of these doctors continue to view such practices as common and are thus little given to questioning their actions.

(iii) The Appropriation of Descendants

a) Definition of the problem: The handing over of children born to mothers who were missing or held in prison to people who are not related to them was typical of

Argentina's secret prison camps. Estimates are that over 300 children were taken away from their blood relations and given up for adoption in this manner.

In an interview on this issue with the Spanish weekly *Interviú*, Ramón Camps, a high-ranking officer with the Argentine army, stated almost as if programmed: "… it wasn't people who disappeared, it was subversive elements. I personally never killed a single child; what I did was hand them over to charity organizations so they could find new parents. The subversive parents raise their children to be subversive. This has to be prevented..."

The report by CONADEP includes the names of several doctors who took part in these activities directly: "As soon as the child was born, the mother was "invited" to write a letter (which invariably stayed in the camp files) to her family members who were to receive the child… We have found out from commentaries that a list of couples in the marines who were unable to have children was in the naval hospital, waiting to receive these children in adoption. A gynecologist with the hospital was responsible for the list."

R. Salguero goes into the specifics of this procedure: "Patients (the imprisoned-disappeared mothers) were especially labeled using cards with 'N.N.' instead of their names.''

b) Scientific searches for stolen children: The emptiness left behind by the "vanished generation of parents looking – also through legal channels – for the children born in prison was filled by the 'Grandmothers of the Plaza de Mayo'. These were the mothers of the disappeared, who, knowing that their grandchildren must have been born in the camps, fought for their return."

The progress of genetics as a biomedical discipline proved invaluable for identifying these children, who were illegally given up for adoption to couples who supported the regime.

To determine the children's identities and relationships, hematological studies of genetic material were carried out using modern methods (blood groups, protein and enzymes of the blood, serum, histological compatibility).

The results of these examinations offered proof of both the identity and the relationship were taken up in regular cases before the courts.

◆Medical-ethical reflections: A "conspiracy of silence'' still surrounds many of the children born during their parents' incarceration. In Argentina, the Grandmothers of the Plaza de Mayo have collected many clues that can be used to continue the search. As it is clear that doctors in Latin America participated in the illegal adoption of children, the powers of the authorities both within and outside of the profession must be strengthened to prevent this from happening again.

(iv) Doctors and the Philosophy of Military Dictatorship

The special roles that doctors played during these dictatorships in South America consist of both participating in and resisting these regimes. The extent to which doctors were active not only in their professions, but also in founding and spreading totalitarian ideas remains an important question.

In this context, a Chilean military doctor's actions are worth mentioning. He summarized his thoughts on dealings with members of Allende's government after the military had toppled it in an article published in the influential newspaper *El Mercurio* on 11 October 1973, entitled "The Unredeemable". He divided the "44% who voted for the Unidad Popular in March 1973" into five groups: a) extremists; b) very dangerous and intelligent activists; c) ideological activists; d) people who were active in the parties of Unidad Popular; and e) sympathizers of Unidad Popular. He then suggested special repressive measures designed for such attitudes.

In Uruguay, Dr. Martin Gutiérrez, the head doctor of the Libertad prison and later an advisor to the governing junta, made the following statements about conditions in prisons and military barracks: "The war continued in the prisons. Day by day, rule by rule, its stated aim was to cause psychological harm."

On the unconditional loyalty of doctors to the upper ranks of the military, Dr. Marabotto, also from Uruguay, stated in no uncertain terms: The military doctor's function in every country and under every political regime is to provide the commander with technical support. The commander is ultimately responsible for what is done or not done in his unit; the doctor is a "staff officer" under his command, in other words a medical advisor.

◆Medical-ethical reflections: The question of doctors' philosophical outlook, particularly that of military doctors under totalitarian regimes, has become increasingly important, as it is hardly plausible that they acted as puppets of the respective tyrants. Rather, their ideas may have fostered the attitude among military personnel that, say, torture is just another tactic of war.

2.3 The Other Side of the Story

This study of medical practice under military regimes in Argentina, Chile, and Uruguay would not be complete if we didn't include the dimension of active reactions against the totalitarian intentions of these regimes. During that time of suppression, doctors also participated in activities to uphold ethical responsibility, go-

ing beyond passive resistance, and giving meaning to fundamental principles of professional ethics.

Indeed, during these dictatorships there were many personal initiatives and ecumenical groups devoted to furthering human rights, for example in Chile: “One of the doctors who offered aid to torture victims was Dr. Pedro Castillo, a thoracic surgeon and member of the American College of Surgeons. During a wave of firings of academics in 1975, Dr. Castillo lost his position as head of the surgical department at the University of Chile. In 1981, he founded the National Commission against Torture… At the beginning of May, agents from the CNI began to keep his house in Santiago under surveillance… (On May 27 he was) arrested at his home and taken to the prison on Borgoño Street… (Shortly thereafter) the Vicaría de Solidaridad and the Chilean Human Rights Commission declared that the secret police were angry that (he and two other) doctors had taken the government to court on charges of torture. These charges contained detailed accounts of torture chambers run by the secret police and, in several cases, confirmed the presence of doctors in these chambers… Three weeks after their arrest, the three doctors showed up in a prison in Valparaiso. The military judge on the case allowed two American doctors to visit Dr. Castillo and his colleagues. Visibly affected by what had happened to them, they reported that they had been kept in solitary confinement for three weeks, blindfolded most of the time, with no access to their family or lawyers. One of the Americans later told the press that they were most worried about the fact that they had been publicly accused of involvement in terrorist acts. Their professional lives could be destroyed by such accusations. On 1 July 1981, a military court in Valparaiso ruled that there was no evidence that the three doctors had been involved in terrorist organizations and that the accusation of illegal political acts fell outside the jurisdiction of the military court. The military judge referred the second accusation to a civilian court, which refused to hear the case and ordered that the men be set free immediately”.

There is also the following report on the treatment of patients in Uruguay: “After an armed conflict between the army and the Tupamaros, I was called in to treat the wounded as a surgeon. I determined that Mr. Z., a Tupamaro, had been shot in the chest and that a bullet had grazed an officer on the buttocks. I ordered that we begin treatment of Mr. Z. but was told that he could wait as long as there was an officer to be treated. I insisted that the treatment of more severe injuries has medical priority and devoted myself to Mr. Z...”

◆Medical-ethical reflections: Even after the return of parliamentary democracy, the horror of the totalitarian phase lives on in the consciousness of those who experienced it. Recognition of actions to protect the principles of medical ethics at

the time is important as there were examples of active, daily resistance by doctors in the situations studied.

Trials of Doctors under Conditions of Legal Amnesty

Although no judicial proceedings were undertaken in the three countries to clarify the personal responsibility of those who participated in torturing, murdering, and abducting people, it must be emphasized that doctors' associations have looked for ways to define the limits of professional ethics under military dictatorships. To a greater or lesser extent, professional organizations have shown clearly that doctors' activities in supporting the state system of repression cannot be viewed as acceptable under any circumstances. This *inter pares* ethical ruling has met with enormous resonance among the public in the three countries.

In Argentina, a "Health Tribunal on Ethics against Impunity" was held on 3 December 1987. Three doctors, whom former inmates accused of being directly responsible for torture, kidnapping, and murder, were tried in absentia.

Dr. Diana Kordon based her arguments as prosecutor on the ethical code and further stated: "Article 1 of the ethical code ratified by the Doctors' Association of the Republic of Argentina in 1955 clearly states: 'The doctor must treat the ill with care all the time and respect their human condition. He shall not use his medical knowledge against the laws of humanity.'" Her accusations were further supported by statements from people who had suffered under state terrorism, directly at the hands of the doctors on trial (cf. the above statements by Dr. Liwsky). The prosecutor explained in her opening statement:

"Doctors' participation was necessary for the application of repressive methods. They determined how much torment the prisoners could bear. They directed and oversaw the continuation of torture in order to receive a maximum of information. The most despicable task of these doctors was to prescribe the amount of torture and to actively participate in the torture. They also participated in the kidnapping of children born in prison by caring for the imprisoned pregnant women and (then) filling out false reports…"

The tribunal unanimously found them guilty of having committed serious ethical violations and crimes against humanity. In its final statement, the tribunal called on universities, the academic community, medical associations, health institutions and authorities to refuse these doctors any access to teaching, research, or practical positions.

Due to its long institutional tradition with legal statutes (declared invalid by the military dictatorship in 1973), Chile's medical association, the *Colegio Médico de Chile* (CMC), began to rule on ethical conflicts based on political repression as early as 1983, shortly after its first internal elections without military government

intervention. Research by its ethics committee drew people's attention, because doctors who had collaborated with repressive regimes were being called to task before an internal court, without delay.

In this way, the committee fulfilled the function of a parallel court that by its very existence was bringing this topic to light and calling on the repressive system to answer for specific cases.

From 1983 to the present, many cases involving doctors' participation in repression have been heard outside the courts. Only those cases in which the doctors were found to be directly responsible beyond the shadow of a doubt were ever made public.

In light of this, it is not surprising that from 1983 to 1989, the military government also persecuted CMC board members, holding them as political prisoners for several months.

In Uruguay, there was a similar development in the medical associations, the *Federación Médica del Interior* (state medical association) and the *Sindicato Médico del Uruguay* (Uruguay doctors' union). G. Martirena remembers the impetus behind the founding of the National Commission for Medical Ethics: Even if this constitutes an affront to Uruguay's medical establishment, it is nonetheless irrefutable that some doctors actively or passively participated in torturing political prisoners or violated ethical standards in service to higher authorities to whom they had sworn allegiance… In light of this, the Seventh National Congress of Physicians took place in July 1984, when the dictatorship was still in power in Uruguay… With the votes of all delegates, the National Commission for Medical Ethics was founded.

Shortly after the Commission began its functions, the government passed a resolution signed by then-defense minister Dr. Justo M. Alonso Leguisamo, which incorrectly described the commission as a tribunal:

(1) It is forbidden for military doctors to make any sort of statement before ethical tribunals of the Seventh National Medical Congress. The speaker must be informed when any such situation occurs.

(2) For publication and distribution among the armed forces health service and for the archives.

Despite this ban, the ethical commission's investigations of court martials found amongst the numerous accusations enough violations of professional ethics to form their own opinion.

♦ Medical-ethical reflections: It can be argued, especially in light of the official aversion to any form of questioning the time of the dictatorships in all the three countries, that these initiatives by medical associations and organizations were socially and culturally unique. As these ethically motivated acts failed to be imitated by other associations and legal systems, these examples shed light on the conditions of the post-dictatorial years.

2.4 New Topics and Future Directions in Medical Ethics

It can be assumed that the years of the dictatorships included not only the dimension of terror but also the questioning of all areas of social life, which suggests that new challenges for professional ethics arose and/or became apparent during those years. The thesis here is that an accentuated awareness of ethical conflicts exists in the post-dictatorial era. In this section, we will touch upon some areas that serve as the basis for professional ethics and have not yet been culturally dealt with and for which no final solutions have been found. It is, however, important to take the concrete experiences of many doctors during the repression into account in order to understand, for instance, the special sensibility for the living conditions of people who, for whatever reasons, were imprisoned.

a) Former torturers and their psychotherapeutic treatment: Even if there are no moral scruples in wartime about doctors treating the injured of the opposing army, the psychotherapeutic treatment of active participants of torture is a very touchy subject today in South America.

From Argentina, D. Lagos reports the clinical history of a former torturer shortly after the return of democracy. The patient, who had often been treated for nervous problems in the previous eight years (1978-1986) in Buenos Aires and was then taking part in individual psychotherapy, exhibited symptoms of depression and paranoia. It seemed as though the vow of silence about his activities as a torturer was renewed with each new psychotherapist and these were then not dealt with during psychotherapy for that reason. This corresponded to the patient's behavior towards the therapist: he only wanted to stop the symptoms. D. Lagos then began reflecting on the behavior of some other therapists who, in keeping to this vow of silence, had become accomplices. They had only supported his efforts to nullify the symptoms and tacitly exculpated him by recognizing him in his role as a patient, without going into the clinical history of elements fundamental to his biography and psychopathology.

b) Doctors and the death penalty: The active participation of doctors in the death penalty is a very timely topic as death by injection could conceivably be accepted as a quite aseptic form of execution. The CMC has categorically rejected any attempt to require that doctors perform these functions (the death penalty still exists in Chile's penal code). The CMC's rejection was based on the refusal of Dr. Start (1982) in the United States to carry out the death penalty in Oklahoma by giving a man an intravenous injection. This refusal led to an intense debate on professional ethics (the Hippocratic Oath explicitly forbids the administering of lethal drugs) and the functions of prison doctors. It undoubtedly speaks well of the CMC that this form of execution was not taken from the US into a country that otherwise generally belongs to the avant-garde when it comes to taking up such "progressive measures" from Western culture.

c) Doctors and hunger strikes: Professional practice and ethical conflicts faced by health personnel are the central topics of debate in Uruguay. M. de Peña, M. Jáuregui and G. Mesa analyzed their some 25 years of experience in the field of medical practice:

"… In the case of a hunger strike, the participants are healthy and prepared to put their health at risk, even to the point of death, for a higher goal that has nothing to do with their health. Their interests thus conflict with those of the doctors… The disregard for this confrontation between the equal "duties" of the two groups can lead to the failure of the treatment..."

They side with the WMA declaration when they say, "it is the duty of the doctor to respect the autonomy of the patient. A doctor needs the expressed consent of patients before his knowledge can be put to use to help them..."

d) Ethical standards for the medical treatment of prisoners: The directors and many members of Chile's Medical Association had, as mentioned, entered into very close contact with the opposition to the dictatorship and become familiar with the physical conditions in Chile's prisons and the arbitrariness that characterized relations between guards and inmates. As early as 1985, this awareness led the CMC to issue a declaration on the medical treatment of prisoners.

e) Legislation regarding crimes against humanity: The medical organizations in the three countries have not only pushed for more respect for human rights within medical practice, but also taken initiatives to break through the "zones of denied services and silence" that remain prevalent in legislation. Uruguay's medical association has proposed legislation on crimes against humanity in which all possible crimes that play a role in terror regimes are listed and specific sanctions suggested.

Even if it is not possible to enact this law retroactively, its passing would nonetheless spark the hope that the events involved in state terrorism truly do belong to the past and that doctors (and other professional groups) will no longer be able to play innocent when human dignity is attacked.

Future directions

Based on all the examples discussed here from areas associated with medical activities, it is clear that the systematic representation of concrete examples of medically assisted human rights violations can help to open new access routes to a hitherto unknown professional sphere and raise awareness of this knowledge among the public.

Military doctors are the main people responsible for human rights violations in South America. Admittedly, these doctors in the three countries did not have unlimited room to act. Individual resistance was often a possibility, and there is nothing to suggest that doctors who held to the Hippocratic Oath were attacked or treated disadvantageously; some military doctors even stepped down from their positions in order to avoid a collision between their own political and ethical principles. Collective resistance came about during the military dictatorships in Chile and Uruguay for one specific purpose: to make public the human rights violations committed by doctors and to foster closer scrutiny.

To find out and understand how doctors were active in and against the system of repression, a better understanding of this period and how people acted back then is useful, along with ways of recognizing possible tendencies in this direction, even in times of peace.

D.3 Conclusions

3.1 Summary of Specific Observations

This section seeks to relate the qualitative and quantitative results from two different aspects of this study. The first group of observations is based on an analysis of the direct interviews, while the second reviews statistical data from the questionnaire completed by our sample of physicians in three South American countries.

Observations Based on the Qualitative Analysis

Interview content allows us to recognize the following argumentative lines offered by interviewees:

a. Without exception, organized violence constitutes a major life and historical reference point for all the doctors participating in this study;

b. The transition to democratic rule didn't seem (at the time of the interviews) to be questioned as such;

c. Most approve of breaking through former limits in medical technology (such as gene manipulation), while those who are opposed base their arguments on religious concepts;

d. Respondents questioned the universal validity of the main axioms of medical ethics (such as not inflicting damage or losses). This "ethical relativism" seems to be linked to physicians' involvement in human rights violations during totalitarian regimes;

e. Individual ethical obligations (such as doctor-patient confidentiality) enjoy wide recognition today.

Observations Based on the Quantitative Analysis

A brief review of data obtained from questionnaires offered the following tendencies of opinion:

a. The interviewees know a great deal about human rights violations during totalitarian regimes, in terms of both their general form (e.g., torture, executions, disappearances), and especially in terms of medical ethics (e.g., doctors' complicity in torture).

b. The groups defined according to their position on the military regime proved to be consistently homogeneous (within the group). At the same time, there were enormous differences (that were very statistically significant) in the answers from the three groups on critical issues.

c. The terror left specific traces in the biographies of some of the interviewees and we could recognize clear psychological consequences of the fear and pressure they had experienced.

d. A significant number of interviewees showed a remarkably docile attitude toward authoritarian conduct (e.g. approval of doctors' participation in executions, silent tolerance of hierarchical arbitrariness).

3.2 General Observations

The following analysis of the interviews seeks to connect the central questions of the study and the theoretical framework, especially its main hypotheses. We can conclude that the overall response to the basic questions dealt with in this study can be summarized and grouped according to four main aspects:

3.2.1 Experience of Daily Life and Medical Practice

For the most part, the doctors interviewed define daily life and medical practice during the military government as a "state of permanent exception". It is a period rife with precise connotations in the lives of all the doctors interviewed, despite the fact that at first some of them considered it a mere parenthesis, expressed as follows: "It was an unusual period, per se, but its purpose was a return to normalcy, that is to say building toward normalcy." This perspective was also expressed in the following way: "The military government, by applying some more drastic decisions, perhaps forced the country to work in a set way" (both quotations: Chi-040-Pro).

Generally speaking, we have hypothesized that the events of the period would have left a major mark upon the biographies of interviewees, particularly those who suffered particularly unusual experiences: "I was in charge of the work sec-

tion, around the year 1983. I think that I received Sebastián Acevedo (after he set himself on fire with benzene) and he told me: 'I did it because I have my two children, my daughter and my son, prisoners in a place of the CNI (Chile's secret police of the period).' And he described the place, in front of PP, and told me: 'They are prisoners and what I want is to protest, because nobody wants to listen to me… and to make them let my children go, because I did this.'" I even took pictures of Sebastián Acevedo and I at the time, and I sent a letter, which I have kept, to the person who was the president of the Medical Board of XY, doctor XX" (Chi-07-Opposition).

Others experienced a genuine upheaval of their basic faith in state institutions: "Suddenly, in the year '74, at the beginning, I would say that when the DINA was formed, we began to have information that was a little strange, incongruent. The thing was that someone gets killed for firing a gun in a false confrontation; and then we started to hear that somebody knew that he had been tortured. At that time, we began to suspect that things were leading into unacceptable practices" (Chi-013-Neutral).

The state of permanent exception led some people to passively accept arbitrary institutional decisions: "My first contact (with state violence) in the university was the result of having to sign a letter… It was an antidemocratic letter, where one had to swear a kind of a oath, signing agreement to many things that went against my principles… I questioned myself a lot about whether I should sign that letter to stay at the university. In the end I signed it. It was a bit difficult, but everyone who entered the university had to sign it" (Urug-07-Young physician).

Or we find the direct experience of organized violence: " (...) Here we lived in terror, in fear, that is to say, it was very difficult to speak with anyone; people were watched, and if I spoke I implicated another. It was common to see the military come running in broad daylight, screaming political slogans in front of our houses... in front of my house, of my wife and my small children, who were standing at the door, to order: 'Hit the ground' —eighty or ninety soldiers with machine guns— and proclaim: 'for the nation, we are going to kill the communists', during the ten years of the dictatorship" (Uruguay-34-Opposition).

State violence meant direct personal suffering for some interviewees, which remains more or less alive to this day: "We were eight detainees, between auxiliary doctors and students, of which five appeared dead, among them, the head of personnel, who was a priest; two are missing, a medical student and an orderly, and I was the survivor. It was a real persecution, in terms of the arrest, and later on discharge, undoubtedly for example, the director of the hospital allowed them to enter the hospital and he permitted names to be given. One of the arguments that I used with the officer where I was arrested —a very special, personal dynamic de-

veloped — was that I felt no resentment toward him, since my name had been provided by a civilian and that those who were governing were civilians, something that annoyed him very much and I believe that was one of the decisive factors in their not executing me" (Chi-016-Opposition).

The physicians who graduated at the end of or after the dictatorship (our "Young Physician" group) proved to be so deeply involved that their answers do not constitute a distinct group, but rather fell within our other categories: "Pro", "Neutral", and "Opposition". An illustration of their opinions follows: "(In 1977) a very young group of people close to me disappeared, friends, among them a cousin, (we were) first cousins. We knew perfectly well what it was, that they were illegal prisoners. We didn't really know about the concentration camps yet, but we knew that they were in some district barracks, somewhere, we knew they were being tortured and that this would never be known" (Arg-019-Young Physician).

All the examples above confirm the first general hypothesis, in the sense that the military intervention had a genuine impact on the lives of physicians in these three countries.

3.2.2 Degree of Knowledge about Doctors' Participation in Crimes against Humanity

Doctors' participation in crimes against humanity under totalitarian regimes clearly constituted a point of reference in the interviews. It would be impossible, therefore, to try to argue ignorance about the facts in question: "Yes, see, I knew about a case from here, Dr. XX, who was a medical colonel, (and that) upon examining a cadaver, discovered traces that it had been subjected to illegal treatment ("pressure"). Then they sent him a military style communiqué: 'Please, Mr. Colonel, proceed to explain what you mean by "illegal pressures."' So he said: '*illegal pressures'* is what is commonly called torture', and (he added) a postscript: 'Send a copy of the autopsy report to the International Court (of Justice) from The Hague', that is to say, he stopped them. Therefore, there were relevant attitudes in the ethical and moral sense among colleagues" (Urug-43-Neutral).

It is also true, however, that there were efforts made to make some questionable treatments or procedures acceptable, from the perspective of a military doctor. One example involved the medical examinations of people who were blindfolded: "Well, we are analyzing situations of exception in the sense that a mechanism of self-protection exists, upon living in a state of exception your life is at risk. I believe that a little of that happens in a certain moment of self-protection. I think that

you have the complete right to protect yourself, fulfilling your function as a professional" (Chi-040-Pro).

Another example comes from a doctor from the Opposition group, asked about obeying an order to examine a patient who is blindfolded: "I believe that it depends on the circumstances, because (it's one thing) if an individual is being aimed at with a machine gun and told: "You have to do this… If not, I will kill you." If there is no coercion involved, I believe that this is absolutely punishable" (Chi-07-Opposition).

There are, indeed, some situations, such as for example the taking of newborn children of detained mothers (condemned to disappear), which were not common knowledge in Chile and Uruguay. But the possibility of doctors' direct complicity in human rights violations, for example, through torture or false medical reports, was never questioned by any of the interviewees. With regard to "torturing doctors" (that is, doctors who torture), we found opinions such as the following: "I find it extremely serious. It is perhaps where the sense of the medical profession is most altered" (Arg-019-Young Physician).

Thus, the second general hypothesis was confirmed, ie that there was genuine, public knowledge of human rights violations —even on the part of doctors. This was a consequence of the military's policy of intimidation, rather than an attitude of concealment of such facts from the majority of the population.

3.2.3 Current Attitudes Towards that Time

Broadly speaking, the current perception and interpretation of the events of that time varies according to the line of the three basic attitudinal groups (Pro, Neutral, Opposition) captured in the analysis of the interviews.

Positive attitudes towards the military regime are typically reflected in opinions such as the following: "(As an explanation for the coup at the time) I would say that the only important issue that I can see in this sense, is the question of the struggle against subversion by what is now called 'State terrorism'. For me, if Argentina had not had this – undeclared – war, it would have fallen apart" (Arg-040-Pro).

Some opinions are more obscure and/or paradoxical, such as the one belonging to a member of the "Neutral" group, who explained the reasons behind the massive arrests of the period thus: "My personal experience in this respect demonstrated that everyone arrested was somehow connected to other people who could

have had suspicious attitudes. It is clear, I don't blame some of them nor the others: the military had the power and they decided who would be and who wouldn't be. There was a kind of forced order, to explain it in some way, someone established an order and enforced [put in action] the mechanism to accomplish such order" (Arg-010-Neutral). Likewise, a member of the "Pro" group declared himself against "quick punishment" on the grounds of moral and judicial-military criteria: "Torture has no justification at any time, not even in police procedures. On this matter, I can speak with pride, as the son of an officer, who became a general of the Chilean Armed Forces. I think that within the code of military justice, which is the most severe, even, the act of torture, is punishable" (Chi-019-Pro).

The last two opinions seem less obscure if one keeps in mind that by then there was widespread acceptance of terrible actions against human beings (such as the arbitrary deprivation of freedom) among passive supporters of the authoritarian regime. On the other hand, it was not usual during military rule for some to justify human rights violations under the states of exception. Arguments to deal with issues such as massive arrests or torture on military premises demonstrate these two physicians' interest in expressing convincing opinions about these aspects of the recent past.

In some of the interviews we can see a latent tendency to accept the "excesses" that occurred during the states of exception, and an explicit interest in reducing the condemnatory attitude toward that time: "(...) I also have the impression that people were against the guerillas. I believe that ninety five percent of the population did not really want to see what some said was happening. I think that I would dare to say that, ninety five percent of Argentines looked the other way, because we were aware that extremism had to be eliminated. It could not be done any other way and, well, I maybe have the impression, that we pretended to be distracted" (Arg-025-Neutral).

A willingness to clarify transgressions of medical ethics under military government is present today in all four groups under study. Initially, however, only representatives of the "Opposition" group and a few members of the "Neutral" group — despite campaigns to intimidate them— assumed the risk of publicly and actively denouncing this contempt for medical ethics: "We fought… (for there to be) an analysis of military doctors' conduct during the *de facto* period, and to punish those doctors who participated (in the repression) in violation of ethical standards" (Urug-016-Opposition).

In summary, we have reviewed the evidence regarding the first two hypotheses. It is clear that the military intervention intensely affected the life plans of physicians at that time and that their current attitude does not involve trying to hide what happened in the area of human rights and medical practice.

3.2.4 Sensitivity to Issues in Medical Ethics and Their Relationship with Ways of Life under Dictatorship

Some opinions stood out among interviewees, in the sense that they accepted torture as "normal" in the context of a social situation conceived of as a civil war. In some, presumably implicated individuals, this caused a clear tendency to relativize judgment of events, in the sense of neutralizing the evidence: "(Torture?) I would say, yes, but not that it could be so evident. If you want, my conviction is that in war one appeals to absolutely evil resources. I could not do it; but I don't know if in war, in combat, I would not have done it… Not me or anybody else. That is to say, I could have not done it, but that doesn't mean that I don't believe there was any torture. Simply that we have no certainty, beyond the story of patients themselves, as it could not be evident to a judge, more than because of the story or the experience" (Urug-025-Pro).

During this study, it was possible to perceive signs of resignation or absolute respect for authority among some doctors of the "Pro" and "Neutral groups". While, in turn, amongst members of the "Opposition" group and some members of the "Young Physicians" group, we observed an attitude of resistance to the possible abuses.

With regard to the problem of medical ethics, the current ethical-professional sensibility could be considered from two perspectives: either within a context of social conflict or as a response to new technologies. In terms of the former (social conflict), the evidence from this study offers the following facts:

a) The obligation to obey, expressed by some representatives of the "Pro" and "Neutral" groups when faced with a medical superior who abandons a surgical operation in progress in order to assist a patient of higher economic position: (After the medical superior left surgery) "Should I finish the operation? Yes, of course. I hope I won't have to do it, because I don't know how to do it. I hope that the chief surgeon will not pass him to me. I would be careful to do it well, assuming that I knew how to do it… And if my chief tells me and makes a mistake and I can't assist him. I would take charge and finish" (Urug-025-Pro).

b) The treatment of certain rights of the patient (such as doctor-patient confidentiality, for example) inspires a high degree of knowledge and respect among interviewees from all three groups. For instance, regarding the hypothetical question of informing all students' parents at a given school of a case of AIDS affecting the father of one family: "I could not reveal this, without prior authorization from the person. Categorically, confidentiality has a very special meaning in this field — and I believe that there I am entering into a very complex topic— and I think that

confidentiality should be upheld until such time as all other efforts have been exhausted and the attitude of the individual is putting third parties at risk. At that point, I would feel myself to be released due to my obligation as a doctor to protect the third party (through) compromising confidentiality" (Chi-019-Pro).

c) Respect for civil rights (the question regarding the right to participate in a hunger strike) produced a schism in the ethical positions within every group. An extreme position considered the hunger strikers to be presumed suicides, who should be robbed of their civil rights. In the face of an official order of forced feeding: "If we start on the basis that life is the main right of the individual, I would make the maximum efforts to ensure that the person on a hunger strike is aware of the real risks, and of the unnatural and immoral nature of such an attitude. Looked at from the point of view of my formation, it is immoral and a slow form of suicide. Now, where this attitude were absolutely negative, and based on thinking that a person in this state is not physically or mentally able to exercise sound judgment — as with a child— I would cooperate in providing these people with mandatory treatment" (Chi-019-Pro).

In contrast, we can see that most interviewees opposed forced intervention, on the basis of the right to self-determination (forgetting the *lapsus linguae* of considering a striker a patient): "I am a doctor, I believe that I have to act like a doctor. But, fundamentally, in order to act as a physician, I need the sick person's consent. That is to say, if the sick person accepts it, I would act. If he/she says no, and is in a condition of saying it by himself/herself, I would not do it" (Urug-037-Pro).

In summary, most interviews revealed a highly attuned sensitivity to situations of social conflict and medical ethics. Opinions involved respecting or questioning patients' rights, and also attitudes of obedience to authority or rejection of hierarchical arbitrariness, and the arguments provided were very consistent. Excluding the issue of a hunger strike, we observed correct knowledge about and application of standard principles of professional ethics among all groups.

With regard to medical-technological innovations, most participants exhibited an attitude of frank approval, with no differences among the groups, even when they tended to suspend the usual limits on professional ethics. One outstanding point here is that it was the "Neutral" group, which brought together the most decided defenders of new technologies. This was evident in the case of the issue of possible organ transplants from unidentified donors, an issue of enormous judicial and practical importance in this area of medical management. "My personal opinion on this is that a law should exist establishing that all bodies capable of donating organs and in conditions of vegetative death should donate their organs. You

should not have to request authorization, but rather this situation should be settled in advance. Only and explicitly if a person decides not to donate the organs, should the donation not exist, and we should determine this in the opposite way; that is, about not donating. If they do not want to donate and the decision, well, has been established: The person who doesn't want to donate organs leaves it established and, therefore, in a central file. I suppose that this will be the formula. If the body can't be identified, then the organs should be donated, that is to say, they should extract the organs" (Arg-010-Neutral).

An explicit relationship between personal experience with critical situations and a general attitude to moments critical to professional ethics is observed only in members of the "Opposition" group. And that translates into an attitude of rejecting arbitrary occurrences and possible abuse of power regarding the absolutely free management of organs from unidentified bodies: "Under current conditions, I fear that this could lend itself to abuses, because you know that if we allow organs to be removed from an N.N. (unidentified corpse), many could find themselves turned into an N.N." (Chi-07-Opposition).

Negative or cautious opinions about *genetic surgery* are apparent within the "Pro" group, since these physicians support emotional support for those affected, as an alternative to medical effort in this area. For them, such intervention would seem like "interfering in the designs of Divine Providence". When asked, Would you approve genetic intervention? the reply was: "Absolutely not. In this case, I am in very close contact with a relative, whose daughter has mucoviscidosis. I know of her tremendous fears in the night. I went to see her in Santiago, a month ago, when the daughter had to receive surgery, newly born, for an obstruction, produced by the illness" (Chi-019-Pro).

Members of the "Neutral" group tend to provide religious-based arguments about genetic intervention: "I don't have enough knowledge. What I would not agree with is that a child could be aborted without giving him/her any opportunity. But if one could intervene to prevent him/her from having hemophilia, of course. No doubt. For that intervention, not for another" (Chi-013-Neutral). In turn, physicians from the "Young" group support genetic intervention, on the basis of cost and value: "I find it extremely useful to do this, if it will result in a benefit. I think that if technology could achieve it and could prevent that child from suffering from an illness in the future (...) I believe that there the cost-benefit would prevail, in the sense that if that child is going to have an illness in the future, we are doing something good for him, without risk. It is acceptable" (Chi-049-Young Physician).

Regarding key issues of ethical conflicts related to doctor-technological innovations, critical opinions are apparent among the "Pro" group, based on traditional

values. In the face of the *host-guest (surrogate) pregnancy*: "I would say that I disagree, on principle. I believe that maybe the situation that could solve the problem is adoption. One of my daughters became RH sensitive. She was able to have only one child. Later on, there was an unborn child and later a premature boy who died and ended up draining her childbearing capacity. The impact she had upon knowing she was sterile was so strong that, as soon as she recovered from the last operation, I called her and said: "Adopt a child". She did that and today she has adopted two children" (Chi-040-Pro).

Among the "Neutral" group, opinions tend to be more formalistic and members tended to show virtually absolute confidence in progress: "The surrogate uterus is justified, if there is agreement among parties. I don't think you should give the matter any more thought. If the parties agree, the husband, the wife and the surrogate. Yes, sir, that has to be very well done" (Urug-046-Neutral).

Upon matching these results with the content of our third general hypothesis, one could conclude that only in situations of social conflict is there a significant relationship between the sociopolitical perspective of the doctors interviewed and their perception of the issues at hand. Thus, it is in the face of conflicting moments (related to unquestioning obedience to authority) that there is a clear link between the sociopolitical group ("Pro", "Neutral", "Opposition") and the expressed opinion. Among members of the "Pro" group arguments tend to be traditionalistic, while the "Neutral" group use solid arguments based on formal logic, and the "Opposition" group often hold opinions based on personal experiences with abuse of power. On the other hand, in terms of perceptions of new medical technologies it is not possible to find substantial differences between the members of the three groups. Rather, there tends to be a wide spectrum of opinions within each group.

3.3 Final Remarks

We want to conclude the second part of this book by examining three general questions underlying the empirical research on medical ethics under military regimes in South America:

> (i) Can the doctors surveyed be considered competent witnesses of the era?

(ii) What is essentially reflected in the responses provided by the surveyed doctors: group political positions or individual points of view about the diverse problems in question?
(iii) Can the information serve as the basis for generalizations or should it simply be interpreted as the personal opinions of those interviewed?

The answer to the first question is yes, considering the argumentative depth demonstrated by the opinions provided on each and every topic. The fact that interviewed doctors were selected according to their personal participation or personal experiences during the totalitarian regime doesn't influence this result. Moreover, each individual's willingness to respond to questions about personal involvement in the course of the interviews was often marked by a captivating sincerity. In order to meet basic requirements as competent historical witnesses, the interviewees had to have profound knowledge of the situations referred to in the interview and to form their own opinions on the subject matter. The interviewed doctors' textual affirmations offer eloquent testimony of vast historical periods and of practically each of the problems put forth.

On the second question, responses fluctuate significantly between the poles of individual versus group vision. In some sections of the interview, for example concerning life under military rule, points of view that appeared to be common — determined by the political group — were frequent. In other aspects of the interactions under study, for example, attitudes toward situations of conflict regarding medical ethics, very personal opinions were collected, with the position of the political group giving way to a wide range of individual positions.

The third question can be answered in two steps. First of all, we can state that there is a profound knowledge of, and a marked thematic sensitivity toward medical ethics, evident amongst the majority of the interviewees. This points to a possibly ongoing discussion of these matters, which would explain the high degree of discursive congruence in the responses obtained. This, in turn, finally leads us to conclude that the textual declarations cited here reflect specific attitudes expressing the "spirit of the era" [Zeitgeist] with respect to this area of socio-cultural phenomena.

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