HOW HEALERS BECOME KILLERS:
PHYSICIANS AS SUICIDE BOMBERS

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The 2007 terrorist attacks in the United Kingdom startled many since the alleged attackers were physicians, people who take an oath to save lives. What type of motivation could trigger these healers to become killers? People are astonished that two highly educated and intelligent individuals orchestrated last year’s failed suicide bombing attacks in London and Glasgow. How could any well-to-do physician and Ph.D. engineer plan such violence against innocent club-goers and airline passengers? In this article we attempt to use psychological tools to understand the motivation of these suicide bombers. First, we explore the motivation of suicide bombers in general (those without M.D. or Ph.D. degrees) and then we focus on clinical suicide cases to present the differences/similarities between suicide bombers and suicide in the clinical population. This effort is to understand more about the suicide bomber’s motivation. At the end, we present our speculation in regard to the motivation of physicians and other highly educated professionals in becoming suicide bombers.

UNRAVELING THE PARADOX

Before exploring how to unravel this paradox (i.e., healers becoming killers), we would like to identify a few issues:

1) **Understanding is not justifying:** When one tries to understand and explore the psychodynamics of suicide bombers, it is deemed by critics as “justification.” Understanding them, how they got to this level of violence, is not justifying their behavior. As forensic psychiatrists we try to understand the evolution of terrorists as well as serial murderers and child rapists. These behaviors are not inborn but are developed (1).

2) **Are these bombers “suicidal”?** Obviously the majority of suicide bombers do not consider their actions as specifically suicide which is forbidden by their religion. They identify themselves
instead as soldiers who are assigned to carry a bomb from point A to point B. If they have a helicopter or F-14 they use that, if they have nothing else, then they use the body as a vehicle to carry the bomb.

3) **Our definition of suicide bombers:** We define suicide bombers or warriors as people who must die first in order to harm or kill their enemies. This is different from other combatants. In spite of the imminent danger to them, if there is the possibility that the attack can be carried out without the attacker’s dying, it is not considered a suicide attack. The primary objective of both fighters is that the enemy will be killed or injured (2).

4) **“Name” controversy:** We have attempted to remain neutral in regard to the interchangeable terms of suicide warriors/terrorists/bombers on both sides of the current conflicts. One such term, “suicide missionaries,” I learned from an Israeli psychiatrist during her presentation at the American College of Forensic Psychiatry Symposium in April, 2006, as she used this word instead of “bomber” to respect neutrality (3).

One of the problems with defining terrorism is that the label terrorist is not static. Salman Akhtar, a psychoanalyst, has defined it as being “time-bound.” As political loyalties shift, today’s terrorist becomes tomorrow’s hero (4). A “freedom fighter” can become a terrorist, or a terrorist can become a peacemaker (and get the Nobel peace prize). It is a gray area to define exactly when that role changes. Joseph Sobran questioned whether terrorism should be defined in an ideological way. He raised such questions as: Can the end justify the means? Is it possible to be a terrorist and a freedom fighter at the same time? Is it possible to use bad methods for good purposes (5)?

In general, the definition of terrorism/suicide bombing is in the “eyes of the beholder.” The news media have used labels/names such as “martyrdom operation” to “freedom fighter” to “homicidal bomber” depending on whom the suicide bomber is bombing and on which side of the world’s hemisphere the “eyes of the beholder” are residing. As the Talmud has advised us, “We don’t see things as they are; we see them as we are.”
ARE DOCTORS (EDUCATED PEOPLE) ALSO CAPABLE OF ATROCITIES?

Is the Hippocratic Oath a Hypocritical Oath?

Surprisingly, throughout human history, those in our profession and other highly educated individuals have been involved in human atrocities, war crimes, revolution and freedom fighting. Not long ago, for example, a small number of American physicians and nurses were involved in not treating black patients with syphilis (the Tuskegee Study of Untreated Syphilis in the Negro Male, 1932–1972) to witness/explore the end states of this killer disease. Che Guevara, the Marxist revolutionary, was a physician. George Habash, a pediatrician, led a Palestinian militant group, and Ayman al-Zawahiri—the No. 2 Al Qaeda leader—is a surgeon. It was a Tokyo physician who planted the toxic gas on the Tokyo subway trains. In July, 2008 Radovan Karadzic, a psychiatrist, was arrested by the United Nations Tribunal Court in Europe with charges of human atrocities toward Bosnian Muslims. Allegedly he was involved in the genocide of Srebrenica. History has revealed the horrendous role that physicians played in Nazi Germany during the Holocaust. We all know that the people who created the atomic bomb, poison gas and torture machines were also all very well educated (6). Dr. Baruch Goldstein, an Israeli-American physician, carried out the 1994 massacre of Palestinians in the West Bank, killing 29 people who were praying in the Mosque and wounding 150 innocent civilians.

Many Americans were horrified to see the news and pictures taken of the tortured prisoners held at Abu-Ghraib and Guantanamo Bay. Yet what was the role of physicians in these actions? According to the International Committee of the Red Cross (ICRC), physicians at Guantanamo Bay violated medical ethics by sharing patients’ medical files which would be used for interrogation purposes. Bloche and Marks (7) carried out their own research in Iraq and Guantanamo Bay and discovered a longer trail of doctor involvement. Colonel Thomas M. Pappas, the chief of military intelligence at the Abu Ghraib prison stated that beyond sharing patients’ files with non-medical personnel, physicians and psychiatrists were involved in planning detainee interrogations. The measures of which included “dietary manipulation…environmental manipulation…sleep management…sensory deprivation…isolation…stress positions…and presence of working dogs” (7). In addition, there were reports in the news media that the certificates of death,
signed by the physicians, of prisoners who died in Abu-Ghraib under torture, falsely indicated other causes. Yet certain physicians did not see this type of work as a breach of the Hippocratic Oath. According to Dr. David Tornberg, Deputy Assistant Secretary of Defense for Health Affairs, “Physicians assigned to military intelligence have no doctor-patient relationship with detainees and, in the absence of life-threatening emergency, have no obligation to offer medical aid” (7). Pentagon officials and certain military physicians have supported this viewpoint by stating that in times of war, physicians act as combatants, not doctors, “when they put their knowledge to use for military ends,” and as such they are not bound by physician ethics. “The Hippocratic ethic of commitment to patient welfare does not apply” (7).

**SUICIDE BOMBERS IN THE GENERAL POPULATION: MOTIVATIONAL FACTORS**

We have reviewed the literature available to us (from both sides, West and East) in regard to the motivation and incentive of suicide bombers in recent years. These motivational factors are varied and complex yet can be divided into “internal” and “external” entities. On the basis of this exploration, we have speculated that the most common (frequently and consistent) variable is the occupation/invasion of the bombers’ homeland or holy places. This is the primary external factor. Internal motivational elements are identified as nationalism, perceived injustice and humiliation, rage/revenge and religion.

**The Element of Nationalism**

Pape (8) suggested that nationalism is the primary motivation for suicide bombers rather than rage or despair or the promise of an afterlife. He proposed that the individuals who become suicide bombers are those who have become assured that a high level of violence will achieve their community goals. In human beings the sense of nationalism/group identity develops in early childhood. Volkan (9) examined orphaned children in Palestine whose strong group bonds extended beyond their orphanage to understand the formation of nationalism. He noticed that these children mimicked throwing stones while watching children of the Intifada on television throw stones at the Israeli soldiers. He speculated that the orphans could identify with those in an occupied territory. Personal identity then becomes that of the group
rather than the individual. This group identity then develops into nationalism especially with a strong national leader/mentor. One is willing to give up his/her life to support “group identity” and nationalism.

**Perceived Injustice and Humiliation**

Psychiatric literature indicates that a primary emotional factor in aggression is shame. Studies by Armstrong (10) showed that this shame has played a significant role in stimulating countries to go to war. Studies by Prusher (11) focused on the despair, hopelessness and humiliation that Palestinians feel in the occupied territories. These factors, combined with the phenomenon of large group identity (9), provide the basis for generations of perceived injustice specifically in the Middle East. These are the internal feelings which have resulted from the external factor of invasion/occupation.

**The Element of Rage/Revenge**

In the letters or videotapes that some suicide bombers left before their missions, they state that their motivation is revenge. In psychiatric literature revenge is considered a defensive mechanism to externalize guilt and self-hatred rather than turning those feelings inward. It has even been labeled as a “vindictive triumph” (12). Rage may also be a result within the grieving process for the traumatic loss of someone (13). Connecting with a group can provide an outlet for these feelings of revenge and rage. The action of revenge by a suicide bomber is celebrated and reinforced by this larger group, the community, as a way to reverse the powerlessness and hopelessness of loss.

One of the phenomena that increases rage, discontent, frustration and a sense of perceived injustice and discrimination is the double standard and prejudice by the Western news media/governments. There is apparently one set of morals for the West and another for the “rest.” In Saint Augustine’s *City of God* the pirate says to the King, “because I do it with one small ship, I am called a terrorist. You do it with a whole fleet and are called an emperor” (14).

**The Element of Religion**

To the contrary of what our news media declare, most of the suicide bombers are not fanatic/religious practitioners of a specific religion. Some of
their violence has a more political than theological basis. Suicide attacks have been conducted by many groups, including leftist Marxists. Between 1980 and 2001, the Tamil Tigers (a Hindu group with Marxist/Leninist elements) conducted 75 of the 186 attacks (8). As Roy (15) has mentioned, the Al-Qaeda’s violence is against what is politically inspired not religiously: “Al-Qaeda did not target Saint Peter’s Basilica in Rome, but the World Trade Center and the Pentagon. It targeted modern imperialism as the ultra-leftists (around the world) of the late 1960s and 70s did with less success” (15).

However, religion can be a tool that is used by some as a motivator, by some as a justification, and by many as a phenomenon which approves, gives reward to, and decreases the fear and existential anxiety of death/annihilation. In general, researchers have concluded that religious fanaticism is neither necessary, nor sufficient, to explain suicide terrorists.

Survivor Guilt (PTSD)

“Survivor guilt” is one of the cardinal symptoms of posttraumatic stress disorder. For example, many inhabitants in occupied territories are suffering from PTSD after years of trauma created by homelessness, displacement, humiliation, and loss of family and friends in conflict with the occupying army. When one member of a tribe is killed, jailed or tortured, survivors wonder why they themselves were spared while a comrade suffered. To cope with this guilt, the survivors may involve themselves with “martyrdom operations,” increasing the number of young volunteers who are willing to give up their lives by using their bodies as a vehicle carrying weapons (16).

PSYCHOLOGICAL STRUCTURE AND PSYCHODYNAMICS

Splitting and Projecting

Splitting off the “bad part” and projecting it onto others may be another psychodynamic explanation. John Sanford indicated that all of us may have “inner feelings” that we do not discuss with anyone. However, most of us are able to detect a way to compromise and live in peace with this “inner adversary.” The terrorists disown their inner adversarial parts and split and project them outward onto others. Terrorists simply cannot accept these adversarial inner feelings and the co-occurring anxiety without decompensating. The split and projection of this bad part promotes an “intact” sense of self (17).
Pies (18) has speculated on the general ego defense mechanism of terrorists (not specific to suicide attackers). He felt that they exhibited two main mechanisms: 1) paradoxical narcissism and 2) projective identification. In paradoxical narcissism, the individual appoints himself or herself as judge, jury, and executioner of his or her cause. The terrorist feels the world must conform to his or her needs, and if it does not, someone must pay the price to make it fit. From our point of view, this narcissism would not explain how the same persons will then “sacrifice” their “self” and their life for the “welfare” of others, as many suicide bombers perceive that they do. The other criticism of Pies’ theory is that these qualities are not exclusively seen in terrorists. One may speculate that some western governments have used this same ego mechanism in regard to the invasion and control of other countries (e.g., France with Algeria; Belgium with the Congo; and the United States with Granada, Panama, and Iraq) and dictating to other nations what kind of governmental system they should have.

**Dehumanization of the Enemy**

One may also become motivated toward violence through the process of dehumanization—making someone less human. In general, the dehumanizing of enemy soldiers and civilians is a well-known war tactic. Soldiers are “brainwashed” so that they consider the enemy as inhuman and dangerous to humanity. As a result, such soldiers feel that they have a license to kill.

**Rationalization and Justification**

Any suicide bomber is partially or totally a product of his/her community. The cultural aspect needs to be considered, especially the concept of tribal tradition of “an eye for an eye” to restore justice. This is an important factor that needs to be considered in regard to how the suicide bomber justifies killing innocent people. When a child is killed (even if it is labeled “collateral damage”), the family (or the victim tribe) may claim a kind of permission or entitlement to kill a child of their enemy. This just perpetuates the conflict. The other rationalization occurs when the suicide bomber justifies killing civilians because they may be “future combatants.” These civilians are perceived to be the past, present, or future enemy soldiers, prison guards, or tormenters, so killing them is a defensible policy. Sohail (19) wrote that the western democratic process allows the suicide warrior a rationale for killing civil-
ians, because the inhabitant populace is responsible for electing leaders who are implementing the policies that the terrorists oppose. For example, Khan’s (a London suicide bomber) videotape of his last message revealed that the invasion of Iraq by the British government was the motivation for him to kill innocent British civilians (20). However, from our point of view, there are indications that one may first develop desires to kill (murderous wishes) and then look for justification or rationalization. In these cases, feelings come first and then one looks for plausible causes, motivation, or justification, because human beings have difficulty in accepting their actions without having the “right reasons.”

**CLINICAL SUICIDE AND SUICIDE BOMBING: SIMILARITIES AND DIFFERENCES**

Overall, there are more differences than there are similarities between these two categories. We also must acknowledge that both groups contain heterogeneous aspects. Despite the variations, the analysis did reveal some similarities and differences.

**Similarities**

Both the clinical population and the suicide bombers perceive themselves to be victims who suffer unfair treatment in their lives. These issues produce deep wounds and possible feelings of hopelessness, frustration, anger, and helplessness, as well as other kinds of psychic pain.

Sneidman (21) provided six aspects of clinical patients who commit suicide that may be considered in understanding suicide bombers. These include situational characteristics, motivational traits, affective responses, cognitive characteristics, relational factors, and serial characteristics. The most common predisposing situational characteristic in suicide is an “unendurable psychological pain.” Although it was noted that suicide terrorists do not tend to have mental disorders, their psychological pain may emanate from what they perceive to be a more powerful oppressor. Over time, this feeling of oppression may create its own “unbearable psychological pain.” Within this schema, there is the motivational trait of “attempting to seek a solution.” The solution for the clinical population may be to use suicide as a means to stop consciousness. The solution for the suicide bomber is to overcome powerlessness with his only weapon—himself. The suicide bomber causes the death of others by dying himself and broadcasting the message of his/her
perceived injustice/victimization to the world. They want to “right” the perceived “wrong” through death and destruction (22).

The affective responses noted in the clinical population seem to be a sense of hopelessness and helplessness within the context that they have “nothing to lose.” These traits also may be applied to the suicide bomber but in a different context. With their impending deaths, the suicide bombers may experience feelings of hopelessness, but at the same time they may be hopeful that there might be much to gain over the political oppression that they or their tribe may be experiencing. The cognitive characteristics of suicide individuals include a kind of “tunnel vision” in which no other alternative ideas can emerge. This tunnel vision may also be the view of the circumstances of the lives of the suicidal bombers. Suicide provides not only a way out of the oppression for the potential suicide bomber but also a way into an act of glory. The individuals within both groupings who turn to suicide view their worlds in conflicted and narrowed states and are not able to see other options. The relational factors of suicide focus on the interpersonal behavior of the act. In other words, suicide is a form of communication to those who are living (22).

In serial characteristics, an individual shows specific lifelong coping mechanisms when upset, distressed, threatened, and enduring some psychological pain. As issues increase and are perceived to be unsolvable, the person may attempt suicide if he/she is oriented toward lethality and dying. Does the suicide bomber also experience these serial characteristics and is he oriented to death as a coping mechanism? Their view of death often is linked toward the stress of a political issue, which serves to provide more impetus for action.

Differences

Although some of their internal responses may be similar, there are still marked differences between a clinical patient who resorts to suicide and a suicide bomber. The focus of suicide in the clinical population is death, where as the focus of the suicide bomber is the death of other people and to terrorize countless numbers of others. Death for the suicide bomber is a “by-product” of the act. Another key distinction between these two groups is that in the clinical population there are serious mental health issues, whereas sui-
cide bombers are generally free from serious psychopathology. Moreover, it is important to note that even society reacts differently toward both groups. In the clinical population, suicide is often covered up or not discussed. However, suicide bombers actually rely on the publicity that their actions will generate throughout the world.

Freud has written about the pleasure versus pain principle and maintained that it is human nature to run toward pleasure and away from pain. In referencing this theory, how do we define the actions of a suicide bomber? In clinical suicide cases we know that the pain of life is more severe than the possible pain of death. Therefore, a depressed person may choose suicide as a way to escape the pain of life by seeking the numbness (or pleasure due to an absence of pain) of death. In addition, we have interviewed a number of patients who were depressed and suicidal and also had certain religious convictions. Several of them held a belief that they may “go to hell” if they committed suicide. Yet, they considered their life to be more painful than any perception they had of hell. In relating Freud’s theory to suicide bombers, the psychic pain that they may feel can be caused by a variety of factors. Some of them may feel humiliated, invaded, traumatized, assaulted, or tortured or are suffering from a death of loved one by an “enemy.” For them there may be pleasure to be gained through revenge or by ending perceived injustice (22).

SPECULATION REGARDING DOCTORS’ MOTIVATION:
IN THE EYES OF BEHOLDER

Doctors Are Part of the Culture, Not Superior

Physicians are part of their communities, and may not be detached from the trends and opinions of their cultures. For example, in the 1800s, some physicians—like their fellow citizens—believed slavery to be a legitimate and necessary enterprise. It is widely reported that more than several hundred thousands Iraqi civilians have died since the U.S.-led invasion—one that promised to bring prosperity and security to the region. Many living in the Middle East, rightly or wrongly, blame the West for this tragedy. Mirroring their communities, a small number of doctors and other highly educated individuals advocate or justify violence as a reaction to perceived injustices. They are possibly rationalizing that the deaths of a few innocent people may
prevent the deaths of thousands of innocent people. There are precedents to this phenomenon. For example, World War II ended after the U.S. bombed Hiroshima and Nagasaki, and Churchill claimed that the Allied Forces’ carpet bombing, which deliberately killed civilians, demoralized the German army.

There is an old cultural story of a “bad man” who was throwing innocent people off a bridge. There were a number of doctors/nurses who were treating these injured and wounded people, one after another, when they fell to the ground. Eventually someone among these healers suggested that one of them should climb the bridge and stop this “bad man” from doing these atrocities, possibly throw him off the bridge and therefore rescue a lot of others. A physician became the volunteer. The best treatment is prevention!

McCauley (23) has theorized that suicide bombers view themselves as sacrificing their lives for the greater good and regret that they only have one life to give for their cause. If we accept this opinion, then physicians, who are known for their dedication to society and the greater good, may rationalize that their participation in the terrorism is part of their duty and greater gift.

Identification with Aggressor

Peter Ustinov has said, “Terrorism is the war of the poor, and war is the terrorism of the rich.” One of the alleged London terrorists, British-born Dr. Bilal Abdullah, reportedly was affected personally by the U.S.-U.K. invasion of Iraq, when his family was forced to flee their home. (His father is a respected orthopedic surgeon.) This personal reality, coupled with the tribal customs of Middle Eastern cultures—which espouse an eye for an eye philosophy—might have made the need for revenge very real. Furthermore, I wonder whether these physicians felt that the United Kingdom had committed terrorism against their “ummah” or nation. Perhaps these physicians identified with the aggressors, and allegedly used violence to wage their own war (6).

Identification with Martyr

As the number of suicide bombers increases and the culture glorifies such individuals, other young activists may identify with the martyrs and follow their path. There has been evidence of this type of identification in
Palestine and Chechen. Dr. Sarraj, a prominent psychiatrist in Gaza, has reported that children in the occupied territory have grown to idolize suicide bombers and others who have given their lives for the Palestinian cause. In Gaza 36 percent of 12 year-old-boys have accepted the oxymoron that dying as a martyr is the best thing in life (11).

**Choosing Bad Versus Worse**

History shows that under certain circumstances, mentally stable people have felt justified in deliberately killing nonmilitary citizens. Take, for example, the case of commanders who ordered the nuclear bombings of Hiroshima and Nagasaki. There is a justification/rationalization of choosing between “bad” and “worse.” Killing foreign innocent civilians is bad, but it may be worse if one’s own people are killed. Perhaps this was the type of dilemma that President Truman and his entire cabinet dealt with when deciding whether or not to drop the bomb on Hiroshima. The bombing of Japanese innocent citizens would be “bad,” but perhaps the other alternative of American soldiers being killed, was considered to be “worse.”

**No Way Left**

Feelings of helplessness, hopelessness, and frustration due to perceived injustice that remains unnoticed or unexpressed may contribute to suicide, especially if someone rationalizes that violence by him/her may stop violence by the enemy invaders. Helplessness and hopelessness are not in themselves catalysts, but suicide is a reaction to the reasoning that “in no way can I defeat the enemy or inform the world of the injustice that is done to me and my tribe. No one will listen” (24).

**CASE STUDIES OF DOCTORS INVOLVED IN THE LONDON AND GLASGOW BOMBINGS**

In the aftermath of the failed car bomb attacks on Glasgow and central London on June 30th 2007, eight people were arrested. Two individuals were initially arrested perpetrating the attack at the site of Glasgow airport. One of them was 27-year-old British born Iraqi, Dr. Bilal Abdullah. The second man detained at Glasgow Airport was a 27-year-old Indian Ph.D. engineer, Kafeel Ahmed. Six additional people were arrested afterward in the ensuing investigation. Five of these arrested were physicians and one was a physician’s
wife. Since then three physicians and the physician’s wife were cleared of any involvement and were released. Three physicians faced charges, Dr. Bilal Abdullah, Dr. Sabeel Ahmed (younger brother of Kafeel Ahmed) and Dr. Mohammed Asha, a colleague of the principle attackers. Kafeel Ahmed was detained but subsequently died a month later from the burn injuries sustained during the attack.

Dr. Bilal Abdullah was born in England and moved to Iraq with his parents as a child. His father was a physician and encouraged his son to follow him into his profession. Dr. Abdullah was finishing up his medical training at the University of Baghdad when the U.S. invasion of Iraq took place in 2003. According to his professor, he had become one of the most radicalized students after the war began. He was engaged in continual protests and active in forming resistance groups inside the college. Abdullah said, “We should not learn medicine. We should learn how to fight the occupation” (25). The war had a devastating personal impact on Abdullah beyond the disruption of his medical studies. His father was one of Iraq’s top orthopedic surgeons and had a private clinic in Baghdad which was reportedly destroyed in the war. In 2005, his father was forced to flee Baghdad to northern Iraq after being threatened. He was also greatly affected by the killing of one of his closest friends at the university in Iraq by a militiaman. According to one of Abdullah’s acquaintances, Shiraz Maher, “Bilal talked about the validity of jihad, about expelling American and British troops. He described jihad as the highest pinnacle of Islam….He would laugh when we talked about a particular bomb attack in Iraq. We all rejoiced then” (25).

The seeds of his participation in the plot were partially sown by the invasion and occupation of Iraq, the murder of perhaps hundreds of thousands of Iraqis, the incarceration and torture of thousands more, and the civil war between Sunni and Shia sparked by the destruction of the country and fuelled by the policies of the U.S.-led occupation forces (25).

Kafeel Ahmed was the second man detained at Glasgow Airport. He was a 27-year-old Ph.D. engineer from Bangalore, India who subsequently died from his burn injuries on August 2, 2007. He studied for his Ph.D. at Anglia Polytechnic University in Cambridge. His motivations are not fully understood, but from the email message he sent to his younger brother, Sabeel Ahmed, before the attack, it is clear that he sympathized with the views
shared by Dr. Bilal Abdullah. In an email suicide letter to his brother he wrote. “Please take care of Abbu [father] and Ammi [mother]. At any time, don’t hold back from joining the Jihad by money, words and actions. Allah makes it easy for those who do so.” News media reported that Ahmed felt he was protesting and fighting against the humiliating occupation of Muslim lands in Iraq, Afghanistan and Palestine by foreign troops (26).

Kafeel Ahmed’s younger brother, Dr. Sabeel Ahmed, 26, had been working in the northwest of England. He is from Bangalore in India and his parents are both doctors and live in an affluent neighborhood there. He was arrested in Liverpool on June 30, 2007 and accused of not disclosing information that could have helped police arrest a suspected terrorist. He was sentenced to 18 months imprisonment. He spent 270 days of the sentence in prison, was released on May 7, 2008 and promptly sent back to Bangalore (27).

Dr. Mohammed Asha, 26, has remained in custody awaiting trial. He was arrested on June 30, 2007 along with his wife who was subsequently released. He was charged with conspiracy to cause explosion. No evidence has emerged publicly against Dr. Asha, and no details have been released as to what his role was in any plot. Dr. Asha is of Palestinian descent, born in Saudi Arabia. In 1991, his family moved to Amman, Jordan, where his father thought his children had a chance at a better education. He completed his medical studies in Jordan in 2004. One of his professors, Dr. Azmi Mufazhal, said “He was brilliant, a genius. He would know his subject so well that his questioning often sounded like an interrogation” (27). Unlike many other medical students at the school, Dr. Asha had no political affiliation and rarely took part in political rallies on campus. Instead, he eschewed politics for his studies and family life.

Although there has been no connection proven between these perpetrators and al-Qaeda, one news media reported that an al-Qaeda leader in Iraq may have hinted to a senior British cleric working in Bagdad that “those who cure you will kill you.” The cleric passed this information on to the government in April, 2007. After the events at London and the Glasgow airport, some of the news media speculated that this statement could have referred to the alleged involvement of physicians in the attacks (28).
CONCLUSION

As we continue to process these events, it is important to keep in mind that we, as physicians, are trained as healers. History has shown repeatedly that violence breeds more violence, and killing results in more killing. War and violence are pathological entities that need healing. We are healers. Even if some of us have perceived ourselves as “wounded healers,” we cannot inflict wounds on others to heal our injuries. In addition, we must remind those physicians involved in London and Glasgow that they had lawful means in which to show their objections to perceived injustice and military invasion. In the West, the power of the ballot is stronger than the force of the bullet in changing policies. Great Britain is not the Middle East.

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