

**“... the deep sleep of forgetfulness”: Reflecting on
disremembering**



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Set your flags at half-mast,
 Memory.
 At half-mast
 Today and for ever.

Shibboleth, Paul Pessach Antschel

Paul Antschel wrote many poems including ‘Todesfuge’ - Deathfuge, the most famous poem of the Holocaust and, arguably, in modern German. He was a Jew and a survivor, returning in 1944 to find the vibrant Jewish community of Czernowitz, his childhood home, gone, its province, Bukovina, divided between the USSR and Romania. Deathfuge was written in 1944 or 1945. In 1947 he left for Bucharest where, before fleeing to Vienna, by anagram, Paul Antschel became Paul Celan. He eventually travelled to Paris, passing through Germany as he had on *Kristallnacht* 1938. In 1988 Todesfuge was recited in the *Bundestag* to commemorate the fiftieth anniversary of that night.

Celan is not the only survivor remembered by their birthname’s anagram. The Austrian Jew, Hans Maier fled to Belgium after the *Anschluss*, becoming Jean Améry when the Germans followed. He joined the resistance, was arrested, tortured and sent to Auschwitz. Améry, and Celan have more in common – both died by suicide – Celan drowned in the Seine in 1970 and Améry took his life in 1978. Others also ‘survived’ the Holocaust only to succumb to another horror beyond the power of words to exorcise, for instance Tadeus Borowski, author of ‘This way to the gas ladies and gentlemen’ who died, by gas, in Warsaw in 1951 and Primo Levi, who plunged to his death in Turin in 1978.

Similarities and differences. Améry and Celan, both anagrams – both authors who wrote in German – the language of their tormentors. But very different responses to Germans. Celan, feted in Germany, Améry paraphrasing Celan’s Todesfuge in 1976 to emphasise resurgent German anti-Semitism as: “playing with the fire that dug a grave in the air for so many” (in Felstiner, 1995, p. 289). The year before he died he wrote:

The victims are dying out The hangmen, too But new generations, molded by origin and environment, are constantly rising in both camps, and between them the old unbridgeable chasm is opening again. Someday time will close it, that is certain. But it must not be done by hollow, thoughtless, utterly false conciliatoriness, which already now is accelerating the time process. On the contrary: since it is a moral chasm, let it for now remain wide open. (1986, p. xix)

While two of these authors, Jean Améry and Primo Levi, survived Auschwitz, their writings suggest very different attempts to incorporate that trauma. However, despite being in that terrible place at the same time, their experiences were, in fact, very different (Stille, in Améry, 1986). Levi, from a country that was fascist but not, relatively, antisemitic, was able to return to a Jewish community and family. He was not deported by Italians but Germans. Améry was captured, tortured and deported by fellow German-speakers, probably including many Austrians. He could not return. But regardless of their differences, both were fascinated by the paradox of the intellectual in Auschwitz – Levi writing on this theme in Survival at Auschwitz, and Améry in At the minds limits.

Celan called for the surrender of memory. By contrast, Améry and Levi were dismayed that memory may fade, tarnish, or disappear, and were driven to question whether the intellectual was better able to find meaning in the inverted world of the camp, or in memories. As the ultimate fate of all three suggests, for them it did not.

Now brood no more
 On the years behind you
 The hope assigned you
 Shall the past replace,
 When a juster justice
 Grown wise and stronger
 Points the bone no longer
 At a darker race.

Song of Hope, Oodgeroo of the tribe Noonuccal

Oodgeroo Noonuccal was born in 1920, the same year as Paul Celan but a world away, growing up on Stradbroke Island. As he, she underwent a name change, formerly being Kath Walker. Her writing was also a response to injustice – the experience of being an Aboriginal woman in a patriarchal European settler-colonial society. Unlike Celan her name change was to reclaim identity, although her medium, like him, was the language of the oppressor. But is it reasonable to consider these experiences together? Well, even Levi and Améry, both of whom were at Auschwitz at the same time, present enormous difficulties to any with the temerity to generalise. To consider the Holocaust and the experiences of Australia’s Indigenous populations in the same space seems reckless.

That is how I felt in 1991 after return from Yad Vashem in Jerusalem where I had been studying medical professionals as perpetrators during the Nazi era and where I had begun to consider the relationship between doctors and Indigenous Australians. Thus a paper that was never submitted. Instead, it became two, dealing with each issue separately (Hunter, 1991; 1993). At the time I felt associating these issues was unfair and unlikely to gain a sympathetic hearing among my medical peers. That proved to be true, sensitivities close to the surface. In this paper I return to the original project, but consider medical professionals as perpetrators, bystanders and victims of the trauma of the Holocaust and colonisation. I argue that this history is critical to understanding the social and political context of professional work with these traumatised populations, and that to not do so may lead to complicity in rationalising and trivialising the harms done.

I begin by considering genocide in Australia. Over the last decade this term has come into common use in the Indigenous context, often with reference to the 1948 Convention on the Prevention and Punishment of the Crime of Genocide, in which subclause 2 (e) includes: “Forcibly transferring children of the group to another group”.

Figure 1: United Nations Convention on the Prevention and Punishment of the Crime of Genocide (1948):
 Article II

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, such as:

- (a) Killing members of the group,
- (b) Causing serious bodily or mental harm to members of the group;
- (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- (d) Imposing measures intended to prevent births within the group;
- (e) Forcibly transferring children of the group to another group.

Thus, in Bringing them home the Human Rights and Equal Opportunity Commission (1997) report on the removal of Indigenous children, the Commissioners state:

The Australian practice of Indigenous child removal involved both systematic racial discrimination and genocide as defined by international law. Yet it continued to be practiced as official policy long after being clearly prohibited by treaties to which Australia had voluntarily subscribed. (p. 266)

This position has been most forcefully put by Colin Tatz (1999) who emphasises that Article II does not stipulate degrees or absolute destruction, but “acts committed with intent to destroy” a group. As such, Australia may be guilty of four acts of genocide:

First, the essentially private genocide, the physical killing committed by settlers and rogue police officers in the nineteenth century ...; second, the twentieth century official state policy and practice of forcibly transferring children from one group to another with the express intention that *they cease to be Aboriginal*; third, the twentieth century attempts to achieve the biological disappearance of those deemed “half-caste” ...; fourth, a *prima facie* case that Australia’s actions to protect Aborigines in fact caused them serious bodily *or* mental harm. (p. 6)

Allegations of genocide are now so common (Havemann, 1999) that there is a danger, ironically, of trivialisation and denial. If accusations are to be taken seriously – Where are the trials? Can we talk of genocide in living memory and not prosecute? Is it too late? Too late to prosecute Konrad Kalejs for crimes committed in the Second World War? Is it because the accused is above accountability? Well, consider actions filed in The Hague against the United Nations, under whose auspices the Genocide Convention emerged, in relation to Rwanda and Srebrenica. Is it because the accused would insist that they were ‘following orders’ and had ‘good intentions’? Well, remember Nuremberg, which dismissed such evasions in laying the foundations for crimes against humanity.

Prosecutions are unlikely. Regardless, there is much discussion including, in 1999, books by three prominent Australians which consider together the Holocaust and the history of Indigenous Australians. Geoffrey Robertson (1999) addresses both within a wider context of the history of ‘Crimes against humanity’ since Nuremberg. Inga Clendinnen historian of Aztec and Mayan civilizations, was stimulated by the Demidenko/Darville affair to consider her and our ‘forgetting’, in Reading the Holocaust (1999a). She tackled a more proximate ‘forgetting’ – of Indigenous Australians - in the Boyer lectures, published as

True stories (1999b). Finally, Raymond Gaita (1999) who, rhetorically, asks why, if there are allegations of genocide there are no trials, considers both in A common humanity

Genocide, ethnocide – crime against humanity? The Genocide Convention, which was signed in Paris in December 1948 the day after adoption of the Universal Declaration of Human Rights, emerged in response to the events of the Second World War. The definition reflected that context with many signatories concerned about trouble in their colonial back yards. Minority rights received no mention in either the Charter of the United Nations or the Universal Declaration and were not seriously considered for several decades. Furthermore, this is a legalistic swampland, as Robertson suggests:

The Australian policy of taking babies and small children from their Aboriginal mothers and fostering them with white families has been alleged to be genocidal, but this would depend on whether force (rather than persuasion) was used and whether the purpose of the policy ('assimilation') was to destroy the group 'as such', as distinct from altering its culture. (p. 310)

Robertson is not dismissing the attribution or minimising the trauma but pointing, as a lawyer, to the legal complexities. He also emphasises that progress in the wider human rights arena, that is, progress rather than talk about human rights, is more about dedication than declaration. History demonstrates that progress is possible, but is incremental rather than instrumental. That is not to suggest that instruments and conventions should not or are not being used by Indigenous peoples; they should and are (Barker, 1997). But it is by using rather than simply making them that their potential is realised. Finally, history teaches that human rights concern everyone and that relevant debate and decisions should not be left to intellectuals, professionals or academics. If these were the only voters in 1967, the Commonwealth Referendum regarding citizenship for Aboriginal Australians may not have been passed, as it was, with a 90% yes vote.

In what follows I will consider these groups with particular attention to medical professionals, in terms of their contribution to the traumatising of Holocaust victims and Aboriginal Australians. I am not suggesting equivalence but exploring how the lessons of the former may support critical reflection in Australia. I will start by briefly examining medical professionals as perpetrators during the National Socialist era. Briefly because there is now an enormous literature, most emerging in the last decade, including works available in English by Paul Weindling (1989), Michael Burleigh (1994), Burleigh with Wolfgang Wippermann (1991), Gotz Aly, Pewter Chroust and Christian Pross (1994), Michael Kater (1989), Arthur Caplan (1992), George Annas and Michael Grodin (1992), Stefan Kuhl (1994), Henry Friedlander (1995) and, of course, Robert J Lifton (1986). There are also works by Benno Muller-Hill ((1988) on genetics, Robert Proctor (1999) on public health, and Geoffrey Cocks (1985) on psychotherapy.

The available information is far too extensive and now well known to review. Suffice it to say that there is a lineage from the racist science of the nineteenth century, of Gobineau, through the likes of Richard Wagner's English son-in-law Houston Stewart Chamberlain, to the medical profession within the Nazi bio-medical state. Foundations for medical murder were laid well before the Nazis came to power and articulated in

1920 by Professor Karl Binding, a jurist from the University of Leipzig, and Alfred Hoeh, professor of psychiatry at the University of Freiberg in an influential book – The permission to destroy life unworthy of life. Medical murder masquerading as euthanasia was implemented in Germany in 1939 through the T4 program, which was in direct lineage to the death camps in Poland, as Henry Friedlander notes:

In 1940 German concentration camps were growing in number and size, but they did not yet possess the facilities to kill large numbers of prisoners at one time ... The SS therefore [sought] to determine how to utilise the T4's killing capabilities. Early in 1941 Reich Leader SS Himmler conferred with [T4 program] chief Philip Bouhler concerning "whether and how the personnel and facilities of T4 can be utilised for the concentration camps." Soon thereafter, in the spring of 1941, a new killing operation commenced, aimed at prisoners in the German concentration camps. (p. 142)

Medicalised murder by gas was subsequently transferred, through the 14f13 program, to the more pressing job of extermination in the east, first at Chelmno where carbon monoxide, as in Germany, was used. Perhaps the best known extermination camp Kommandant, Franz Stangl, good catholic, diligent policeman and the subject of Gita Sereny's (1974) masterly Into that darkness, was recruited into the T4 euthanasia program in 1940. He subsequently went to the 'Foundation for Institutional Care' at Hartheim, working and killing under medical direction. In 1942 he was sent east to set up Sobibor and was convicted in Dusseldorf in December 1970 of co-responsibility in the murder of 900,000 people during his tenure as Kommandant of Treblinka.

Stangl was not a medical professional but his career exemplifies the connection between the murder of unwanted Germans under medical supervision and the Holocaust. Many doctors, such as Josef Mengele (Lagnado & Dekel, 1991) participated in perversely rationalised medical murder in the camps largely motivated by opportunism and self-advancement. Maneuvering for power, prestige, and favour on a personal and institutional level was rife throughout the Third Reich among academics who Alice Gallin (1986) refers to as Midwives to Nazism, and particularly among doctors, who were probably the first beneficiaries of the anti-Jewish laws of 1933.

Of those directly involved (Robert Lifton (1986) estimates about 350) only a minority were ever prosecuted, and most careers continued, supported by professional denial and collusion. No senior doctors responded to a call from the German association of physicians to observe the Nuremberg medical trial (Maretzki, 1989). A young doctor and a medical student (Alexander Mitscherlich and Fred Mielke) subsequently produced a report, which was met by silence, unsurprising given their comments on complicity:

only the secret consent of the practice of science and politics can explain why the names of high ranking scientists are constantly dropped during this trial, of men, who perhaps did not right off commit any crime but took advantage of the cruel fate of defenceless individuals. (in Pross, 1992: 40)

I believe that the responsibility of doctors and the profession of medicine during the National Socialist era must be considered on the following levels:

- as providing and refining the ideological and intellectual foundations for race theory and medical killing;
- as influential supporters lending legitimacy to an immoral regime, both by silence and complicity;
- as planners and administrators within the bureaucracy of state sanctioned killing;
- as designers and refiners of systems for expeditious killing;
- as executioners;
- as beneficiaries of the suffering and deaths of their victims (through payment for processing euthanasia evaluations of psychiatric patients, power within the state medical system, and advancement through 'research');
- and as survivors, who have frequently fared far better in the aftermath of the War and the Holocaust than other supporters of the regime.

The greatest responsibility lies at the level of ideas. The racist science of the Third Reich was not a consequence of political events - it was itself the ideological agenda. While not a Nazi creation or confined to Germany, racist science was central to the party's platform. It provided a bio-medical vision of racial purity that galvanised support and gave direction to political events that focused hatred and violence. Race science and Nazi ideology existed in symbiosis, the institutions of one essential to the other. They nurtured each other and devoured their children. Can these events, now extensively documented, be overlooked. Well, as Benno Muller-Hill (1988), Professor of Genetics at the University of Cologne, comments:

When I think today of how genetics was once put to use ... I see a wasteland of desolation and destruction. The blood of human beings, spilt millions of times over, is completely and resolutely forgotten. The recent history of these genetically orientated human sciences in action is as full of chaos and crime as a nightmare. Yet many geneticists, anthropologists, and psychiatrists have slipped from this dream into the deep sleep of forgetfulness. (p. 3)

Forgetfulness or 'disremembering'? In Australia, a "cult of disremembering" is how Bill Stanner (1979) described the "great Australian silence" – by which the surviving Indigenous people of this land were 'disappeared' from the consciousness of most Australians until recent decades. Silence certainly about the abysmal state of Indigenous health, something of which the medical profession should be ashamed. Indeed Brendon Nelson, then head of the Australian Medical Association, loudly proclaimed at the 1993 Aboriginal Mental Health Conference that he was ashamed to be a doctor for the profession's failings. I was in the audience and admit to feeling angry. The AMA had little investment in Indigenous health and of the doctors in the audience, many of whom had worked in Aboriginal health for years, few, if any, would have been AMA members. I felt slighted and resentful – sensitivities close to the surface. But, regardless of motives, at issue was responsibility by omission – medical professionals as bystanders to Indigenous trauma and ill-health. This has been commented on variously over the last decades, including by the Royal Commission into Aboriginal Deaths in Custody (1991)

and in Bringing them home, (HREOC, 1997). But is there more to consider than responsibility by omission? I think so and will examine two issues – discriminatory treatment and the conflation of medical and political roles in controlling Indigenous lives.

Gross inequities in health care, let alone health status, persist for Indigenous Australians (Deeble, Mathers, Smith, Goss, Webb & Smith, 1998). Indeed, as late as the 1960s there were segregated hospitals in certain parts of Australia (Hunter, 1993). However, the discriminatory practice that I will focus on relates to sexually transmitted diseases (Hunter, 1998). In Western Australia at the turn of the century there was widespread concern about leprosy and venereal diseases. The responsibility for these, it was declared, lay with Asians and Aborigines. In 1898 the Health Act was amended to provide police with special powers for the control of infectious diseases and from 1909 Aboriginal lepers were confined on Bezout Island off Roebourne, beginning a history of discriminatory detention that continued to the closing of the Derby leprosarium in 1985.

Venereal diseases were thought to be widespread and blamed on Aboriginal immorality with legislation from 1905 prohibiting cohabitation of Europeans and Aborigines. In 1907 Perth doctors called for segregation and were supported by the Chief Protector of Aborigines who explained: “The menace to the white population, although probably the seeds of evil have been sown by them in the first instance, is becoming so great that ... some drastic steps should be taken to check the spread of the disease” (in Mulvaney, 1989: 185). In 1908 desolate Dorre and Bernier islands off Carnarvon, were selected as sites for lock hospitals which remained in operation for a decade despite a recommendation of the Australasian Medical Conference in 1911 that venereal diseases should be treated in general hospitals (Lewis, 1988). Indeed, although in 1914 the Commonwealth provided for free testing and treatment for syphilis, the scheme specifically excluded Aborigines, the Federal Director of Quarantine, noting that they “are not included in the scheme” (in Lewis, 1998: 376).

Conditions on Dorre and Bernier were described by a visitor, Daisy Bates, who referred to them as the ‘isles of the dead’:

Now and again a dead body would be wrapped in a blanket and carried away to burial in the sands, and the unhappy living could not leave the accursed ground of its spirit. Some became demented, and rambled away and no one of an alien tribe would go to seek them. One day an old man started to "walk" back over thirty miles of raging waters to the mainland. These shores are infested with sharks, and he was never seen again. Another hid in the thick scrub, and died there, rather than be operated on. A third sat on the crest of a little rise all day long, pouring sand and water over his head, wailing and threatening, in his madness. (in Healy, 1978: 133)

With no training, police were empowered to examine, identify and detain Aborigines suspected to be infected. Dr Herbert Basedow (1932) recalled that: “A special expedition collected as many natives as possible between the Ashburton River and the Eastern Gold Fields” (p. 181). Visitor and author EL Grant Watson gave a more detailed description:

The method of collecting the patients was not either humane or scientific. A man unqualified except by ruthlessness and daring, helped by one or two kindred spirits, toured the countryside, raided the native camps and there, by brute force, 'examined' the natives. Any that were obviously diseased or were suspected of disease were seized upon. These, since their hands were so small as to slip through any pair of handcuffs, were chained together by their necks, and were marched through the bush, in the further search for syphilitics. (1946, p. 112)

'Patients' or prisoners, they were segregated by sex and set to work. Over a quarter of those who survived abduction and transportation died (table 1) before the last twenty-four inmates were removed in 1919 to the "Depot for Diseased Natives" in Port Hedland (Mulvaney, 1989) where their misery continued.

Table 1. Lock Hospitals (W.A.): Mortality 1909 – 1917 (from Jebb, 1984)

	Male	Female	Total
Admissions	209	426	635
Deaths	46 (22%)	116 (27%)	162 (26%)

There are historical links between northern Western Australia and north Queensland. The Queensland 1897 Aborigines and Restriction of Sale of Opium Act, the basis for discriminatory legislation that continued until the late 1970s, was taken as the model for the 1905 Aborigines Act in Western Australia. Involved with both was Dr Walter Roth, who became Northern Protector of Aborigines in Queensland in 1898. There were similar concerns about venereal diseases in north Queensland where Asian men and Aboriginal women were held responsible. Roth initiated an isolation compound in Cooktown gaol in 1904, various sites subsequently used to detain 'syphilitics' with 'chronic cases' sent to Palm Island until nearby Fantome Island lock hospital opened in 1928. As in Western Australia, fear spread as the inmate population increased to 227 in 1933. In 1932 the head of the Australian Institute of Tropical Medicine, Dr Raphael Cilento, described his vision for Fantome:

The whole abo population should be worked through Fantome & then regraded into new cases, incurable aged, incurable young & part cured & thence drafted when clean back into Palm from which they can be sent out into the mainland to be (1) assimilated if white enough; (2) employed under supervision & protection; or (3) kept on Palm as minor officials or peasant proprietors working personal strips around a collective farm. (in Yarwood, 1991: 63)

Conditions for the inmates were poor and mortality through the early 1930s was similar to Dorre and Bernier (table 2). The limited resources that were available were further compromised by corruption, rationalised by blaming the patients for their miserable state,

Chief Protector J.W. Bleakley, noting that the inmates: “are admitted to Fantome Island through their own fault” (in Kidd, 1997: 113).

Table 2. Lock Hospitals (Qld): Mortality 1930-1937 (from Lewis, 1998)

Year	Admissions	Deaths	Percentage
1930	45	12	27
1931	70	8	11
1932	128	28	22
1934	36	16	44
1935	69	30	43
1936	213	19	11
1937	193	28	15
TOTAL	754	141	19

During the Second World War concerns abated, detentions fell and ceased in 1945. But that did not end Fantome as a medical prison. In 1940 it began receiving lepers, and continued as a lazarette until the transfer of the last inmates to Palm Island in 1975 (Patrick, 1987). For both leprosy and sexually transmitted diseases policies were discriminatory and not consistent with best practice (Saunders, 1990). Largely due to the influence of the likes of Raphael Cilento in Queensland and Cecil Cook in the Northern Territory, isolationists prevailed. This leads to the second issue – the conflation of medical and political roles. Both of these influential doctors were vocal supporters of the White Australia Policy, held abiding suspicions of Asians and were influenced by then current eugenic theories in their consideration of the ‘Aboriginal problem’ (Yarwood, 1991; Austin, 1990; McGregor, 1997). Indeed, the first Aborigines Act in the Northern Territory fused political and health roles – the Chief Protector of Aborigines was also Chief Medical Officer. The first occupant, Herbert Basedow, soon after appointment called for a system of identifying all Aborigines by scarification, which could: “be done in an absolutely painless way and without disfigurement. The space occupied by the mark need not exceed one or two square inches and would be chosen in quite an inconspicuous position” (in McGregor, 1997, p. 69). His proposal was rejected by more sensible and humane bureaucrats and his tenure was short.

Cecil Cook, who held these positions from 1927 to 1938, was more influential and an advocate of eugenics, seeking clarification in 1933 as to whether he: “could demand the compulsory sterilisation of those half-caste children who were classified as ‘congenital idiots’ or as ‘mentally defective’” (in McGregor, 1997, p. 161). His support for absorption was enduring. In 1937 he stated at the Conference of Commonwealth and State Aboriginal Authorities:

The policy of the Commonwealth is to do everything possible to convert the half-caste into a white citizen. The question arises whether the same policy should not be adopted in regard to the aborigines ... My view is that unless the black population is speedily absorbed into the white, the process will soon be reversed, and in 50 years, or a little later, the white population of the Northern Territory will be absorbed into the black (in McGregor, 1997: 177)

The political influence of doctors was such that the statement by historian Raymond Evans that: “white colonists obtained vital support for their racial attitudes from the most respected thinkers of the nineteenth century, the natural and social scientists” (Evans, Saunders & Cronin, 1993, p. 16) I believe, may be paraphrased – ‘white bureaucrats obtained vital support for their racial attitudes from the most respected professionals of the first half of the twentieth century, medical practitioners’.

So far I have discussed doctors as perpetrators in Europe during the Nazi era, and as complicit bystanders in Australia through the same period. Drawing on the typology – Perpetrators, victims and bystanders (Hillberg, 1993) – I will now consider doctors as victims, returning to Europe (Hunter, 1997). Raphael Cilento is a connection. In the closing days of the War Cilento was sent to Europe with the United Nations Relief and Rehabilitation Association, eventually becoming UNRRA Director of the British Zone of Germany. He was with the first civilian allied medical team to enter Belsen. Later he was the UN Director of Disaster Relief in Palestine leaving in 1948 after the assassination of his friend Count Folke Bernadotte (Fisher, 1994) which cemented his anti-Semitism.

Among the refugees moving across Europe at that time were Jewish doctors who documented their experiences of survival. These include the Polish pediatrician and resistance fighter Adina Blady Swager (1990), who survived the Warsaw ghetto, another Pole and ghetto doctor, Abraham Wajnryb (1979), for whom there is now an annual lecture in Sydney, and the Polish partisan Michael Temchin (1983). However, there were also Jewish physician survivors of Auschwitz who wrote at war’s end, including the Hungarian gynaecologist, Gisella Perl who published I was a doctor in Auschwitz in 1946, the Dutch physician Elie Cohen, whose 1952 Doctoral thesis became Human Behaviour in the concentration camp (1988), Myklos Nyiszli, a Hungarian forensic pathologist who released Auschwitz: A doctor’s eye-witness account (1973) in 1946, and Victor Frankl, an Austrian psychiatrist, who published From death-camp to existentialism in 1946, known in English translation as Man’s search for meaning (1984). Because their experiences were so similar and yet, as I will explain, so different, I will focus on the last three. In a way that recalls the typology of victim, perpetrator and bystander, it is their identity as medical practitioners that is central to these differences.

Elie Cohen sets out to present an 'objective', scientific account of his experiences, so much so that, recognising the: "danger that lack of objectivity may prevent me from viewing the problems I have set to solve in their true proportions ... in furtherance, therefore, of objectivity – I have given priority to the accounts of others rather than my own" (p. xxiii). Cohen clearly sees his medical identity as having contributed to his survival, but not without conflicts, such as about accessing extra resources and the roles of other doctors in the killing of prisoners – even the roles of German doctors. After presenting material from the Doctors' Trial supporting charges of medical murder, he concludes: "For me to pass verdict on the attitude of German physicians during the Hitler rule would be going outside the scope of this study" (p. 268). In a conflicted sense, Elie Cohen's medical identification is clear, but that of a bystander.

Miklos Nyiszli also identified as a doctor: "When I lived through these horrors, which were beyond all imagining, I was not a writer but a doctor. Today, in telling about them, I write not as a reporter but as a doctor" (p. 19). Yet very different was his relationship to his medical identity. Nyiszli was laboratory assistant to Dr Josef Mengele and his story is all the more horrible given his relationship to Mengele, whose "research" – Nyiszli's term – is discussed with what seems a mixture of horror, awe and admiration: "Dr. Mengele was indefatigable in the exercise of his functions. He spent long hours in his laboratories, then hurried to the unloading platform where the daily arrival of four or five trainloads of Hungarian deportees kept him busy all day" (p. 36). He talks also of the "vast possibilities for research" explaining that: "The abundance – unequalled anywhere in the world – of corpses, and the fact that one could dispose of them freely for purposes of research, opened even wider horizons" (p. 51). While Mengele saved Nyiszli's life, reflecting on moments of closeness seems unfathomable, such as the following, immediately after Mengele had sent a trainload from Riga to the flames:

During our numerous contacts and talks together, Dr Mengele had never granted me what I might call a private conversation. But now, seeing him so depressed, I screwed up my courage. "Captain," I said, "when is this destruction going to cease?" He looked at me and replied: ... "My Friend, it goes on and on ..." His words seemed to betray a note of silent resignation." (p 127)

Nyiszli's survival involved affirming his professional role and identifying with a medical perpetrator whose inhuman acts seem sealed off from his medical identity. Perhaps not entirely without conflict for Nyiszli, as suggested by a comment regarding his future: "I would begin practicing, yes ... But I swore that as long as I lived I would never lift a scalpel again" (p. 158).

Very different is Victor Frankl's account. While Cohen struggled to present facts in as unbiased a fashion as possible, Frankl insists that: "this book does not claim to be an account of facts and events but of personal experiences, experiences which millions of prisoners have suffered time and again" (p. 21). Whereas Nyiszli clearly stated that he survived and wrote "as a doctor", Frankl states that: "this story is about my experiences as an ordinary prisoner, it is important that I mention, not without pride, that I was not employed as a psychiatrist in camp, or even as a doctor" (p. 25).

That Frankl emphasises that he did not work as a doctor is important and seems to reflect his desire not to be advantaged over others. Frankl was, of course, an exceptional man and in his account his medical identity does not feature. Rather, it is of his identification with fellow prisoners rather than a select group of colleagues that we read. What allowed Frankl to survive was surely not his profession. As his Viennese contemporary, Bruno Bettelheim, himself a survivor, but as a political prisoner who was released before the war began, commented: "Those who stood up well in the camps became better men, those who acted badly soon became bad men; and this, or at least so it seemed, independent of their past life history and their former personality make-up" (1970: 25). That Frankl "stood up well" was critical for survival. That he did so by not being a doctor may have enabled his return to Vienna and his profession after the War. The strength that Frankl deployed in surviving and writing was despite rather than because of his medical identity – his identification was with the victim rather than the doctor.

While the paths of these three doctors differed, they all led to Auschwitz and all were victims. Yet they have evoked very different reactions. Bettelheim is scathingly critical of Nyiszli stating: "Those who tried to serve their executioners in what were once their civilian capacities ... were merely continuing if not business, then life as usual". He continues that: "The same business-as-usual attitude that enabled Dr. Nyiszli to function as a doctor in the camp, that motivated him to volunteer his help to the SS, enabled millions of Jews to live in ghettos where they not only worked for the Nazis but selected fellow Jews for them to send to the gas chambers" (in Nyiszli, 1973, p. 9). This is an extraordinary accusation and takes us to what fellow Auschwitz survivor Jean Améry called "the mind's limits" in terms of ethical analysis. The camps made terrible demands of those who fought for survival, as much of doctors as of others. As victims all, there was no ethically privileged starting point. And neither did those who survived leave redeemed by suffering, as Améry (1986) explains: "in Auschwitz we did not become better, more human, more humane, and more mature ethically. You do not observe dehumanized man committing his deeds and misdeeds without having all of your notions of inherent human dignity placed in doubt" (p. 20).

Was some higher morality or altruism expected of doctors because they were doctors? Nazi doctors render that untenable. Was there more expected of prisoner doctors? If so it is unfair and unreasonable. Unfair for presuming greater capacities for personal and family sacrifice; unreasonable in assuming ethical superiority by virtue either of being doctors or being prisoners. As we have seen, neither is justified and we should not be surprised by same range of survival responses of doctors as of other victims. There was probably very little if anything in the training of these doctors that related to issues of ethics and moral decision-making. There was nothing that could have prepared them for Auschwitz. Nazi doctors should serve to warn us of the folly of assuming a correlation between academic attainment and professional standing on the one hand, and humane and ethical behaviour on the other. Their actions were a matter of choice and should be judged accordingly. By contrast, the actions of prisoner doctors were not, and they should alert us to the danger of judging those trapped in dehumanising and coercive systems.

In The drowned and the saved Primo Levi asserts that: “To confuse [the perpetrators] with their victims is a moral disease or an aesthetic affectation or a sinister sign of complicity; above all, it is a precious service rendered (intentionally or not) to the negators of truth”. In this presentation I have considered doctors as perpetrators of, bystanders to, and as victims of various systematic, state sanctioned and professionally supported traumatisations. As the reactions to the ways in which the three Auschwitz doctors survived suggests, even with knowledge of the enormity of trauma, it is easy to blame the victim. There are parallels in terms of providing the imprimatur of the medical profession to victimising Aborigines. Thus, a 1991 article in the Sydney Morning Herald (Spectrum, 16 February 1991) written by a Dr Margaret Harris, titled “Black violence: why whites shouldn’t feel guilty”, commenced by quoting psychiatrist, Dr Jock McLaren: “Brutality is part of black culture, and it’s time whites shed their guilt for Aboriginal violence”. The author argues that because there was violence in Aboriginal societies before colonisation, and as most contemporary perpetrators and victims are Aboriginal, Europeans bear no responsibility. This neatly elides two centuries during which almost all the violence involved European perpetrators – it is giving professional support to a form of denial, it is professional complicity in perpetuating trauma.

Thus two final issues – denial and responsibility. Richard Hovannisian, an Armenian genocide scholar, describes three faces of denial; straight denial (“it didn’t happen”), rationalisation (“war is hell, collateral damage”), and trivialisation (“there are lots of genocides, what about the baby whales”). This may be used to consider, for instance, the Stolen Generations. Denial is the ‘disremembering’ of the Great Australian Silence. Why weren’t we told? Henry Reynolds (1999) rhetorically asks in the title of his recent book about a personal search and a national forgetting. For very self-serving reasons, he concludes. That would seem no longer possible, but consider Padraic McGuinness’ comments on ABC Lateline (August 25, 1998) that memories of abuse reported by the stolen generation were examples of “false memory syndrome”.

Rationalisation is the expedient: “it would have been worse if they had remained on the reserve”. Thus, in Parliamentary debate on the Queensland Children’s Services Act 1965 in support of removal it was stated that “No group of children is more neglected than those who are living with their coloured parents in the fringe-dwelling areas of many of our country towns” (in HREOC, p. 80). There are many examples. Trivialisation includes pointless comparisons to other ‘genocides’. It may also occur inadvertently, even with best intentions. The commissions into Deaths in Custody and the Stolen Generations both resulted in significant reports, there for all to read and, perhaps, to say – “we’ve dealt with that”. Sadly but predictably institutionalisation and racism have led to the internalisation of denial, rationalisation and trivialisation by many Indigenous victims, compounding the collective trauma and, in turn, supporting mainstream denial.

Medical professionals have been involved at all levels. In terms of denial, the disruption of families was known to many doctors who were better placed than most to observe the events and consequences. They supported discriminatory treatment and rationalised racist policy. They may contribute now to trivialisation by medicalising human rights violations. Following release of Bringing them home serious debate was politically

stifled. The government's formal response was a marginal increase in funding for Indigenous social and emotional wellbeing, specifically grief and loss counselling. Clearly there is grief and a need for healing, but this has effectively consigned a human rights issue to a mental health arena, forcing Indigenous people to voice their grievances through its idiom. Unquestioning health professionals support that process. At times it is more cynical. Grief and loss counsellors generally have non-recurrent positions and, often, little or no training. One year will probably make little difference. But it is a worker for a year and looks good on paper. Done that.

This leads me to the last issue. Reflecting on the Holocaust and Indigenous Australia, Colin Tatz (1983) wrote fifteen years ago on 'atonement', pointing out that it involved acknowledgment, restitution and reparation. A decade ago Paul Keating acknowledged that "it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the diseases. The alcohol. We committed the murders. We took the children from their mothers" (in Tatz, 1999, p.41). Restitution is restoration of that which can be returned and in Australia has involved engaging with Aborigines and Torres Strait Islanders around their just claims to land and resources. To date this has been contested at nearly every point by successive State and Federal governments. Reparation - compensation for that which cannot be given back - will ultimately be the most difficult and important national task. The Human Rights and Equal Opportunity Commission's inquiry uses a similar framework, reparation involving:

- 1) acknowledgment of the truth and an apology;
- 2) guarantees that these human rights won't be breached again;
- 3) returning what has been lost as much as possible (known as restitution);
- 4) rehabilitation; and,
- 5) compensation.

Monetary compensation, the Commission contends, is due for breaches of human rights. While they also demanded improvements in the mental health services and for grief and loss to be addressed, in no way can this be understood as reparation, which would be a gross example of trivialisation. No amount of tears on the Parliamentary floor, or crosses on the Parliamentary lawn, changes that fact. Raymond Gaita (1999) makes this point:

We must therefore not be sentimental about reconciliation. We should resist especially the kind of sentimentality expressed in 'Sorry Day', which, good hearted though it may be, really hides from us the terrible evil the Aborigines have suffered and our responsibilities to them. (p. 105)

Which is not to diminish the importance of symbols. However, we should not be blinded by them, by representations rather than responses. Each time I have visited Yad Vashem in Jerusalem I have been overwhelmed by the monuments that testify to the events of the Holocaust - particularly the children's memorial. I was thus surprised to encounter Raul Hilberg's comment that: "the Yad Vashem memorials are 70% kitsch The children's memorial with all those lights - what's the difference between that and the walkway between Terminal B and Terminal C at United Airlines in Chicago" (in Markle, 1995, p. 132). I would not characterise those memorials, as does Hilberg, as "holokitsch", but there are some products that I would so describe, and somewhere between Todesfuge and

“holokitsch” there is a point where trivialisation and denial begin. That point is about foregoing thought for feeling. It is the point where the emotional response is the end point rather than reflection. It is the difference between feeling sorry for Aborigines versus reflecting on why one should so feel. Gaita (1999) talks about this in terms of “remorse” – that is, “pained acknowledgement” (p. 93) of our past – not just feeling but reflecting. Returning to the issue of medicalised responses, Gaita also comments, I believe insightfully, that responding must be to more than the consequential emotional pain:

Relief of the material and psychological misery of many of the Aborigines will not count as reparation, however, unless the spirit in which that relief is given is informed by a recognition of the wrongs they have suffered

Acknowledgment of those wrongs as a source of torment distinct from and not reducible to their mental or psychological consequences is, I believe, what Aborigines desire when they ask for a national apology” (p. 100).

Exploring responsibility, Gaita suggests, may lead to difficult places: “Unless trials become thinkable for us, I believe, we cannot claim fully to understand the moral dimensions of our past” (p. 128). They are thinkable to some. Gary Foley noted in 1993:

There is an Aboriginal kid sitting on death row in Florida . . . The man who signed the adoption papers to take that kid away from his mother that ultimately resulted in him being in a cell on death row in Florida, is still working in the Office of the Minister of Aboriginal Affairs in Victoria – to this day! Now folks, if it’s good enough for this Australian government to drag decrepit old pensioners – decrepit old Nazi pensioners – out of wardrobes in Adelaide and stick them before the court for war crimes – crimes committed fifty years ago half way around the world – then some of the people that have done some of the things to us need to have the same thing done to them. (Aboriginal Medical Service, 1994)

Will we have trials? Probably not of individuals as perpetrators, thus weakening any cases. Should there be doctors in the dock? I don’t think so, but we should strive to answer why not. Mental health professionals should consider not only how to address the symptoms of trauma, but reflect on the profession’s past and the political implications of contemporary interventions. The suit brought by Joy Williams, an Aboriginal woman, against the State of New South Wales is instructive. While the human rights violations of family terrorism, of which she was a victim, are cast in mental health terms, because she was demonstrably mentally ill her cause was lost. So - if you were removed it is not a human rights violation, but can cause mental health problems – but, if you have mental health problems it is not because you were removed, it was probably your genes. She was victimised by the State, the mental health system and the judicial system.

I have considered a number of issues relating to medical identity stemming from reflecting on the Holocaust and the experiences of Indigenous Australians. I am not suggesting equivalences but calling attention to resonances which, I believe, have relevance for those who seek to relieve the pain of trauma. That requires engaging with someone’s pained memory and its meaning, in an asymmetrical power relationship that in certain respects may resonate with the experience or context of the original harm. That may be amplified in circumstances where, historically or directly, medical activities have contributed to

traumatisation. I have presented examples of doctors as perpetrators and complicit bystanders causing harm to whole groups. I have also described how, even as victims of extreme trauma, doctors' professional identity can influence their experiences, including their acceptance of medical complicity in their own harm. I have also noted, in both contexts, that doctors can contribute to blaming the victims. They may do that because they are unaware – or unwilling to be aware. Perpetrators have their remedy – amnesia. Bystanders may surface only fitfully from the “deep sleep of forgetfulness”. Our patients, victims, must live with their memories – “today and forever”. Unlocking memory in the service of healing demands respect, and both professional and personal reflection.

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Todesfuge

Black milk of daybreak we drink it at evening

We drink it at midday and morning we drink it at night

We drink and we drink

We shovel a grave in the air there you won't lie to cramped

A man lives in the house he plays with his vipers he writes

He writes when it grows dark to Deutschland your golden hair Marguerita

He writes it and steps out of doors and the stars are all sparkling he whistles his hounds to
come close

He whistles his Jews into rows has them shovel a grave in the ground

He commands us Play up for the dance

Black milk of daybreak we drink you at night

We drink you at morning and midday we drink you at evening

We drink and we drink

A man lives in the house he plays with his vipers he writes

He writes when it grows dark to Deutschland your golden hair Marguereta

Your ashen hair Shulamit we shovel a grave in the air there you won't lie to cramped

He shouts jab this earth deeper you lot there you others sing up and play.

He grabs for the rod in his belt he swings it his eyes are so blue

Jab your spades deeper you lot there you others play on for the dancing

Black milk of daybreak we drink you at night

We drink you at midday and morning we drink you at evening

We drink and we drink

A man lives in the house your goldenes haar Marguereta

Your aschen haar Shulamit he plays with his vipers

He shouts play death more sweetly this death is a master from Deutschland

He shouts scrape your strings darker you'll rise then as smoke to the sky

You'll have a grave then in the clouds there you won't lie to cramped

Black milk of daybreak we drink you at night

We drink you at midday Death is a master aus Deutschland

We drink you at evening and morning we drink and we drink

This death is ein meister aus Deustchland his eye it is blue

He shoots you with shot made of lead shoots you level and true

A man lives in the house your golden haar Marguerete

He looses his hounds on us grants us a grave in the air

He plays with his vipers and daydreams der Tod is ein Meister aus Deutschland

Deine goldene haar Marguerete

Deine aschen haar Sulamit.