Psychiatrists as a moral community? Psychiatry under the Nazis and its contemporary relevance

Michael Dudley, Fran Gale

Objective: In Nazi-occupied Europe, substantial numbers of psychiatrists murdered their patients while many other psychiatrists were complicit with their actions. This paper addresses their motivations and actions, and with particular reference to Australia, explores issues of contemporary relevance.
Methods: The events are reviewed in their historical context using mainly secondary sources.
Results: The assumption that the term 'Nazi' denotes a closed and unrepeatable chapter is questioned. As with the Holocaust that followed, medical killing of psychiatric patients was an open secret with gradations of collective knowing. Perpetrators were impelled by pressure from peers and superiors, unquestioning obedience, racist ideology and careerism. Perpetrators and bystanders' denial was facilitated by use of deceptive language, bureaucratic and technical proficiency, and notions such as 'a greater cause' or 'sacred mission'. Dissociation and numbing were common. Psychiatrists were the main medical speciality involved because Nazi race and eugenic ideology (accepted by many psychiatrists) targeted mentally ill people for sterilization and euthanasia, and because psychiatrists were state-controlled and tended to objectify patients. Few psychiatrists resisted.
Implications: Nazi psychiatry raises questions about medical ethics, stigma and mental illness, scientific 'fashions', psychiatry's relations with government, and psychiatrists' perceived core business. Psychiatric resistance to future similar threats should be based on commemoration, broad-based education and reflection on cultural values, strong partnerships between psychiatrists and patients, and willingness to question publicly policies and attitudes that disadvantage and stigmatize groups. The principle fundamental to all these practices is an orientation to people as subjects rather than objects.
Key words: denial, ethics, Holocaust, Nazism, psychiatry, social responsibility.

Australian and New Zealand Journal of Psychiatry 2002; 36:585–594

More than half a century after the Second World War and the demise of the Third Reich, the emergence of Holocaust remembrance as a worldwide phenomenon has been matched by the rise of Holocaust denial [1].

A core component of a nation's identity is its history. Taking collective responsibility for this record may involve nations and their citizens acknowledging and making reparation for certain past events. The contested meaning of national histories has been evident in the United States in relation to slavery, Nazified countries in the Holocaust, and postcolonial peoples in the expropriation and genocide of indigenous peoples [2]. Australia shares with a number of these countries a 'culture of

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Received 26 April 2001; 2nd revision 26 April 2002; accepted 30 April 2002.

forgetting' about such matters [3–5]. Professional groups, such as doctors and psychiatrists, may also experience collective amnesia around breaches of moral responsibility in relation to such events.

The present paper originated with a month's study course for educators at Yad Vashem, the Holocaust Martyrs and Heroes Remembrance Authority in Jerusalem, and subsequent visits to four of the six Nazi death camps in Poland. We had several motivations for attending this course. We wanted to examine the potential of the Nazi era as a means of sharpening reflections on values and ideologies with trainee psychiatrists and social work professionals. Our work contact with Aboriginal people, who arguably have been subject to genocidal policies, was also a key motivator [6] (see further below).

A broader contextual reason, however, concerned the Nazis as a defining moment in Western culture. For those in the West, the Nazis are especially familiar in their modernity [7]; their technological, economic, environmental and public health emphasis is both fascinating and confronting. The subject, like that of nuclear war and the destruction of the environment, is one for universal concern.

Numerous historians and psychiatrists [e.g. 8–16], offer compelling accounts of how 'ordinary men' became mass killers under Nazism, and advance various theories concerning how this occurred. Professional status provided no barrier to participation, and in many cases, facilitated it. Medicine was prominently represented [17]. Substantial information is now available concerning doctors under the Nazis [see, e.g. 14,17–38].

The Nazis arguably represent the all time low point in the history of psychiatry, since this appears to be the only documented situation where a body of psychiatrists set out to systematically exterminate their patients. Psychiatry, the chief medical speciality represented in the killing programmes, has received some attention [14,22,23,27,33,34,39] as has psychotherapy [24,26]. However, of the former scholars, only Lifton seems to have been a psychiatrist. Not surprisingly, the International Association of Scientologists, a persistent opponent of psychiatry, sponsored one of the few full-length studies of psychiatrists under the Nazis [40].

Drawing primarily on secondary sources, this paper addresses psychiatrists' motivations and actions during the Nazi era, and, with particular reference to Australia, explores issues of contemporary relevance. Medical and psychiatric involvement in the 'euthanasia' programme and its connection to the death camps will be described and the particular roles of psychiatrists explored. Lessons for contemporary Australia concerning medical complicity in these events, with a particular focus on the responsibilities of psychiatrists and their organizations, are then addressed.

Killing by Nazi doctors and psychiatrists

Medical involvement in the Nazi 'euthanasia' programme and death camp selections was crucial to those programmes' success [e.g. 14,27,28]. Under the auspices of the Nazi state, the program was conceived and operated by physicians, who killed over 200 000 patients in a methodical manner [28]. The patients were insane and institutionalized, severely disabled, tubercular and retarded, but rarely terminally ill. In their doctors' eyes, their lives 'were not worth living'. The physicians were generally not sadistic or psychopathic personalities, but frequently pillars of the German medical and scientific establishment. Some had international reputations [27,28].

In Nazi Germany, close to half of 15 000 physicians were Nazi Party members, the largest percentage of any profession. This included 3000 psychiatrists, the largest national group of psychiatrists at the time, roughly equivalent to the current membership of the RANZCP. Alexander Mitscherlich thought approximately 350 doctors were actively engaged in the killing programme, though he told Robert Lifton that this was probably the tip of the iceberg [32 p.17].

Twenty-one of 55 doctors acting as intellectual mentors of German racial research and euthanasia, advising the 'euthanasia' programs, heading children's killing wards, and in charge of the euthanasia killing centres, were psychiatrists [27 pp.47,89,124,128]. These programmes formed the template for the extension into concentration camps (so-called 14f13) and the 'Final Solution' which killed six million Jews.

The euthanasia program was well-known within medical and psychiatric professions. Detailed briefings were given not just to medical leaders but to large numbers of practising doctors. Although initially doctors and other notifiers may not have been aware of the programme's intention (see below), one must assume that eventually all German physicians were aware of the programme's existence, and almost without exception, raised no significant objections [28 pp.62,179].

Several strands of evidence dispel doubts about this. One is that the T4 program (named after Tiergartenstrasse 4 in Berlin where the program was administered) and its lethal intent were well-known in the community at large. According to Dietrich Allers, a T4 executive speaking after the war, at least 20 000 people knew directly of the programme's operation [28 p.179; 32 p.28]. Victims were often well aware: adults resisted and had to be sedated, while children played games involving coffins, astonishing their nurses with their knowledge of what was happening [27 pp.84,94,170–171]. The killing programme became widely known to the German public through many mechanisms. Children in townships, seeing the grey

bus which carried the disabled and mentally ill to the extermination centres, would say 'there goes the murder box', or calling each other names would say 'You're crazy, you'll be sent to the baking oven in Hadamar' [28 pp.12,15]. The sickening smell of burning bodies pervaded neighbourhoods around the killing hospitals. Frequent administrative blunders concerning fake causes, times and places of death alerted families. Death notices in local newspapers filled entire columns with the names of persons from a particular asylum or nursing home, all of whom had died on the same day [27 pp.177–181; 28 p.177].

Evidence also exists that suggests doctors and psychiatrists in particular were aware of the program. Firstly, doctors and psychiatrists in 1933 welcomed the Weimar republic's demise, sending the Fuhrer congratulatory telegrams and pledges of loyalty. In *Deutsches Arzteblatt*, their widely circulating main periodical, they announced the Fuhrer's intention to rid Jewish intellectuals from Germany's spiritual, cultural and medical life, and their intention to cooperate [29 p.1456]. Secondly, the T4 program caused professional anxiety among psychiatrists. The chief army physician apparently warned Max de Crinis (a professor of psychiatry and T4 consultant) that 'with mental patients being taken care of by euthanasia, who will wish to study psychiatry when it becomes so small a field?' [33 p.42, quoted in 28 p.63]. At a 1941 psychiatric congress, Karl Schneider cautioned that sterilization and euthanasia might put psychiatry out of business [28 p.164]. Relatives of potential patients shunned psychiatric institutions, medical students avoided specializing in psychiatry, and junior psychiatrists became demoralized [27 p.156]. Despite misgivings, psychiatrists provided direction for T4, hoping the profession's status would improve after victory, when those not killed would be cured with 'active' therapies.

Knowledge of the program was not confined to Germany or the Axis powers: William L. Shirer's best-selling 'Berlin Diary' was excerpted in the June 1941 *Reader's Digest*. The *American Journal of Psychiatry* of July 1942 contained two articles, one in favour, one opposed to killing children with a disability [quoted in 28 pp.94–95].

The killing began with children with a disability. Hitler ordered head Nazi doctors to design the project with high ranking administrators; high ranking doctors then realized and maintained it [14 p.50]. Hitler managed the program illegally and outside normal administrative channels, using frontline shell organizations to disguise it [28 pp.215–216]. Midwives and doctors notified children as having a disability by completing a questionnaire that resembled a statistical registration procedure. A medical expert panel then made non-independent decisions in favour of life or 'treatment' solely by consulting the questionnaire. Children's families were told 'the child would receive the best and most modern treatment available' [14 p.52]. The process was bureaucratized, designed to diffuse individual responsibility (in courts later, doctors and administrators tried to blame each other). Eventually, 30 killing institutions were established within Germany, Austria and Poland. Doctors overdosed children with a disability with sedatives, pneumonia being the given cause of death. The illusion was that this was 'a putting to sleep'. Psychiatrists often headed these institutions [14 pp.57–61].

A 'Fuhrer decree' extended the programme to adult mental patients in October 1939. Physicians who after 'the most careful diagnosis' found the patient 'incurably sick', could kill but were not directed to do so [28 p.46]. Psychiatrists, including prominent academics such as Professors Heyde, Schneider, de Crinis, and Nitsche [14 p.64; 27 pp.44,58], decided the institutions and victims, processed the paperwork, and supplied and counselled the killers [27 p.154; 39 p.167].

Again, questionnaires that psychiatrists helped develop resembled an administrative or scientific survey and were the sole basis for decisions. They were distributed to psychiatric institutions and all hospitals and homes for chronically ill patients. Three medical (usually psychiatric) authorities and then a senior psychiatric expert reviewed them. The patients, sent to one of six euthanasia institutions [27 pp.88–93], were photographed for 'science' propaganda films, to demonstrate their supposed inferiority. SS personnel wearing white coats then transferred them in large grey windowless buses, whose destination was often an open secret for the victims and bystanders. Senior doctors made policy and decisions while younger doctors did the killing: they calmed patients and undertook cursory identifications. Carbon monoxide (suggested by psychiatrist Heyde) was usually preferred to shooting, injections or starvation since it was quickest, surest and least traumatic for the killers [14 pp.78–79]. Gas chambers were disguised as shower rooms. Families received false death notices and were charged for the killings [28 p.105]. Gold dental work enriched the programme or the looters' pockets, physicians dissected corpses for anatomy practice, and eminent research scientists (e.g. neurologist Julius Hallervorden (of Hallervorden-Spatz disease)) removed brains [27 pp. 96–97; 28 p. 197].

Jewish and Gypsy inmates did not have to meet special criteria, and were to be totally exterminated. In this respect, their fate prefigures the 'Final Solution' [14 pp.62–79].

After the war, without acknowledgement, the medical and psychiatric professions resumed business. Nurses and doctors were acquitted of murder, found guilty of manslaughter, or held in later years to be medically unfit

to stand trial. Moves to ban participating doctors from practice failed, on the grounds that their actions did not constitute a severe breach of medical ethics. In 1946, senior physicians declined to report on the Nuremburg doctors' trial for the West German Physicians' Chambers. Alexander Mitscherlich, a young psychiatrist and junior university lecturer, and Fred Mielke, a medical student, produced an abstract of proceedings. The report [32] disappeared from the Chambers and never appeared in bookstores. The authors were ostracised. Ironically, the World Medical Association cited the report as a significant reason for readmitting the German Medical Association after the war [28 pp.259–266].

Formed in 1945, in response to Nazi crimes, the World Medical Association was morally compromised by three presidents coming from Nazi organizations [30,41]. Hans-Joachim Sewering, a Nazi SS officer involved in killings and elected president in 1993, was forced to resign. In a 1986 *Lancet* article, a young biogeneticist from Mainz, Hartmut Hanauske-Abel, alluded to Nazi medical crimes as a moral responsibility for present-day West German doctors. Three weeks later he was dismissed from his post as an emergency physician. He sued, and though he won his case, the association appealed, placing him in indefinite limbo [30 p.10]. Karsten Vilmar, the president of the Federal Chamber of Physicians who supported Sewering, castigated Hanauske-Abel and others attempting to examine doctors' roles in the Third Reich [41 pp.213–234]. The German Society for Psychiatry and Neurology was similarly tainted. Of its 12 presidents from 1945 to 1980, three were T4 consultants, and several others were students of T4 participants, knew about T4 but turned a blind eye, or were active 'mental hygienists' [40 pp.89–146]. As late as 1985, German doctors published papers utilizing specimens acquired through Nazi experiments and killings. In 1989, such specimens were buried by some German universities and research institutes [29].

Resistance by psychiatrists

No definitive profile of those who resisted and/or rescued potential victims from the Nazis has emerged, despite many studies devoted to illuminating this question [e.g. 14,42–45].

A few psychiatrists resisted Nazism to varying degrees [14]. Oswald Bumke cautioned that schizophrenia could not be eliminated by sterilization because of its hereditary complexity. Karl Bonhoeffer was ambivalent about sterilization, recommending exemption of people who combined hereditary defects with unusual qualities or talents: he later admitted that he had not strongly opposed the Nazification of German universities. Bonhoeffer, whose sons and son-in-law were killed for their resistance, helped his son Dietrich find psychiatric grounds for not delivering patients in church institutions to T4. Hans Creutzfeldt of Kiel attacked T4 proponents as murderers in his lectures. Gottfried Ewald, invited to become a project leader, refused and distributed his extensive critique to medical authorities. Psychiatrists in religious institutions offered sporadic if limited resistance. The extent of silent resistance, such as subverting diagnoses, releasing patients, and emphasizing patients' work capacity, is difficult to evaluate, as is the extent of early retirements. French psychiatrist Adelaide Hautval was deported to Auschwitz because she had insisted on wearing a yellow star in sympathy with Jews. She refused to participate in forcible sterilizations. When SS Doctor Wirths said to her, 'Cannot you see that these people are different from you?', she replied, 'There are several other people different from me, starting with you' [46 pp.159–160]. However, of many letters and petitions the authorities received protesting the killing of mentally ill patients, not one is known to have been written by a psychiatrist [33 p.71].

How psychiatrists became involved in killing programmes

How did physician involvement in T4 occur, and why were psychiatrists overrepresented? Various 19th century antecedents provided fertile soil. Forms of social Darwinism enunciated in Germany and elsewhere stressed 'survival of the fittest' [47 p.62]. Eugenics was conceived as an overarching biological metascience, combining and harmonizing disciplines such as population statistics, genetics, anthropology, psychometrics, and even history and religion into a preventive medicine that aimed to define and eradicate inherited diseases [29 p.1457]. 'Race hygiene', closely related, asserted a racial hierarchy, and discussed regeneration and interracial struggle using biological metaphors [27 p.11; 47 p.73; 48 pp.1138–1139]. In Germany, influential author scientists such as Ernst Haeckel believed different races equated to different species, and that racial differences in intelligence and cultural development separated western Europeans from Negroes. The 'lower races' were believed psychologically nearer to mammals than to civilized Europeans, and 'we must therefore assign a totally different value to their lives' [14 p.442]. (The fact that we are all mammals escapes him). Eugenics also attained prominence in the USA, whose sterilization of the chronically disabled from the 1920s to 1950s was a source of admiration in Germany [27 pp.5–6; 28 pp.80–84,92].

German psychiatry offered conducive conditions. From mid-19th century, a somatic approach dominated, the

psychiatrist Griesinger asserting that 'mental disease is brain disease'. Emil Kraepelin's classification reflected therapeutic pessimism; for example, schizophrenia was organic, incurable and deteriorating. Analysing the mind was 'philosophical', 'metaphysical', or 'unscientific'. The notion of an 'unconscious' was particularly criticised [22 pp.32–33]. Psychotherapy was separated from psychiatry, and regarded as suspect [22]. Traditionally, psychiatrists were state servants in mental institutions and academic departments, rather than independent practitioners [14 pp.112–113]. Prevention, public education and hygiene and 'neutralization' of deviants were emphasized [49 pp.112–113]. Criminology and forensic psychiatry also had a biological emphasis. Even for less dangerous criminals, German criminologists believed that sterilization and even capital punishment were eugenic remedies.

Haeckel and the polemicist Jost advocated voluntary and involuntary euthanasia in 1868 and 1895, respectively [14 pp.46–47; 23 pp.12–13,300], but the jurist Binding and professor of psychiatry Hoche, in their 'Permission to destroy life unworthy of life' (1920), were most influential. Binding argued that the Great War sacrificed the best genes, leaving the worst to proliferate. Medicine, being progressive and humane, worked against natural selection, enabling the 'weak and inferior' to survive and procreate. Medicine therefore had to engage in 'counterselection'. Binding confounded the suicide rights of terminal cancer patients with destroying 'unworthy lives' of healthy but 'degenerate' individuals [27 pp.15–16; 39 p.155]. Hoche characterized those with mental disorders, brain damage and mental retardation as 'mentally dead', 'human ballast' (Ballastexistenzen) and 'empty shells' (Nazism later popularized these terms [14 p.47]). Disability was an economic burden, and national well-being outweighed individual rights. Binding and Hoche, pp.61–62, stated that a 'higher morality would [not] heed the demands of an inflated concept of humanity' [14 p.47]. This cost-benefit analysis superseded the Hippocratic injunction 'do no harm'. Hitler incorporated Binding and Hoche's ideas in 'Mein Kampf', and let his name be used in advertisements for Hoche's books [27 p.13; 28 p.92].

Doctors and psychiatrists, as noted, did not challenge the Nazis' program when the latter came to power. Nazi ideology was highly influential: 960 educators (including prominent philosopher Martin Heidegger) endorsed the regime [14 p.37]. Carl Jung, who loved pagan symbolism and myth, was interested in the German peoples' revitalization and National Socialism's potential [50 p.264]. Under the Nazis' aegis, new deans with dubious credentials expelled Jews and communists, and controlled medical appointments. Race hygiene became a compulsory subject. Intellectualism and concepts of equality and liberty were roundly criticized [14 pp.40–41 and passim; 28 p.19; 30, passim]. The Nazis ceased to ratify advanced Weimar republic legislation on human experimentation [29 p.1461; 51]. They also manufactured a series of films stereotyping mentally ill and disabled people (for example as vicious, lascivious, sinister or grotesque), popularizing 'natural selection', and promoting voluntary and involuntary euthanasia [23,28 p.92].

Nazi racial ideology and psychiatry converged when the Nazis enacted compulsory sterilization laws. The architect was the distinguished psychiatrist, Ernst Rudin. A powerful lobby of doctors, psychiatrists, welfare, church and community groups supported them. Mandatory reporting of those suffering from schizophrenia, manic depressive insanity, epilepsy, hereditary alcoholism, Huntingdon's chorea, as well as hereditary blindness, hereditary deafness and gross bodily malformation, ensued. Confidentiality did not apply. Doctors and psychiatrists heard cases in secret sterilization courts, and victims were often uninformed until they appeared before them. Law and police power backed the process [14 p.25]. Surgeons and gynaecologists performed procedures on tens of thousands, and many died of complications [39 pp.161–162].

Why they did it

Scholars have expended enormous energy examining the reasons for perpetration. The briefest of summaries is provided here. Friedlander [27 pp.195–196,225,235] summarizes explanations for managers and doctors' participation under several headings: duress, peer pressure, authoritarianism, careerism, and ideology. States of denial [52] also require explanation.

The war crimes trials generally ruled out duress as an explanation, since it proved hard to demonstrate that anyone was penalized for refusing to participate [9, passim; 27 p.235], though putative duress and/or fear of death or reprisal was clearly a consideration in some cases. In Milgram's famous postwar studies, most volunteers for a supposed 'experiment on the psychology of learning' offered no resistance to commands to give subjects increasingly severe electric shocks [53]. Duress, however, did not appear to apply to higher ranked perpetrators, such as physicians and psychiatrists, who apparently freely chose their tasks.

Peer pressure, tribal loyalty and 'male bonding' [54 pp.328–334] also seem to be more relevant at rank-and-file level. Police battalion 501, comprising mostly older family men from the social democratic city of Hamburg, was given the task of murdering Jews in Polish villages. After initial significant trauma, they became progressively desensitized, murdering 70 000–80 000 people

[9]. However, T4 professional and managerial groups apparently had more freedom of choice over involvement and task assignments.

According to Alexander [19], Hitler applied Genghis Khan's technique of Blutkitt ('blood cement') to the SS (and to Germany). Group loyalty is proven by committing a crime contrary to one's values or interest, in service of a 'greater cause' or 'sacred mission'. As crimes were repeatedly performed, the person either had to believe that he was performing extraordinary service to the cause, or acknowledge he had violated his own values. With the party, he was everything, without it, nothing [28 p.198; 54]. Lifton [14] demonstrates this dynamic among Nazi death camp doctors.

Thus, peer pressure links to ideology. Historians vary in the emphasis they give to pure ideological commitment or situational pressures from peers or superiors (Goldhagen & Bauman, quoted by Cohen [52 p.77]), but often both were present. Doctors and psychiatrists were often committed Nazis, who 'selected' for the nation's health. Following Nietzsche, they sought to replace traditional morality with hardness and ferocity. Judeo-Christian compassion was weakness, cowardice and self-deception [54 pp.315,327]. Ethnic nationalism and victim blaming also buttressed this stance. The Nazis answered German defeat and humiliation by promising a glorious future, technology and modernization, public health for most, reform. Their price was cooperation, consolidation of Nazi power, and elimination of enemies.

Many researchers note a deeply internalized commitment to obey, based on cultural precept and often a strict and rigid father-dominated upbringing (e.g. Theodor Adorno [55], Henry Dicks [16], Alice Miller [56]). Others (Glover [54]) have commented on the absence of a culture of political satire. However, the T4 commission was a plum to be sought: manager Philip Bouhler wrested it from Leonardo Conti. The Fuhrer's orders did not compel collaboration [27 pp.195–196].

Denial (and specifically the state of not knowing yet knowing) is central to genocidal perpetrators and bystanders, cultures and nations. Denial can be personal, cultural or official in manifestation; to paraphrase Cohen [52 pp.7–9], it also can be literal ('nothing is happening'), interpretative ('what is happening is not what it seems') or volitional (the implication being 'it's got nothing to do with me'). One method of denying knowledge is to split off or disown certain personal acts. Relabelling, routines and compartmentalization made the abnormal or morally wrong seem normal: so railway workers used the same fare schedule for tourists as they did to send Jews to Auschwitz. Limited morality enables focus on job performance, in which incidentals such as not looting, behaving in soldierly ways or technical efficiency, loom larger than the effects. One may believe that one is a moral person in an aberrant situation, (e.g. not disliking Jews, merely inheriting what they leave behind: Jewish land, Jewish medical practices). Others note a dissociation of action and emotion [52 pp.93–95; 14]. Lifton [14] describes Nazi doctors' disavowal of their actions through dissociation of a portion of self from the rest of self, numbing of emotions and separating them from knowledge, and 'doubling', whereby a portion of self becomes the whole (or 'Auschwitz self'). There is some doubt whether this explains why many Nazis loved their children, their dogs and the music of Bach yet still killed those they regarded as aliens [23,53,57 pp.225–226]. However, distancing language and attention to task and technique [14 pp.420–455] accurately denote mechanisms used by T4 psychiatrists: these operate even more successfully when perpetrators are not face-to-face with their victims [9, passim; 57 pp.64–68].

Career considerations, including security, recognition, material benefits and power, were pre-eminent among doctors and psychiatrists. The Nazis offered private deals to the medical professions, including better wages, more career opportunities and influence, and chances for scientific research. As Jewish doctors were excluded from medical practice, non-Jewish doctors' prestige, assets and income, deteriorating under Weimar, rose. They did not object. Psychiatry was a low prestige career that the Nazis made prominent in the national task of identifying and excluding inferior Germans [33 p.22, quoted by 27 pp.123–124].

Psychiatrists' involvement in the killing programs and the development of the ideologies which underpinned them would have altered significantly if their orientation had been to people as subjects rather than as objects to be studied or manipulated. The enduring relevance of this 'lesson' is now discussed in the context of contemporary Australia.

Lessons from history?

Yehuda Bauer argues that the Nazis' technology, bureaucracy and non-pragmatic murderous ideology made the Holocaust unprecedented [1]. Yet to assume 'the term "Nazi" implies historical uniqueness, designates a chapter closed', may imply that such events will not recur [29 p.1454]. It is now widely recognized that the extreme denial story is incredible (i.e. that a small group of fanatic perpetrators planned and carried out the killings while most of the public was a passive, distant, anonymous mass who knew nothing). Human beings, not demons, were involved, and the intellectual elites were especially responsible [1 pp.20–21,31–35; 9]. The Holocaust was an

open secret with gradations of collective knowing. Deception was built in from the beginning, in the 'language rules' [58 pp.84–86] which enabled obfuscation of what was really happening [52 p.79].

For traumatized people and communities, remembrance has been held to be important to recovery [59–60; 61 p.71]. However, this task is most difficult when individuals, groups or communities are implicated in atrocities as perpetrators or bystanders, as the case of psychologically incapacitated Nazi generals illustrates [9 p.25; 14 pp.159,437]. As noted, German medicine and psychiatry have struggled with this awareness.

Can we assume such events could not occur in Australia? At the 1938 Evian conference that addressed the problem of refugees fleeing Nazi Germany, the Australian ambassador pronounced that 'since Australia has no racial problem, it is not desirous of importing one' [62]. By contrast, many Nazi war criminals came to stay after the war when Sir Garfield Barwick represented Australia as a land where 'the slate was wiped clean' [4 p.447]. The Hawke Labor government formed the Special War Crimes Investigations Unit but the Keating government disbanded it. Currently, Australia has no legislation to detect and prosecute war criminals [4, passim]. This greatly concerns witnesses to atrocities or torture victims who fled totalitarian regimes. Australian misinformation is such that a novel about this period, Helen Demidenko's '*The hand that signed the paper*', won three major Australian literary awards in 1995 before being exposed as an antisemitic diatribe and a hoax [5].

The ambassador's disingenuous comment demonstrates this blindness. Australia alienated and damaged its indigenous peoples through successive expropriation, massacres, forced relocation and child removal; several commentators argue that at least some policies were genocidal [3,6,63]. At Federation in 1901, Australia endorsed an ethnic concept of nationhood (a nation of Anglo-Saxons) above Whitehall's civic alternative model. 'White Australia' dominated Australian nation building throughout the postwar immigration scheme and at least until 1967, when Aborigines became acknowledged as citizens and obtained the vote. Scientific racism and eugenics were cornerstones of medical ideology through the interwar years [64]. Doctors working with indigenous people contributed to racist ideology and the programs and policies based on such theories [65].

Some would claim that ethnic nationalism remains a key organizing principle [63]. The present Commonwealth government refuses to apologize for state actions towards indigenous peoples, despite the merits of an apology [57,63]. Asylum seekers and their children are detained for prolonged periods and treated as criminals: this dishonours Australia's international covenantal obligations to refugees, to children and probably results in significant psychological injury [66,67]. In the last five years, Australia's human rights standards relating to social welfare and women also declined [68–77]. Protective democratic institutions are not guaranteed but historically contingent. Many Germans, including German Jews, who saw themselves as fully culturally integrated, were surprised by the Weimar republic's demise at the hands of (what began as) a tiny right wing splinter group.

Relevance today

The Nazi psychiatrists issue several challenges to current psychiatric practice. The first concerns medical ethics. The Nazis' assault on humanity and moral identity throws into relief the dignity of the human person as a central tenet of major religious and ethical codes and of democracies. The Nazi era casts a long shadow over psychiatry, confirming that psychiatry, in line with prevailing currents of western social thought, can be tempted to side with the forces of instrumental rationality. This alignment is with 'thinkers and planners who treat the environment and society as mere objects whose utility is to be exploited in a rational way', rather than seeing all individuals as 'subjects or moral agents, whose value does not derive from their utility to the purposes of powerful others, but rather on the dignity of conscious human life' [78].

The Nuremburg medical trials led to new codes of research ethics [20]. Yet treatments and experiments involving mentally ill and handicapped people without their informed consent have continued (e.g. the Chelmsford deep sleep therapy scandal in New South Wales) [79]. Psychiatrists' training and clinical duties have not made them more ethically responsible or tolerant than other branches of the medical profession. Medical tribunal lists reveal that even senior clinicians and academics are not exempt from serious breaches of ethical codes [80 p.486]. This raises the question about what and how psychiatrists learn about ethics in their training and whether this has any protective value for their patients and themselves. Regulation of psychiatry is especially necessary in relation to life and death issues (e.g. euthanasia [81]), and legal executions [82].

Historical examples of hostility to people with a disability and with mental illnesses are legion. It is unknown to what extent psychiatrists' attitudes to their patients reproduce community stereotypes regarding marginal groups. Physicians and psychiatrists may distance themselves to survive when faced by the extreme symptoms of their chronically ill patients, which may stimulate negative responses [83]. Nazi physicians in the name of science and the new order acted out their hostility against patients [19,28 pp.199–200].

A related issue concerns how and why there are scientific 'fashions'. The doyens of science, medicine and psychiatry subscribed to eugenics, which like its predecessor phrenology, is today regarded as pseudoscience. The eugenicists failed to recognize that conditions such as schizophrenia, depression, paralysis and epilepsy were not necessarily inherited. People with a disability were treated as one group. Bodily deformities were often, it was held, associated with mental and moral ones [28 p.88]. Like anyone else, scientists are immersed in cultural milieus, and are susceptible to cultural influences. Aspects of today's science may be tomorrow's mythology.

Another challenge concerns the relationship of psychiatry with its economic and political context. The Nazi merger of medical professional politics and government interests [29 p.1461] raises the issue of psychiatry's engagement with the state. Nazi social corporatism held that the 'body' was more important than its individual members; this led to individual and group rights violations [51 p.185]. The move from individual to national or population health, and towards increasing state power and fiscal control over health care, has intensified since the Nazis. The rationing of scarce health care resources poses the problem of distributive justice. Is the 'good' of the majority paramount, and are the rest 'someone else's business', or does one specifically target disadvantaged groups? In the US, government-backed, profit-making health maintenance organizations enrol vulnerable 'public sector' populations in mandatory managed care programs. This creates additional potential for abuse [84]. Psychiatrists increasingly combine professional and managerial roles. The dominance of managerial concerns and the pressure for fiscal rationing increase the danger that professional and ethical imperatives may be eclipsed.

Psychiatry often supports the mainstream, but the mainstream is not neutral. The language of 'partnership' and 'community capacity' emerging in many government documents pertaining to the prevention of suicide, crime, substance abuse, homelessness is the language of consensus [85]. While partnerships are critical for achieving coherent responses to community and government-identified problems, they potentially obscure situations where conflicts exist, and may disguise working arrangements between partners of unequal power.

Psychiatrists' responses also may be constrained by medicine's traditional focus on the individual patient. Genocide, as a complex and ill-defined social phenomenon [1,3], falls outside psychiatry's province, except to create individual patients. Thus, Charny's comprehensive bibliography [86] cites 2491 articles on holocaust survivors, including many by psychologists or psychiatrists. However, psychiatrists generally are not trained in social science or the philosophy of science, and may regard themselves as too busy with health systems and patient care to get involved in genocide awareness and prevention. Like the prevention of nuclear war, psychiatrists may see it as someone else's speciality or an esoteric area. Psychiatry's business is mental disorders, not the nature of evil.

Yet this has not been an isolated event. The Crusades, the Inquisition and witch burning are well-known premodern examples, and pogroms and genocides in recent history are innumerable. Psychiatry has been misused by totalitarian regimes (abuses of psychiatry in the USSR [87] and even by democratic states (e.g. in relation to executions in the USA [82])). The distinguished tradition of the German Psychiatric Association prior to Nazism did not protect it from genocide complicity during and after the Nazi era.

Historians and educators commemorate victims and survivors, and through their stories, use the Holocaust as a mirror to examine the moral health of nations and professions. Bauer's '11th commandment', 'Thou shalt not be a perpetrator, thou shalt not be a victim and thou shalt not be a bystander' [1], might serve as the goal of this process. A key to unlocking the Nazi era was the failure of the modern German state to achieve and maintain a robust democracy [88]. A social climate of equity, openness and free discussion acts as an early warning system to prevent human rights violations.

There are several pillars of psychiatric resistance to future similar threats. Remembrance of these events is central. A broad-based initial and continuing education enables reflections on cultural values and ideologies that influence the world view of psychiatrists. Such a curriculum would entail the systematic study of subjects such as stigma, the history and philosophy of science, reflection on applied ethics, and cultivation of what might be called the 'moral-historical imagination' [54]. However, education alone is insufficient: such outcomes will also require available models and professional cultural changes. Psychiatrists need to be prepared to act as advocates with their patients and to publicly question prevailing policies and attitudes which disadvantage and stigmatize groups. Changes in systems of governance within health organizations might enable users to influence health service processes, and psychiatrists to work more closely with patients for full citizenship, when the latter is in question [89].

One of the cattle cars used by the Nazis to transport Jews to the 'Final Solution' stands as a memorial at Yad Vashem. Next to it is the following poem, which succinctly enunciates the vital importance of an orientation to people as subjects rather than objects.

'Written in pencil in the sealed railway car' – Dan Pagis

Here in this sealed car
I am Eve with my son Abel
If you see my other son
Cain son of man
Tell him that I

Acknowledgements

We thank Alan Rosen for comments on the manuscript, and Winton Higgins for conceptual input regarding citizenship, ethics and the Australian context of the Holocaust. Alan Rosen and Ernest Hunter recommended the Yad Vashem course. Ephraim Kaye, Kathryn Berman, and the Yad Vashem archives and pedagogy centre enabled us to access a wide range of primary and secondary materials.

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