Review Paper

Psychiatry in the Nazi Era

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Objectives: To update Canadian psychiatrists on recent information from newly discovered Berlin archives about the actions of physicians, especially psychiatrists, during the era of National Socialism in Germany and to encourage introspection about the role of the medical profession, its relationship with government, and its vulnerability to manipulation by ideology and economic pressures.

Method: This is a selective review of the literature on the collaboration of physicians, especially psychiatrists, in the sterilization, experimentation, and annihilation of patients with mental illness before and during World War II.

Results: Directed to value the health of the nation over the care of individual patients and convinced that a hierarchy of worth distinguished one person from another, German psychiatrists were enlisted to commit atrocities during the Nazi period.

Conclusions: The values of care and compassion can be eroded; this knowledge demands constant vigilance.

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Clinical Implications

- A tension exists between individual care and preventive health.
- Ideological and economic pressures are difficult to resist.
- Constant vigilance is necessary to maintain psychiatric values.

Limitations

- Only secondary sources were available.
- Others may draw different implications from the historical record.
- This article does not do justice to the complexities of the issues covered.

Key Words: *Nazi psychiatrists, history, medical ethics*

Richard von Krafft–Ebing (1840–1902), Emil Kraepelin (1856–1926), Sigmund Freud (1856–1939), Eugen Bleuler (1857-1939), Julius Wagner-Juaregg (1857–1940), Alois Alzheimer (1864–1915), Carl Jung (1875–1961), Karl Jaspers (1883–1969)—these names attest to the intellectual ferment in German, Swiss, and Austrian psychological circles during the late 19th century. The debt we owe to these pioneers makes it all the harder to understand how, before the new century was 30 years old, German psychiatrists were gassing children with mental handicaps and sterilizing adults with mental handicaps and mental illness or using them as subjects for scientific experimentation before putting them, often brutally, to death (1–10). Psychiatrists who once were much admired—Ernst Rüdin, Franz Kallman, Carl Schneider—were complicit in these activities. Devotees of preventive health approved of the practices. Social reformers participated. Disciples of humanism and followers of the holistic medicine movement colluded in the atrocities. Academicians and scientists were at the centre of them. Even well-meaning child and adolescent psychiatrists willingly took part.

Physicians were among the first to support National Socialism in Germany. The National Socialist Physicians League was formed in 1929. By early 1933, almost 3000 physicians (6% of the entire medical profession) had joined the League. By late 1933, 11 000 physicians were members. Undoubtedly, some joined not out of conviction but out of occupational necessity. Eventually, 45% of German physicians belonged to the Nazi party, about 7 times the mean rate for the employed male population of Germany. Physicians moved with alacrity from looking after individuals to upholding an idiosyncratic ideal of national health (*Volksgesundheit*) (1). They seemed to easily accept a hierarchy of human worth that put the infirm, the disabled, and the genetically imperfect on the bottom rung (1). Contemporary evidence suggests that, of the medical specialties, psychiatry was the most involved (4).

Science, statistics, and economics conspired to beget the notion that appropriate sterilization of the genetically disabled would improve the health of the nation. The belief that life needed to be "worthy" to merit government-supported health services caught on among the public. However, "euthanasia" was carried out whether the public consented or not.

The otherwise laudable concept of holistic health (that is, biological integrity, social well-being, and spiritual right-mindedness) led first to the sterilization and ultimately to the "euthanization" of not only the handicapped but, eventually, of the socially and spiritually unworthy—persons with mental illness, the socially wayward, criminals, Gypsies, homosexuals, and Jews. Psychiatrists helped in the selection.

Can this happen ever again? Can this happen today? In a one-payer government system, are Canadian physicians sufficiently independent of the ideology of the government in power? Can we, like German psychiatrists from 1920 to 1940, come to value the health of Canadian society sufficiently to remove from that society those who threaten its health? In one sense, we do it now when we impose involuntary hospitalization on those with mental illness; will our motives for doing so be questioned by history? We currently prescribe large amounts of tranquilizing drugs that sometimes inadvertently impair our patients' health. Are we being hoodwinked into acquiescence by a profit-driven pharmaceutical industry? After all, this is the industry that supports our meetings, whose advertisements sustain our journals, whose backing partly pays for our continuing education, whose funding often assists our clinical projects, whose deep pockets sometimes reimburse individual psychiatrists for recruitment into drug studies. Pressed by internal and external demands of career advancement, do we straightjacket our patients into DSM-IV–defined diagnostic categories? Can we, in other words, resist the pressure to close ranks behind our ideological leaders?

Since Nuremberg, we have developed tight legislation to place constraints on human experimentation, but no such safeguards exist against biases that may influence our clinical decisions. We cannot subject individuals to research against their will, but we can decide, for instance, that a woman with schizophrenia is not a good enough mother. We can decide whether to lend credence to sexual-abuse narratives. We can hold families responsible for mental illness and choose, under the mantle of confidentiality, not to speak to them. We can buy the rhetoric of the superiority of community treatment to the extent of depriving patients of the safety of a hospital bed. Autonomy can currently trump beneficence to such a degree that patients with mental illness are left untreated, abandoned. Sometimes they starve, though not to death, as they did in Nazi Germany.

Fürsorge and *Vorsorge*

The concern of one individual for another (*Sorge* in German) ruled the practice of German medicine in the early years of the 20th century (9). As in Canadian medicine today, equal emphasis was placed on 2 main forms of health care: *Fürsorge,* or care for the ill individual, and *Vorsorge,* or prior care, that is, preventive medicine. Then, as now, a tension existed between health interventions to benefit society as a whole (the realm of preventive medicine, health promotion, and community and public health) and measures that addressed the immediate needs of individual patients (treatment, rehabilitation, and palliation). At all times, governments with limited resources must continually weigh spending on preventive health against spending on the alleviation of suffering. This tension is reflected in contemporary expositions of health care ethics (11). Smith and colleagues articulate this unresolvable dilemma:

> While the duty of individual health care workers is primarily to the individual patients whose care they assume, caregivers must be aware that the interrelationships inherent in a system make it impossible to separate actions taken on behalf of individual patients from the overall performance of the system and its impact on the health of society. Doctors and other clinicians should be advocates for their patients or the populations they serve but should refrain from manipulating the system to obtain benefits for them to the substantial disadvantage of others (11, p 250).

Physicians also have a responsibility to themselves and their families; in other words, while caring for their patients and for society, they need to earn a living. The code of ethics of the American Psychiatric Association (APA) emphasizes the psychiatrist's fiduciary responsibility to individual patients but does not help clinicians struggle constructively with the

question of how it is possible to both "care about patients" and "care about money" (12).

The dilemma in Germany was resolved in favour of *Vorsorge*. Three historic factors contributed to the shift from *Fürsorge* to *Vorsorge* (9). Germany had a prior record of public health that emphasized early detection of illness and the promotion of occupational health and safety. The country had adopted the doctrine of holistic medicine (*Ganzheitslehre*), which advocated not only the comprehensive (that is, body and spirit) needs of the whole person but also those of the whole society in which the person lived. Belief in holistic medicine was probably a response to what was widely regarded at the time as overspecialization, bureaucratization, and the dominance of medical reductionism. Concurrently Germany stood at the centre of a worldwide eugenics movement whose overarching aim was to weed out population weaknesses (just as today, in many parts of the world, science is used to prevent the birth of unwanted [girl] babies). The science of eugenics expanded after World War I in that population weaknesses were deemed to include not only biological infirmities but also social and economic conditions.

In 1920, Karl Binding, a lawyer, and Alfred Hoche, a psychiatrist, published an influential text with an extraordinary title, *Permitting the Destruction of Unworthy Life* (13). In this book, Binding states:

> Reflect . . . on a battlefield strewn with thousands of dead youths. . . . Compare this with our mental hospitals, with their caring for their living inmates. One will be deeply shaken by the strident clash between the sacrifice of the finest flower of humanity in its full measure on the one side, and by the meticulous care shown to existences which are not just absolutely worthless but even of negative value, on the other. It is impossible to doubt that there are living people to whom death would be a release, and whose death would simultaneously free society and the state from carrying a burden which serves no conceivable purpose (cited in 14).

Hoche, the psychiatrist, notes that physicians may sometimes need to destroy the life of "complete idiots . . . and the mentally ill who are empty human shells and whose existence weighs most heavily on the community . . . in the interest of a higher good" (cited in 14).

What was this "higher good"?

> In part, this burden [of caring for the institutionalized] is financial and can be readily calculated by inventorying annual institutional budgets. . . . I have discovered that the average yearly cost for maintaining idiots has till now been thirteen hundred marks. . . . It is easy to estimate what incredible capital is withdrawn from the nation's wealth for food, clothing and heating—for an unproductive purpose (cited in 14).

The Binding and Hoche book was controversial, and the idea of destroying "worthless" lives did not at first gain wide support among German doctors (14). However, it might have influenced Erwin Liek, a Swiss German cancer specialist. Squarely in the preventive medicine camp, Liek promoted bans on pesticides, smoking, drinking, use of X-rays, and poor nutrition. He also railed against the state of medicine as mechanical and overly scientific (15). The first obligation of the medical profession, argued Liek, was the health of the nation, even if it meant sacrificing specific individual needs. The new social security medical insurance system, wrote Liek, had changed German physicians from "priests in the temple of the art of healing" into *Kässenartze* (those who were reimbursed directly by the government, literally "cashier physicians"), "lowly wage-earners" in the "magnificent hall of social insurance" (cited in 9). Echoing the concerns of today, Liek also blamed the pharmaceutical industry for turning doctors into pill pushers. Medicine, he said, was becoming depersonalized, moving away from the bedside and toward subspecialization and diagnosis by laboratory results, rather than by clinical judgement (9).

Care of the individual patient, he went on to argue, brought little satisfaction because, under the new system, there were so many people to be looked after. However, he found a plus side to large numbers. Physicians could now clearly see that not everyone was prone to illness to the same degree. Some, of good constitution and good habits, resisted illness easily while others could not, demonstrating the primal importance of constitution and heredity. "The physician understands that a higher task awaits him than the care of the individual human being . . . namely, the future of his people" (cited in 9). These conclusions by an eminent cancer specialist were probably derived from the textbook *Human Heredity and Racial Hygiene*, which went through 5 editions between 1921 and 1940. It received rave reviews in contemporary journals and was considered the standard textbook on racial hygiene (16).

Liek himself died in 1935. Foremost among his followers was Karl Kötschau, a leader in the natural healing movement, who organized a "New German Therapy"(*Neue deutsche Heilkunde*), which synthesized scientific medicine, naturopathy, and homeopathy. This fusion promoted wholesome effects—consumption of whole grain bread, avoidance of alcohol and tobacco, plentiful exercise, and herbal remedies. Herbs, incidentally, were not necessarily wholesome in Nazi Germany. Fertility experiments were conducted with botanicals, and in 1941, Nazi SS Reichsführer Heinrich Himmler was told that extracts of the South American plant *Dieffenbachia seguine* could be used for the mass sterilization of racially undesirable war prisoners (17).

Sterilization of the Unworthy

On January 30, 1933, Adolph Hitler became Chancellor of the Third Reich, and *Vorsage* became the justification for his eugenic sterilization programs. On July 14, 1933, the Law for the Prevention of Genetically Defective Progeny was passed, mandating the involuntary sterilization by vasectomy or tubal ligation of carriers of so-called hereditary disease: the "weak-minded," schizophrenics, alcoholics, the insane, the blind, the deaf, and the deformed. At the same time, to encourage population growth among the Aryan race, the regime restricted access to contraception and outlawed voluntary sterilization as well as abortion, unless it was necessary to save the mother's life (14).

Upon passage of the law, Dr Ernst Rüdin, professor of psychiatry, director of the Kaiser Wilhelm Institute of Psychiatry of Munich, and the "father of psychiatric genetics," celebrated the occasion with these words:

> It is thanks to him [Hitler] that the dream we have cherished for more than 30 years of seeing racial hygiene converted into action has become reality. . . . In the words of the Führer: 'Whoever is not physically or mentally fit must not pass on his defects to his children. The state must take care that only the fit produce children' (cited in 18).

In the first year of the Sterilization Act, Germany's genetic health courts received 84 525 physician-initiated applications and reached 64 499 decisions, 56 244 in favour.

> Doctors competed to fulfill sterilisation quotas; sterilisation research and engineering rapidly became one of the largest medical industries. Medical supply companies made a substantial amount of money designing sterilisation equipment. Medical students wrote at least 183 doctoral theses exploring the criteria, methods, and consequences of sterilisation (7, p 1460).

Within 2 years, up to 1% of citizens aged 17 to 24 years had been sterilized. Within 4 years, about 300 000 patients had been sterilized—at least one-half for "feeble mindedness," as evidenced by their failing scientifically designed intelligence tests (7). In 1939, sterilizations came to an end except for adolescents at "high risk of reproduction" (19). Rüdin's monograph on the genetics of dementia praecox served as scientific validation for the forced sterilization (20).

Euthanasia for Persons With Mental Illness

The primacy of *Vorsorge* and Rüdin's scientific discoveries were also used to justify the murder of large numbers of "unworthy" individuals. Preparing for war, Hitler decided that mental illness and physical disability were not sufficient grounds for occupying hospital beds needed for wounded soldiers. Most academic psychiatrists embraced the Nazi philosophy and seemed content to lead the way in the "final solution" for psychiatric patients (20,21). It was possible, though costly, to resist. Among others, Karl Jaspers warned colleagues of the dangers of racial hygiene. The National Socialists did not appreciate Jaspers' opinions, and in 1933, he was relieved of most of his teaching duties. By 1937, he was ousted from the university (to which he returned after the War).

No law authorizing medical killing was ever debated or passed by the Reichstag. It was authorized by "Führer decree" in October 1939. All state institutions were required to complete questionnaires and report patients who had been ill for at least 5 years and unable to work. Forty-eight doctors were appointed to review nearly 300 000 applications for euthanasia; of these, about 75 000 patients were selected for death. The decree was backdated to September 1, 1939, to cover the initial phases of the invasion of Poland, during which 4000 Polish psychiatric patients were shot (14). The entire process was named Aktion T4 after Tiergarten 4, the address of a confiscated Jewish home in Berlin that housed the administrative offices of this operation. In January 1940, Dr Karl Brandt, Hitler's personal physician, tested a new means of mass killing—the administration of carbon monoxide in a gas chamber disguised as a shower. This experiment was conducted at the Brandenburg psychiatric hospital. It was then replicated at 5 other psychiatric hospitals throughout Germany, each of which was outfitted with a gas chamber. The alleged aim was to create 70 000 beds for casualties of war. False death certificates were issued with diagnoses appropriate for age and previous symptoms, and payment for "treatment and burial" was collected from surviving relatives. Between 1939 and 1945, 180 000 psychiatric patients were killed in Nazi Germany (14).

Cost–benefit analyses were a prominent feature of Nazi medicine. Schoolchildren were sent home with mathematics problems that required balancing the cost of housing units for young couples against the costs of looking after "the crippled, the criminal and the insane." The killing of 70 000 patients in the T4 program was calculated to save 245 955.50 Reichsmarks daily, which freed up "4,781,339.72 kg of bread, 19,754,325.27 kg of potatoes," a total of "33,733,003.40 kg" of 17 categories of food, plus "2,124,568 eggs." Projected over 10 years, these savings were predicted to amount to "400,244,520 kg" of 20 categories of food worth "141,775,573.80 Reichsmarks." Removal of these patients from the wards saved estimated hospital expenses of "245,955.50 Reichsmarks per day," or "88,543,980.00 Reichsmarks per year." Further, the "State of Prussia invest[ed] annually 125 Reichsmarks for a normal pupil, 573 Reichsmarks for a slow learner, 950 Reichsmarks for an educable but mentally ill child, and 1500 Reichsmarks for a child

born blind and deaf" (from documents examined and reported in 7).

In the spring of 1940, several family members brought murder charges against the directors of 2 of the killing institutions, but the courts dropped charges when they learned that Hitler himself had authorized the operation (14). Some of the asylums from which patients with mental illness were selected for killing were church-run organizations, and church officials protested. The most famous public statement against Aktion T4 came from Catholic Bishop Clemens Graf von Galen in a sermon delivered on August 3, 1941:

> Have you, have I, the right to live only so long as we are productive . . . If you establish and apply the principle that you can kill "unproductive" fellow human beings, then woe betide us all when we become old and frail! . . . If one is allowed to forcibly remove one's fellow human beings then woe betide loyal soldiers who return to the Fatherland seriously disabled, as cripples, as invalids (cited in 14).

Von Galen's sermon was copied and circulated across Germany, provoking large-scale demonstrations. Not long thereafter, Hitler issued an order halting Aktion T4. It is uncertain whether this was done in response to the protests or because Aktion T4 had by then met its initial goals (22).

However, the practice of killing the disabled continued. From 1941 onward, patients who suffered from mental illness were killed by neglect and starvation and, when this method proved too slow, by lethal injection. The selection process for this phase of "wild euthanasia," as it is called in Nazi documents, was carried out by individual psychiatrists (23). Patients were selected to die not only because they were nonproductive but also because they were hard to manage or because they displayed homosexual behaviour. "Wild euthanasia" was extended to slave labourers who were ill, to residents of reform schools, and to the elderly, especially those in institutions for the poor. In 1990 previously unknown documents from the Nazi era, preserved in the central archives of the Ministry for State Security, were found in Berlin. Nearly 30 000 of the more than 70 000 psychiatric patient files surfaced. A sampling of 185 files indicated that most of the victims had been hospitalized over long periods and classified either as schizophrenic or feeble-minded. Five percent of the victims were not unproductive—they were employed (24).

Euthanasia found its way to the concentration camps under the program code-named 14f13 (25). 14f referred to the code number for the Inspectorate of Concentration Camps, and 13 referred to the "special treatment of sick and frail prisoners." The program was devised by Himmler to rid the camps of sick prisoners (14). In the Auschwitz concentration camp alone, thousands of disabled and mentally ill people were murdered in gas chambers.

Children

In 1935, a young protégé of Ernst Rüdin's, Dr Franz J Kallman, presented a paper at the Berlin International Congress for Population Science, in which he argued for the sterilization of even the apparently healthy relatives of those with schizophrenia, along with the patients themselves, to eliminate defective genes. Kallmann's genetic studies were used partly to justify the murder of patients, many of them children (26). The killing of children with mental and physical disabilities was carried out in so-called Specialized Children's Departments (27). Information on these children was sent to Berlin, where it was reviewed by a panel of 3 medical experts who decided whether a particular child was to be killed. The decision was made without the expert examining the child and without the consent of parents. The children selected for death were transported to one of the designated killing centres in Germany, while the parents were told that the transfers would allow for "the best and most efficacious treatment available." After the children arrived, the process of euthanasia was delayed for several weeks to give the impression that treatments were being tried. The actual murder was by barbiturate injection. Some doctors did not waste medications on their "patients," preferring to starve them to death. The parents of the deceased child were informed via form letter that the infant had died of pneumonia or another made-up cause (14).

Although the children's program was initially restricted to children under age 3 years, this age limit was soon extended. The German Association of Child and Adolescent Psychiatry and Allied Professions was founded in 1940 in Vienna. At the first conference, speakers found a solution for the problem of "asocial" minors: They were separated from their families and given special education. The object of this effort was to indoctrinate them into the ideology of National Socialism. Physicians then determined the value of each child's life according to economic criteria. Children with negative ratings (for example, those deemed unlikely to be able to work or showing a low IQ test score) were killed by fasting "cures" or by barbiturates. Some 6000 children were killed by the end of the war. In addition, children were used as research subjects, because German scientists were very interested in brain research (19).

Julius Deussen (1906–1970), head of the Department for Hereditary Psychology at the Deutsche Forschungsanstalt and a close coworker of Carl Schneider (1891–1946) at the University of Heidelberg, coordinated studies on children with the aim of correlating clinical and laboratory findings with brain histopathology. Ernst Rüdin supported the activities of Deussen in Heidelberg and repeatedly noted that they were

important for the health and population policy of the Nazi regime (28).

Carl Schneider, head of the famous Department of Psychiatry at Heidelberg until 1945, was known for advocating intensive therapy for patients to reintegrate them into society. At the same time, he suffered no apparent compunction about killing those he considered beyond the reach of active therapy. There were 52 children with mental handicap in the research program that he headed, and the historical record shows that 20 were killed in the asylum of Eichberg so that their brains could be examined in Heidelberg (29). Professor Schneider committed suicide in 1946.

Dr Elizabeth Hecker, a pioneer of child and adolescent psychiatry in Germany, was director of a clinic for adolescent psychiatry in Silesia. This clinic was one of the first to be dedicated solely to adolescent psychiatry. Any child in this clinic who did not pass intelligence and behaviour tests was reported to the Reich Committee for the Scientific Registration of Severe Genetically and Constitutionally Determined Diseases in Berlin and was then transferred to a local "special department." Despite this, in 1979 the German Association of Child and Adolescent Psychiatry appointed Hecker an honorary member because of her postwar commitment to the cause (30).

What Does This Teach Us?

One lesson for contemporary psychiatry is that *Vorsorge*—preventive health—must never be prized above treatment for those who are ill. Preventive health saves money. Treating the ill is costly. The design of public health measures is a white-collar activity. The care of the ill is bloody, back-breaking, grimy, unglamorous, and often unrewarding. The physician's core values are healing, relief of suffering, and compassion. Responding to human suffering is the primary responsibility of psychiatry. To quote Barondess,

> With regard to health, the priorities of the state and of society must flow from priorities of concern for the individual rather than the reverse. Medicine has a clear responsibility to see that those priorities are articulated and represented in public policy (1, p 897).

Another lesson is that the care of the sick must never be subverted to an ideology, whether imposed by the state, by the church, by science, or by commercial interests. Professional relations with governments require our constant vigilance. We must forever be wary of political and economic pressures that impinge on our decisions about the delivery of health services, the distribution of resources, and the support for some kinds of educational endeavours above others or for some kinds of research pursuits at the exclusion of others (10).

An editorial in the *British Medical Journal* alerts us to the fact that today's physicians are not immune to political pressures:

> if biomedical insights grant physicians sudden new explanatory and technological powers, if economic trends intensify pressures to rationalize health care costs and develop utilitarian strategies, if state political forces directly enlist the medical profession in an agenda of social and economic transformation, and if an ideology of hate and stigmatization permits the dehumanization of one sector of the populace, then we may see a turning towards something we had relegated to bitter mid-20th century memory (31, p 1415).

The same editorial also issues a warning about science:

> Substantial support accrues to scientific endeavour when the state, for political, economic, or ideological reasons, grants high priority to finding answers and using them in formulating public policy. Physicians stand at the pinnacle of the health care hierarchy, where issues of population health, resource allocation, medical teaching, scientific research, and patient care must be debated and resolved. These issues are often in conflict (31, p 1414).

Medical science must always concern itself with the human implications of its discoveries, must recognize that its conclusions are at best tentative (1), and must not permit the requirements of a research agenda to trump individual well-being. In answer to the *British Medical Journal's* Nuremburg issue that this editorial prefaced, readers pointed out that the policy of compulsory sterilization of "defective" people was first implemented not in Germany but in the US in 1907; by 1913 sterilization was legal in 12 states. More than 60 000 people were sterilized in the US between 1907 and the 1970s. These laws were drafted by doctors, upheld by the US Supreme Court in 1927, and in 1985, were still valid in 19 states (32). In 1928 Alberta passed similar laws, under which 3500 Native women were sterilized. After British Columbia passed a sterilization law in 1933, The United Church of Canada established 2 major centres on the West Coast, and missionary doctors sterilized thousands of Native men and women. This practice continued until the 1980s (33,34).

In what ways do such practices differ from assisted suicide and mercy killing of the profoundly disabled (motivated not by an ideological or personal agenda but by the wish to stop unbearable suffering—as in Robert Latimer's 1993 asphyxiation of his daughter, Tracy)? This issue has preoccupied Canadian bioethicists in recent years (35). We must be humble in what we think we know. Diagnostic and motivational uncertainties are everywhere in psychiatry, and our ability to prognosticate is very poor. Treatment response is variable and often unpredictable. We have done little about the large

numbers of individuals who have limited access to mental health services and about the inequalities in the calibre of psychiatric care that exist between privileged and disadvantaged groups of people. This implies the existence of hierarchies of human worth, a disturbing echo of the Nazi era (1). We have done little for those who seek help and are stigmatized for it. We have done little to collectively endorse and publicize the fact that there is no single universally right method to treat mental illnesses, that many valid approaches coexist.

We must be careful about the commercial exploitation of our research findings, especially the eventual discovery of susceptibility genes for psychiatric disorders (36). When these genes are found, we must apply all our collective wisdom to prevent a new biological determinism from sweeping our profession.

Current pressures in the health care system make it imperative that we protect the traditional values of caring for the sick. Short hospitalizations that help the bottom line of institutions pose as reflecting the best interests of patients. Do they? Recent reforms of the mental health system seem to be based mainly on considerations of cost. The Nazi era has taught us that medical values are malleable and can all too easily be shaped by priorities of the state, personal agendas, careerism, the profit motive, and deep biases in society and in ourselves (1).

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Résume : La psychiatrie à l'époque nazie

Objectifs : Fournir aux psychiatres canadiens l'information récente sur des archives de Berlin récemment découvertes à propos des actions des médecins, en particulier des psychiatres, à l'époque du national-socialisme, en Allemagne, et encourager l'introspection au sujet du rôle de la profession médicale, de sa relation avec le gouvernement, et de sa vulnérabilité à la manipulation par les pressions idéologiques et économiques.

Méthode : Il s'agit d'un examen sélectif de la documentation sur la collaboration des médecins, en particulier des psychiatres, à la stérilisation, l'expérimentation et l'élimination de patients souffrant de maladie mentale, avant et pendant la Deuxième Guerre mondiale.

Résultats : Poussés à valoriser la santé de la nation plus que les soins aux patients individuels, et convaincus qu'une hiérarchie de valeur distinguait une personne d'une autre, les psychiatres allemands étaient enrôlés pour commettre des atrocités, à l'époque nazie.

Conclusions : Les valeurs d'amour et de compassion peuvent s'éroder; cette connaissance exige une vigilance constante.