This book is about the ethics of nursing and midwifery, and how these were abrogated during the Nazi era. Nurses and midwives actively killed their patients, many of whom were disabled children and infants and patients with mental (and other) illnesses or intellectual disabilities. The book gives the facts as well as theoretical perspectives as a lens through which these crimes can be viewed. It also provides a way to teach this history to nursing and midwifery students, and, for the first time, explains the role of one of the world’s most historically prominent midwifery leaders in the Nazi crimes.

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Nurses and Midwives in Nazi Germany
The “Euthanasia Programs”

Edited by
Susan Benedict and Linda Shields
This book is dedicated to Traute Lafrenz Page, MD. Since 1997, Dr. Page has accompanied me to many archives in Europe and Israel to obtain documents for this book. She has translated literally thousands of pages from German to English, carefully writing each translation by hand. Without her, this book would not exist.

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Traute is my most admired person, and I thank her for all of her help throughout the years.

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We dedicate this book to Hilde Steppe, whose work first brought to light the crimes and circumstances of nurses and midwives under the Nazis. At the time she wrote, in Germany, it must have taken a high degree of courage to do so. Sadly, Hilde Steppe died in 1999.

Importantly, we dedicate this book to those victims—infants, children, and people with mental illnesses, disabilities, and physical illnesses who died by the actions of nurses and midwives during the Nazi era. By invoking their memory, we hope this book will help prevent such actions from occurring again.

Linda Shields and Susan Benedict
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# Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Setting the Scene</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>LINDA SHIELDS AND THOMAS FOTH</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Fertile Ground for Murder</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>SUSAN BENEDICT</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Nursing during National Socialism</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>THOMAS FOTH, JOCHEN KUHLA, AND SUSAN BENEDICT</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Psychiatric Nursing during the Era of National Socialism</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>SUSAN BENEDICT, MARY LAGERWEY, AND LINDA SHIELDS</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The Medicalization of Murder: The “Euthanasia” Programs</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>SUSAN BENEDICT</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Meseritz-Obrawalde: A Site for “Wild Euthanasia”</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>SUSAN BENEDICT</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Klagenfurt: “She Killed As Part of Her Daily Duties”</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>SUSAN BENEDICT</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>German Midwifery in the “Third Reich”</td>
<td>164</td>
</tr>
<tr>
<td></td>
<td>WIEBKE LISNER AND ANJA K. PETERS</td>
<td></td>
</tr>
</tbody>
</table>
Contents

9 From History to Memory: Using the “Euthanasia” Programs to Teach Nursing Ethics 198
   ELLEN BEN-SEFER AND DGANIT SHARON

10 Changing Perspectives: From “Euthanasia Killings” to the “Killing of Sick Persons” 218
   THOMAS FOTH

11 Conclusion 243
   LINDA SHIELDS AND SUSAN BENEDICT

Glossary 249
Contributors 253
Index 259
Figures

4.1 Regulations for acceptance, training, and examination of nursing staff for the mental institutions in the area of Nassau. 53
4.2 Questionnaire to assess training of nursing staff in all psychiatric hospitals. 57
4.3 Curriculum of nursing course, Eichberg, 1939. 59
5.1 Meldebogen I. 88
Tables

5.1 Nurses and Caregivers Who Worked in *Aktion Reinhard* Camps: Male Nurses and Caregivers from T4 9

9.1 Survey of Israeli Undergraduate Student Responses to the Class (77 students)

9.2 Survey of Australian Undergraduate Student Responses to the Class (168 students)
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1 Setting the Scene

Linda Shields and Thomas Foth

1.1 INTRODUCTION

The role of physicians in the crimes of the Nazi era in Europe has been extensively studied, but nurses and midwives have been largely ignored. Many of the crimes for which doctors were charged and punished occurred in hospitals, and nurses make up the main work force in any hospital; ergo, they, too, were at least complicit in, and often primarily responsible for, many of the same crimes. Nowhere is this more pronounced than in the so-called “euthanasia” programs, where people, including children, were systematically killed because they were considered “life unworthy of life” or “useless feeders”. (It is worth noting here that the term “euthanasia” is a misnomer. While the word means “a good death” there was nothing good about how these people died. However, it continues to be used in the context of these crimes.) Midwives were mandated to report infants born with deformities so they could be killed, and the midwives were paid per capita to do so. Psychiatric hospitals were cleared of their patients and used for barracks to house soldiers. Killing took place in the hospitals, and often a crematorium was built on site to dispose of the dead. A telling film exists—now held by and publicly available from the US Holocaust Memorial Museum—which shows a nurse in uniform helping naked men and boys into a gas chamber. The care she takes to put a blanket around their shoulders makes us wonder how a nurse, who is educated and trained to think that caring is the platform on which her/his work is based, can regard killing as a legitimate part of that caring. This is the essence of this book.

While there is a large literature about the roles of the medical profession in the Third Reich, the reason that nursing and midwifery have been largely ignored until recently is open to supposition. Two authors have been dominant in the area (apart from the contributors to this book). A German nurse, Hilde Steppe (1947–1999), first published reports of the role of German nurses in the Nazi era in the early 1980s in German and then in the 1990s in English. Historian Bronwyn McFarland-Icke published a book about psychiatric nurses in Nazi Germany in 1999. Other investigations in the area have been piecemeal, and a conference held in Limerick in Ireland...
Linda Shields and Thomas Foth

in 2004 highlighted the dearth of scholarship in this area of nursing and midwifery history. Perhaps this deficit relates to the fact that females have traditionally dominated these professions, and it has been assumed that women would not commit such crimes. It could be due to the fact that people hold nursing and midwifery in high regard, and believe (as we have been told on several occasions) that “nurses would not do those things”. Such unenlightened thinking inhibits full and proper examination of a dark side of the history of nursing and midwifery. Unless this is addressed, we cannot develop the professions to their full potential.

This book has eleven chapters. This first introductory chapter, called “Setting the Scene”, does just that, with explanations of the primary political theories of fascism and Nazism, how the Nazis came to power, the role of propaganda in influencing the lives of the German people, and a description of the “T4” programs, which were the planned and systematic killing of people with a range of illnesses and disabilities. Chapter 2 examines the role played by eugenics in the development of the racially motivated killings in which nurses were complicit, and Chapter 3 discusses nursing in Nazi Germany, describing how the profession developed and was structured in that era. Chapter 4 explains how psychiatric nursing was structured in Nazi Germany, and how it was the main specialty of nursing under which the killings were done, while Chapter 5 discusses the “euthanasia” programs in detail. Chapter 6 explains the actions of nurses at Meseritz-Obrawalde, one of the psychiatric hospitals that were killing centers, and, using trial transcripts, examines the nurses’ justifications for their roles in murder. Chapter 7 includes more detail from another institution and testimonies of the nurses who killed. Chapter 8 describes the role of midwives, while Chapter 9 is a discussion on how the lessons learned from the euthanasia program can be taught to nurses and midwives today. In Chapter 10, there is a discussion of the philosophical and sociological theories that could account for the nurses’ and midwives’ actions, while Chapter 11 rounds off the discussion with some questions as to whether this could happen again, and some reflections on how similar things are happening in twenty-first-century nursing and midwifery practice.

1.2 BACKGROUND AND BEGINNINGS

1.2.1 Fascism

The beginnings of fascism are debated, with some historians describing it as having its origins in the opposition to the positivism and liberalism of the late nineteenth century, while others describe it as not existing before World War I (Hayes 1973). Be that as it may, fascism’s main evolution occurred in Europe at the beginning of the twentieth century, with the rise of Benito Mussolini in Italy (Mann 2004). With the decline of the Weimar Republic
following massive inflation and economic hardship caused by reparations payments at the end of World War I, Germany was ripe for the development of an authoritarian movement that could create economic recovery and social cohesion, and so fascism morphed into National Socialism, or Nazism, in Germany (Burleigh 2001).

Fascism is characterized by a totalitarian, hierarchical structure with a right-wing nationalist philosophy. It is in fundamental opposition to democracy and liberalism. The term derives from the *fasces*, a bundle of rods bound together to denote unity with an axe head denoting leadership, as used by the ancient Romans. Mussolini developed this iconography as he led his new movement to power in Italy in 1922 (Taylor 2009). Not confined to Italy, fascism was the basis for Nazism, and was implemented in various countries—*Action Française* in France, the Falangists in Spain, and the Arrow Cross in Hungary, for example. Fascism has five main principles: extreme nationalism, a belief that in the past the nation was great and now needs regeneration; this racial decline is racially oriented and there is a need for purification of the race; racial decline is caused by conspiracies of other nations; and capitalism and liberal democracy are divisive, designed to break up the nation and make it even more subordinate to other nations (Taylor 2009). Fascist governments/movements believed that the highest priority was to restore the purity of the nation, restore the nation’s dominance in the world order, and to do this to reorganize the polity, society, and economy.

Based on distortions of social Darwinism, a core tenet of fascism is the development of an elite and the centrality of the leader (Hayes 1973). The leader (*Fürher* in German) is not one person, but rather the collectivization in one person of all in the nation, with his decrees expressing eternal truths; all initiative and decision-making rest with him, all are accountable to him, and complete obedience to his will is absolute (Jones 1940). The individual does not exist, has no individual will, and must obey the state as personified in the leader.

Churchill described fascism as “the shadow or ugly child of communism” (Churchill 1948, 30), and other historians see it as a progression from, as well as an opposition to, communism (Neocleous 1997). While there are similarities between the two regimes (totalitarianism, dictatorship), a large diversity of tenets in fascist states creates difficulties in its definition (Paxton 2004). Russell explains that for Communism and Marxism, revolution is needed to remove the dominance of classes in society, while fascism (and Nazism) emphasizes will, which is concentrated in certain races and individuals, who thus have the right to rule (Russell 1994).

Nazism dominates every aspect of life; in fact, as with fascism, the individual is nothing but the state is all, and is personified in the leader (*Fürherprinzip*). To a fascist doctrine, Nazism added the use of terror as a tool of state to its official policies, an overarching anti-Semitism, the purity and dominance of the “Aryan” race, and the need to remove from society the weak and disabled, and those considered “anti-social”.
In summary, and for the purposes of the topic of this book, fascism is a political system that developed in the early twentieth century in Europe. Its main principles are the dominance of the state or nation over everything, the personification of the collectivity of the nation in one leader, whose will is absolute, and to whom everything and everyone is subjugated and must be totally obedient. In Germany, in the 1920s and 1930s, Nazism developed from fascism.

1.2.2 Nazism

The history of Nazism is more complex than that of fascism, despite the fact that it developed in only one country, Germany. Nazism had a more nebulous evolution than fascism, as, in a very simplistic description, it would seem that Hitler and his cronies took the principles of fascism and added their own as they went along, to suit their own ideals and prejudices (one could argue that this is a characteristic of governments everywhere). Nonetheless, Nazism became the epitome of evil, with its ultimate aims of the ascendancy of the “Aryan” race, survival of the fittest and strongest, protection of the “purity” of the race; and removal of all who did not fit the racial model and those who opposed or questioned the regime.

In the early twentieth century, German culture was fiercely nationalistic, with concepts of ethnicity and commitment to the völk, roughly translated as “people” (Mann 2004). However, the concept was much deeper and more complex than that. The volkisch movement embraced a mix of Nordic-German historical legends, race mysticism, pseudo-biology, extreme nationalism, and anti-Semitism (Broszat 1960). Volkisch ideas had been an ingrained part of German psyche for generations (Mosse and Leeden 1978). During the Weimar Republic, which followed Germany’s defeat in World War I, a plethora of volkisch movements enlarged and implemented those ideas and ways of thinking and consequent organizations that provided a rich ground for the development of an intense nationalism with a focus on race.

The German economy was badly affected by the large reparations payment following the Treaty of Versailles (which ended World War I); a national shame existed because of both the defeat and the crippling reparations payments, and the culture was ripe for the development of the volkisch movements that gave the people nationalistic pride. From these the Nationalsozialistische Deutsche Arbeiterpartei or National Socialist German Workers Party (NSDAP) or, as it was known, the Nazi Party, led by Adolf Hitler, flourished. Hitler had been imprisoned for nine months for his role in trying to overthrow the government in 1924, and he used that time to write Mein Kampf (My Struggle). This rambling, often illogical and hard-to-read book is full of Hitler’s vision for what Germany could become if he led it—he talks of killing those “unworthy of life”, ridding the world of its Jews, and the penultimate need for war.
The Hitler dictatorship and the NSDAP (Nazi Party) ruled Germany from 1933 until the end of World War II, in 1945, and with war and occupation, covered much of Eastern Europe.

1.2.3 The Rise of Adolf Hitler

After World War I, developments in nursing were set in a changing and unstable political situation. Germans resented the perceived unfairness of postwar reparations and the Treaty of Versailles. Rampant inflation, industrial collapse, and extreme levels of unemployment caused political turmoil. In 1928 a key event occurred. In the general election, the Nazi Party won twelve seats in the German parliament, the Reichstag. Societal problems such as unemployment and inflation continued to favor the Nazis and their denunciation of Jews as the cause of the economic problems. In September 1930, an election was called and the number of Nazi seats in the Reichstag increased from 12 to 107. The Nazi Party was now the second largest party in Germany. In the June 1932 presidential election, Field Marshal Hindenburg, the incumbent, won with 53 percent of the vote. Hitler garnered over 36 percent, coming in second. By July 31, 1932, the Nazi Party held 230 seats, giving Hitler enough strength to establish a coalition government. He, however, refused to do so unless he was chancellor. Lengthy political crises led to negotiations, and Hitler was appointed chancellor on January 30, 1933, at the age of forty-three (Gilbert 1985).

Coupled with the rise to power of Adolf Hitler was the surge of anti-Semitism across Germany. From the beginning of the twentieth century, anti-Semitism had been an integral part of the conservative political platform. Jews had been successful in German academic, professional, and business circles in Germany. As the economy declined and unemployment rose, they became the scapegoats. Once assimilated with a fairly high rate of intermarriage with non-Jews (ibid.), they soon found themselves to be the objects of social and economic discrimination. Thus with Hitler coming to power, the smoldering anti-Semitism of the Nazis and right-wing political groups ignited.

Part of Hitler’s philosophy was that of “Lebensraum” or “living room” for the German people, and so he invaded several countries to the east. After the invasion of Poland in September 1939, World War II began as Britain and France declared war on Germany.

It can be difficult today to understand how Hitler and the Nazi Party could take over an entire population of one of the most educated and sophisticated countries in Europe, the home of people such as Beethoven, Goethe, Einstein, and so on. While the role of propaganda and its use by the Nazis are described in the next section, for a cogent, illustrative description of how the Nazis came to take over the minds and lives of the German populace, see Martin Davidson’s book The Perfect Nazi (2010).
1.2.4 Propaganda

It is difficult today to understand how a nation could become so entranced with a leader, and a single party and way of thinking, and that the extremes of which the party and its leader were guilty could be either, at best, unnoticed, or at worst, ignored. It is challenging for modern-day nurses and midwives to understand how nurses and midwives of the Nazi era could be so caught up in the thinking of the day that they became culpable in one of the largest crimes in history. History can explain some of this—the underlying myths of Germanic ideals that were part of thinking in that part of the world, the economic disasters following World War I and the humiliation of the Treaty of Versailles, and the surge of nationalist feeling promoted by Hitler, who was seen as the savior of Germany. Under the new Nazi Party rule, unemployment dropped from 33 percent in 1933 to full employment in the course of World War II (Burleigh 2001), while rearmament (despite the banning of this under the Treaty of Versailles) repaired national pride and at the same time created manufacturing and new jobs. Additionally, an innovative regard for and provision of welfare and recreation facilities for the working class provided the right environment for a totalitarian regime to implement its programs with impunity.

Hitler was well aware of the importance of propaganda to influence the thought of the people. Many definitions of propaganda exist, the simplest being “the systematic propagation of a given doctrine” (Delbridge 1981, 1381). However, such simple concretizations have been questioned, and its uses for both negative and positive persuasion have been examined in depth (Marlin 2002), though they are outside the scope of any discussion here. The real art of the Nazi propaganda machine, under the leadership of Dr. Josef Goebbels, was the appeal to the masses, which it used with frightening effect. Obvious and unsubtle examples of the propaganda of the time can be seen in the vitriolic messages used to indoctrinate the populace about Jews and other “subhumans” (Untermenschen), such as Gypsies and Slavic people. However, for the purposes of this book, we must discuss the role propaganda played in swaying the minds of nurses and midwives, and patients and families whom they served.

Burleigh (1994) gives a detailed explanation of the role of propaganda in the “euthanasia” programs, where children and adults were killed if they were considered unfit for life and a burden on the state. Colorful posters, graphic films of disabled children and the costs to society of their care were exhibited, and carefully choreographed visits to institutions where the most visibly disabled children and adults were orchestrated. These tools were part of the propaganda that portrayed the mentally ill, disabled, alcoholic, and those with epilepsy and a range of other conditions as dehumanized so the populace would regard them negatively. As well as categorizing people as a burden, the message also described them as being beyond hope, and suffering—ergo, better off dead. Doctors and
scientists lent credibility to the message with statements about the benefits, such as relieving suffering. Nurses and midwives spread the messages and encouraged families to put their disabled family members into institutions, which led to them being killed, and some actively encouraged parents to have their children killed (ibid.; Benedict, O’Donnell, and Shields 2009). The Nazi message described these people as inhibiting the war effort through use of resources that could be better used by soldiers at the front, and school children were given arithmetic exercises that used calculations of the cost of keeping disabled people alive. Popular films were shown in cinemas about “mercy killing”. The propaganda language included terms such as “useless feeders”, “life unworthy of life”, and “mercy killing” (Burleigh 1994).

Consequently, the whole populace was subjected to these messages, and it would not have been possible for nurses and midwives to avoid them. However, Mosse and Leeden (1978) argue that the theatre and ritual that were such a strong and overt part of fascist and Nazi movements were stronger than the propaganda messages. If strength, youth, health, wholesomeness, and the primacy of the race, nation, and leader are constantly reinforced through ritual, mass rallies, and theatrical events, then the propaganda will be better absorbed and its messages internalized. Nurses and midwives were caught up in the propaganda of the time, though some were able to resist it (Benedict 2006).

1.3 INTRODUCTION TO NURSING DURING NATIONAL SOCIALISM:

In Germany, Austria, and occupied Europe during the years 1939 to 1945, approximately three hundred thousand people became victims of the different forms of “euthanasia” killings under the National Socialists (Nazis) (Faulstich 2000; Jaroszewski 1993; Winkler and Hohendorff 2010). About seventy thousand of these people in psychiatric asylums, 60 percent of them with the diagnosis of schizophrenia, were killed by carbon monoxide in six killing facilities (Rotzoll 2010a, 2010b). The first systematic mass destruction of people under National Socialism was named “Aktion T4”, (T4) after the street address of the central government agency in Berlin, Tiergartenstraße 4. Aktion T4 was a centrally coordinated mass murder of patients in asylums and of residents in nursing homes for disabled people (Heilerziehungsanstalten) (Friedlander 1995; Klee 2009). On August 24, 1941, after the public protest of the bishop of Münster, Clemens August Graf von Galen, Aktion T4 was abruptly interrupted (Benedict, O’Donnell, and Shields 2009). Nevertheless, the killings of sick persons continued even after the end of the World War II in special pediatric wards (Kinderfachabteilungen), in “hunger houses” (Hungerhäuser), and in specialized asylums (Faulstich 1998). The killings of Soviet psychiatric patients by the SS
strike force (SS-Einsatztruppe) under the leadership of the German army (Wehrmacht) remain largely unknown (Winkler and Hohendorff 2010). The killing of patients was intertwined with the killing of other minorities and the Jewish population in the Holocaust.

Nurses were a vital part of these murders, making killing part of their everyday practice and participating in the execution of patients (Benedict and Kuhla 1999; Foth 2012). Although nursing has traditionally been regarded as a caring profession, nurses actively and intentionally killed thousands of their most vulnerable patients—children and adults with mental and physical disabilities—and these killings occurred within the not-too-distant past. While a large body of scholarship about the roles of doctors and medicine in these crimes exists, until now, nurses and nursing have been largely ignored. A small body of research in the history of nursing has explored how the caring professions of nursing and midwifery could become not only supporters of a government’s murderous policy but also its enthusiastic implementers (Steppe 1991, 1992, 2001, 2006; Steppe and Ulmer 2001; Benedict and Kuhla 1999; Benedict, O’Donnell, and Shields 2009; McFarland-Icke 1999; Hoskins 2005; Schweikhardt 2008). This book uses existing research to support the exegesis of nurses’ and midwives’ actions and decisions that led to their participation in one of the most heinous crimes in history. In short, nurses and midwives came to see killing their patients as a legitimate part of their caring role.

An important point to make at the beginning of this book concerns the use of the term “euthanasia”. Euthanasia in its truest sense means “a good death”, and has come to describe what, in the vernacular, is called “mercy killing”. There was nothing good or merciful about how these people died; however, the abundant propaganda produced by the Nazis tried to convince people that the term in this instance was correct. Hence, the programs have come to be known as the “euthanasia” programs. We retain this usage throughout this book, but put quotation marks around each use of the word to remind readers of its chilling inappropriateness.

One theory about how this came about has been to blame the specific situation in Germany at this time, because nursing was neither a well-organized nor a powerful profession prior to World War II. Lack of strength through a unified professional organization, according to this argument, was likely a strong factor in determining the behavior of nurses during the “euthanasia” program, in that there was no professional policy against the killings nor was there an organization that would have supported those who objected to them (Steppe 1991, 1992, 2001, 2006; Burleigh 1994; Benedict and Kuhla 1999; McFarland-Icke 1999). Indeed, compared with the historical evolution of nursing in countries like the US, nursing followed a very different tradition in Germany. From the nineteenth century on, the Catholic and Protestant churches dominated German nursing under the specific organizational form of the motherhouse.
Setting the Scene

According to the Christian ideal of care, nursing was considered not a job but rather a vocation (Kreutzer 2010). Women in the motherhouse subordinated their lives completely to the service of the community and to the care of the sick. The motherhouses demanded absolute submission to the will of the pastor, who was the director of the motherhouse. The large motherhouse sisterhoods of Caritas (from the Catholic Church), the Inner Mission (from the Protestant Church), and the German Red Cross dominated the nursing vocation in Germany. In the US, by contrast, a professional strategy emphasizing efficiency, standardization, and scientific management began to characterize the development of nursing in the nineteenth century, and deaconess institutions, such as those in Germany, remained marginal (ibid.). From this perspective, German nurses appear powerless, and the fact that National Socialists were able to reorganize nursing without protest seems to be an indication of a lack of professional identity and strength.

However, newer research highlights that patients were being assassinated before and after the Nazi regime (Faulstich 1998, 2000; Foth 2012), and therefore it would be misguided to explain the involvement of nurses in these killings merely by the particular state of their professional organization under the Nazi regime. Furthermore, to reduce the participation of nurses in the killings of hundreds of thousands of their patients to a lack of strength of a unified professional organization, a deficient education, and a subordinated position to physicians implicitly reproduces the defensive strategy used by perpetrators after the end of the Nazi regime (Benedict, Caplan, and Lafrenz Page 2007; Schoska 2008). Nurses involved in the killings of patients argued after 1945 that they just obeyed the orders of physicians and that they had no choice. In order to understand the role of nurses in the killings of their patients it is necessary to analyze the complex interplay of discourses, politics, and practices of active, affirmative participation (Benedict and Kuhla 1999; Benedict and Georges 2006; Benedict, Caplan, and Lafrenz Page 2007).

Since the 1990s, historical studies have emphasized the broad spectrum of participants in Nazi Germany (Wildt 2007; Bajohr and Wildt 2009). Canadian historian Robert Gellately (2001, 2009) highlights that the Nazi regime functioned foremost because Germans voluntarily denounced citizens whom they perceived as dangerous to the community (Volksgemeinschaft). He thereby deconstructs the myth of the omnipotent state apparatuses. This kind of research tries to “explore the territory of active participation”, the “own-active participation of the many” (Lüdtke 2008, 20).

The question of “the own-active participation of the many” is still not a satisfactory explanation for nurses’ participation in the murder of their patients. A first step to achieve such an answer would be to analyze, in detail, the organizational forms of nursing since the nineteenth century and to focus on the question of whether nurses were simply a “powerless
profession” or if they must rather be seen as both powerless and powerful. Such a perspective enables an analysis of the impact of nurses on the health policies, not only during the Nazi regime but also in modern societies. This is the topic of Chapter 3.

REFERENCES


Linda Shields and Thomas Foth


2 Fertile Ground for Murder

Susan Benedict

2.1 INTRODUCTION

In order to understand how euthanasia could be an acceptable and sanctioned practice, it is necessary to know of the evolution of eugenics—the “science” of developing a superior “race”. Nursing would become a profession that was key to the successful implementation of the “euthanasia program” of Nazi Germany.

Eugenics was the basis for the race hygiene philosophies that led to nurses and midwives becoming involved in one of the greatest crimes in history. To understand their involvement, one must understand the context of eugenics as implemented by the Nazi regime. This chapter details the development of eugenics, and the way it underpinned the actions of the German society and, in particular, nurses, midwives, and doctors who served that society.

2.1.1 Eugenics: Blueprint for a Perfect People

In 1869, Francis Galton, an English psychologist and cousin of Charles Darwin, published *Hereditary Genius*. Galton postulated that “incompetent, ailing” people were a threat to society because their children were “impoverished, sick, and miserable”. These people were to be encouraged, or even compelled, to have fewer children, whereas upper classes should be encouraged to have more children. It was Galton who introduced the term “eugenics”, meaning “good birth” in 1883 (Heberer 2001). This eugenics movement sought to apply the scientific principles of natural biology to human society with the stated goal of improving and strengthening the human race. In 1895, a German eugenicist, Dr. Alfred Ploetz, published *The Excellence of Our Race and the Protection of the Weak*, in which he argued that the protection of the weaker members of society was threatening the quality of the race (Lapon 1986). Also in 1895, a German psychologist, Jost, from Göttingen, published *Das Recht auf den Tod* (*The Right to Die*).

In the early part of the twentieth century, the eugenics movement gained momentum in Europe and in the US. In 1904, the *Archiv für Rassenkunde und Gesellschaftsbiologie* (Archives of Race Theory and Social Biology) was founded by Dr. Ploetz and was the main journal of the eugenics movement.
in Germany. In the following year, he founded the Gesellschaft für Rassenhygiene (The Society for Racial Hygiene) (Müller-Hill 1988). It was Ploetz who introduced the German term, Rassenhygiene (racial hygiene) in 1895 (Heberer 2001). In the same year, the Carnegie Institution established a biological experiment station at Cold Spring Harbor, New York.

In 1907, the world’s first compulsory sterilization law was passed in Indiana and applied to “confirmed criminals, idiots, rapists, and imbeciles” who were confined in state institutions (Lapon 1986). Meanwhile, the eugenics movement was growing in Europe. The English Eugenics Education Society had over one thousand members by 1914, with branches throughout the United Kingdom. A Eugenics Society was established in Russia in 1919 and in Belgium in 1920 (Mehler 1988). The First International Congress of Eugenics was held in London in 1912. Leonard Darwin, son of Charles Darwin, directed it. Winston Churchill served as vice president of the Congress. A second international congress on eugenics was hosted by the American Museum of Natural History in New York in 1921. Over three hundred delegates from many nations attended, including Herbert Hoover, and Alexander Graham Bell, who served as honorary president of the Congress (ibid.). Eugenics was so accepted that it was taught at such US universities as Columbia, Harvard, Cornell, Brown, Wisconsin, Northwestern, and others by 1914 (Lapon 1986).

In 1922, H. H. Laughlin, the expert eugenics agent of the US House of Representatives Committee on Immigration and Naturalization, published the Model Eugenic Sterilization Law. It was this model law that formed the basis for sterilization laws in the US as well as for the sterilization law eventually passed in Germany in 1933 (quoted in Lapon 1986). Among those subjected to compulsory sterilization were the socially inadequate classes, regardless of etiology or prognosis . . . are the following: (1) Feeble-minded; (2) Insane (including the psychopathic); (3) Criminalistic (including the delinquent and wayward); (4) Epileptic; (5) Inebriate (including drug habitues); (6) Diseased (including the tuberculous, the syphilitic, the leprous, and others with chronic, infectious, and legally segregable diseases); (7) Blind (including those with seriously impaired vision); (8) Deformed (including the crippled); and (10) Dependent (including orphans, ne-er-do-wells (sic), the homeless, tramps and paupers. (Ibid., 79)

A blueprint for the horror on the horizon for people not genetically, mentally, or physically “desirable” was apparent in Hitler’s Mein Kampf, published in 1925.

Far-reaching and important decision will have to be made. It would be doing things by halves if incurables were given the opportunity of infecting one healthy person after another. This would be that kind of humanitarianism which would allow hundreds to perish in order
to save the suffering of one individual. The demand that it should be made impossible for defective people to continue to propagate defective offspring is a demand that is based on most reasonable grounds and its proper fulfillment is the most humane task that mankind has to face. Unhappy and underserved suffering in millions of cases will be spared, with the result that there will be a gradual improvement in national health. A determined decision to act in this manner will at the same time provide an obstacle against the further spread of venereal disease. It would then be a case, where necessary, of mercilessly isolating all incurables—perhaps a barbaric measure for those unfortunates—but a blessing for the present generation and posterity. The temporary pain thus experienced in this century can and will spare future thousands of generations from suffering (Hitler 1925, 146).

In July 1933, only a few months after Hitler seized power, the first law affecting people diagnosed with psychiatric conditions was passed. The Law for the Prevention of Offspring with Hereditary Diseases (Das Gesetz zur Verhütung erbkranken Nachwuchses) mandated sterilization for people with hereditary disorders such as hereditary epilepsy, schizophrenia, mental deficiency, Huntington’s chorea, hereditary blindness and deafness, certain birth anomalies, and severe alcoholism. More than 350,000 patients were sterilized in Germany between 1934 and 1939 (Burleigh 1994). A commentary on the law by Gütt, Rüdin, and Ruttke in 1934, Gesetz zur Verhütung erkranken nachwuchses vom 14.7.1933, stated that

the law should be seen as a clean break with the debris and faintheartedness of an outmoded Weltanschauung (philosophy of life), and the exaggerated suicidal compassion of past centuries. There is, however, something else which has achieved importance as a basic principle of the law. That is the primacy and authority which the State has conclusively secured for itself over life, marriage and the family. (Quoted in Meyer 1988, 576)

Thus did the continuum of elimination begin: from sterilization of people deemed unsuitable for reproducing to the murder of people who were devalued by German society. The next section explains eugenics in detail.

2.2 THE EUGENIC MOVEMENT IN GERMANY
Alison O’Donnell, John Drummond, Murray Simpson, Susan Benedict, and Linda Shields

2.2.1 A Brief History of Eugenics
German nationalism had long entailed a strong sense of moral, physical, and cultural superiority, which easily translated into racist, and particularly
anti-Semitic feelings during the 1920s and 1930s. As early as the 1850s, Comte de Joseph Arthur Gobineau (1816–1882) published his Essay on the Equality of the Human Races (1853–55) (1967), which attempted to place traditional racist attitudes on an academic footing through a selective reading of world history. He claimed to have demonstrated that race was the driving force of history and, in opposition to Darwinism, argued for fixed, pure racial stereotypes. Of these, the “Aryan” type claimed to be superior, and marriage between races was denounced as a form of “pollution” that undermined the natural hierarchy (Biddiss 1970).

Although not widely accepted in academic circles until the 1890s (Mosse 1978), Gobineau’s work created an intellectual climate in which anti-Semitism and a belief in Aryan superiority came to be regarded as the norm. With a handful of notable exceptions, cultural and anthropological researchers in Germany emphasized the unique identity and history of the German Volk, gradually adopted the notion of the Nordic or “pure Aryan”, and began to cast the Scandinavians in the role of archetype.

Weindling (2004) emphasizes that much medical and political thought in Germany prior to World War I derived from eugenic theories associated with Charles Darwin’s theory of evolution. Yet the original theory, that of the process of “natural selection”, was often lost from the critical academic debate of the time. But the idea of being able to manipulate the survival of the most desirable human qualities was further developed through the teachings of eugenics founder and cousin of Charles Darwin, Sir Frances Galton (1822–1911) (Porter 1997).

Galton had suggested the term “eugenic” in 1883, taking his inspiration from the American social Darwinist Herbert Spencer. Galton further developed his theories while working in the overcrowded slums of London in the late nineteenth century. Here he observed the rise of what he perceived as an underclass, “an undesirable” race, and from these observations he began to formulate a theory relating to heredity. Galton believed that improvements in the human race could be obtained by “selective breeding” (Weindling 1989), rather than by the natural course of genetic inheritance. As this term began to be incorporated into the academic debate at this time within the scientific community, its use by doctors as advocates of social hygiene had, as Weindling (1989, 67) notes, “authoritarian” and ultimately “murderous implications” (Cowan 1977, 133).

Baly (1995) proposes that Galton supported the view that Mendelian law be applied not only to physical characteristics but also to human intelligence and, ultimately, ominously to fecundity through compulsory sterilizations (Burleigh 1994). Galton began to suggest that those who have influence in society—namely, medical men—support the notion of social purity and racial hygiene through therapeutic and medical intervention, thereby preserving the hereditary worth of a race. In 1904, Professor Albert Ploetz (1860–1940) founded the German Society for Racial Hygiene in Berlin. This organization began to fund racial hygiene “chairs” in most of the
prominent medical schools (Proctor 1986; Weindling 1989). The tenet of “racial hygiene” began to be widely supported as physicians sought to halt what they perceived as the biological and psychological deterioration of the German Volk (Franzblau 1995). Thus the intellectual and political ethos of Weimar Germany was fertile ground in which to foster eugenic attitudes. Many of the ingredients of fascism were taken from the racial and anthropological theories that had emerged in the wake of Darwinism and the pioneering genetic studies by Mendel and Galton.

The leading German fin-de-siècle exponent of social Darwinism, Ernst Haeckel, irrevocably united the state, the individual (blood), and nature (soil) in a way that laid the foundations for the ardent nationalism of the post–World War I years (Holmes 2007). Gasman argues that although traditionally regarded as a progressive liberal, Haeckel’s monistic organismism embodied the principles of German National Socialism to the extent that it can justifiably be called “proto-Nazi” (1971, xiv). This same author observes that Haeckel sought authoritarian solutions to Germany’s problems, was anti-Marxist, anti-Christian, anti-Semitic, and fervently nationalist, and actively supported German imperialistic aspirations. He was immersed in the German tradition of romantic idealism, but subscribed to a positivistic science in which all existence was subsumed under a monistic materialism. In Haeckel’s view, the inner world and the outer world are bound together in a single unity, and intuition is capable of grasping the essential reality of the whole; this totality was seen as evolving along a natural pathway that would maximize the realization of human potential. It is noteworthy that both these claims resurface in the work of Martin Heidegger during the 1930s (Koonz 2003).

Just as Fichte had done a generation earlier (Gasman 1971), Haeckel regarded Germany as capable of attaining the highest possible cultural form and its people of reaching the pinnacle of human achievement. Darwinism indicated the conditions under which this was possible—namely, competition, struggle, and the survival of the fittest. Gasman suggests that Haeckel’s Darwinism “became one of the most important formative causes for the rise of the Nazi movement” (ibid., xxii), endorsing the fascist emphasis on “blood and soil” and leading biology to collude in the horrors that were to come.

Proctor (1988, 340) does not share this interpretation of Haeckel’s role, and points out that “his ideas were later to find disfavor among some Nazis”. Nevertheless, Proctor notes that the peculiar character that Haeckel’s work imparted to German Darwinism was

a pseudo-scientific religion of nature worship and nature mysticism combined with notions of racism. It was based on both the social Darwinian ideas of Haeckel and the ideology of Volksism which was related to and largely inspired by his writings. (Proctor 1988, xxiii, original emphasis)
Volkism was, in turn, the chief single source of inspiration for the political program that brought Hitler to power. It is of interest here because it subsumed conceptions of health and disease and, hand-in-glove with eugenics, underwrote the creation of progressively more radical racial hygiene measures, which paved the way to the horrors of the “final solution”.

Alongside the development of this particularly explosive atmosphere, there emerged the technical knowledge upon which eugenics was based. The study of human genetics in the wake of Darwin, Mendel, and Galton, the interplay between the development of evolutionary theories, human genetics, and eugenics has been described by Shipman (1994). Throughout the closing years of the nineteenth century, human heredity had been studied by mapping the occurrence of particular defects, syndromes, and physical characteristics across generations and among relatives. In the US, the genealogies of two families, the Jukes and Kallikak families, had been carefully mapped and criminality “proven” to be inherited, by Richard Dugdale in 1874 and H. H. Goddard in 1912, respectively (Proctor 1988). Both of these American works were translated into German. Proctor notes that German racial hygienists also founded their own racially biased families—the Zero, Victoria, and Markus family trees—each of which recalled a similar story to those of the Jukes and Kallikak families (ibid.).

Additionally, in the early part of the twentieth century, German physicians claimed to have discovered the hereditary nature of many psychiatric conditions. Findings were interpreted and explained not only in genetic terms but also by using the degeneration theories that had originated with Benedict Augustin Morel (1809–1873) in France. Substandard genetic material was accepted as the direct cause of most forms of physical disability, mental illness, and intellectual handicap, and by the 1920s this extended to all manner of criminal, addictive, sexually abnormal, or socially undesirable behavior (Koonz 2003). The establishment of these restrictive criteria was also applied to the elderly (O’Donnell et al. 2009). However, as the diagnostic net was being cast ever wider and the numbers of people being treated and the cost of treating them was spiraling, eugenic policies seemed the only solution to an increasingly difficult fiscal crisis. The findings of the German psychiatrists also fuelled the popular belief that the quality of the nation’s genetic pool had been struck a mortal blow by World War I losses, and was rapidly deteriorating. Once again, eugenics seemed to offer a rational solution. The ubiquitous dissemination of these views in German social, political, and academic life during the late 1920s and early 1930s is detailed by Koonz (2003).

This same author demonstrates that there was no part of German life or society that was not subject to the “new moral order”; kindergartens, schools, youth groups, workplaces, the home, clubs, the judiciary, the army, associations, and social events all were increasingly influenced and directed by racial propaganda (ibid., 16). The emergence of scientific genetics created the possibility that mankind could shape history by actively intervening in
its own racial development. Eugenicists grasped this possibility and invited Germans to become masters of their own destiny in a new and powerful way. In the context of rigid social discipline and fanatical militarism, the individual and the individual differences of the people were subordinate to the greater good of the state. This ethos was to prove irresistible to political extremists and ruling elite alike. Under the crushing conditions of the post–World War I years, and with the emergence of a charismatic leader who could rekindle and harness these passions and the sense of discipline to a vision of a new and greater Germany, it was but a short road to war and the Holocaust.

It was the crisis of defeat in World War I that Weindling (2004) singles out as the most important catalytic factor in the development of the German eugenic movement and its subversion to Nazi political ends. Defeat brought with it not only a profound malaise and sense of bitterness but also an all-encompassing economic crisis. This urgent situation plunged the majority into a new and frightening poverty, and created a huge and expanding underclass of unproductive and demoralized people. The sense of predicament was exacerbated by the proliferation of itinerants, Gypsies, and “cosmopolitans”, and by the increasingly high national and international profile of Jews and Bolsheviks. There was a perception that various forms of “degeneracy”, including alcoholism, prostitution, criminality, mental illness, and feeblemindedness, were increasingly out of control. Many people questioned the wisdom of providing burgeoning health and welfare services out of the dwindling state purse.

The populace faced starvation and illness, and soaring mortality rates created a mood of pessimism and alarm (Evans 2003). Urgent action was thought to be required to check the epidemic of degenerative symptoms, including the falling birthrate among those sections of society on whose future Germany depended, and a rising birthrate among the counterproductive sections. Concern over the quality as well as the quantity of Germany’s population was fuelled by the view that the best of the nation’s genetic pool had been sacrificed in the war, and that its future survival depended upon taking decisive action. The various economic events of the 1920s were largely attributed to the punitive conditions of the Treaty of Versailles, and this intensified nationalist fervor. Many people were already preparing for another war, which would unite the Vaterland, eliminate anti-Germanic elements, and so break the Versailles yoke. The impending war would allow the economy to be regenerated and create “the Lebensraum, the breathing space” Hitler so eagerly sought (Domarus 1990, 338).

Thus support for eugenics came from politicians pursuing ultranationalist racist policies, concerned about the future of the nation’s genetic vigor, the falling birthrate, and the spiraling costs of health and welfare programs. It came from anthropologists, convinced that the Nordic type was the superior form to which patriotic Germans should aspire; from cultural historians, who revitalized heroic and romantic nationalist myths. Psychologists
subscribed to a social psychology based on national and racial difference, as well as biologists, who believed in innate inequalities between individuals and races and warned of the dangers of miscegenation. Philosophers preached holistic theories in which personal meaning was to be found by submitting to the greater designs of the state. In medicine, doctors saw no other way to control the epidemic of sexually transmitted diseases, disabilities, and degenerative conditions, while women’s rights campaigners viewed eugenics as a way of obtaining appropriate birth control for women, protection from sexually transmitted diseases, and a reduction in prostitution (O’Donnell et al. 2009).

Political theorists and ideologues perceived in eugenics a practical program of racial hygiene that would gradually eliminate the Untermenschen, the underclass, while encouraging the creation of a “master race”. Economists could see no rationale for continuing to divert vast sums of money to the maintenance of counterproductive sections of society. In addition, lawyers, the judiciary, and criminologists were increasingly alarmed by rising crime rates, acutely aware of the high recidivism and the Lombrosian idea of criminal types, and concerned about inadequate resourcing of correctional facilities. In terms of the clergy, the Protestant faith viewed eugenics as a welfare measure, as an effective means of controlling immorality and crime, and consistent with its strong nationalism ethos, thinly disguised anti-Semitism (Weindling 1989). Only the Roman Catholic Church offered any sustained resistance to the development of eugenics. Burleigh notes that the Roman Catholic Church, through its welfare work of the Caritas Association, was “not entirely impervious to eugenic fashions” (1997, 132). He also explains that the Roman Catholic Church adopted “positive” and “negative” eugenic measures; some bishops and parish priests salved their parishioners’ consciences by stating that doing one’s duty overrode doing another harm.

These then were the main factors that facilitated the acceptance of the German eugenic movement after World War I. Fascism as it arose in Europe between the two world wars appeared to offer a new way of thinking and acting that diagnosed and remedied the ills of the times. It conjured an intoxicating antidote to unemployment, low morale, loss of meaning and purpose, loss of personal and national pride, and the prospect of continued social disintegration and degeneration. This ethos was further supported as the effects of the Treaty of Versailles became more apparent in the interwar years.

2.2.2 Investment in Eugenics to the Nazi Cause

As Burleigh (1994) explains, the first significant application of the eugenic philosophies arose in the work of Adolf Jost and Ernst Haeckel and came in 1920 with the publication of the Approval of the Extermination of Worthless Human Lives [Die Freigabe der Vernichtung lebensunwerten Lebens: Ihr Mass und ihre Form] by a jurist, Karl Binding, and a psychiatrist, Alfred Hoche (Evans 2003, 492). Both Evans (2003) and Burleigh
interpret that Binding and Hoche noted that there were no jurisprudential arguments preventing legislation that would allow for the termination of lives considered not worth living. The same authors explain that Binding and Hoche’s stance was primarily associated with the “forlorn” and described individuals as “useless eaters”, who sought release—that is, death—from incurable illness, and “imbeciles” who were unaware of their own existence (Burleigh 1994, 12). Hoche distinguished this termination of life from “killing”, on the grounds that the former individuals chose to die and that their termination was an act of mercy, while for the latter group, life was in any case meaningless and its termination carried no negative moral implications (Evans 2003, 145). Baader (1992, 47) considers Binding and Hoche’s text as the basis for a “therapeutic idealism” in which euthanasia is regarded as an act of healing. Hoche refers to a “ballast existence” of these individuals and points to the “social usefulness” of such a strategy (Evans 2003, 145).

German medicine was not alone in espousing these kinds of theories, as eugenic programs were also introduced in other European and Scandinavian countries, North America, and Australia. In 1907, the German medical profession drew further inspiration from the radical and pioneering sterilization program in Indiana, US (Gwyther and McColville 1989). Proctor notes that German racial hygienists not only advocated sterilization programs but also pointed to American immigration screening programs where only the “fittest” were admitted and “inferiors sent back to the European motherland” (1988, 98).

Influential academics adopted and supported these views, and such thinking occurred not only in Germany but also in the US and other countries. As Thompson (1998) notes, in the United Kingdom, the prominent birth control campaigner Marie Stopes espoused a viewpoint with a eugenic stance, stating, “For the careless, stupid or feeble-minded who persist in producing infants of no value to the State and often a charge upon it, the right course seems to be sterilization” (Stopes 1927, 42). However, some of the most radical statements about the value of these programs were offered by American and Swedish scientists (Maier 1934). Charles Davenport, for example, an associate professor at Harvard and president of the International Congress of Eugenics (ICE), made his views on the question of social engineering patently clear at the 3rd International Eugenic Congress, held in 1932:

One may even view with satisfaction the high death rate in an institution for low grade feeble-minded, while one regards as a national disaster the loss of a bold and successful aviator, or even the infant child of exceptional parents. (International Congress of Eugenics [1932] 1984, 21)

Davenport recommended at the 3rd Congress that marriage advice stations that had sprung up in Germany should be set up across America, that “future research should also focus on mate selection”, and that “a high
birth rate and high death rate . . . are nature’s method of race improvement” (ibid., 18–21). In fact, German medical authorities were envious of the eugenic policies adopted in some American states in the 1920s, especially as they related to interbreeding and miscegenation, and regretted that uneducated popular opinion precluded their adoption in Germany. However, their situation rapidly changed, and it is ironic that, as Proctor (1992, 34) notes, just as German psychiatrists were sending the last of their patients to the gas chambers in 1941, an article appeared in *The Journal of the American Psychiatric Association* calling for the killing of “retarded” children, which it described as “nature’s mistakes”.

Kater (1989) reiterates a number of key points that will help map the route that eugenics took as a practical public health strategy in Germany from the 1920s onward. He notes the desire for medical advance in the context of a positivistic, ultranationalist intellectual climate, and the perception, widely shared internationally, that German medicine was at an advanced stage of development. It was also regarded as being in a unique position to capitalize upon the advanced state of other physical sciences, especially genetics. If the science of eugenics were to move forward anywhere it would be in Germany; how it would do this was a critical issue. There was a fetishistic attitude toward experimentation linked to an unswerving commitment to the deductive method of hypothesis formation and experimental testing (ibid.). When, after 1933, the Nazi party made science its servant, and pursued knowledge in an unlimited way, medical research came to be conducted for its own sake as pure science beyond the bounds of what was necessary or ethical.

The end point of research became the point at which one could simply go no further, rather than an aim determined by ethical or rational considerations. In the pursuit of this outcome, it was considered necessary to go beyond the limitations imposed by using only animal subjects. Eventually, Nazi dogma set the agenda and the hypotheses to be tested. This occurred *ad nauseam* until “proof” was found; cause and effect became confused, and statistics were manipulated to fit the hypotheses and generate the politically correct outcomes (Holmes 2007). If this could not be done, “reasons” were hypothesized and the whole process began again, generating evermore irrelevant and grotesque experimentation. Rigid positivist science was thus gradually transmuted into scientism and eventually into a pseudo-science serving personal and political rather than scientific ends (Weindling 2004).

Proctor (1988, 290) argues that in some respects the Nazis sought to politicize science and that “Nazi racial science represented a revolt against the liberal ideal of value-free science”, but that it also involved a particular type of depoliticization. The Nazis, writes Proctor,

depoliticized science by destroying the possibility of political debate and controversy. Authoritarian science based on the “Führer principle”
replaced what had been, in the Weimar period, a vigorous spirit of politicized debate in and around the sciences. The Nazis “depoliticized” problems of vital human interest by reducing these to scientific or medical problems, conceived in the narrow, reductionist sense of these terms. The Nazis depoliticized questions of crime, poverty, and sexual or political deviance by casting them in surgical or otherwise medical (and seemingly apolitical) terms. Confronting crime with the knife of the surgeon, justifying genocide on the grounds of quarantine, racial hygienists allowed a reductionist biologist to obscure the political character of social problems. (Ibid., 293)

By these means, the Third Reich made “medical science into an instrument of political power—a formidable, essential tool in the complete and effective manipulation of totalitarian control” (Alexander 1948, 16).

Initially, the eugenic strategy had involved legal compulsory sterilization, and Baader (1992) estimates that 200,000–350,000 people were sterilized during the 1920s and 1930s. In the transition to war, this gave way to active killing. Killing centers were set up in psychiatric hospitals for the elimination of certain groups, targeting the mentally ill, epileptics, alcoholics, and sexual offenders. The program involved the murder of approximately six thousand children (Pfäfflin, Rüb, and Göpfert 1992), and more than seventy thousand patients from mental hospitals from all over Germany (Proctor 1992, 34). As O’Donnell et al. (2009) illustrate, the killing centers were the test beds for the extermination camps, and doctors and nurses were enthusiastic supporters and its most loyal agents (Burleigh 1989; Holmes 1996). Nevertheless, like so many scientists today, throughout this period “racial scientists sought to portray their work as neutral, objective science, standing above politics” (Proctor 1988).

Harrington (1996, 182) refers to Nazi medicine as “objectivity run amok”. This implementation process had key players in the production of this policy. A leading exponent of the Nazi eugenic vision, and the man Hitler charged with selling it to the German people from 1933, Walter Gross, conducted an intensive campaign of persuasion and propaganda in which individual worth was based exclusively on eugenic credentials (Schieber 1993). His work, and that of the Nazi propaganda machine as a whole, must be considered a significant factor in the widespread acceptance of the eugenic philosophy, for it was a gradual shift in thinking that traversed from race hygiene (Koonz 2003) to the thinking of genocidal anti-Semitism. Eugenics did not provide genuine scientific grounds for anti-Semitism, but it did offer a theory that could be misused to account for the supposed inferiority and dangerousness of the Jews and other victims of Nazi prejudice. As Junker and Hoßfeld point out in their review of Nazi affiliation among German geneticists, “It is well known that the link between eugenics and racism—especially in its anti-Semitic version—by National Socialism is historically contingent” (2002, 239). At the time, the scientific basis for
the relationship was readily accepted; few people actually understood the genetic science that was supposed to underlie eugenics, and that included the Nazi hierarchy. Koonz (2003) explains that Walter Gross was chosen to lead the campaign precisely because he was persuasive without recourse to the technical details; the leadership, like the general public, was impressed by his passion and earnest conviction and was not interested in the scientific credibility of his message.

Eugenics was embraced by the German people because it appeared to offer an exciting new vision that embodied their aspirations for future generations. It was a convenient justification for suppressing and liquidating those who might undermine the vision, based on the notion of a natural order in which genetically inferior people are eliminated from the gene pool. Parallel to this, eminent German geneticists Erwin Bauer, Eugen Fisher, Fritz Lenz, Theodor Mollison, and Ernst Rüdin promoted the definition of different human phenotypes; health, sanity, and intelligence were perceived as positive and superior phenotypes (böhervertig) while sickness, insanity, and mental retardation were viewed as negative attributes (minderwertig) (Müller-Hill 1992). Identification of genetic inferiority merely reflected existing antipathies, prejudices, and fears, culminating in an approach to science that had racial and eventually murderous overtones. Nurses and midwives were as influenced by this thinking as any other person in Germany.

REFERENCES


Fertile Ground for Murder


Jost, A. 1895. *The Right to Die [Das Recht auf den Tod]*.


3 Nursing during National Socialism

Thomas Foth, Jochen Kuhla, and Susan Benedict

3.1 INTRODUCTION

Nurses were a vital part in these killings, supporting them in their everyday practice and taking part in the deliberate execution of patients (Benedict 2003; Benedict and Kuhla 1999; Foth, 2013, 2012, 2011; McFarland-Icke 1999; Steppe 2001, 1992, 1991). Although nursing has traditionally been regarded as a caring profession, nurses actively and intentionally killed thousands of their most vulnerable patients—children and adults with mental and physical disabilities—and these killings occurred within the not-too-distant past. Some research in the history of nursing has thus explored how the caring professions of nursing and medicine could become not only supporters of a government’s murderous policy but also its enthusiastic implementers (Barker and Rolfe 2002; Benedict 2003a; Benedict, Caplan, and Lafrenz Page 2007; Benedict and Georges 2006; Benedict and Kuhla 1999; Berghs, Dierckx de Casterlé, and Gastmans 2007; Brush 2004; Fürstler and Malina 2004; Gaida 2006; Hoskins 2005; McFarland-Icke 1999; Reich 2001; Schweikhardt 2008; Steppe 2000, 2001; Steppe and Ulmer 2001).

One answer to this question has been to blame the specific situation in Germany at this time, because nursing was neither a well-organized nor a powerful profession prior to World War II. Lack of strength through a unified professional organization, according to this argument, was likely a strong factor in determining the behavior of nurses during the “euthanasia” program, in that there was no professional policy against the killings, nor was there an organization that would have supported those who objected to them (Benedict and Kuhla 1999; Burleigh 1994; McFarland-Icke 1999; Steppe 1992, 2001). And indeed, compared with the historical evolution of nursing in countries like the US, nursing followed a very different tradition in Germany. From the nineteenth century on, German nursing was dominated by the Catholic and Protestant Churches under the specific organizational form of the motherhouse system. According to the Christian ideal of care, nursing was considered not a job but rather
a vocation (Kreutzer 2008, 2010b, 2010c; Nolte 2010; Schweikhardt 2000–2001). Women in the motherhouse subordinated their lives completely to the service of the community and to the care of the sick. The motherhouses demanded absolute submission to the will of the pastor, who was the director of the motherhouse. The large motherhouse sisterhoods of Caritas (from the Catholic Church), the Inner Mission (from the Protestant Church), and the German Red Cross dominated the nursing vocation in Germany. In the US, by contrast, a professional strategy emphasizing efficiency, standardization, and scientific management began to characterize the development of nursing in the nineteenth century, and deaconess institutions remained marginal (Kreutzer 2010c). From this perspective, German nurses appear powerless, and the fact that National Socialists were able to reorganize nursing without protest seems to be an indication of a lack of professional identity and strength.

However, newer research highlights that patients were being assassinated before and after the Nazi regime (Faulstich 2000; Süß 2003), and therefore it would be misguided to explain the involvement of nurses in these killings merely by the particular state of their professional organization under the Nazi regime. Furthermore, to reduce the participation of nurses in the killings of hundreds of thousands of their patients to a lack of strength of a unified professional organization, a deficient education, and a subordinated position to physicians implicitly reproduces the defensive strategy used by perpetrators after the end of the Nazi regime (Benedict 2003a; Benedict, Caplan, and Lafrenz Page 2007; Benedict and Kuhla 1999; Gaida 2006; Schoska 2009; Steppe 1992, 2001; Steppe and Ulmer 2001). Nurses involved in the killings of patients argued after 1945 that they just obeyed the orders of physicians and that they had no choice. In order to understand the role of nurses in the killings of their patients it is necessary to analyze the complex interplay of discourses, politics, and practices of active, affirmative participation (Benedict 2003a, 2003b; Benedict and Kuhla 1999; Benedict, Caplan, and Lafrenz Page 2007).

Since the 1990s, historical studies have emphasized the broad spectrum of participants in Nazi Germany (Bajohr and Wildt 2009; Wildt 2007; Gellately 2001, 2009). Canadian historian Robert Gellately highlighted that the Nazi regime functioned foremost because Germans voluntarily denounced citizens whom they perceived as dangerous to the community (Volksgemeinschaft) (Gellately 2001, 2009). He thereby deconstructed the myth of the omnipotent state apparatuses. This kind of research tries to “explore the territory of active participation, the own-active participation of the many” (Lüdtke 2009, italics added).

The question of “the own-active participation of the many” is still not a satisfactory explanation for nurses’ participation in the killings of their patients. A first step to achieve such an answer would be to
analyze in detail the organizational forms of nursing since the nineteenth century and to focus on the question of whether nurses were simply a “powerless profession” or if they must rather be seen as both powerless and powerful. Such a perspective enables an analysis of the impact of nurses on the health policies, not only during the Nazi regime but also in modern societies.

This chapter starts with a brief summary of how nursing developed in the nineteenth century, with special emphasis on the organization and aims of motherhouses. Nurses in these motherhouses were in a somewhat paradoxical situation: They had few personal liberties and were subordinated to both the directors of the motherhouses and to physicians, but outside the motherhouse they provided a form of pastoral care and were considered competent employees in hospitals and parishes, where they worked primarily autonomously. Because pastoral care allowed nurses to have a commanding influence over populations, nursing had significant theoretical and powerful importance in in the governing of modern societies. At the end of the nineteenth and beginning of the twentieth centuries, so-called free sisterhoods emerged that tried to act as a counterbalance to the strict hierarchy of the motherhouse system. Nevertheless, the working and living conditions of the free sisters were shaped by the same concept of “religious calling” that influenced the lives of those in the traditional system.

The last part of the chapter outlines the attempts of the National Socialist government to reorganize nursing under different umbrella organizations, which ultimately failed because motherhouses remained the dominant organizational form for nursing. An analysis of pastoral power, however, reveals why Nazi politicians depended on the work of nurses to implement their health policies. Racial biology was an integral part of nursing discourse long before the Nazis came to power. Nurses openly supported the Nazi regime and were an important pillar of its racist policies, and thus the apparent powerlessness of a professional nurses’ organization cannot account for the special significance that nursing gained under the Nazi regime.

3.2 MOTHERHOUSE CONCEPT

According to historian Susanne Kreutzer, it was taken for granted that a “good” nurse would consider her occupation more of a vocation than a job until well into the 1950s in West Germany (Kreutzer 2008, 2010a). For nurses, nursing was not labor but service. The large motherhouse sisterhoods of Caritas, the Inner Mission, and the German Red Cross dominated nursing in Germany before, during, and after the Nazi regime. Joining a sisterhood meant that women vowed to subordinate their “lives completely
to the service of the community and to the service of the sick and needy” (Kreutzer 2008, 180). In return, the motherhouse provided training, lifelong support, and a minimal amount of pocket money.

It was during the nineteenth century that the motherhouse system developed into the dominant form of nursing organization in the German Reich, and it remained relatively unchanged well into the second half of the twentieth century. From the nineteenth century on, nurses claimed particular requirements for the education of nursing trainees and the Protestant and Catholic Churches had a crucial impact on the development of “modern nursing care” (Friedrich 2008, 52; Sticker 1960). The Protestant Church, for example, reinstalled the formerly well-known office of the deaconess that had been most popular in Protestant parishes in the Netherlands. Theodor Fliedner especially, supported by his two spouses Friederike (1800–1842) and Caroline (1808–1892), shaped a religious ideal of community-integrated service that was realized through practical charity (Sticker 1961). Although the focus of the motherhouse was on sending nurses out to work in communities, this model was not meant to be limited to the parish nurse (comparable to what we call public health nurses nowadays) but was also used for nurses working in hospitals. The motherhouses considered themselves communities for life: places of service and faith for unmarried women. Deaconesses should be “servants of Lord Jesus, servants of the sick for Jesus’ sake, and servants among one another” (Friedrich 2008, 55). Work should be regarded as charity service, based on Christian faith and not as a profession or means of livelihood (Kreutzer 2008). The parish deaconess was regarded as the “crown of the Female Diaconate” (Kreutzer 2010b, 137), and her work was based on strict boundaries. According to Friederike Fliedner, “Every Deaconess who wants to fulfill the duties of her office to please the Lord and to the contentment of the direction (of the motherhouse) in order to serve the one who suffers must be governed by the love of Christ, which becomes her inner law. Then she is less in need of external laws to guide her behavior” (quoted in Sticker 1961, 359). Fliedner described the nurse as a woman “who is always ready to serve (and therefore) will never elevate herself or try to dominate. She will do good quietly and unassumingly and will always strive to deny her own desires” (quoted in Sticker 1960, 275). At the center of the deaconess’s work stood the devotion of the missionary and the companionship of the neighbor—her curing role was not her primary function. “The noble sacred office of nursing care emerges in its whole solemnity as well as in its fullest significance at the bedside of the dying. Here, where the assistance of the physician has already found its limit, the love of the nurse is still relentlessly active to assist her sick person with caring hands and mild mind in the hour of fight and dissolution, in order to provide him with relief and comfort” (ibid., 278).
3.2.1 The Inner Organization of the Motherhouses

The motherhouses were disciplinary institutions and organized, according to American sociologist Erving Goffman (1961), along the lines of “total institutions”. A primary characteristic of the total institution is the isolation of the inhabitants from the wider community; they live within an enclosed, formally administered life and are excluded from decisions concerning their fate (ibid.). Philosopher Michel Foucault (1995a) used an abstract model of the panopticon, developed by Bentham, to analyze the functional operation of disciplinary power. The panopticon is a circular building with a watch tower in its center. Around the center is a circle of cells arranged so that every individual is accommodated alone. This individual is visible from the tower at all times, but, in contrast, the tower windows have blinds so inmates cannot see when they are observed and when they are not. Individuals gradually perceive that their behavior is under permanent visibility and observation, and eventually learn to observe themselves through the eyes of their observers and to control themselves according to imposed norms (Foucault 1995). During the eighteenth century a number of disciplinary institutions emerged that functioned according to the principles of the panopticon—for example, the men’s prison at the Port Arthur penal colony in Tasmania, Australia.

One abstract example of a panopticon is the monastery, which was based on the organizational principle of making the single individual visible and controllable. Disciplinary power functioned by measuring and, either explicitly or implicitly, evaluating the behavior of individuals according to a norm, and an aberration from this norm could be either registered or sanctioned.

The motherhouse in Kaiserswerth adopted elements of the monastic organizational principle from the Catholic sisterhood of the Sisters of Mercy (Sticker 1961; Schmidt 1998). In the motherhouse, the barracks-like accommodation enabled an all-embracing surveillance of the deaconesses that included their behavior inside and outside of work. Fliedner conceived a strict regulation; not only was the worker’s performance controlled but also her daily routine. “They were furthermore urged to regularly perform “self-inspections” by means of a questionnaire. With this technique nurses should learn to self-monitor themselves regarding their compliance with the rules and norms” (Arnold 2006, 158). This explanation described Fliedner’s definition of “the inner law” of the nurse. It also highlights that power has a productive effect; the disciplinary system in the motherhouse profoundly shaped the nurses not only because they acquired technical knowledge but also, most importantly, because they learned to develop personal attributes such as obedience and self-denial, which were considered to be the basis for nursing care understood as charitable activity.

Nevertheless, the motherhouses were one of the few institutions in nineteenth-century Germany that provided women with sound training and a
lifelong occupation, offering them a socially approved way of living and working outside marriage. Motherhouses ran their own charitable hospitals and, in addition, entered into contracts with other institutions. Kreutzer emphasizes that in this way “the influence of motherhouses extended far beyond their immediate locality” (Kreutzer 2008, 182).

3.2.2 Pastoral Power

The deaconess was considered a “Christian mother of the parish” and charged with a wide spectrum of tasks “including nursing, social service work and pastoral care or ‘care of the soul,’” to distinguish it from the work of parish pastors. At the center of the Christian understanding of nursing was “the idea of nursing body and soul together” (Kreutzer 2010b, 134; Nolte 2010). Apart from providing nursing care in the strictest sense, nurses were also to perform pastoral functions and provide patients with religious strength. Part of a Christian nurse’s obligation was to listen to the sick person, to pray with him or her, and to strengthen his or her faith (Kreutzer 2010a; Nolte 2010). The motherhouses trained nurses to work in parishes and hospitals, since they maintained their own confessional hospitals and also contracted with secular hospitals to send their nurses to work there.

The Christian interpretation of sickness assured nurses an independent, religious-based role within the German health care system. The medical fraternity in the confessional institutions had to struggle to implement their biomedical understanding of health and sickness, which was based purely on scientific concepts (Schmuhl 2003). As Kreutzer pointed out, “The great importance of nursing is documented, for example, in the by-laws of the Henriettenstiftung (one of the big German motherhouses) in which nursing care was defined as the main task of the motherhouse. Medicine, according to the self-definition of the foundation, was seen as only part of nursing care” (Kreutzer 2010a, 172). The strong hierarchical position of nurses was also demonstrated by the fact that physicians were not represented in the administration of the hospital until the end of the 1970s. The traditional administrative structure of the confessional hospitals was controlled by the theological head, as represented by the mother superior (ibid., 172). The portrayal of nursing as subordinate to medicine cannot be maintained for the confessional hospitals. Rather, physicians and nurses were considered complementary occupational groups with distinct roles in curing patients.

Fliedner’s idea for the motherhouse was to train nurses to send out as “country missionaries” to combat illness, poverty, and faithlessness, particularly in poor communities. This “inner mission” was based on the underlying assumption that material and spiritual impoverishment were closely related. “It was hoped that deaconesses, because their training was (considered) nonacademic, would have more immediate contact with the poor than pastors” (Kreutzer 200b, 137; Nolte 2008). Fliedner’s concept was
anything but apolitical. Nurses were deemed able to influence the behavior of the people they cared for due to their ability to get to know patients in their personal family settings, and due to the intimate knowledge that they gathered, available to no other professional group. Furthermore, the parish nurse was often the first contact in cases of illness and other emergencies, because the next doctor was usually far away (Kreutzer 2010b). Nurses therefore had to have trusting relationships with their patients and their families. “When they succeeded in fulfilling their various tasks and integrating themselves into parish life, they acquired a prominent position in their communities—a high social standing that was also based on their specific expertise” (ibid., 141). From this perspective, nurses in both parishes and hospitals were indispensable to the governing of modern societies, and, as will be demonstrated in the course of this chapter, Nazi politicians especially appreciated this aspect of these nurses.

3.3 THE DIVERSIFICATION OF NURSING

In the last third of the nineteenth century, the Kaiserswerth motherhouse system and confessional nursing care at large came under increasing scrutiny. Industrialization, urbanization, and the differentiation within societies led to new approaches in nursing. Furthermore, motherhouse nurses were numerically no longer able to meet the need for nurses and they were becoming less welcomed because of their allegiance to the motherhouse rather than to physicians. New organizational forms emerged, like the Protestant Deaconess Association, for example, which was founded in 1894 by pastor Friedrich Zimmer and which consciously tried to distinguish itself from the motherhouse system by its structure as a cooperative (Friedrich 2008, 55).

At the beginning of the twentieth century, so-called free sisterhoods were founded as an alternative to the motherhouse system. Their members did not establish a permanent bond with their sisterhood, and they received a salary for their work, although they were at the bottom of the salary scale. The working and living conditions of the free sisters were shaped, however, by the same concept of “religious calling” that influenced the lives of their religious counterparts. Like the motherhouse sisters, they lived in hospital residences and often worked 70–80 hours per week. It was understood that they would remain unmarried (Kreutzer 2008, 181; Schmidbauer 2002).

Against this backdrop nursing developed into an ideal occupation for “middle-class” women. The professional ethical frame was constructed around the principles of Christian, unpaid nursing care, and the main ideas of pastoral care became paramount for these sisterhoods too. Such principles were nearly identical with middle-class feminine morality. The cornerstone of “good secular nursing care” became obedience, altruism, self-denial, and humility. The development of German nursing in this way,
in which it was understood as pastoral care and invaluable, explains why it was consequently so difficult to organize around waged labor. If “self-denial is a vocational element (this is to say, it is a precondition for nursing care) it is nearly impossible to ask for something or to formulate demands in the interests of employees.” Attempts of this kind were consequently outlawed as “socialist turnovers” (Steppe 2001, 35).

Nurses sympathetic to the middle-class feminist movement (above all, Agnes Karll, 1868–1927 [Sticker 1984]) complained that the motherhouse hierarchy was too rigid, and founded the Berufsorganisation der Krankenpflegerinnen Deutschlands (BOKD) (German Nursing Association) in 1903. For these women, obtaining personal, individual “liberty” was a priority, and for them, “free nursing”, in opposition to motherhouse nursing, was an emancipatory step (Steppe 2000). Jewish nurses, too, organized into an association in 1893 in Frankfurt, and even though this association oriented itself to existing models (for example, motherhouses), it developed an independent nursing tradition that was very important for Jewish congregations (Friedrich 2008; Steppe 2006).

But the price these different sisterhoods had to pay was high: They still had to deny themselves and obey physicians. This paradoxical situation was reflected in the journals of that time, where side-by-side articles described the exploitative aspects of everyday nursing, while at the same time they waxed eloquent about the self-fulfillment a woman could realize only in nursing (Steppe 2001). Nursing as a German occupation was a paradigmatic example of the gender-specific division of labor.

Nursing in Germany was paradoxical. On the one hand, the strong emphasis on obedience as a valued nursing trait and the internalization of patriarchal civil morality provided assurance that nurses would not question the structures that made them subordinate and required their unquestioning obedience. On the other hand, nurses assumed a very powerful position vis-à-vis their patients, and within the health care system, because they mobilized a large repertoire of techniques to influence the conduct of their patients, they had acquired a distinct body of knowledge, and they possessed an independent sphere of action with respect to physicians. An historical analysis of the role nurses played in the killing of thousands of their most vulnerable patients must consider this paradoxical position of nurses in Germany. Such an analysis must also consider the significance of nursing for the government of modern societies, because it was this aspect of nursing that made it so valuable to the Nazi regime.

### 3.4 GOVERNING THROUGH NURSING

“Government” is understood here in a “nominalistic” manner (Rose 2005). It is neither a concept nor a theory, but rather a perspective that emphasizes the heterogeneity of authorities, who tried to govern the
behavior of citizens, as well as the heterogeneity of strategies and means deployed by these authorities (ibid., 55). Governmentality describes a new characteristic of governing that developed in sixteenth-century Europe. It was intertwined with the invention, operationalization, and institutionalization of specific forms of knowledge, disciplines, tactics, and technologies, which were all related to the governing of health, self, children, and state. This new rationality of governing was related to the emergence of the large territorial and administrative states and the colonial empires, as well as to the challenges to religious leadership by the Reformation and Counter-Reformation. The appearance of diverse discourses around the government of the family, the self, and the state constituted a revolutionary break with the Machiavellian conception of power, which had assumed that the power of the prince had to be guaranteed through sovereign power (Foucault 2004). Henceforward, government must be more than the “right disposition of things” because it must be concerned about the “common welfare and salvation for all” (Johnson 1995, 8). This new rationality of government (Foucault 2004) comprised several crucial features that political scientist Brown has described:

First, governing involves the harnessing and organizing of energies in any body-individual, mass, international—that might otherwise be anarchic, self-destructive, or simply unproductive. And not only energies but needs, capacities, and desires are harnessed, ordered, managed, and directed by governmentality. Governing thus concerns what Foucault calls “the conduct of conduct”—it orchestrates the conduct of the body individual, the body social, and the body politic. Second, as the conduct of conduct, governmentality has multiple points of operation and application, from individuals to mass populations, and from particular parts of the body and psyche to appetites and ethics, work and citizenship practices. Third, far from being restricted to rule, law, or other visible and accountable power, governmentality works through a range of invisible and nonaccountable social powers, of which Foucault’s best example is pastoral power. And fourth, governmentality both employs and infiltrates a number of discourses ordinarily conceived as unrelated to political power, governance, or the state. These include scientific discourses (among them medicine, criminology, pedagogy, psychology, psychiatry, and demography), religious discourses, and popular discourses. Governmentality, then, draws on without unifying, centralizing, or rendering systematic or even consistent a range of powers and knowledges dispersed across modern societies (Brown 2008, 80, italics in the original).

The “art of government” paved the way for a “science of government”. Population became the core object of governance, and political economy became its core scientific knowledge (Foucault 2004). This new form of
governing required an ensemble of institutions, processes, analyses, calculations, reflections, and tactics, which all together constitute governmentality, “a very specific albeit complex form of power” (Johnson 1995, 8). From the eighteenth century onward, expertise became a crucial part in the process of governing. Like the formalistic, bureaucratic, and administrative machinery, expertise became the foundation of political power. By now, one could govern rightly only under the condition that the liberty, or a certain form of liberty, was really respected (Foucault 2004). Furthermore, expertise had an epistemological character, because it comprised specific conceptions of how, for example, spaces, persons, problems, and objects should be governed, and it comprised specific forms of languages. Hence, all government projects included a certain element of rationalization. Political rationality and expertise performed by “experts of truth” were from the beginning intertwined (Rose 2005).

It is in this context that nursing became a vital aspect in the government of populations because of its ability to influence the conduct of conduct. As the analysis of the motherhouse system emphasized, nurses were a powerful group of experts in the provision of health care. They were in direct contact with individuals, communities, groups, and populations, and due to their subordinated, nonacademic position they were able to develop and maintain a particularly trusting relationship with people. Only nurses were able to reach into the finest ramifications of society—they possessed a kind of microscopic power. Nurses were powerful because they were able to influence and to form individuals through their interventions, and, moreover, they possessed a scientific “savoir” that was broadly accepted as true (Holmes and Gastaldo 2002). Nurses operated within a network of power relations that was on the one hand determined by society and on the other hand constituted by nurses themselves.

Nursing interventions were regulated through disciplinary and pastoral power, which distinguishes nursing from other health care professions. Pastoral power developed from the relation between a pastor (as a leader) and an individual or congregation. The pastor is thought of as a shepherd of his flock, who, while knowing every single sheep, is also concerned for the well-being of the flock. In the Western world, pastoral power developed into an individualizing form of power, which knows its subjects in great detail and is linked to expert knowledge. Holmes describes pastoral power as a power technique “which penetrates souls, decode hearts, and reveals the most intimate secrets. It seeks disclosure of unconsciousness; it penetrates the soul and acts upon it to ultimately direct it” (Holmes 2002, 86; Holmes and Gastaldo 2002).

The most important tool to generate this kind of power is confession, and the key element is confidence; the aim is to discover the inmost secrets of patients. Pastoral power produces a complete knowledge about the individual, an important element in enabling the governing of the individual. Confession is the encouragement to speak, and it is carefully stimulated
by the nurse. Fliedner’s idea of the nurses’ “inner mission” integrated the pastoral use of confession, introspection, and self-examination into the day-to-day work of nurses, and made all these characteristics an integral part of nursing care. Although at the end of the nineteenth century and the beginning of the twentieth century new forms of nursing organizations emerged, the conception of nurses as the ones responsible for the care of the soul survived, as did the idea that nursing care should be regarded more as “charity service” than as a profession or means of livelihood.

3.5 THE ORGANIZATION OF NURSING UNDER THE NAZI REGIME

For nurses, racial biology was an integral part of nursing discourses long before the Nazis came to power, as can be demonstrated in contemporary nursing journals. For example, in February 1930, a certain Dr. T. Fürst asked the rhetorical question, “Is the woman able to practically support the program of racial-hygiene?” in the nursing journal *Unter dem Lazaruskreuz*, and answered the question with “yes” all around (quoted in Gaida 2006, 30). This journal was the official organ of the German Nursing Association (BOKD) and was by no means a right-wing journal. Fürst meant by “woman” the public health nurse whom he described as “the soul of welfare” and whose task should be the clarification of the causal relationship between the “social need for help and congenital predisposition” (quoted in Gaida 2006, 30).

Not only did physicians like Dr. Fürst make an argument for the impact of nurses in the politics of eugenics, but also nurses themselves also campaigned for eugenics to be considered an urgent task for nursing. Historian Ulrike Gaida (2006) discusses an article written by nurse Minna Bahnson in 1930 in *Unterm Lazaruskreuz*, entitled “Three Requirements for Population Policy”. Bahnson noted that physician Bonne calculated the financial charges evolving from accommodation and care of “inferiors” (people with disabilities), concluding that the state had to pay more than two billion marks per year for these “sick persons” and that this money was lost because these humans were “worthless, if not even harmful” to the entire nation. For example, Bahnson noted, “in the case of the completely moronic children in Bethel [a protestant institution for the accommodation of people with disabilities and a psychiatric asylum] one can no longer speak of ‘human beings’ at all, which means it would be better if they were erased from time” (quoted in ibid., 31). Bahnson openly supported the assassination of people with disabilities in this article, providing her theoretical basis for the killings. It must be emphasized that these articles appeared three years before the Nazis came to power and nine years before the official start of the “euthanasia” killings. Nurses openly supported the Nazi regime and were an important pillar of its racist policies. As Gaida emphasized, the number of cases of people with purported potential
hereditary defects reported to the health authorities by nurses far exceeded the number of cases reported by physicians (ibid.). Nurses did so in the clear consciousness that their reports might lead to severe consequences for those on whom they reported.

Nurses played a crucial role in Nazi health policies—a biopolitical program, based on scientific assumptions, that was focused on the health not of the individual but of the people in the aggregate—the health of the “Volk”. The individual became valued only for his contribution to society in general (Steppe 1993). Those who were unable to contribute had no right to be cared for, and, in fact, society was to remove them for the good of the health of all people. Public health’s new slogan was “Vorsorge statt Fürsorge”, which literally translates into “Precaution not welfare” (ibid., 3).

In an early speech before the National Socialist Physicians’ League, Adolf Hitler argued that he could, if need be, do without lawyers, engineers, and builders, but that “you, you National Socialist doctors, I cannot do without you for a single day, not a single hour. If you don’t, if you fail me, then all is lost. For what good are our struggles, if the health of our people is in danger?” (quoted in Proctor 1988, 64). In 1934, Bavarian minister Hans Schemm declared that Nazism was nothing but “applied biology” (Proctor 1988, 64).

These quotes highlight the important part that biology and medicine played in Nazi Germany. They also emphasize the important role of physicians to Nazism, and in a talk just after the National Socialists came to power in January 1933, Adolf Bartels, the deputy leader of the Reich’s medical profession provided a blueprint of the future of nursing under the Nazis:

The requirements which German nurses in social and medical service have to meet in the new state are completely different from the previous period in many respects. The new state does not only want to look after the sick and weak; it also wants to secure a healthy development of all national comrades, and also to improve their health, if their inherited biological predisposition allows for it. Above all, the new state wants to secure and promote a genetically sound, valuable race and, in contrast to the past, not to expend an exaggerated effort on the care of genetically or racially inferior people. Of course, such people must be looked after, but no longer be supported and promoted at the cost of the more valuable people. (Quoted in Hahn 1994, 143–150)

Nurses under the Nazi regime had a biopolitical task that was openly acknowledged and propagated by Nazi politicians. Seen from this perspective, nursing became a state-supporting vocation, and this obviously enhanced the status of nurses in Nazi society. This might be one reason why nurses supported the Nazi health policy so broadly and uncritically. Nevertheless, it must be emphasized that the two recognized confessional associations differed in their attitude to the “Law for the Prevention of Hereditary Diseased Offspring” (Gesetz zur Verhütung erbkranken
Nachwuchses) that regulated the forced sterilization of so-called mentally ill patients and criminals. On the Protestant side, the central committee of the “Inner Mission” welcomed the legislation, whereas the Caritas Association of the Catholic Church dismissed it (Kaiser 2001, 56). Cases are documented in which the Catholic nurses refused to assist in these surgeries (Schweikhardt 2000–2001). However, all confessional nursing organizations supported the aims of Nazi health policy. As a Nazi politician stated,

In the future, nursing should not only be concerned with the sick and suffering, should not consist ONLY in caring for the ill, in relieving the effects of poverty or current need. It must go further. Nursing must lead the people in questions of health. A nurse is the one who should carry out the will of the State in the health education of the people.

(Quoted in Steppe 1993, 3)

The fact that nurses were to lead and educate patients in questions of health is significant. The Nazi regime well acknowledged the specific capacity of nurses to influence people’s behavior in questions of sickness and well-being, but as the foregoing suggests, this capacity was understood to be a task supporting the state. In order to carry out the will of the state nurses had to clearly understand their work as political activity based on political consciousness. The chief physician of the Rudolf-Heß-Krankenhaus in Dresden, Dr. Hermann Jensen, wrote in 1934,

With us every national comrade (Volksgenosse) must be a political soldier. I use the word “political” here very consciously even though I know that the connection between nurse and politics will be rejected in many places. . . . Because for us politics means: active participation in the life of our people’s community and active pursuit in the service of the nation. That is what is called politics! And that is what the nurse has to do with politics. Especially today she cannot deprive herself of these obligations to this end. She occupies too important a position in the frame of our people’s community.

(Quoted in Gaida 2006, 112)

The Nazi regime tried to harmonize the different German nursing sisterhoods and organizations, attempting to enforce political conformity in nursing by implementing a bundle of organizationally and bureaucratically regulatory actions. After the takeover on January 30, 1933, different National Socialist party organizations competed against each other to extend their influence on nursing, including the German Worker’s Front (Deutsche Arbeitsfront [DAF]) and the National Socialist People’s Welfare (Nationalsozialistische Volkswohlfahrt [NSV]). The NSV, which established itself against the DAF, was particularly relevant for nursing. Under the umbrella of the NSV, the National Socialist’s Sisterhood (NS Schwesternschaft)
was founded in May 1934. This organization aimed to constitute a nursing elite in order to translate the goals of the German National Socialist Worker’s Party (the party of Adolf Hitler) (Nationalsozialistische Arbeiter Partei, NSDAP) into practical actions. The NS-Schwesternschaft adopted a congregational structure from the confessional sisterhoods (Gaida 2006). Members were known as the Brown Sisters (Braune Schwestern) because of the color of their uniforms. The Braune Schwestern were sworn in under the following oath:

I swear unswerving loyalty and obedience to my Führer, Adolf Hitler. I obligate myself as a National Socialistic nurse, to fulfill my professional requirements wherever I will work in a loyal and conscientious manner in my service to the people, so help me God. (Quoted in Steppe 1993, 8)

Part of their duties was community nursing, with the aim of crowding the confessional nurses out of this domain. Numerous struggles between confessional nursing organizations and the NS sisterhood flared up around the responsibility for single villages and towns. National Socialist sisterhood nurses also had to serve the party: They maintained the military hospitals of the “Protection Squadron” (for the Sturm Staffel [SS], which was responsible for the vast majority of war crimes and was the primary organization that carried out the Holocaust), and they worked in concentration camps—for example, in the women’s concentration camp of Ravensbrück—and in the occupied territories (Schweikhardt 2008). In 1942 the NS sisterhood merged with the “Imperial Association of Free Sisters” (Reichsbund der Freien Schwestern und Pflegerinnen), founded in 1936. This new organization was named the “German Nurses National Socialist Imperial Association” (NS-Reichsbund Deutscher Schwestern [NSRDS]).

Historian Christoph Schweikhardt (2008) concludes that it was much easier for the regime to bring the nonconfessional nursing associations under its control than it was for the Nazi regime to gain access to the confessional sisterhoods. As has been shown, these sisterhoods had been under the protection of the churches and their educational institutions had been established as nongovernmental institutions with a high degree of autonomy during the empire. In order to protect the way of life of the Protestant nurses, the evangelical sisterhoods merged with the deaconesses and the associated sisterhoods (Verbandsschwestern) in 1933. The new association was named the “Diaconia Fellowship” (Diakoniegemeinschaft) (Gaida 2006). In October 1937 the free Catholic sisterhoods merged into one umbrella organization named “Imperial Association of Free Caritas Sisters” (Reichsgemeinschaft freier Caritasschwestern) and constituted together with the Catholic order the “Caritas Sisterhood” (Caritas Schwesternschaft).

In 1933, the unions were broken up in Germany, and the Deutsche Arbeitsfront assumed from then on the negotiation of collective bargaining
agreements and labor legislation of the unionized “Nursing Association of the Reichssektions Public Health” (Schwesternschaft der Reichssektion Gesundheitswesen).

The Red Cross received a centralized organizational structure in order to provide a kind of ambulance corps for the Wehrmacht (Riesenberger 2002) and was aligned to the principle of the “Führer state” (Führerstaat). In 1936 the Imperial Association of Free Nurses (Reichsbund der Freien Schwestern und Pflegerinnen) was constituted, which organized all self-employed nurses. The former nursing association “German Nursing Association” (BOKD) was forced to dissolve in 1938.

In order to control the different vocations involved in delivering health services, the Nazi regime implemented in 1933 a professional umbrella organization called the “Imperial Association for Vocations and Professions in Social and Medical Services” (Reichsarbeitsgemeinschaft der Berufe im sozialen und ärztlichen Dienst [RAG]). According to Schweikhardt, one important task for this association was to bring self-employed nurses under National Socialist leadership (Schweikhardt 2008; see also Breiding 1998). Nevertheless, in 1936 the association was again reorganized and the members of this new organization were the nurses of the Red Cross, the Protestant Nurses’ Organization, the Catholic nurses, and the Federation of Free Nurses and Caregivers. This newly constituted umbrella organization was another attempt to align nursing (Breiding 1998).

The NS nursing sisterhood nonetheless remained smaller than the larger faction of nurses, who were still organized in traditional nursing associations. Until 1939 the NS sisterhood contained 10,000 nurses, but in contrast, 21,599 nurses were in the Imperial Association of Free Nurses, 14,595 in the German Red Cross, 46,500 in the Protestant Diaconia Fellowship, and around 50,000 in the Catholic Caritas Sisterhood (Schweikhardt 2008; see the statistics about membership in Breiding 1998). These numbers of nurses outside the NS sisterhood support the argument that nurses were not coerced by an omnipotent Nazi organization and clearly indicate the enormous influence of confessional nursing organizations on nursing in Germany. There was actually no need to push for the unification of nursing, because most of the nursing organizations, both nonconfessional and confessional nursing associations, did not resist Nazi politics and even openly supported fascist health policies. The influence of confessional nursing continued even after the end of World War II and into the late 1960s (Kreutzer 2010a, 2010b). The Diaconia Fellowship (Diakoniegemeinschaft), too, was sympathetic to the ideas of National Socialism and did not identify a conflict with the organization’s religious affiliation. For example, in 1934, Deaconess D. Bauer wrote that

National Socialism and Socialism are both not foreign words to the world of deaconry. The Deacon Mother Houses were always ready to serve when the nation called on her people . . . And socialism is one of
the considerations of the birth of the deaconry . . . Out of this social movement originates the thrust to serve and the duty to the community . . . the totalitarian demand of National Socialism is also a term we know well because it is something within us, although it is characterized differently . . . This totality demands struggle. Struggle is the basic motive of National Socialism. Struggle is a sign of viability. The deaconry has also fought for 100 years for its basic existence and has 54,000 nurses today . . . The Führer’s thought has been executed in the deaconry ever since the beginning . . . where discipline and obedience are promoted . . . Thus the deaconry has worked for 100 years on a National Socialistic bases and greets it with an open heart . . . The events of this world receive their significance through the Gospel, and we carry the fate of this life with strength from above. This is how our lives and our tasks receive their deeper meaning. A nurses’ association with this ideology can only strengthen a National Socialistic state. (Quoted in Steppe 2001, 82)

Nursing again underwent reform in 1938 with the passing of the first national law governing all of nursing, the “Law for the Reorganization of Nursing” (Gesetz zur Neuordnung der Krankenpflege) of September 28, 1938. This law defined nursing and set criteria for education. This first legal regulation of nursing, which introduced binding regulations for the first time in Germany, demonstrates once again the importance that Nazi politics attached to nursing. Incoming students had to have the equivalent of a junior high school education, be eighteen years of age, and had to have spent one year of domestic service in either one’s family home or that of another family, school, or public institution. Applicants had to be deemed “politically responsible” and of German or related descent, and this heritage had to be documented by providing birth certificates of both parents and grandparents (Law for the Reorganization of Nursing, 1938).

Public hospital administrators were obligated to found and maintain nursing schools, and all education was to take place in these state-recognized schools. Nursing education was under the domain of the Reich’s Minister of the Interior, and all schools were to be headed by a physician with a nurse as his/her assistant. Male and female students were to be educated separately, although they could, on occasion, attend the same courses. The mandated curriculum, which was to be eighteen months long, included such courses as “Genetics and Race Studies, Genetics and Race Care, and Population Politics” as well as “Execution of Doctors’ Orders”. Racist and eugenic thought was contained under the headings “occupational studies”, “legal issues for nurses”, or “Eugenics and racial care” in the official nursing textbooks (Reichsausschuß 1939). Other courses included anatomy and physiology, professional ethics, infectious diseases, nutrition, pediatrics, accident prevention, and health insurance. The
emphasis was to be on the practical aspects of nursing care, but the course also contained two hundred hours of theoretical content, of which at least a hundred were to be taught by physicians. Following the completion of the curriculum, graduates had to pass a state examination. Until October 1, 1940, individuals who had worked as nurses prior to September 1938 could take the examination without attending nursing school. The titles “Krankenschwester” and “Krankenpfleger” were reserved for female and male nurses, respectively, who had successfully completed their education and examination (Law for the Reorganization of Nursing, 1938). After successfully completing the requirements, nurses had to work for one year in a hospital before they were allowed unrestricted work. Apart from first aid in emergencies all nurses had to limit their actions to the execution of physicians’ orders (Reichsausschuß 1939).

This same nursing law delineated rules for Jewish nurses. Jewish nurses were allowed to practice nursing only on Jewish patients or in Jewish institutions. The education of Jewish nurses could take place only in Jewish nursing schools, and persons of German or related heritage could not be educated in these schools. Jews practicing nursing outside of a hospital were required to place a sign on their door stating “Jewish Nurse” or “Jewish Male Nurse” (Law for the Reorganization of Nursing, 1938).

During World War II, the need for nurses greatly increased in both regular and military field hospitals. Nursing schools associated with hospitals were unable to keep up with the demand, thus new types of programs were initiated. In 1940, men were able to become nurses by attending greatly abbreviated programs. The professional journal *The German Male Nurse* regularly advertised these courses, which required as few as eighty hours of theory and only three months of clinical experience (Weisbrod-Frey 1996, 113). In some instances, men were allowed to pursue their training outside of the officially recognized schools. Paradoxically, the training for female nurses increased from 1.5 years to 2 years, and the one-year obligatory hospital work period ceased in 1942. However, in February 1943, the German Red Cross (Deutsches Rotes Kreuz) curriculum was shortened to 1.5 years. To further fill the need for nurses, the “racial” requirement was relaxed in 1944 so that people with one Jewish grandparent were again permitted to study nursing.

REFERENCES


Thomas Foth, Jochen Kuhla, and Susan Benedict


Reichsausschuß für Volksgesundheitsdienst [Reich’s Committee for the Health of the people]. 1939. Krankenpflegelehrbuch [Textbook for Nurses].


4 Psychiatric Nursing during the Era of National Socialism

Susan Benedict, Mary Lagerwey, and Linda Shields

4.1 INTRODUCTION

While the previous chapter described the structure of nursing in Nazi Germany, this chapter focuses on psychiatric nursing. This is important because most of the murders were carried out in psychiatric hospitals. The chapter gives an overview of the context and background in which psychiatric nurses worked, describes the way psychiatric nurses were educated and how the specialty was affected by the Nazi laws and philosophies, and concludes with a case study of nurses at one psychiatric hospital, Hadamar, which was one of the main killing centers.

4.2 BACKGROUND AND CONTEXT: PSYCHIATRIC NURSING IN NAZI GERMANY

Stories of the individual nurses give little evidence of sadism or overt evil, suggesting that one must look elsewhere than at personal characteristics for clues to understanding nursing participation in the Nazi T4 and wild “euthanasia” programs. Instead, a close look at the organizational and value foci of German nursing in the Third Reich gives insight into the appropriation of a pivotal profession, composed mostly of “ordinary women”, yet singled out for service to the state and overshadowed by studies of medicine in much of the scholarship on health care in the Third Reich. This is evident in the Deadly Medicine Exhibit at the US Holocaust Memorial Museum (2012) and in countless publications and conferences on the Holocaust.

The preexisting structure of nursing and psychiatric care in Germany, combined with significant changes in nursing under Nazi control, made possible nursing’s involvement in murders of the disabled and others (see Chapter 3). Nursing provided one opportunity for paid work for women under the Third Reich. The curricula, values, and authoritative structure of nursing dovetailed with the eugenic, rule-based hierarchy and the emphasis of the state over the individual of the Nazi government. Although much of nursing’s and women’s roles in general was not unique in Nazi Germany, nurses were specifically targeted by the Nazi government to further the will of the state.
American historian McFarland-Icke (1999) has provided an in-depth history of psychiatric nursing in the nineteenth century and first half of the twentieth century. For much of the nineteenth century, German psychiatric nurses, then often called psychiatric attendants, both men and women, were of low status, with no formal nursing or psychiatric training. Working conditions were poor. They were expected to live at the prison-like asylums, be available around the clock, and (especially in rural areas) had virtually no privacy or personal lives. Changes came gradually, were generally opposed by psychiatrists, and were without the active support of most psychiatric attendants. In the late nineteenth century, some psychiatric institutions gave the formal title of “psychiatric nurse” to psychiatric attendants in an attempt to raise their status and improve staff retention. Unions worked to improve some of their conditions, advocating for change to improve patients’ and the public’s health (ibid.).

By the early twentieth century, psychiatric care was increasingly medicalized, as asylums took on more of a hospital atmosphere and psychiatrists gained power. Nursing hours were decreased, but nurses still were held responsible for keeping order, keeping patients involved in the institution’s activities, and preventing patients from harming themselves or others. Psychiatric literature in Germany at that time emphasized the “shared humanity among staff and patients” (and) “behavior as symptoms” (ibid., 45–46, 141–142). Psychiatric nurses were instructed to remain humble and to consider themselves no better than their patients (and far below psychiatrists). The nurses could assist and observe, but could never give an opinion or diagnose. Training for psychiatric nurses remained minimal and separate from general nursing. With no more than a high school education, individuals could apply for on-site training. Others became psychiatric nurses through in-house transfers from other departments within an institution. Psychiatric nursing remained separate from general nursing, as evidenced by the 1938 Gesetz zur Neuordnung der Krankenpflege or Law for Reorganization of Nursing, which excluded psychiatric nursing from its mandates, as it was not considered “real nursing” (ibid., 133). Psychiatric nurses had little independence, prestige, or power, and were organizationally separate from general nursing. Thus the main focus for training and regulations for psychiatric nursing practice lay within the institutions where the nurses trained and worked.

Conditions were far from ideal, but there was little in the Weimar Republic nursing milieu that would indicate the dire changes to come. Many nursing values and developments were similar to those throughout the rest of the Western world. Through the 1920s, there was general agreement among psychiatrists that it would be illegal and unethical to take eugenics as far as it had gone in the US programs of forced sterilization of psychiatric patients (ibid.). Chapter 2 describes the role that eugenics played in the actions and decisions of the nurses, and in Chapter 1, the influence of the all-pervasive propaganda—a characteristic of the Nazi regime—is discussed.

Rapid changes followed Hitler’s rise to power in early 1933. As a result of extensive propaganda aimed at the public and health care providers,
including some specific to nurses regarding the necessity of eugenics (ibid.),
eugenics gained wider acceptance. Major themes of this propaganda were
the wastefulness of providing health care to the chronically mentally ill and
the hereditary nature of undesirable physical, mental, and social traits. So-
called voluntary sterilizations soon became coerced or forced. Psychiatrists,
however, initially distinguished between curable and incurable psychiatric
patients, allowing a façade of treatment and cure (ibid.).

German historian Hilde Steppe (1992, 1993) has meticulously researched
and documented the development of nursing prior to and during the Third
Reich. In the 1990s, her publications on nurses in Nazi Germany became
available in English. According to Steppe, the year 1933 marked the begin-
ing of major ideological shifts within German nursing, with an increased
emphasis on the health needs of the nation, the Volk, even to the exclusion
of health needs of individuals and their families. Nursing also increasingly
became defined as a form of patriotic service to the Fatherland, with mili-
tary-like notions of duty and service.

It was not necessary that the majority of nurses become ardent supporters of
the Nazi regime for them to enact the will of the Reich. Steppe noted that the
majority of nurses who participated in T4 killings of patients “tried to remain
good nurses”, with an estimated less than 10 percent enthusiastic supporters
of Nazi practice (Steppe 1993). As in other spheres of public life, the state
subsumed independent professional nursing organizations, leaving the nursing
profession with no means of expressing opposing or dissenting views.

Nazi ideology emphasized traditional female traits, obedience, humility,
modesty, duty, selfless service, and loving care (Steppe 1992, 1993; Koonz
1987, 1992). Within this framework, nursing was one of the few sanctioned
areas in which women could work outside the home; it was an ideal profes-
sion for the German woman of the 1930s. Its sphere was separate from and
subordinate to the male-dominated sphere of medicine, yet could take a
leadership role in supporting goals of the Third Reich: avoiding depopula-
tion, maintaining high health standards for Aryan Germans, and identi-
fying the unhealthy (Bridenthal and Koonz 1984). Furthermore, Roman
Catholic and Protestant religious traditions, within which the majority of
nursing training and practice took place prior to 1933, reinforced nursing
as appropriate work for respectable women (Hahn 1994).

4.2.1 Eugenics and Nursing

For a detailed discussion of the role of eugenics in the development of Nazi
race policies and their subsequent effect on nursing and midwifery, see
Chapter 2. A brief outline is given here.

One central aspect of the context within which nurses practiced in Nazi
Germany was the eugenics movement and debate in the Western world
and Nazi Germany (Koonz 1992). It is clear that nurses were involved in
eugenics in the US. Records from the American Eugenics Society indicate
that nursing was singled out by them as uniquely important enough to hold a conference on May 14, 1937, on “The Relation of Eugenics to the Field of Nursing”; separate conferences addressed the relation of eugenics to medicine, education, and recreation. At this nursing conference, Charles Davenport, director of the American Eugenics Society, and nursing leaders such as Naomi Deutsch, director of Public Health Nursing at the Federal Children’s Bureau, and Lillian Hudson, professor of nursing education at Teachers College in New York City, addressed nurses and representatives of the American Eugenics Society on the importance of nurses understanding eugenic problems and on curricular guidelines for teaching eugenics. A review of National League for Nursing (NLN) Curricular Guidelines found that in 1919 it was recommended that ten hours be devoted to “Modern Social Conditions” and that this content include a focus on “feeble-mindedness . . . degeneracy” and various social ills, all central concerns of the eugenics movement (Committee on Education of the National League of Nursing Education 1919). In 1927 and 1932 eugenics was named specifically as an expected aspect of nursing curricula. In the guidelines published in these years, the “Modern Social and Health Movements” section directly addressed heredity by specifying that the history and aims of the eugenics program should be taught, along with euthenics (the study of improvement in human functioning and well-being through improvement of living conditions), and Mendelian genetics (Committee on Education of the National League of Nursing Education 1927, 1932). In 1937 the social and health movements sections are present, although without any reference to eugenics (Committee on Education of the National League of Nursing Education 1937).

Prior to World War II, professional nursing publications participated in discourses of eugenics. They portrayed eugenics as providing a scientific basis for the positive eugenics promoting reproduction among the healthy (often of northern European descent) middle to upper classes and negative eugenics encouraging limited reproduction and forced sterilization of the “unfit” (who were often poor, uneducated, and more recent immigrants) as reasonable. A review of US nursing literature, including journals and textbooks from the first three decades of the twentieth century, found that eugenic language was most prevalent in public health and psychiatric nursing texts, and in discussions of poverty, immigrants, cleanliness, and social problems. Indications of support for some aspects of the eugenics movement can be found among nursing leaders such as Lillian Wald, Mary Breckinridge, and Lavinia Dock.

Clinically, eugenics focused on two main areas, psychiatric patients and public health (Comfort 2006; Conrad 2001; Iredale 2000; Nehring 1999; Schoen 2005). Comfort (2006), in fact, noted its easy fit with public health of the early twentieth century. Both involved “surveillance and monitoring of patients and likely patients, balancing concern for the ill and the healthy, and a tension between the needs of the population and those of the
individual” (ibid., 454) and relied on the language of prevention. The argument by eugenics societies was that if eugenics was part of public health, it was a legitimate branch of medicine.

Neither the eugenic philosophy nor the nursing values espoused at the Hadamar trials were unique to Nazi Germany. The popular US movement that predated Nazi Germany’s adoption of eugenic practices became glossed over and minimized. Although the term “eugenics” fell out of favor following the abuses of the Nazi era in which negative sterilization progressed to murder of millions, legal eugenic sterilizations continued in the US into the 1970s. After the war, when knowledge of the events at Hadamar and other Nazi death centers became known to the world, the term “eugenics” faded from popular usage because of its association with the racial policies of Nazi German.

4.3 PSYCHIATRIC NURSING—EDUCATION AND STRUCTURE

The Nursing Law of 1938 did not apply to psychiatric nurses (McFarland-Icke 1999); thus their educational requirements and curricula differed from those of other nurses. Articles and textbooks dated before the war often described psychiatric nursing as requiring more than general nursing. Psychiatric nurses had to not only know diseases, conditions, and treatments but also have the physical and mental stamina to deal with potentially dangerous situations that could occur in the psychiatric setting (ibid., 50). However, for this difficult occupation, inadequate financial compensation had to be supplemented with emotional compensation such as gratitude (ibid., 51).

Attributes of ideal psychiatric nurses included patience, self-control, thriftiness, and objective observation. Later, during the war years, thriftiness became a prime virtue to the extreme as hunger diets were implemented and incurable patients were starved to death as described in Chapter 10. Government expenditures on psychiatric patients decreased, and “bed-therapy” became favored over “work-therapy” because the former required less staff (ibid., 136). Nursing the mentally ill was portrayed in propaganda as being a waste of resources (ibid., 133). The eventual implementation of euthanasia of psychiatric patients was often supported by the notion that valuable resources were being spent on the mentally ill when such resources could be better used on the mentally healthy.

4.3.1 The Education of Psychiatric Nurses

Figure 4.1 contains a description of the training and examination of the nursing staff of the psychiatric institutions in Nassau approved by the order of the Oberpräsident in Kassell on March 31, 1937 (Regulations for Acceptance, Training and Examination of Nursing Staff for the Mental Institutions in the Area of Nassau, 1937).
Regulations for acceptance, training, and examination of nursing staff for the mental institutions in the area of Nassau, 1937

1. The acceptance of trainees for caregivers is done in accordance with the need, the household (institutional) plan and the plan for positions by the Oberpräsident (administration of the area Nassau).

   The Director of the institution will submit a proposal together with the applications of the prospective caregivers to the Landeshauptmann (Division 1A). Membership of the candidates in the NSDAP or other organizations is to be reported. The proposal is to be made together with the employment offices and with the local leader of the NSDAP. In some cases, the acceptance of the trainee will be made by the Office of Employment or the administrative offices of the local federation.

2. In general the male caregivers should be at least 20 years old and the female caregivers should be at least 18. Fully trained nurses (Schwestern) should be considered for employment for every third free position. Due to the special situation in Hadamar, a more frequent percentage would be acceptable.

   Newly employed caregivers have to pass a physical examination. The applicant has to submit proof of being free of any contagious bacilli. People who are carriers of diphtheria bacilli or any intestinal tract pathological bacilli or who are suffering from contagious diseases like tuberculosis cannot be accepted as caregivers or any other position in the institution that may bring them into contact with food or water supplies.

3. The applicants will have to bring proof of their Aryan descent. Members of the NSDAP or other related organizations are to be preferred for employment.

4. In principle, all employment will have a probationary period of three months.

5. The training will take two years beginning with the first day of employment. The practical training will take place in daily service at the bedside. The theoretical part will consist of special courses held in every mental institution and will be under the constant supervision of the Director.

6. The courses will take place during the winter semester. The scheduling of the courses is left up to the Director of the institution. Every caregiver will have to attend two courses.

   State licensed nurses (Schwestern) will have to attend the psychiatric courses. They will not have to take an examination.

   Craftsmen and other personnel who will come in contact with the patients will also have to attend theoretical instruction. Craftsmen and other employees make take part in the courses for caregivers and when successfully completing the examination after two years, may be employed as caregivers.

(continued)
The instruction will take place for approximately two hours per week. Whenever possible, the instruction should take place during the hours of service. However, the trainees are obligated to attend courses during their free time if necessary except during vacation.

The courses are to be given by physicians attending the institution. The Director will assign the physician and the themes of the classes. The course should follow the official “Book for Nursing” edited by the state and Prussian Ministry of the Interior. The “Guide for Psychiatric Care” by Scholz should also be added. The trainee is expected to acquire these two books.

The following subjects are to be included:

I. General Training
   Professional duties of the caregiver. Special consideration is to be given to the laws of the state welfare offices. Care of the buildings, washing regulations.
   Anatomy and Physiology of the Human Body
   General Health and Hygiene
   Inheritable diseases
   General Health and Patient Care
   A. Building and installations of hospitals, hallway or pavilion system, furnishing sickrooms, lighting, heating, ventilation, cleaning, water supply.
   B. General illnesses: Signs and symptoms, especially fever, pulse, contagious open wounds, fractures, asepsis and antisepsis.
   C. Care of the sick, hygiene, carrying patients, positioning and bedding, bathing patients.
   D. Following physicians: prescriptions, regulations about storing medications, administering medications.
   E. Nutrition and diets
   F. Observation of patients and reporting to physicians.
   G. First aid in accidents, poisonings and other acute illnesses (management of acute hemorrhages, artificial respiration.
   I. Infectious diseases including sexually transmitted diseases, dysentery, tuberculosis, typhoid fever. Care of patients with infectious diseases. Disinfection.
   J. Helping the dying: Signs of death, treatment of corpses.
II. Training for the Care of Psychiatric Patients
   A. History of the care of psychiatric patients.
   B. Signs of mental illnesses.
   C. Care of mentally ill patients.

(continued)
D. Care of the mental patients, especially the imbecile, the paralytic, the epileptic, the restless, and the violent.

E. Social interaction and occupation for the psychiatric patient.

‘10 After completing the courses, an examination will take place for all persons accepted in accordance with ‘6 for the training. The applications should be forwarded by the Director of the institution to the Oberpräsident Administration Area Nassau. The Oberpräsident will decide about the applicants. Enclosed with the application should be the following:

1. A short handwritten curriculum vitae and a short report about their work at the institution.
2. A recommendation by the Director and a report about the participation in the training course.
3. An assessment by the Director about the status of the trainee and his qualification for the profession of caregiver.

‘11 A committee of examiners will evaluate the examinations. The committee should consist of the following:

1. The head of the institution as chairman.
2. The medical director as vice-chairman and medical examiner.
3. The head of the course instructors (the physician with the longest service hours). If the chairman is unable to attend the committee of examiners, another medical doctor or instructor should be present.

‘13 The subject and results of the examination of each candidate shall be written out and signed by every member of the Committee of Examiners. These shall be kept in the personnel files.

The Committee of Examiners will decide whether the examination was passed with Very Good, Good, or Satisfactory or if the candidate failed. The candidates’ work on the wards and at the bedside are to be considered.

‘14 If the examination has been successfully passed, a diploma should be given to the candidate. The following format is suggested:

DIPLOMA

Mr. Miss ____________________ in ____________________

has absolved the examination
for Pfleger(in) at one of the mental institutions within the area federation Nassau on ____________ (Date)

with ________________ (Grade).

___________ Date ____________ Place

Signature: Committee of Examiners

Figure 4.1 Regulations for acceptance, training, and examination of nursing staff for the mental institutions in the area of Nassau (Hessisches Hauptstaatsarchiv, file 430/12435).
In late August and early September 1938, the Examination Committee, consisting of Drs. Bernotat, Memmecke, Kilb, and Gorgass and Inspector Wierig, arrived at the psychiatric institute Eichberg to administer examinations to four female and two male members of the nursing staff. The four female members were Meta Altenkirch, Hedwig Krimmel, Meta Schill, and Katharina Weimer. The male caregivers were Ferdinand Geiger and Georg Nitze. The written examination was administered on August 30, 1938, in the women’s pavilion of Eichberg under strict supervision. Two questions were posed and one hour was allowed to answer each one.

1. Describe an epileptic seizure and what needs to be attended to as a caregiver (practical question).

2. Which illnesses are considered to be inherited in accordance with the health law of inheritance? Describe one of these illnesses (theoretical question).

The results of the written examination were judged by two of the examiners. Dr. Bernotat examined the answers and determined that all six candidates could proceed to the oral examination.

The oral examination was administered in the Eichberg conference room on September 2, 1938. It lasted from 1:00 p.m. until 2:20 p.m. Dr. Gorgass asked each candidate questions concerning anatomy and physiology of the human body. All gave satisfactory answers. Dr. Kilb posed questions about psychiatry, which were satisfactorily answered by all candidates. Dr. Memmecke asked about the duties of caregivers and laws about the profession of nursing, and these, too, were answered correctly by all candidates. Questions about political viewpoints, the history of the NSDAP, and hospital
<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 What sort of nursing staff do you employ in your institution? (For example, independent personnel with pay scale? Sisters (Schwestern) (nurses)? Red Cross Sisters (Red Cross nurses)? Brown Sisters (Nazi nurses)? Deaconesses (Diakonissen) (protestant nurses)?</td>
<td>Aside from those still in training, all are licensed</td>
</tr>
<tr>
<td>2 Independent nursing staff on pay scale</td>
<td>A. Female nursing staff</td>
</tr>
<tr>
<td></td>
<td>B. Male nursing staff</td>
</tr>
<tr>
<td>3 Do you employ licensed trained nursing staff (except those who are still in training)? Or is some of your nursing staff not required to take an examination?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Female nursing staff</td>
</tr>
<tr>
<td></td>
<td>B. Male nursing staff</td>
</tr>
<tr>
<td>Do you differentiate in your institution between fully trained nurses (Schwestern) and un-trained or not fully trained caregivers?</td>
<td>No</td>
</tr>
<tr>
<td>Between fully trained caregivers (Male) and untrained caregivers?</td>
<td>No</td>
</tr>
<tr>
<td>Is there organized training in your institution?</td>
<td>A. Female nursing staff</td>
</tr>
<tr>
<td></td>
<td>B. Male nursing staff</td>
</tr>
<tr>
<td>Is the training followed by an examination?</td>
<td>A. Female nursing staff</td>
</tr>
<tr>
<td></td>
<td>B. Male nursing staff</td>
</tr>
<tr>
<td>What are the regulations for training and examining your personnel: (State, county). In accordance with the rules licensing? In-house licensing? Please enclose a copy of these regulations and regulations by the President in Kassel dated 31 March 1937.</td>
<td>Yes</td>
</tr>
<tr>
<td>4 What are your plans for continuous training of nursing continued training of nursing staff at your institution?</td>
<td>Regular courses for continued training</td>
</tr>
<tr>
<td>5 In order to obtain a higher position within your institution (Oberschwester, Oberpfleger, Department Head) does the person need to pass a special examination or have special training?</td>
<td>No</td>
</tr>
<tr>
<td>6 What is the length of time you would propose for the training of nursing staff in psychiatric institutions? For state licensing? Are you of the opinion a training period of 1-2 years is sufficient—as stated in the regulations of September 9, 1938? Would you propose a shorter duration? Please give a short explanation.</td>
<td>According to our experience a training period of 1-½ years is sufficient. This allows the trainee to gain enough practical experience by working on the wards. During this time it is also possible to offer the necessary theoretical training through courses.</td>
</tr>
</tbody>
</table>

*Figure 4.2  Questionnaire to assess training of nursing staff in all psychiatric hospitals (Hessisches Hauptstaatsarchiv, file 430/12435).*
administration were asked by Dr. Bernotat. The candidates were not as well informed about these areas but nevertheless passed the section. The examination at the bedside of the patients was waived because the physicians had seen the candidates daily in their practice.

At the conclusion of the oral examination, the candidates were asked to leave the room while the examiners discussed the results. The clinical portion of the examination was judged to be “very good”. Despite some difficulties with the history of the NSDAP and hospital administration, all candidates received the grade “Fully Satisfactory” On February 16, 1939, the Society of German Neurologists and Psychiatrists in Dresden sent a questionnaire to assess the training of the nursing staff in all psychiatric hospitals, shown in Figure 4.2. (Questionnaire to Assess Training of Nursing Staff in All Psychiatric Hospitals, 1939).

4.3.2.1 Curriculum

Figure 4.3 shows the curriculum of a nursing course provided at Eichberg beginning on April 25, 1939, and concluding on August 1, 1939. There were twenty-two students, twelve women and ten men. Classes were held two afternoons per week, Tuesday and Friday, and were taught by the physicians of the institution (Curriculum of Nursing Course, Eichberg, 1935).

4.4 THE NURSES AT HADAMAR PSYCHIATRIC HOSPITAL: A CASE STUDY BY MARY D. LAGERWEY

We have dealt with psychiatric nursing as a separate entity here because it was the psychiatric nurses and caregivers who, along with physicians, became the professionals primarily responsible for the implementation of the Nazi “euthanasia” program in adult populations. To illustrate more effectively how psychiatric nursing became so embroiled in the Nazi “euthanasia” movement, we present a “case history” of one of the largest and most important killing centers, Hadamar Psychiatric Hospital.

On October 8, 1945, in Wiesbaden, Germany, Irmgard Huber, head nurse at Hadamar, sat in front of a US military commission, on trial for her life. She was represented by Dr. Kurt Kaufmann (National Archives and Records Administration 1980, 3). She and six others—all men—were accused of killing 476 non-German men, women, and children by lethal injections. The victims were Russians, Poles, Serbians, Lithuanians, and one Italian (Kintner 1949). Irmgard Huber was forty-five years old, had received training at the Hadamar Institute, and had worked at the Institute since 1932. She was the only woman prosecuted at the first Hadamar Trial. Specifically, Huber was “charged with obtaining the lethal drugs, being present when some of the fatal injections were given, and being present when the false death certificates were made out” (National Archives and Records Administration 1980, 4). The prosecution would argue that she
### Curriculum of nursing course, Eichberg, 1939.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Instructor</th>
<th>Hours</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 25, 1939</td>
<td>7–8pm</td>
<td>Director</td>
<td>1 hour</td>
<td>Opening of the training course</td>
</tr>
<tr>
<td>May 2–19</td>
<td>4.30–5.30pm</td>
<td>Dr. Himmelsbach</td>
<td>6 hours</td>
<td>Human anatomy and physiology</td>
</tr>
<tr>
<td>May 23</td>
<td>4.30–5.30pm</td>
<td>Dr. Hib</td>
<td>1 hour</td>
<td>Building and installation of hospitals: Hallway and pavilion systems,</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>furnishing side-rooms, lighting, heating, ventilation, cleaning waterlines</td>
</tr>
<tr>
<td>May 26–June 2</td>
<td>4.30–5.30pm</td>
<td>Dr. Stadler</td>
<td>3 hours</td>
<td>General illnesses, signs and symptoms: Fever, pulse, contagious diseases,</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>wound care, fractures, asepsis and antisepsis</td>
</tr>
<tr>
<td>June 6</td>
<td>4.30–5.30pm</td>
<td>Dr. Kilb</td>
<td>1 hour</td>
<td>Nursing techniques, cleanliness, carrying and supporting patients,</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>bedding, bathing</td>
</tr>
<tr>
<td>June 9</td>
<td>4.30–5.30pm</td>
<td>Dr. Kilb</td>
<td>1 hour</td>
<td>Reading doctors’ prescriptions, administering medications, storing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>medications, nutrition and diets</td>
</tr>
<tr>
<td>June 13</td>
<td>4.30–5.30pm</td>
<td>Dr. Kilb</td>
<td>1 hour</td>
<td>Observing patients and reporting to physicians</td>
</tr>
<tr>
<td>June 16–20</td>
<td>4.30–5.30pm</td>
<td>Dr. Stadler</td>
<td>2 hours</td>
<td>Accidents and first aid, poisonings and other acute illnesses,</td>
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<td></td>
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<td></td>
<td>management of acute hemorrhage, artificial respiration, assistance</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>during examinations and surgery, preparation of instruments and bandaging</td>
</tr>
<tr>
<td>June 23–June 27</td>
<td>4.30–5.30pm</td>
<td>Dr. Himmelsbach</td>
<td>2 hours</td>
<td>Infectious diseases, especially sexually transmitted diseases, Ruhr</td>
</tr>
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<td></td>
<td></td>
<td>(dysentery), tuberculosis, typhoid fever. Care of infectious patients,</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>disinfection</td>
</tr>
<tr>
<td>June 30</td>
<td>4.30–5.30pm</td>
<td>Dr. Stadler</td>
<td>1 hour</td>
<td>Care of dying patients, signs of death, care of corpses</td>
</tr>
<tr>
<td>July 4</td>
<td>4.30–5.30pm</td>
<td>Dr. Mennecke</td>
<td>1 hour</td>
<td>Professional duties</td>
</tr>
<tr>
<td>July 7</td>
<td>4.30–5.30pm</td>
<td>Dr. Mennecke</td>
<td>1 hour</td>
<td>General health and inheritance</td>
</tr>
<tr>
<td>July 11</td>
<td>4.30–5.30pm</td>
<td>Dr. Mennecke</td>
<td>1 hour</td>
<td>Psychiatric diseases and the history of psychiatry. Special installations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>in psychiatric institutions</td>
</tr>
<tr>
<td>July 14</td>
<td>4.30–5.30pm</td>
<td>Dr. Stadler</td>
<td>1 hour</td>
<td>Signs and symptoms of mental illness</td>
</tr>
</tbody>
</table>

*(continued)*

*Figure 4.3* Curriculum of nursing course, Eichberg, 1939 (Hessisches Hauptstaatsarchiv, file 430/12435).
Susan Benedict, Mary Lagerwey, and Linda Shields

was present at the “conferences every morning where the despicable death certificates were filled out with falsified reasons assigned as the cause of death, with spurious dates of death” (Kintner 1949, 216) and that she controlled access to the drugs used in the killings, thus “knowing and participating, aiding and abetting” in the killings” (ibid., 217). Two other nurses were also on trial, Heinrich Ruoff and Karl Willig, identified specifically in trial documents as male nurses. They were “charged with administering the fatal injections” (National Archives and Records Administration 1980, 4).

How could these nurses, members of one of the most trusted professions, stand accused of scores of murders? Were these nurses sadistic? Amoral? Enthusiastic supporters of Hitler and the Nazi Party? Nurses, though central to Nazi strategy, are often overlooked in scholarship on Nazi medicine, such as the Deadly Medicine Exhibit sponsored by the US Holocaust Memorial Museum (USHMM). This exhibit includes references to nurse Irmgard Huber, but contains little on nursing specifically (US Holocaust Memorial Museum 2012).

In this section the events at Hadamar are placed within the context of gender, eugenics in North America and northern Europe, general and psychiatric nursing in the Third Reich, the T4 and wild euthanasia programs, and ways in which Nazi ideology permeated all of health care in this society to find clues about the behavior of nurses like Huber. American media coverage of the Hadamar trial—the first US war crimes trial—is also explored for clues about the significance of the trial and the images it created. This examination gives a glimpse into the contexts within which seemingly ordinary citizens murdered those entrusted to their care. We argue that, from a vantage point of over half a century later, thousands of miles away, and a nation that has not experienced combat on its mainland for over one and a half centuries, it is not constructive to simply condemn the nurses’ behavior as unimaginably horrific and unethical.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Instructor</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 18</td>
<td>4.30–5.30pm</td>
<td>Dr. Stadler</td>
<td>1 hour total Care of the mentally ill</td>
</tr>
<tr>
<td>July 21</td>
<td>4.30–5.30pm</td>
<td>Dr. Kilb</td>
<td>1 hour total Care of the mentally ill, especially the imbecile, the paralyzed, the epileptic, the restless, and the violent</td>
</tr>
<tr>
<td>July 25</td>
<td>4.30–5.30pm</td>
<td>Dr. Mennecke</td>
<td>1 hour total Conversation with patients, occupation, social interaction</td>
</tr>
<tr>
<td>July 28</td>
<td>4.30–5.30pm</td>
<td>Dr. Mennecke</td>
<td>1 hour total The National Socialist party, political schooling</td>
</tr>
<tr>
<td>August 1</td>
<td>4.30–5.30pm</td>
<td>State Inspector Wierig</td>
<td>1 hour total Administrative duties of the nursing staff</td>
</tr>
</tbody>
</table>

Figure 4.3 Curriculum of nursing course, Eichberg, 1939 (Hessisches Hauptstaatsarchiv, file 430/12435).
The details of the trial are primarily taken from trial documents edited by Kintner (1949) as part of a War Crimes Trials Series, Staff Judge Advocate Colonel Bard’s military report and recommendations regarding the verdicts (1946), research done by Patricia Heberer (1989, 2001), and press coverage of the trials. In addition, the groundbreaking work of Hilde Steppe gives some insights into general nursing of that time, and Bronwyn Rebekah McFarland-Icke adds to this with a closer look at the unique and changing roles of psychiatric nursing prior to and during the Third Reich.

4.4.1 Context: T4 and Wild Euthanasia Programs

The killings at Hadamar began as part of the T4 program of “euthanasia” of disabled Germans. The setting for the killings was the Landes-Heiltenstalt Institute (at times referred to as Landescheilanstalt Hadamar) just outside the small German town of Hadamar in the province of Hessen. The hospital was established in the nineteenth century as a sanatorium and state hospital (Friedlander 1995; National Archives and Records Administration 1980). From October 1940 through July 1942 Hadamar was run as a T4 “euthanasia” site by a Berlin-based foundation and was one of six designated institutions in Germany for killing the mentally ill. In 1940 all of the institution’s employees were required to take an oath of secrecy, swearing not to discuss anything about the institution (Kintner 1949; Heberer 1989). About ten thousand patients were killed from January to August 1941, and an additional 3,000–3,500 from August 1941 to August 1942 (Kintner 1949). In addition, on April 15, 1943, a ward called an “educational home” was set up for mixed-race children with Jewish heritage. Children from around the Reich, from all accounts completely healthy on arrival, were sent there and killed with injections. The numbers are not known. The sanatorium was the site for the murders of an estimated 10,000–15,000 German citizens diagnosed with mental illnesses (ibid., 226).

Gassings of patients began January 13, 1941, and continued at a rate of one hundred a day until August 24, 1941, when the T4 program was officially halted. A second phase of “euthanasia,” referred to as “wild euthanasia” began in 1942 and continued into 1945 (Friedlander 1995). During this phase patients were killed with lethal injections. Many of those who had been active in the gassings had moved on to concentration camps, where they used similar means to murder camp inmates. Initially the bodies of Hadamar victims were cremated, but when townspeople complained of the smell, the town cemetery was used. In September 1942, the burial site was moved to mass graves near the institution. Similarly to the nurses described earlier, nurses at Hadamar prepared patients for their deaths, directed the entire nursing staff of the institution, and were present at the daily conferences at which death certificates were completed. They also controlled access to lethal medications and may have determined amounts of the drugs to be used.
Nurses Ruoff and Willig told the newly arrived “patients” that they were to be treated for communicable diseases and gave them fatal injections and/or oral medications. Within two hours of arrival on the wards, the patients were presumed dead. All were buried in mass graves. Approximately twenty other groups followed. Other nurses ensured that awaiting beds had fresh linen, put the arriving patients to bed in shifts, with the women and children first. The sanatorium secretary, Judith Thomas, prepared death certificates, which were completed and signed by the physician, Wahlmann. Cause of death was listed as lung disease, and dates of death were falsified by as much as a month.

In the summer of 1944 a letter from the Gau Employment Office in Frankfurt requested that some institution be appointed to care for foreign “incurable tubercular laborers”, and Hadamar was chosen. Two weeks later Bernatot (Landesrat administration councilor at Wiesbaden) visited Klein and Wahlmann (chief physician at Hadamar) and informed them that “incurable eastern workers should be transferred to Hadamar and that they should die there” (Bard 1946, 5, 45–46, 142). Seventy-five mostly Russian and Polish laborers, including fourteen women and two children, arrived from Hersfeld on June 5 or 6, 1944.

On March 26, 1945, US troops entered the town of Hadamar, and on March 29, they went to the institution. They found ten kilograms of Veronal and Luminal, powerful barbiturates (US Holocaust Memorial Museum 2012), about 550 mentally ill patients, starving patients, and only a few remaining staff (Heberer 2001). The Associated Press described the event with the headline, “Death Dungeon Seized: Crazy Folk Run Amok as Nazi Hypo Puts 20,000 out of Misery” (Boyle 1945, 1, 4).

When Irmgard Huber was arrested by US troops in March 1945, the extent of her involvement in the murders of foreigners was unclear. She was an active participant in the murders of German patients, but she and her coworkers denied that she had been involved in killing foreigners in 1944 and 1945. She was released, but was reapprehended in August 1945 when it became clear that she was aware of the killings and took no steps to stop them. The two male nurses had left the institution, but were arrested in the village of Hadamar—Willig on April 20, 1945, and Ruoff in late summer 1945. The evidence was clear that they had directly killed foreigners admitted as patients to the institution.

### 4.4.2 The Trial

The four other defendants were as follows:

- **Alphons Klein**: thirty-one years old, director of the institution and local Nazi Party leader
- **Adolph Wahlmann**: sixty-five years old, chief physician, who had been at the institution since 1942
• Adolf Merkle: thirty-five years old, clerk, who kept case histories, sick lists, and the death register
• Phillip Blum: thirty-five years old, doorman, switchboard operator, undertaker, and nephew of Klein. Blum had been an employee of the institution since before 1940 (Heberer 1989).

The seven defendants jointly faced a common charge of Violation of International Law that they,

acting jointly and in pursuance of a common intent and acting for and on behalf of the then German Reich, did, from on or about 1 July, 1944, to on or about 1 April, 1945, at Hadamar, Germany, willfully, deliberately and wrongfully, aid, abet and participate in the killing of human beings of Polish and Russian nationality, their exact names and number being unknown but aggregating in excess of 400, and who were then and there confined by the then German Reich as an exercise of belligerent control (Kintner 1948, xxiii).

All seven pleaded not guilty.

The specific ethical arguments used by the defense at the first Hadamar trial have been examined in depth elsewhere (Lagerwey 1999, 2006, 2009). The defendants, their attorneys, the health care professions of Nazi Germany, and the Nazi leaders themselves misappropriated ethical traditions of duty and obedience and the virtues of selfless service and relieving suffering, as well the centrality of individual character and prevention (Steppe 1992). These common ethical foundations for practice were distorted into rationalizations for the killings, and made possible by the “shift in the center of moral gravity” (Koonz 1992, S17) from the individual to the state, and the equation of worth with productivity and ability to contribute to the aims of the state. These changes involved replacing the individual patient with the Aryan nation as the center of care, whose well-being came first. In brief, the nurses who testified spoke of their duties to remain at their assigned posts, regardless of personal feelings. Duty lay not in relationship to individual patient needs but within the hierarchies of the institution, medicine, the Führer, and the nation. Obedience to such hierarchical authorities went hand in hand with claims of powerlessness, inadequate knowledge to judge the morality of their actions, and denial of accountability. The defense argued that the nurses were not in positions to determine whether people were as ill as they were led to believe, and whether German law that called for killing German citizens with physical or mental illnesses equally applied to killing foreigners. As nurse Kathe Gumbmann testified when questioned by the defense, “I thought it was assumed by a nurse that she followed all orders that were given her” (Kintner 1949, 143). Duties to patients were limited to so-called kindness, consisting of bringing small gifts to pediatric patients and taking care to prevent patients from knowing
they would soon be killed. In this context, their actions to make the killings go more smoothly are defined as acts of kindness preventing disruption on the ward and patients’ fear of death. The defense argued that “because great care was taken that none of the others was seen to die, nobody saw a thing of what was going on” (ibid., 234), and that, rather than criminal activity, this was an act of kindness:

Huber wished to render a last service to these people. She did not want to do them any harm. She did not even want to give them any idea that death awaited them, but wanted to do them good since they were there, and then she left them. . . . She had a clear conscience. (Ibid., 241, 241)

In the arguments about duty we see the strongest influence of the national military model for nursing; nurses were to act as political soldiers. In defense of Wahlmann, the institution’s physician, a Dr. Kupfer explained to the court, “It was further explained that everyone had to do his duty at that time. Everyone was a soldier just as though they were at the Front, and the matter had to be kept secret” (ibid., 227).

4.4.3 Press Coverage

Although the major publication of US nursing at the time, the American Journal of Nursing, did not cover the Hadamar trials (Lagerwey 2006, 2009), large city newspapers in the US gave regular and sometimes prominent coverage to the first Hadamar trial. The trial quickly became known in the press as the Case of the Hadamar Murder Factory. The New York Times, the Washington Post, the Chicago Tribune, and the Atlanta Constitution covered the trial in enough detail that one can reconstruct the importance of this trial for later trials and how the nurses were portrayed. Coverage began months before the trial started, and was often sensational. On April 9, 1945, a front-page article in the Atlanta Constitution reported that physician Adolph Wahlmann and Nurse Irmgard Huber were captured. Here Huber was described as “about six feet tall and built like a football player. She was as ugly as a witch” (Boyle 1945). Although only forty-five, she was described repeatedly in the press as elderly. The most sympathetic descriptions portrayed her as weak and powerless, the only defendant brought to tears during the trial. Throughout the trial and at sentencing, photographs and verbal descriptions showed Huber weeping. The Los Angeles Times, for example, reported, “Tearfully, she testified that ‘I worked all the time under compulsion . . . Where could I go?’” (Los Angeles Times 1945a, 6).

In subsequent news stories Heinrich Ruoff and Karl Willig were variously identified as nurses and attendants. Most of the coverage went to “head male nurse” Ruoff, who was fifty-five, described as elderly and
balding, and repeatedly characterized as emotionless in testifying to killing hundreds. One heading read, “German Nurse Calmly Admits Executing 400” (Washington Post 1945b, 4). Another article of the same date quoted Ruoff as insisting, “I never did anything wrong” (New York Times 1945, 6). At sentencing, the Washington Post reported “Ruoff and Willig . . . took their death sentences impassively” (Washington Post 1945d, 1).

From October 8, 1945, when the first Hadamar trial began, through October 15, 1945, when sentences were given, there was daily press coverage. Earlier dispatches covered discovery of the use of this institute as a killing center, arrests, and the events leading up to the trial. The Institute itself was referred to as a “shudder house” or Schauerhaus (Los Angeles Times 1945a, 1945b), a death factory (Thompson 1945), a murder factory (Washington Post 1945), a slaughterhouse (Atlanta Constitution 1945), and a starvation camp (Stringer 1945; Washington Post 1945c).

4.4.4 Portraits of the Nurses

Leon Jaworski, forty-year-old prosecutor and trial judge advocate for the first Hadamar trial, who later gained fame as the Watergate prosecutor, wrote in his 1961 book After Fifteen Years of his assessments of the three nurses. He described Heinrich Ruoff and Philip Willig as “family men . . . who at one time been active in church” (Jaworski 1961, 118). Heinrich Ruoff was the “head male nurse” (sic) and a member of the Nazi Party who had worked at the institution since 1926. Karl Willig had been an employee of the Institute since 1941, as nurse and undertaker. He had been a member of the Nazi Party since 1930. Describing Huber, Jaworski cited character witnesses who attested to her “instances of kindness in days past” and added, “I have no doubt whatever that at one time Irmgard Huber was a good woman” (ibid., 121). Huber’s defense attorney, Kurt Kaufmann, likewise characterized her as “the good spirit of that Institution to whom everyone could turn” (Kintner 1949, 241). More details about the nurses arose from the second Hadamar trial in 1947. In writing of that trial, Patricia Heberer noted that Irmgard Huber and Alphons Klein had been lovers, and he protected her from many of the direct killings, setting the stage for her to claim an “unworthy line of defense” of “see-no-evil, hear-no-evil” (Heberer 2001, 519). Their relationship also complicated Huber’s involvement at Hadamar by giving her a motivation to stay in her position as head nurse in spite of voiced concerns about the “euthanasia” practiced there. Their relationship was not mentioned in the first Hadamar trial documents nor in press coverage of the trials.

Although Institute director Alphons Klein testified that three professional nurses, Emmy Bellin, Minna Zachow, and Kathe Hackbarth (Kintner 1949), worked on the units on which the Russians and Poles were killed, and he assumed these nurses were all involved in killing the Russians and Poles (ibid.), Huber was the only female nurse charged at the first
Hadamar trial. Other female nurses were witnesses, but no other nurses were tried at that time (ibid.; Heberer 2001). Bellin and Hackbarth had been assigned to the Hadamar Institute in December 1940 by the administrators of the T4 program. Nurse Minna Zachow had worked at the Hadamar Institute since 1934. Except for a brief absence from 1941 to 1942, Margaret Borkowski had worked at Hadamar from April 1924 through the outbreak of war in 1939, transferred to Herborn, and returned to Hadamar in January 1943. Emmy Bellin had been at the institution since December 1940. Kathe Hackbarth came from Berlin to Hadamar in 1940. Kathe Gumbmann worked at Hadamar for thirteen years, from July 27, 1932, to July 7, 1945. In addition, and for shorter periods, Nurse Christina Weiland worked on this unit during the time of these killings. It is also apparent that the killings continued when Willig and Ruoff were not at the institute, and that Huber may have been more directly involved during these periods (Kintner 1949). Their testimonies were used to establish the roles and identities of the defendants and in arguments over whether the accused nurses could have resigned from Hadamar.

The prosecution, relying on legal arguments, successfully claimed that these murders fell under the jurisdiction of international law. Honing arguments that would be developed further in subsequent war crimes trials, they maintained the following:

- International law supersedes national law, including German laws.
- Hadamar was not a military station.
- Individuals were responsible for their own actions and could not simply shift this responsibility to those who gave orders.
- Those such as Huber who took leadership roles in aiding and abetting the killing could be held responsible for the killings.

Just one week later, on October 15, 1945, a six-man commission took three hours and forty-five minutes to reach its verdicts. All seven defendants were found guilty of violating international law regarding these deaths, and sentenced as follows:

- Heinrich Ruoff: death by hanging
- Karl Willig: death by hanging
- Alphons Klein: death by hanging
- Adolph Wahlmann: life imprisonment
- Irmgard Huber: twenty-five years’ imprisonment
- Adolf Merkle: thirty-five years’ imprisonment
- Phillip Blum: thirty years’ imprisonment

The sentences were approved at at least two higher levels. The American army reviewing authority approved the sentences on December 21,
Psychiatric Nursing during the Era of National Socialism  67

1945. The commanding general of the US 7th Army and Theater Commander Eisenhower approved them less than three months later, on March 7, 1946. Ruoff, Willig, and Klein were hanged a week later, on March 14, 1946. Huber was transferred to the German authorities on December 17, 1946, and sent to a women’s prison in Aichach, Bavaria, Germany (Heberer 2001).

The first Hadamar trial is important not only for the three nurses tried but also, as a United Nations War Crimes Trial—Group I, for its status as a landmark trial testing the problem of jurisdiction under international law. The trial was held after the Nuremberg Trial was scheduled, but one month before it began, at a time when little was known about health care providers’ participation in Nazi “euthanasia” and genocide. It was one of the first war crimes trials, occurring as Nazi atrocities were being discovered and covered by the US press for an audience eager to hear about Nazi crimes. As the first to try nonmilitary Germans, it further established that nonmilitary individuals could be prosecuted as perpetrators. The trial set precedence for holding accountable those who were “following orders” and were “small fry” and for legitimizing US military commissions trying German citizens. The 1945 Hadamar trial was particularly significant as it set precedence for disregarding defense claims that the Allies had no jurisdiction over actions that did not violate any existing international law and took place prior to Allied occupation of Germany (Bard 1945). The presence of high-level observers from Britain, Poland, the Soviet Army, the US, and the United Nations War Crimes Commission (UNWCC) underscored the pivotal nature of the trial (Heberer 2001). As a trial of a physician and nurses, this trial was a precursor to the Nuremberg Doctors’ Trial in 1946–1947, and was cited in subsequent press coverage of that later trial (ibid.). The 1945 Hadamar trial, however, did not prosecute nurses for the killing of mentally ill or Jewish patients. Those patients had been German citizens, and thus their murders did not fall under jurisdiction of international courts.

4.4.5 The Second Hadamar Trial

In 1947 in Frankfurt, there was a second Hadamar trial, in which twenty-five members of the Hadamar staff were charged with killing German citizens. They were tried by German jurists, and media coverage, although extensive, was primarily in the German press. At this trial, Huber was charged with slayings of fifteen thousand German mental patients, and delivered to the War Criminal Prison I in Landsberg on the Lech. Many of the nurses who were called as witnesses at the first Hadamar trial were now defendants, and other nurses were tried as well. Nurse Lydia Thomas and pediatric nurse Margerete Borkowski, who had served as witnesses during the first Hadamar trial (Heberer 2001), as well as Agnes Schrankel.
and Christel Zielke, were tried (ibid.). Defense arguments tried to lay the blame on those absent—those executed or never captured—and argued that the nurses were simply obeying orders under threat of severe punishment. The prosecution effectively argued that the only substantial threats related to the oaths of silence required of Hadamar employees. By this time the German churches and other German societies were lobbying for minimal prosecution for criminals of the Third Reich. They were unable to have these defendants exonerated, and all except one were found guilty and served “sentences ranging from two and a half to five years”. Nurse Isabella Weimer was found not guilty as she had “feigned pregnancy in order to achieve release from the killing center” (ibid., 525). Huber was sentenced by the German courts to eight years in prison. Four years later, in July 1951, the Judge Advocate Division of the War Crimes Branch recommended that Huber’s sentence be reduced to a sentence of the amount of time already served, or about six years, and in September 1951, the War Crimes Modification Board reduced Huber’s sentence from twenty-five to twelve years. She was released from prison in early 1952. On February 11, 1954, the last defendant from the first Hadamar trial, Blum, was paroled. Four other Hadamar nurses, Pauline Kneissler, Minna Zachow, Edith Korsch, and Kathe Gumbmann, were subsequently tried at the 1948 Grafeneck trial. In sentencing, the courts took into consideration their prior nursing service and the culpability of physicians who had given the orders for killing (ibid.).

REFERENCES

Boyle, H. 1945. “Crazy Folk Run Amok as Nazi Hypo Puts 20,000 Out of Misery.” Atlanta Constitution, April 10, 1, 4.


Curriculum of Nursing course, Eichberg, 1939, File 430/12435, April 25, Hessisches Hauptstaatsarchiv, Wiesbaden.


Questionnaire to Assess Training of Nursing Staff in All Psychiatric hospitals, 1939, File 430/12435, February 16, Hessisches Hauptstaatsarchiv, Wiesbaden.
Regulations for Acceptance, Training and Examination of Nursing Staff for the Mental Institutions in the Area of Nassau, 1937, File 430/12435, March 31, Hessisches Hauptstaatsarchiv, Wiesbaden.


5 The Medicalization of Murder
The “Euthanasia” Programs

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5.1 THE “EUTHANASIA” PROGRAMS

At the beginning of the Nazi era, Hitler’s sinister racial theories were swung into place. This included compulsory sterilization of those considered genetically unfit to procreate (Weindling 1992; Burleigh 1994; Friedlander 1995; Bachrach 2004). However, simply stopping the reproduction of people with mental and/or physical disorders through surgical sterilization was not sufficient to achieve the German goal of a “pure Aryan race”. Soon, the focus shifted to eliminating the people themselves, including children born with physical or developmental conditions. Especially vulnerable were patients in psychiatric hospitals who bureaucrats and many physicians considered to be consumers of valuable resources, without being contributors to the work effort. Thus, involuntary sterilization evolved into systematic killing, indeed murder, which was termed “euthanasia”.

An important event in the development of the German euthanasia programs was the publication in 1920 of a book entitled Die Freigabe der Vernichtung lebensunwerten Lebens (Allowing the Destruction of Life Unworthy of Life). Written by Karl Binding, a German judge and former president of the Reichsgericht, the highest criminal court and Alfred Hoche, a professor of psychiatry at the University of Freiburg (Noakes and Pridham 1983), this book advocated the killing of people who were considered mentally ill or mentally defective. It was within this book that the term “euthanasia” was used for the killing of people with mental illnesses who could not give consent (Lapon 1986). Binding and Hoche asserted that the right to live must be earned and justified and that those who had no capacity for human feeling were living lives not worth living, and their destruction would be humane (Proctor 1988).

Binding proposed that three groups of patients should be killed:

1. those [people who are lost because of an illness or wound, which is beyond salvation, and who, with a full understanding of their condition, have the urgent wish to be liberated and have somehow made this known (Binding and Hoche, 16).
(2) the second group consists of incurable idiots—either whether they were born that way or whether they became that way in the last phase of their suffering as a paralytic. They have neither the will to live, nor to die. (Binding and Hoche, 18).

(3) the mentally sane people who have become unconscious through any kind of event, for instance a very serious, undoubtedly fatal injury, and who, if they ever were to regain consciousness, would wake up to a nameless misery (Binding and Hoche, 20).

Hoche stated that “the disposal of the fully mentally dead does not represent any violation, any immoral act, any instinctive brutality, but rather an allowable useful act (Binding and Hoche, 38). However, under existing German law, this “elimination” was a crime.

In a Nazi party rally held in Nuremberg on August 5, 1929, Hitler stated the following:

If Germany was to get a million children a year and was to remove 700,000–800,000 of the weakest people then the final result might even be an increase in strength. The most dangerous thing is for us to cut off the natural process of selection and thereby gradually rob ourselves of the possibility of acquiring able people . . . As a result of our modern sentimental humanitarianism we are trying to maintain the weak at the expense of the healthy. It goes so far that a sense of charity, which calls itself socially responsible, is concerned to ensure that even cretins are able to procreate while more healthy people refrain from doing so, and all that is considered perfectly understandable. Criminals have the opportunity of procreating, degenerates are raised artificially and with difficulty. And in this way we are gradually breeding the weak and killing off the strong. (Noakes and Pridham 1983, 1002)

Hitler did not propose the systematic killing of psychiatric patients during peacetime because he anticipated the opposition of the German people and the churches. However, the beginning of World War II was judged to be the optimal time because the objections of the people would be lessened if many thousands of German soldiers were being killed in the war. The “euthanasia” program would be more palatable if it was conducted under the rationale of saving valuable resources for the war effort (Trial of Hans Joachim Becker 1970, 719). As early as 1935, Hitler had described his plan to initiate “euthanasia” in the event of war to the Reich doctors’ leader, Dr. Wagner (Noakes and Pridham 1983).

5.1.1 The Killing Films

As one means of producing acceptance of the idea of systematic killing of people with disabilities, movies were produced from the mid-1930s to
The Medicalization of Murder

Two silent documentaries, *Was du ererbt* (What you inherit) and *Erbkranz* (The hereditarily ill) were produced, primarily to be seen by Nazi party members and supporters (Michalczyk 1994). They were among five 16-millimeter silent films made by the Racial and Political Office (Friedlander 1995). *Erbkranz* (The hereditarily ill) was produced in 1936 and was intended to criminalize, degrade, and dehumanize the mentally and physically handicapped (Burleigh 1994). It was approximately twenty minutes long and featured physicians in white coats behind nurses who were leading a group of children with severe and obvious disabilities. The film ended with the caption “Should it go on like this? No, no, no, never!” (ibid., 184). Among the captions in *Erbkranz* were the following inflammatory statements:

> Idiots are kept alive through medical science and the sacrifices of the nursing staff—idiots who for the entire duration of their lives cannot be taught to speak or to make themselves understood.
> Feebleminded girl with a mentally ill mother. Grandfather weak nerves, father mentally ill and a feebleminded brother. Up to now this clan has cost the state 62,300 Reichsmark.
> The prevention of hereditarily ill progeny is a moral imperative. It signifies practical love for one’s neighbour and the highest respect for the God-given laws of nature. (Ibid., 186–187)

*Was du ererbt* (What you inherit) (date unknown) likewise was made under the direction of the Racial and Political Office. It, too, was a silent documentary. Among the strangest content was an accusation against women who owned dogs. *Was du ererbt* accused them of wrongly diverting their procreative instincts toward their pet dogs: “An exaggerated love for an animal is degenerate. It doesn’t raise the animal, but rather degrades the human being” (ibid., 194).

Other films were commissioned by the government. In some, patients were depicted in “before and after” treatment scenarios. Financial support and caregiving were emphasized as burdens (ibid.). One such film was *Dasein ohne Leben* (Existence without life). This film ended with the portrayal of a knowledgeable professor calling for “a merciful destiny to liberate these pitiful creatures from their existence without life” (ibid., 199).

*Opfer der Vergangenheit* (Victim of the past) was made for the public and was to socialize the people into the acceptance of the killings as “euthanasia”. In 1937, it was shown in all 5,300 theaters in Germany (Leiser 1974). The premier of the film was held in Berlin and was accompanied by a speech by Dr. Gerhard Wagner, cofounder and head of the National Socialist Medical Association, who had commissioned the film. The movie featured patients confined to institutions and a discussion of the cost of keeping them alive.
Another film, *Ich klage an* (I accuse) (1941), was seen by over fifteen million people and won a film award at the Venice Biennale (Burleigh 1994). It was based on the novel *Sendung und Gewissen* (Mission and conscience), written by Hellmuth Unger. The movie featured a young woman with multiple sclerosis who pleads for euthanasia, which is eventually implemented by her husband, a physician (Leiser 1974). The director of *Ich klage an*, Wolfgang Liebeneiner, stated that Viktor Brack (one of the organizers of the “euthanasia” programs) wanted to use the film to test the public’s response to the idea of “euthanasia”. A Security Service “Report from the Reich” documented that the film produced great interest and that it was favorably received. The security report found that most Germans approved of the film’s issues in principle, but had some reservations. However, both Catholic and Protestant churches totally rejected the notion of death by request. Some Catholic priests tried to stop parishioners from seeing the film (ibid.). Nonetheless, the overall response of physicians was positive, with younger physicians reacting more favorably than older ones. Five points emerged in evaluating the public’s response to the film:

1. In order to declare a person incurable, it is essential to convene a medical committee in the presence of the family doctor.
2. There is a question about applying euthanasia to all cases of incurable illness because some individuals are still able to work.
3. Consent of the person is essential or, in the case of mentally disabled persons, the consent of relatives must be obtained.
4. Standards must be adhered to in order to prevent abuse. In no case should the decision be left to one person.
5. Only the physician should be given the right to administer euthanasia.

(Ibid., 148)

Although *Ich klage an* had the greatest impact, other films were produced on the topic of euthanasia, including *Das Erbe* (The legacy) 1935), *Lebensunwertes Lebens* (Life unworthy life) (1934–1935), and *Dasein ohne Leben* (Existence without life) (1940–1941) (Amir 1977). *Dasein ohne Leben* (Existence without life) included footage of psychiatric patients as documentation of the limits of therapy. Accompanying remarks included the following: “How indescribably cruel it is to preserve the mentally dead as living corpses until old age” (Burleigh 1990, 15–16).

5.1.2 Devaluing the Different

As appreciation for the genetically fortunate population grew, disregard for people with discernible imperfections increased. People institutionalized because of psychiatric conditions, as well as infants and children with visible disabilities, became the focus of these hostile feelings. A particularly striking example of how psychiatric patients and people with developmental
disabilities were singled out for disdain is seen in a high school textbook. In this book, *Mathematik im Dienste der nationalpolitischen Erziehung*, a mathematics text published in 1935 and written by A. Dorner, a problem was presented for students. They were asked to calculate the annual cost of providing psychiatric care to one person (quoted in Proctor 1988, 183–184). For the general public, posters were displayed throughout Germany depicting the burden of caring for people with disabilities. For example, one such poster, appearing in *Volk und Rasse*, showed a healthy German man supporting on his shoulders the weight of disabled individuals with the caption “You are sharing the load! A genetically ill individual costs approximately 50,000 Reichsmark by the age of sixty” (reprinted in ibid., n.p.).

Tours of psychiatric facilities were organized by Nazi officials to further promote the loathing of those with mental disabilities. In 1934, Eglfing-Haar, a psychiatric hospital close to Munich, hosted guided excursions into the wards with up to one hundred “tourists” in each group (Heberer 2001, 76). Between 1933 and 1939, twenty-one thousand people toured Eglfing-Haar, including six thousand members of the SS (Burleigh 1994).

The elderly and people with serious illnesses, too, were considered by some to be burdens: “It must be made clear to anyone suffering from an incurable disease that the useless dissipation of costly medication drawn from the public store cannot be justified.” And it made no sense for persons “on the threshold of old age to receive services such as orthopedic therapy or dental bridgework; such services were to be reserved for healthier elements of the population” (Proctor 1988, 183). The young, the beautiful, and the perfectly healthy were the icons of National Socialism. Those falling markedly outside of these groups became candidates for elimination by the Nazis in the years prior to and during World War II.

5.1.3 The War Effort and Elimination of the “Unfit”

It was intentional that the beginning of the “euthanasia” program coincided with the invasion of Poland and the beginning of World War II. The poor economy of Germany, plus the added strain of financing the war, greatly affected the funding available to the psychiatric institutions and hospitals. Food for the patients was becoming scarce, and was needed, according to the government, for individuals who were healthier or who had a greater chance of recovery. Likewise, hospital space and health care staff became scarce resources needed for the war wounded (*Hessisches hauptstaatsarchiv* file 461/32061/23, no date given).

Just as the German public was exposed to these attempts at devaluing the ill and those with disabilities, nurses, too were exposed—first, as members of the public, and second through their professional education. These dual effects led many to become accomplices in the killing of the vulnerable, and many more to be bystanders—that is, those who witnessed but did nothing to intervene.
5.2 THE CHILDREN’S “EUTHANASIA” PROGRAM

A precipitating event occurred in early 1939. Among several requests for euthanasia received by the Chancellery of the Führer (Kanzlei des Führers, KdF) was a request from the father of a child named Gerhard Herbert Kretschmar (Schmidt 2007). This child, who was a patient in the hospital in Leipzig, was born blind, missing one leg and part of an arm, and “seemed to be an idiot” (ibid., 118). Hitler ordered Dr. Karl Brandt, one of his personal physicians, to speak with the doctors caring for the child to determine if this description was indeed accurate. If the child was, in fact, as described, Dr. Brandt was instructed to inform the doctors, in Hitler’s name, that they could “euthanize” the child (Noakes and Pridham 1983, 1005). Brandt traveled to Leipzig, examined the child, and concurred with the diagnosis of Dr. Werner Catel, director of the Pediatric Clinic in Leipzig. Upon receiving this report from Dr. Brandt, Hitler gave permission to kill the child. Thus the Kretschmar child became the first known victim of the Nazi euthanasia program (Heberer 2001).

Testifying in November 1960, Dr. Hefelmann of the Führer’s office stated,

Brandt told me later about the Knauer (a pseudonym for Kretschmar) case. Hitler had given him unrestricted authority to let the euthanasia take place . . . at least Brandt told me that the child was put to sleep by Catel. I seem to remember that Brandt said that the euthanasia was done with tablets. Whoever undertook the actual euthanasia, Brandt or Catel, or a different physician altogether or even a caregiver is hard to say. I am quite certain that the euthanasia occurred at the University Clinic in Leipzig. (Kaul 1979, 26)

Subsequent requests for euthanasia were also dealt with at the Kanzlei des Führers and were considered “secret state action”.

This children’s “euthanasia” program was disguised under the title of “The Reich Committee for the Scientific Registration of Serious Hereditary and Congenitally Based Illnesses” (Reichsausschuss zur wissenschaftlichen Erfassung von erb- und anlagebedingten schweren Leiden), known simply as the “Reich Committee” (Trial of Hans Joachim Becker 1970, 720). A goal of the Reich Committee was to determine the number of newborns with problems or conditions and to initiate the killing of these children along with those children with disabilities who were already institutionalized (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

In 1939, a Ministry of Justice commission proposed the following:

Clause 1: Whoever is suffering from an incurable or terminal illness which is a major burden to himself or others can request mercy killing by a doctor, provided it is his express wish and has the approval of a specially empowered doctor.
Clause 2: The life of a person who, because of incurable mental illness, requires permanent institutionalization and is not able to sustain an independent existence may be prematurely terminated by medical measures in a painless and covert manner. (Burleigh 1994, 99)

On August 18, 1939, the State Ministry of the Interior mandated that all physicians and midwives report all newborns with observable physical and/or mental disabilities:

RE: The duty to report deformed births etc.
1. In order to clarify scientific questions in the field of congenital deformities and intellectual under-development, it is necessary to register the relevant cases as soon as possible.
2. Therefore instruct that the midwife who has assisted at the birth of a child—even in cases where a doctor has been called to the confinement—must make a report to the Health Office nearest to the birth place on the enclosed form, which is available from Health Offices, in the event of the new-born child being suspected of suffering from the following congenital defects:
   i. Idiocy and Mongolism (particularly cases which involve blindness and deafness).
   ii. Microcephalie [sic] (an abnormally small skull).
   iii. Hydrocephalus of a serious or progressive nature (abnormally large skull caused by excessive fluid).
   iv. Deformities of every kind, in particular the absence of limbs, spina bifida etc.
   v. Paralysis including Little’s disease (Spastics).
3. In addition, all doctors must report children who are suffering from one of the complaints in (i–v) and have not reached their third birthday in the event of the doctors becoming aware of such children in the course of their professional duties.

The midwife will receive a fee of 2 RM (~$.80 US) in return for her trouble. The sum will be paid by the Health Office. (Noakes and Pridham 1983, 1006–1007)

Reports received from physicians and midwives were reviewed by the medical examiners: Professor Hans Heinze (director of the psychiatric facility at Brandenburg-Gorden), Professor Werner Catel (director of the University Pediatrics Clinic in Leipzig), and Dr. Ernst Wentzler (a pediatrician and director of a private clinic in Berlin). These physicians did their evaluations based solely on the reports—at no time did they actually examine the child. The reports were marked with a “+” if the child was to be killed and a “−” if the child was to be spared.
Parents of disabled children were informed that these *Kinderfachabteilungen*—institutions for children who needed special care—were being established throughout the country. They were persuaded to admit their children to these wards by being assured that the children would receive the best possible care. Although it was possible for parents to refuse, to do so necessitated signing forms stating their responsibility for the supervision and care of their children. Later in the war, mothers were often conscripted for work, thus rendering them unable to provide care and supervision. These women were then forced to relinquish the children they had tried to keep out of institutions (ibid.). Thus the Nazis obtained authorization to “treat” the children. It is unlikely that any of these children were ever returned to their homes or transferred to an ordinary hospital after being admitted to a *Kinderfachabteilungen*, a special institution for disabled children (Sereny 1974). Eventually there were twenty-two of these clinics (Friedlander 1995).

Now removed from their homes, many of these children became victims of medical experiments and research. Experiments could be conducted without parameters, and the results could be immediately evaluated by autopsy. Dr. Carl Schneider, professor of psychiatry and neurology at Heidelberg University, stated the following:

> Reaching far beyond other scientific discussion and research in the field of psychiatry, at last the most practical and immediate questions affecting the health of the nation can be most comprehensively resolved because thanks to the (euthanasia) program, a rapid anatomical and histological clarification can be achieved. (Noakes and Pridham 1983, 1009)

Some children were starved to death, with the process often accelerated by mixing Luminal (phenobarbitone) in their food every morning and evening. The low caloric intake, combined with the sedation, predisposed the children to pneumonia and premature death. Some children were given injections of morphine and scopolamine (Burleigh 1994). Nurses working in these killing wards received a supplemental payment of 25 Reichsmark (~$10) per month, and the physicians often received Christmas bonuses of 250 Reichsmark (~$100) (ibid.). “In some clinics (notoriously the Kalmenhof at Idstein), the tensions of the job were soothed by a visit to the wine cellars to mark every 50th killing with copious amounts of wine and cider” (ibid., 104–105).

An estimated three thousand to five thousand children were killed by physicians and nurses in the children’s “euthanasia” program (Trial of Hans Joachim Becker 1970, 721). Richard von Hegener, an officer for the Reich Committee, estimated that 5,200 children were killed in the program. This number may be a low estimate because in the early years of the children’s program, older children who were killed were included in the adult euthanasia program (Noakes and Pridham 1983).
5.2.1 Nursing in the “Special Pediatric Units”

A number of institutions in Germany and Austria had so called “special pediatric units” founded by the Reichsausschuss for the sole purpose of killing children with disabilities. Children would be admitted to these units under the pretense of receiving the best of treatment and care, only to be killed by the staff.

5.2.2 Kalmenhof

The “special pediatric unit”—the euphemistically named setup for killing children—was established in the Kalmenhof institution in 1942. Prior to the establishment of this unit, the mortality rate for pediatric patients was only one or two per month. After the unit opened, the mortality rate rose to about fifty-five per month. Up to six children died on some days (to Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

Located on the third floor of the hospital, this “special pediatric unit” was overcrowded and several children often had to share a single bed. Most of the children came from Hamburg, Bonn, and the Ruhr area (ibid.).

On August 8, 1943, a transport of children arrived from Hamburg. Because the hospital was overcrowded, twenty of the children were put into the nursing home. Fifteen of these children were brought to the hospital for an intelligence test and never returned. Witnesses later testified that these children were not in such bad condition that they could be expected to die. The smaller children were not mentally disabled and some were even playing. Said a later witness,

\[\text{I never had the thought that the children were suffering from any kind of illness or were so weak that they would have had only weeks left to live. . . . They were 3 to 5 year old children who were all able to walk and did not make the impression that they were weak.} \ (\text{Ibid.})\]

5.2.2.1 Hermann Wesse

Dr. Hermann Wesse was summoned to the Reichkanzlei in Berlin in 1943, where he met Richard von Hegener, who informed him that there was now a “law which made euthanasia legal” (Wesse 1946). This law was to be made public only at the end of the war. This law applied not only to adults but also to “juvenile mental health patients”, according to Hegener. Wesse was assured that a specialist from the Reichsausschuss would provide a detailed report of each child’s physical, neurological, intellectual-psychological, and character condition, along with a comprehensive medical history. These reports would be reviewed by three independent specialists who would decide whether each child was to be killed. Hegener emphasized that only when all three of the specialists concurred on “euthanasia” would the killings be ordered. Following this description of the process, Hegener informed Wesse that he was to
take over the department for the Reichscommission at the Kalmenhof mental institution in Idstein. There he would have to examine every child and send the reports to the Reichscommission. At the time, there were already approximately four hundred children in the department. Wesse did not recall at any time being asked if he wanted the position nor if he would comply with the euthanasia plans. Von Hegener informed him that the law existed and that there would be severe consequences should he fail to follow the order. Likewise, Wesse was told that there would be severe consequences for any breach of secrecy, although no signature or handshake was required. Wesse was not shown a copy of the law by either Hegener or Blankenburg. Wesse’s salary was to be 400 Reichsmark (ibid.).

Wesse arrived in Idstein a few days after this meeting and reported to the hospital. He was shown around and introduced to the only nurse there, Schwester Maria Müller. At this time, there were no children there who had been selected for “euthanasia”. Wesse began his work by starting to examine every child and make the requisite reports to the Reichscommission. After some time, the authorizations for the killings began arriving from the Reichscommission, and these were addressed to Wesse personally. He would then either show Schwester Müller the authorizations, or would simply give her the names (ibid.). Within a few days of receiving the order, Luminal (1.5–2 grams) was mixed in the child’s evening porridge, and, in most cases, this amount was sufficient to kill the child by morning. Schwester Müller reported the deaths to Wesse, who then certified the deaths, usually as pneumonia or circulatory weakness. About twenty-five children were killed in this way during Wesse’s time at Idstein (ibid.).

There were three known instances when fatal injections were used to kill the patients. No ages are provided. The first was Margarethe S., who was “idiotic” and who had seizures that left her increasingly impaired. At the time of the arrival of her authorization, Margarethe had severe tonsillitis, so Wesse gave her an intravenous injection of 1.5 grams of Luminal. At 6:00 a.m. the following day she was waking up, so Schwester Müller called Wesse, who ordered an injection of morphine. Margarethe was dead when Wesse came to work soon thereafter (ibid.).

Ruth P. became the second victim of a lethal injection. She “seemed to be physically and mentally alright”; however, she was a prostitute and thus “totally asocial”. Additionally, one of her parents was Jewish. During her transfer to Kalmenhof, she managed to escape from the attendants and was found on the streets of Frankfurt by a soldier, who brought her to Kalmenhof. There she worked, although she occasionally reported sick and remained in bed. During one of these episodes, she attempted suicide by swallowing an overdose of Eleudron tablets. When asked about this attempt, Ruth replied that she had had an unhappy love affair with a soldier. Since her authorization had arrived a few days earlier, Wesse “took this opportunity” and injected her with 0.5 grams of morphine. A second injection was administered by Schwester Müller in the evening, and death resulted (ibid.).
The third lethal injection was given to one of the patients who was working in the laundry. He experienced rage and hallucinations and attacked, with a pitchfork, several other patients, including Margarethe S. Wesse gave him an injection of 1 cc of scopolamine to calm him. That same night, he died of “heart failure”. The death of this boy had not been planned, although he was an RA (Reichsausschaus—Reich Committee—the term of the special committee) child (ibid.).

Wesse received a bonus of 125 or 150 Reichsmark after his Christmas vacation that year. When he asked for the reason, he was told that it was from the Reichscommission. Schwester Maria and Schwester Anna Wrona received 30 reichsmarks (ibid.). Wesse continued to work as a physician until the day of his arrest, April 25, 1945 (ibid.).

5.2.2.2 Hildegard Irmen Wesse

As mentioned previously, Wesse’s wife, Hildegarde, was also a physician and she, too, worked at Kalmenhof; however, her arrest was for her participation in the “euthanasia” program at Uchtspringe. There she would tell the caregivers of the orders from Berlin for “euthanasia,” giving the order and the name of the child. As children were transferred or admitted to her unit, she would write the “euthanasia” order in their record. She claimed to have seen a copy of the law and was under the impression that she was acting accordingly. She killed about thirty severely ill female patients who had been institutionalized for about forty years. These killings were not directly ordered from Berlin, but were “suggested”. She gave the injections herself after “researching the records and examining the patients. Others were killed by the nurses Dümake and Tiezgen” (ibid.).

5.2.2.3 Schwester Maria Müller

Schwester Müller not only knew what she was doing but also explained how she did the killings to Dr. Wesse when he arrived at Kalmenhof. Another physician, Dr. Weber, testified that she continuously warned Maria about the killings (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

Schwester Maria Müller was, according to Wesse, rather domineering and did not like to follow orders. She was not easy to manage. On the other hand, she was an excellent nurse. I always watched her in this respect, especially with RA cases. I had to watch that she did not act on her own and did not use any more medication than had been ordered. I do not think that she would have killed any patients behind my back.

However, after my Christmas vacation 1944/1945, I was surprised about the death of two children on my return. But I could not find any indication of wrong doing. Both had been RA children but no authorization had been received. I can imagine that Frau Dr. Weber did not
have an easy time with her. It also is true that Schwester Maria urged me to get rid of two other inmates who were working in the hospital. Both of them were RA children, Liesel S. and Erna H. Due to my more positive report on Liesel S., the Reichscommission had ordered her to be released . . . Erna was rather imbecilic and I was expecting an authorization. This was the reason for Schwester Maria’s demand to do away with her. Liesel got worse during these weeks and she turned into a habitual thief and was stealing continuously, also from Schwester Maria. These were her reasons for asking to do away with the girls. I strictly refused to oblige her request in both cases. (Wesse 1946)

Schwester Maria was so responsible for the killings that when she had to take sick leave for six weeks, Dr. Weber asked that the admission of Reichsausschausskinder be halted until Maria returned because “only Nurse Maria could kill them and only she (Dr. Weber) could cover these killings” (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

During this six-week period, not a single child died, whereas the death rate began to climb once again upon the return to work of Dr. Weber and Nurse Maria (ibid.).

5.2.2.4 Anna Wrona

Anna Wrona was a nurse employed on the “special pediatric unit” of Kalmenhof. She had received training as a nurse at the Johannisthal psychiatric hospital near Süchteln, passing her final examination with the grade of A. She began working on a “special pediatric unit” at Waldniel in 1941 and remained there until it closed in July 1943. She worked at two more institutions before beginning her employment at Kalmenhof on June 17, 1944. At Kalmenhof, Anna worked with the head nurse, Maria Müller (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

Anna Wrona was not involved in any of these killings, according to Wesse. She was a friend of his wife, and he requested that she be transferred to Kalmenhof because she was an excellent nurse and, additionally, with Schwester Maria being the only nurse in the hospital, another was needed to relieve. When Wrona did arrive, Wesse explained the RA children and the procedure; however, Schwester Maria became even more domineering, staying in the hospital day and night, so Wrona never even came close to the RA patients (Wesse 1946).

5.2.3 Motivation? Coercion?

Often the question is raised, could the nurses and physicians have been excused from this killing assignment? Dr. Weber identified only three possible ways she could deal with the children’s “euthanasia” program: (1) continue to collaborate in this matter, (2) use health problems as a reason to
get away from the institution, or (3) adjust in order to secure life somehow and to work for the greatest welfare of the children. She later contended that she chose the third option and adjusted by sabotaging the operation whenever possible, and objecting to placing more children in the institution. Throughout Dr. Weber’s adjustment, she continued to receive bonuses of 200 to 250 Reichsmark at Christmas, as well as a vacation bonus (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

Two or three days prior to the arrival of the American troops at the end of the war, Director Grossmann told Wesse that headquarters had ordered all records related to the Reichscommission be destroyed immediately. Thus all authorizations and reports were burned in the courtyard of the institution (Wesse 1946). Although Wesse reported that he was involved in about twenty-five killings, Schwester Maria swore to an American officer that the number of killings in Kalmenhof during the time of the Reichscommission was about fifty to sixty (ibid.). Although it is not possible to exactly establish the number of children murdered there because the patient files were destroyed, it is estimated that 359 children were killed at Kalmenhof between August 1942 and mid-1945. Bodies were buried several to a grave, often on top of or beside other bodies. When there were funerals, a special “drop door” coffin (Klappsarg) was used. When the relatives left after the funeral, the bottom of the coffin opened, dropping the body into a common grave and allowing the reuse of the coffin (Hessisches hauptstaatsarchiv file 461/32061/23, no date given).

5.3 THE EXPANDING WEB OF KILLING: THE ADULT “EUTHANASIA” PROGRAM

In the summer of 1939, Hitler issued the order to expand the euthanasia program to adults with physical and/or mental disorders. Dr. Leonardo Conti (son of Nanna Conti, head of midwifery in Nazi Germany—see Chapter 8), the state secretary responsible for health matters in the Reich Interior Ministry, Reich doctors’ leader, and head of the Nazi Party’s Department of National Health, was instructed to organize the program (Noakes and Pridham 1983). Hearing this, Victor Brack, a department head in the KdF (Kanzlei des Führers, Chancellery of the Führer) and deputy to Philipp Bouhler (head of the KdF), pressed Bouhler to persuade Hitler to let the KdF run the new program. Thus the responsibility was transferred from Conti to Bouhler, and the adult “euthanasia” program became the domain of the KdF and the Public Health Section of the Reich Interior Ministry (ibid.).

In August 1939, Hitler gave orders to Bouhler and Karl Brandt to begin the program with as much secrecy as possible. In the following weeks, many discussions took place among Drs. Heyde, Nitsche, Heinze, and Linden, politically loyal physicians who favored “euthanasia”. The details of the killing procedures and the designated victims were discussed. During
several meetings, the question of a written law permitting the killings arose (Trial of Hans Joachim Becker 1970, 723). Brack reported that Hitler did not want to proclaim such a law because it could become fodder for enemies’ propaganda (ibid., 722).

One such discussion took place in October 1939 in Brack’s office. There were ten people present, including Brack, his assistant, Blankenburg, and Drs. Hefelmann and Linden. The purpose of the meeting was to obtain Hitler’s written order for the killings. Several drafts were written before one was agreed upon. Blankenburg went into Hitler’s private office and found some stationery with the insignia of NSDAP and the name “Adolf Hitler” printed on the top left corner. Blankenburg dictated the agreed upon statement, which was typed on the stationery. The document was then backdated to September 1, 1939, to coincide with the beginning of the war and the invasion of Poland. The typed document was taken by Blankenburg to Hitler, who signed it:

Berlin, 1 Sept. 1939
Reichleiter Bouhler and Dr. med. Brandt are charged with the responsibility to extend the authorization of certain physicians designated by name in order that patients who must be considered incurable on the basis of human judgement may be granted the mercy death after a critical evaluation of their illness.
Adolf Hitler (ibid., 722)

Several copies were made of this letter. Brack kept both the original and the copies in his safe.

This document did not end the discussion about the need for a written law permitting “euthanasia”, however. Although Hitler, as the Führer and Reichschancellor, was able to issue “Führer orders” or “Führermanifest”, which were similar to laws, they had to conform to certain procedures. For example, they needed the countersignature of the special minister and had to be announced in the state legal publication. Neither of these conditions was met in the 1939 “euthanasia document”. Also the stationery upon which it was typed had only the emblem of the NSDAP and not that of the Reich. Both emblems included an image of an eagle, but in the NSDAP emblem the eagle’s head was turned to the left, whereas it was turned to the right in the Reich emblem (ibid., 723).

Drs. Hefelmann, Linden, and possibly Heyde continued to draft legislation permitting euthanasia. Each draft was shown by Bouhler to Hitler, and each time he opposed proclaiming a public law before the end of the war. It was reported that Hitler said, “My proclamation is the law. I am the power of the state”, whenever Bouhler pushed another draft (ibid., 724).

The question of whether such a law ever existed was addressed on April 4, 1946, in an Austrian trial of personnel accused of killing patients at
The Medicalization of Murder

The chairman of the court, Dr. Karl Kugler, made the following statement:

The National Socialist government has never abolished the old Weimar constitution of the German Republic. They only made changes.

Article 70 of this constitution from November 8, 1919 reads as follows:

“The President has to formulate the constitutionally developed laws and has to publicize this within one month in the Reichsgesetzblatt (Reichs Legal Gazette).”

In Article 71, it is further stated: “Reichs laws will be operative 14 days after they have been published in the Reichsgesetzblatt and distributed in the capitol.”

The law about publication from October 13, 1923 states: “Publication of a law can be made via the Reichsgesetzblatt or the Reichsministerialblatt (Reichs Ministerial Gazette) or via the Deutschen Reichsanzeiger. Only decrees by reason of Article 48 can be announced in a different manner.” This Article 48 is solely concerned with abrogation of fundamental rights in disturbances of public safety and order for the sole purpose of reestablishing order and safety. As a matter of fact, the National Socialists made use of this paragraph immediately. The Reichs President decreed on October 28, 1933 and had the decree publicized in the Reichs Law Gazette later modified. With it, the fundamental rights—freedom of the person, of the dwelling, of the opinion, and furthermore secrecy of the letters, of meetings, of founding of associations, and partially of ownership—were abolished.

A very important change of the Reichs constitution took place on March 24, 1933. Through the law to repeal the need of the people and the Reich (24.3.1933—RGBL I, page 141) the so-called “Enabling Act” or legislative authorization (Ermächtigungsgesetz). According to this act, Reichs laws could be enacted in other ways too, especially by the government. These laws, however, had to be formulated by the Reichs Chancellor and had to be published in the Reichs Law Gazette.

The law from January 30, 1937 about the founding of the Reich stated that the government can found new constitutional rights (RGBL I, page 75).

Finally, in the “Decree of the Führer” of August 30, 1939, I.S. 1539, about the founding of a Council for the Defense of the Reich, it is stated that this Council for the Defense of the Reich also is enabled to pass decrees with the same power as a law, unless the Führer gives different orders. This Führer decree is quite questionable as far as the constitutionality is concerned. However, not one of these different orders indicates a change in the constitutional rule to have a new law first published in the Reichsgesetzblatt.
Although the development points more and more towards a despotic government, it appears that the National Socialistic government theoretically upheld the necessity to publicize a new law in the *Reichsgesetzblatt* before it could become constitutionally a law.

Considering all of this and considering the fact that Hitler may have had the habit of disregarding all constitutional rights and acting at random whenever he saw fit to maintain power. For a “law due to habit”, a lengthy acknowledged practice would be necessary. This is not the case in this situation. Here we are dealing with the power of arbitrariness which is not compatible with a constitutional government.

It is quite obvious then: The euthanasia law would have to be constitutionally founded in order to be legal. This did not happen (Trial of Franz Niedermoser 1946, 38).

With this postwar legal opinion in mind, it is now useful to view how the “euthanasia” program was organized and implemented.

### 5.3.1 The Convoluted Organization

“Euthanasia” was declared by Hitler to be a “state secret”. Under no circumstances was the KdF to be identified as the responsible organization. In order to decrease the possibility of a linkage, a different administrative office was established in Columbushaus, Potsdamer Platz I, in Berlin. In early 1940, the office was moved to a private villa used solely for the “euthanasia” program, located at Tiergartenstrasse 4 in Berlin. From this location came the abbreviation “T4”, which was used as the code name for the entire “euthanasia” program (Trial of Hans Joachim Becker 1970, 726).

The central office of T4 had six different departments under the leadership of Victor Brack and his assistant Werner Blankenburg.

1. **The Medical Department**: Under the leadership of Drs. Werner Heyde and later Paul Nitsche, the personnel of this department were responsible for all administrative and medical decisions related to the “euthanasia” of psychiatric patients. Questionnaires were mailed out and evaluated by this department. The transportation of the doomed patients was organized, and the department was responsible for the physicians and caregivers employed in the killing effort (ibid., 727).

2. **The Bureau Department**: This department coordinated all administrative details related to the killings in the euthanasia institutions and included a courier service. Dr. Gerhard Bohne was the administrator until he was replaced by Friedrich Tillmann in October 1941 (ibid., 727).

3. **The Main Administrative Offices**: Administrators included Willy Schneider, followed by Fritz Schmiedel, and Lorent. This office was responsible for inventory, payroll, real estate, and other accounting matters (ibid., 727).
4. The Department of Transportation: This department coordinated the transfer of psychiatric patients to intermediate and “euthanasia” institutions. Reinhold Verberg was the administrator (ibid., 728).

5. The Personnel Department: Friedrich Haus and later Arnold Oels were the administrators. This department did all hiring and firing of T4 employees. It was this department that explained the nature of the work to prospective employees and swore them to secrecy (ibid., 728).

6. The Department of Inspection: Gustav Adolf Kaufmann was the administrator of this department, which was charged with selecting and furnishing the “euthanasia” institutions. Because suspicion could result from related correspondence, four subdepartments were established:

A. Reichsworker Community of Mental Institutions (RAG): This office dealt with transfers of patients and preparations for transports to the “euthanasia” institutions.

B. Community Foundation for Care of Institutions: In this office, T4 acted as employer of nonmedical personnel, and received money from the NSDAP.

C. The Public Transport GmbH (Gekrat): The manager of this department was Reinhold Verberg, who was the administrator of the Transportation Department. Buses used for the transporting of psychiatric patients to the killing centers were owned and operated by this department. The department was established to cover up the fact that the buses were in the service of the KdF.

D. Central Accounting for Mental Institutions: Hans-Joachim Becker was the administrator of this office, which held responsibility for correspondence with other organizations, psychiatric institutions, and relatives of patients (ibid., 728–729).

This intricate organization served as a cover-up for the activities of T4. An additional camouflage strategy was the use of fictitious names when dealing with the killings. For example, Brack used the name “Jennerwein”, Blackenburg used “Brenner”, and Vorberg was known as “Hintertal” (ibid., 729).

5.3.2 Targeting the Victims

With the covert and complex organization established, preparation for the killings began. During October 1939, a proclamation was sent to every psychiatric institution and every hospital that had psychiatric patients, patients with epilepsy, and patients with developmental disabilities. This proclamation ordered the completion of questionnaires on all patients and about the running of each institution. The questionnaires were mailed on October 9, 1939 (Trial of Hans Joachim Becker 1970, 730). There were two questionnaires, which were developed by the minister, Dr. Linden. The white Meldebogen I was designed to report all patients in the care of the institution, and the yellow Meldebogen II was designed to assess the institution for
### MELDEBOGEN I

**Questionnaire I**

If possible use typewriter

<table>
<thead>
<tr>
<th>Registration Number:</th>
<th>Name of Institution:</th>
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<tr>
<th>Address:</th>
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<table>
<thead>
<tr>
<th>First and last name of patient (if female patient, also maiden name):</th>
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<table>
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<tr>
<th>Place of birth:</th>
<th>Date of birth:</th>
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<tr>
<th>Citizenship and race*:</th>
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<th>Diagnosis:</th>
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<tr>
<th>Exact account of occupation:</th>
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<tr>
<th>Since when institutionalized:</th>
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<tr>
<th>Kept as criminal (OR) mental patient:</th>
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<tr>
<th>Crimes:</th>
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<thead>
<tr>
<th>Address of closest relative:</th>
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<table>
<thead>
<tr>
<th>Does patient receive visitors regularly:</th>
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<tr>
<th>Does he have a guardian:</th>
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<tr>
<th>Address of lawful representative:</th>
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<tr>
<th>Who is responsible for hospital expenses:</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Do not write in this space</th>
<th>Signature of the medical director</th>
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*Of German or German-related blood, Jew, mixed Jew 1st or 2nd degree, Negro, Negro-mixed, Gypsy, Gypsy-mixed, etc.

### Questionnaire II

Please type

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<thead>
<tr>
<th>Registration Number:</th>
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<table>
<thead>
<tr>
<th>Name of Institution:</th>
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<tr>
<th>In:</th>
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<table>
<thead>
<tr>
<th>First and last name of patient:</th>
<th>Maiden name:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Date of birth:</th>
<th>Place of birth:</th>
<th>County:</th>
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<table>
<thead>
<tr>
<th>Last address:</th>
<th>County:</th>
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<thead>
<tr>
<th>Single, married, widowed, divorced:</th>
<th>Religion:</th>
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<tr>
<th>Race*:</th>
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<table>
<thead>
<tr>
<th>Previous occupation:</th>
<th>Citizenship:</th>
<th>Military service:</th>
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<tr>
<td></td>
<td></td>
<td>(When? 1914-1918 or Since 9-1-1939)</td>
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<thead>
<tr>
<th>War invalid (also when no connection to mental disease): yes/no</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>How is war casualty confirmed?</th>
<th>Type of injury:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Address of closest relative:</th>
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<table>
<thead>
<tr>
<th>Who visits regularly? Name and address:</th>
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<thead>
<tr>
<th>Guardian or caregiver. Name and address:</th>
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</table>

<table>
<thead>
<tr>
<th>Whopays hospital expenses:</th>
<th>Date admitted to institution:</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Admitted from where, when:</th>
<th>Since when sick:</th>
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<table>
<thead>
<tr>
<th>Was admitted to other institutions, where and how long:</th>
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<tbody>
<tr>
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</table>

(continued)
<table>
<thead>
<tr>
<th>Twin (yes/no):</th>
<th>Relatives with mental illness:</th>
<th>Clinical observation, history, progress notes. In each case enough data about state of mental health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremestressfulness (yes/no):</td>
<td>Bedridden (yes/no):</td>
<td></td>
</tr>
<tr>
<td>Physical incurable illness (yes/no):</td>
<td>Which disease:</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia:</td>
<td>Recent attack:</td>
<td></td>
</tr>
<tr>
<td>Endstage:</td>
<td>In remittance:</td>
<td></td>
</tr>
<tr>
<td>Dementia: Debilitated:</td>
<td>Imbecile:</td>
<td></td>
</tr>
<tr>
<td>Idiot:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy: Psychological changes</td>
<td>Average frequency of attacks:</td>
<td></td>
</tr>
<tr>
<td>Therapy (Insulin, Cardiazol, Malaria, Salvarsan, etc.):</td>
<td>When</td>
<td>Lasting success:</td>
</tr>
<tr>
<td>Admitted because of S. 51, S. 42 StrGB:</td>
<td>By:</td>
<td></td>
</tr>
<tr>
<td>Criminal:</td>
<td>Previous criminal acts:</td>
<td></td>
</tr>
<tr>
<td>Kind of work (Detailed type of work description):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time/part time occupation: Independent worker (yes/no):</td>
<td></td>
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</tr>
<tr>
<td>Evaluation of work (ability compared to average work of healthy person):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature of Medical Director or his Representatives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*German or German-related blood, Jew, mixed Jewish 1st or 2nd degree, Negro (mixed)

There was a special green notice attached to *Meldebogen I* with the following instruction:

All those patients have to be reported who

1. Are suffering from the following diseases and are unable to do any independent work:
   - Schizophrenia
   - Epilepsy (when did it start, give causes: war injuries, others)
   - Senility
   - Paralysis (refractory to treatment)
   - Lues (syphilis)
   - Imbecility, feeblemindedness
   - Encephalitis
   - Huntington and other terminal neurological illnesses
   Or
   - Patients who have been institutionalized for 5 years or longer
   Or
   - Criminals with mental illnesses (p. 730).

![Figure 5.1 Meldebogen I. (continued)](Image)
possible future plans. The type of building, square footage, yearly budget, the number of beds, and the number of medical personnel were included (ibid.). The Meldebogen I underwent some changes over time. Questions were added about diagnosis, probability of recovery and discharge, war injuries, and ability to work. Figure 5.1 shows the Meldebogen I, which was in use in 1939–1940 (ibid., 731).

At a meeting held the same day, October 9, 1939, the following calculation of the number to eventually be killed was presented by Brack:

The number is arrived at through a calculation on the basis of a ratio of 1,000:10:5:1. That means out of 1,000 people ten require psychiatric treatment; of these five in residential form. And, of these, one patient will come under the program. If one applies this to the population of the Greater German Reich, then one must reckon with 65,000 to 75,000 cases. (Noakes and Pridham 1983, 1010)

Not all went smoothly in the questionnaire process. A huge number were completed and returned to T4. As a result, it became necessary to recruit additional evaluators to work under the supervision of Drs. Linden, Heyde, and Nitsche. One of these recruits described the evaluation process:

Herr Brack then requested us or rather asked us whether we were prepared to act as assessors in the program. The criteria were drawn up so that war veterans, or rather those war disabled who had suffered some kind of mental damage from their war disablement, were excluded on principle. The assessment, which was based on the state of the particular patient, was drawn up according to criteria of whether the patient—on the basis of the details in the form—had deteriorated so much mentally and physically that he came into the category of worthless life . . . On principle, patients whose constitution was such that they could perform work, useful work, were to be excluded from this action. It is difficult to draw the line as to what work is useful and what is not. He (Brack) only used the term: capable of work—in terms
of the asylum’s therapy. The comments he made were not precise. As far as I know, he did not elucidate the concept of capacity for work more closely. He gave examples, e.g., a patient who can sole shoes in a workshop is performing useful work. People who had had a stroke and had become mentally defective were excluded on principle.

Herr Brack gave a general instruction that the assessments were to be drawn up so that in cases of doubt or in marginal cases the person should be included in the program, i.e. he (Brack) went beyond the bounds of medically justifiable criteria. In this context he asserted that now, especially during the war, in which so many healthy people were forced to lose their lives, these mentally sick people, who in any case were of no use to the national community, did not matter, and that in view of the bad food situation at least these people would be removed from the food sector. He emphasized further that numerous healthy people were having to lose their lives, and so it was not surprising that the State should adopt these measures and remove these sick people, who in any case did not represent proper life. He kept speaking of the leadership of the State. A written instruction was never given . . .

Then we were asked whether we were prepared to cooperate as secondary assessors along these lines. People were not asked individually, but rather the whole matter was dealt with in the group in which we sat, more in open colloquium . . . The conclusion of the colloquium was that under these circumstances we would be prepared to cooperate with and support these measures. No objections were raised. (Ibid., 1014)

Many questionnaires were incorrectly completed, often because the physicians of the institutions believed that it was just another survey. Other physicians were afraid that the purpose was to identify patients who were capable of work, so these physicians often made the patients seem worse on the questionnaires. Suspicion also arose that there was a plan to kill psychiatric patients. This led to some physicians refusing to fill out the forms (Trial of Hans Joachim Becker 1970, 734).

These difficulties eventually led to the formation of a commission of physicians who favorably viewed the “euthanasia” program. Some of these physicians were sent to the various psychiatric hospitals where there had been difficulties with compliance with the survey. A letter from the director of Neuendettelsau hospital, Dr. Rudolf Boeckh, complaining about the commission’s visit, was sent to the Reich Interior Ministry on November 7, 1940:

Contrary to the instructions of the Bavarian State Ministry, the commission completed several hundred of these forms and sent them off to Berlin without the presence of the senior doctor responsible for the asylums . . . The commission did not examine a single one of the 1,800 patients. The majority of the patients are not in Neuendettelsau
but in branch asylums distributed all over northern Bavaria. Thus, the commission was incapable of forming its own judgment of the situation... Only the nurses were questioned... and their objections were largely ignored. Indeed, it was even observed that the opposite of the true statements of the nursing personnel were recorded on the forms. The staff who composed the commission cannot really be blamed since the majority were medical students and typists who were completely incapable of properly assessing the statements of the nursing staff. The senior doctor on the commission, who worked in a separate room on his own, received the forms which had been completed by the assistants and then gave his judgment without any personal knowledge of the individual cases and without looking at the medical records.

As the doctor responsible for the asylums I protest against this unprofessional method of working by the commission which goes against all the traditions of the medical profession... In view of the fact that the public is aware of the ultimate objectives of this registration of the patients, I have been burdened with a grave responsibility as the senior doctor responsible for these institutions. (Noakes and Pridham 1983, 1016)

The completed questionnaires were sent to the central office, where a card register was started for each patient. Five copies of the questionnaire were made, and three of these were sent to the evaluators. Two copies were used for the eventual transfer of the patient, and the original was kept in the central office (Trial of Hans Joachim Becker 1970, 735).

Initially, six or seven physicians were used to evaluate the questionnaires. Eventually, this number was increased to thirty to forty physicians. A list of evaluators was kept at the Reichsworker Community of Mental Institutions (RAG), one of the subdepartments of the T4 Department of Inspection. A copy of every completed questionnaire was sent to three evaluators, with each evaluator receiving between 100 to 150 questionnaires. The evaluators indicated their decision by a mark on the left-hand corner of the questionnaire: a red “+” if the patient was to be killed, a blue “−” if the patient was to live, and a “?”, or later a “Z”, for undecided. Evaluators were to send these questionnaires back to the T4 office, where the marks were copied onto the original questionnaires. The originals were sent along with the copies completed by the evaluators to the chief evaluators, Drs. Heyde, Nitsche, and Linden. A chief evaluator then also rendered a decision: “+” for death and “−” for life. Approximately two hundred thousand questionnaires were processed in this way by August 1941 (ibid., 735–736).

5.3.3 The Methodology of Killing

Now that the issues related to the selection of the victims were resolved, the question of how to do the actual killings was paramount. Brack discussed the proposed operation with Arthur Nebe, the head of the Reich Criminal Police Office, who, in turn, referred Brack to Dr. Albert Widmann, the head of the
chemical section of the Criminal Technical Institute (KTI). Nebe informed Widmann that the decision to implement “euthanasia” had been made, and that KTI was to serve in an advisory role. Nebe quickly washed his hands of responsibility by saying that the action had been mandated by law. Brack summoned Widmann to T4, where the “euthanasia” program was described, and his advice was sought on the operationalization. Among substances discussed were morphine, scopolamine, prussic acid, and carbon monoxide. Being somewhat of an expert in carbon monoxide poisoning, Widmann recommended it with the idea of pumping it into the patients’ wards at night (Noakes and Pridham 1983). However, this idea became refined with the eventual building of gas chambers at selected psychiatric hospitals.

Questionnaires with a “+” as the final verdict were forwarded to Gekrat (Public Transport GmbH), a subdepartment of the Department of Inspection. This department’s personnel compiled a list of patients to be transported and notified the patients’ institutions to prepare the patients for transfer on a specified date. No reasons were provided for the transfer, and the director of the institution was warned to not inform the patients’ relatives of the impending transfer (Trial of Hans Joachim Becker 1970, 736). During the early months of the “euthanasia” program, the selected patients were taken by bus, or occasionally by train, directly to a killing center. Beginning in the fall of 1940, in order to better conceal the operation, patients were first transferred to intermediate institutions and then, within a few days, to a killing center (ibid., 736).

5.3.4 The Six Killing Centers

In all, there were six institutions that functioned as the killing centers of the “euthanasia program”. Four of them operated simultaneously during 1940 and 1941. (Trial of Hans Joachim Becker 1970, 738)

5.3.4.1 Brandenburg

The first killing center to be established was in an abandoned hard labor penitentiary in the city of Brandenburg on the Havel, an hour’s train trip from Berlin (Heberer 2001). A gas chamber was built for the purpose by workers from the SS Central Construction Office. A room three meters by five meters by three meters high had been especially prepared. The room was tiled and had benches built around the sides. A pipe approximately one inch in diameter and with small holes was installed around the room about 10 centimeters above the floor. The tanks of carbon monoxide were outside the room but already connected to the pipe. There was a peephole in the door. Two mobile crematoria were made available to burn the corpses. The first gassing took place at the Brandenburg institution on January 4, 1940 (Friedlander 1995).

For this first gassing, about 18–20 people were led into the “shower room” by the nursing staff. These men had to undress in an anteroom
until they were completely naked. The doors were shut behind them. These people went quietly into the room and showed no signs of being upset. Dr. Widmann operated the gas. I could see through the peephole that after about a minute the people had collapsed and lay on the benches. There were no scenes and no disorder. After a further five minutes the room was ventilated. Specially assigned SS people collected the dead on special stretchers and took them to the crematoria. When I say special stretchers I mean stretchers specially constructed for this purpose. They could be placed directly in the ovens and the corpses could be pushed into the oven mechanically by means of a device without the people carrying them coming into contact with the corpse. These ovens and the stretchers were also constructed in Brack’s department . . . Following this successful test, Brack—who was naturally also present and whom I forgot to mention—said a few words. He expressed satisfaction with the test and emphasized once again that this action must only be carried out by doctors according to the motto—“syringes are a matter for doctors”. Finally, Dr. Brandt spoke and reiterated that doctors alone should carry out this gassing. With that, the start in Brandenburg was considered a success. (Noakes and Pridham 1983, 1020)

Problems developed at the Brandenburg center. The crematorium built to burn the bodies of the gassed patients did not function properly, and “flames often shot from the three smokestacks” (Heberer 2001, 139). Additionally, the smoke from the crematorium filled the nearby town with the very noticeable smell of burning flesh. A temporary solution consisted of burning the bodies in mobile ovens outside the city, but this was unsuccessful and Brandenburg was shut down as a killing center in September 1940 (ibid.) and replaced in December 1940 by Bernburg.

5.3.4.2 Grafeneck

Grafeneck hospital, in addition to Brandenburg, became one of the first of the six killing centers. At T4, Grafeneck was known under the code letter “A” and Brandenburg operated under the code letter “B” (Trial of Hans Joachim Becker 1970, 738). Grafeneck was the former castle of the dukes of Württemberg and had been a Protestant hospital for people with disabilities. The original patients were transferred elsewhere, and Grafeneck was taken over by the state. It was located atop an isolated hill in Kreis Münsingen (Noakes and Pridham 1983). After it was remodeled, it functioned as a killing center from January until December 1940. The killings took place in a converted coach house located behind the castle (Heberer 2001). By fall of 1940, there was widespread knowledge of the killings at Grafeneck, and Himmler advised Viktor Brack to shut down the killings there. Hadamar was its replacement, and the T4 staff transferred there, taking their killing skills with them (see Chapter 4 for details about the nurses at Hadamar).
5.3.4.3 Hartheim

Hartheim was the third center to become operational. Hartheim, known at T4 as institution “C”, was a former Renaissance castle of the prince of Starhemberg in Austria, near Linz (Noakes and Pridham 1983), and had been a psychiatric hospital since the late 1800s (Heberer 2001). Gassings began at Hartheim in May 1940 (Trial of Hans Joachim Becker 1970, 738) and continued until December 1944 (Heberer 2001). Patients with disabilities from Austria, Germany, Czechoslovakia, and Yugoslavia were brought to Hartheim to be gassed. Because it was located near Mauthausen and Dachau, prisoners from those concentration camps were sent to Hartheim for gassing when they became too ill or debilitated to work (ibid.).

In November 1940, Franz Stangl, who was to eventually head one of the most notorious death camps, Treblinka, was recruited to work as a police superintendent at Hartheim. He was summoned to the T4 headquarters in Berlin, where the program was described to him by Kriminalrat (criminal lawyer) Werner. Werner told him that both Russia and the US had had for some time a law permitting the killing of people who were “hopelessly insane or monstrously deformed” (Sereny 1974, 50) and that this law was about to be passed in Germany and throughout the world. However, the law’s implementation would be done very slowly and with a great deal of psychological preparation “to protect the sensibilities of the population” (ibid., 51).

In the meantime, the difficult task had begun, under the cloak of absolute secrecy. He (Werner) explained that the only patients affected were those who after the most careful examination—a series of four tests carried out by at least two physicians—were considered absolutely incurable so that, he assured me, a totally painless death represented a real release from what, more often than not, was an intolerable life. (Ibid., 51)

Stangl was assured that he would not be directly involved as the process was “carried out entirely by doctors and nurses” and he was to be responsible only for the “law and order” aspects, which included the responsibility for seeing that “the protective regulations regarding the eligibility of patients would be adhered to, to the letter” (ibid., 51). Stangl was given the choice of accepting or declining this new position. The factors that led him to decide in favor were the fact that he had some disciplinary action pending against him, the statement that these killings were already being done in Russia and the US, the “fact that doctors and nurses were involved, the careful examination of the patients, and the concerns for the feelings of the population” (ibid., 52).

Hartheim was staffed by two physicians, Drs. Renno and Lohnauer. There were fourteen nurses, seven males and seven females (ibid., 54). Four groups
of patients were considered exempt from the killings: the “senile”, veterans, recipients of the *Mutterkreuz* (a decoration given to women of exemplary character, who were racially acceptable to the Nazis and who had given birth to four or more children), and relatives of T4 staff (ibid., 54).

5.3.4.4 Sonnenstein

Sonnenstein, a psychiatric hospital not far from Dresden, was known at T4 as institution “D”. Gassings started in Sonnenstein in June 1940 and continued until spring 1943 (Trial of Hans Joachim Becker 1970, 738). The Sonnenstein killing center was unique in that, for the first time, the killing center did not occupy the entire institution. The killing operation, including quarters for T4 staff, was located in three buildings along the perimeter of the hospital grounds. The other building continued to be a part of a working psychiatric hospital known as Mariaheim (Heberer 2001).

5.3.4.5 Bernburg

Known under the code name “Be”, Bernburg functioned as a “euthanasia” institution until spring 1943 (Trial of Hans Joachim Becker 1970, 738). The institution is located in the town of Bernburg near Weimar. To this day, it remains an active psychiatric hospital, and an interesting phenomenon is occurring there: A number of elderly residents of the town of Bernburg who have Alzheimer’s disease or other dementias are thrown into panic states when attempts are made to hospitalize them at the Bernburg hospital. Their long-term memory is preserved, and they recall that patients were killed in Bernburg. They are afraid that they are being led to the same fate (archivist Ute Hofmann of Bernburg, pers. comm.).

5.3.4.6 Hadamar

A detailed description of the nurses at Hadamar and their trials is included in Chapter 4, but some detail is given here.

Nurses employed at Hadamar during the T4 action were from two different groups: the Berlin group and nurses already employed at Hadamar but recruited to the killings by the Berlin Central organization and by the state of Hessen-Nassau. The nurses in the Berlin group had been ordered to enlist in the “General Foundation for Institutional Care” and had been employed at Grafeneck from January until December 1940, and had gained their experience in the “euthanasia” program there. The selection of nurses ordered (*dienstverpflichtung* [service obligation]) to be part of the *Stiftung* (foundation) was accomplished with the assistance of certain trustworthy contact persons from several other psychiatric institutions.

Physicians and administrators were individually selected for the T4 program whereas nurses and administrative staff were not. The nursing
personnel during the gassings of T4 were not required to possess any advanced skills. They were required only to be politically loyal and willing to undertake the work. Once this loyalty and reliability were ascertained, they were summoned to the Chancellery, where they were asked if they were willing, given a brief time to decide, and then were administered an oath of silence (Heberer 2001). One nurse, Pauline K., described the experience:

After the outbreak of the war, I acquired, through the head of the police in Berlin, a notice for preparation that I should get ready for duty which under certain circumstances could last for a few weeks. In December 1939, I followed the order to report on January 4, 1940 to Columbus House. I believe that there was some talk at that point of the General Foundation for Institutional Care that I was not being ordered to the Reich work group for care facilities. At the same time, along with me, there were 12 additional nurses and 10 orderlies at the Columbus House. I still remember that the nurses were there. Then Herr Blankenburg in the presence of Dr. Bohne revealed to us the assignment awaiting us. He apprised us of the fact that we were being called to carry out the euthanasia initiative. It was also presented to us that we were experienced nurses and orderlies from care facilities and could judge the profiles of the sick. It was a viable solution for the terminally ill if one were to take their lives prematurely. We were then asked whether we wanted to carry out this work and, after a quarter hour of consideration, we told an oath and under the threat of severe punishment, we were required to remain silent about the whole affair. Herr Blankenburg told us that Hitler had previously worked out a law which already was finished that would, to be sure, in consideration of the war not be published; therefore the secrecy was necessary. Details about the content of the law and the principles according to which the patients should be selected and the technical execution of euthanasia were not disclosed to us. We were loaded on the same day into a van and set off to Grafeneck. (Quoted in Steppe 1996, 147)

The recruitment of the killing staff at Hadamar before 1940 was likely done by the head administrator, Alfons Klein. Klein had joined the Nazi party in 1930 (Kintner 1949). Factors for selection to work at Hadamar included political loyalty, adaptability, and experience working with psychiatric patients. There was no difference in the criteria for hiring if the staff member was hired at Hadamar or at the T4 headquarters in Berlin.

Upon arrival at the T4 facility, the patients were escorted from the transport bus. Nurses and attendants helped them to undress and led them to the physician’s room for a 1–2 minute examination. This examination helped reinforce a sense of legitimacy in the process and allowed the physician to devise a plausible, albeit false, cause of death. After the physical
examination, the patient’s teeth were examined. Individuals who had gold dental work were marked on the backs or shoulders with a cross so that, after death, these crowns and restorations could be extracted. Each patient was then assigned an identification number, which was affixed to them with adhesive tape. Following this, they were taken to be photographed. These photographs, like the physical examination, imparted a sense of legitimacy to the process, and also served to document physical or mental inferiority for scientific purposes. Following the photography, patients were weighed and measured before being taken down the stairs, in groups of sixty to one hundred, and into the gas chamber (Heberer 2001).

5.4 EXECUTION OF PSYCHIATRIC PATIENTS

The murder of the psychiatric patients in the most eastern parts of the German Reich was not done by gassings in the killing centers. Included in this area were patients from institutions in Danzig, eastern Prussia, Upper Silesia, and Poland. The following is from a Polish book, Builetyn Glownej Komissji badania Zbrodni Niemieckich w Polsce:

The murdering in psychiatric institutions had an overall similar procedure, which is typical for all of Hitler’s mass criminal actions. Exact planning, preparation by the occupational offices, then realization according to a pre-designed plan. The patients were generally taken out of the institution, brought to an unpopulated area and there shot. All traces of the annihilation were carefully covered up. At other times the patients were gassed in special motorcars. In very few cases were they brought to an extermination camp (Grabowski 1961, np).

In a trial being prepared against George Ebrecht in 1962, Kurt Eimann (a commander of an SS unit that shot approximately three thousand psychiatric patients from institutions in Pomerania to make barracks and hostels for ethnic German repatriates; he received a four-year prison sentence [Burleigh 1994]) confessed that he and his (Sturmbann) unit of SS men met several transports of trains bringing mental patients from several institutions in Pomerania. The patients were taken to a secluded, wooded area between Gotenhaven and Danzig and were shot. Eimann further admitted that a group of twelve Polish prisoners from Camp Stutthof had to dig the pits for the burial of the psychiatric patients, and then they, too, were shot. The order to kill the Polish prisoners also was given by Erbrecht (Staatsarchiv München. Untitled file no. 33.029/8, no date given).

The elderly, too, were murdered. Caregiver Anna Stosik gave the following description in 1962 in preparation for the trial of Dr. Georg Renno:
I was sent to Tiegenhof (1942 or 1943). One day in Tiegenhof we admitted several older people from an old folk’s home in Posen. They were not mentally ill, only old. After two or three weeks, they were picked up by the SS in special buses that were absolutely airtight. I asked one of the SS men why they were built that way. He asked why I was interested and I said I was a caregiver and just interested. He told me to mind my own business and that I had better get out of his sight. I still did not quite know what all this was about but I had a real bad feeling and from that day I tried to get away from my job as caregiver.

There was another group of patients picked up in these airtight vehicles. Maybe two more times but I cannot state how many patients and if they were severely ill or not. I remember that the patients fought and screamed when they were loaded on these buses.

I remember two older women from the home in Posen who went to a window saying, “Come on, let us see God’s sun one more time” before they were loaded on those buses. Did they know that this was a trip to their death?

For me it was now clear what would happen to those loaded into those buses. They were scantily dressed and without any provisions or luggage. There were no seats in the bus, only some straw on the floor. The first patients were bedded on the straw and the rest were just pushed in, falling or standing (Stosik 1962).

5.5 KILLING OF WOUNDED GERMAN SOLDIERS

Reports began reaching several European and American newspapers as early as October 1941 that severely wounded German soldiers were being murdered by their comrades. Archduke Robert of Habsburg reported that before launching war against Russia the Germans poisoned all lunatics and incurables in Austria to clear the hospitals for casualties from the Russian front. I learn [sic], too that German N.C.O.s cover the battle-front after a day’s fighting and shoot those of their own men who are too badly wounded to recover (Daily Telegraph 1941).

In April 1942, there were reports in both the New York Post and the Evening Standard about similar actions. On April 6, 1942, the New York Post reported the following:

France has learned, through a grapevine, that the Germans are practicing euthanasia—mercy killing—on their own wounded.

Many horrible casualties return from the Russian front, where severe cold has been far more cruel than Stalin’s armies. The Nazis are afraid
to allow these men to be seen. Frequently, such cases have rotted and gangrenous bodies.

There are two Nazi methods to dispose of them. One is the injection of air into a vein, sending an instant lethal bubble to the heart. Or a sodium cyanide tablet is placed on a sleeping patient’s tongue. He never awakes.

Recently, several secret train loads of horrible casualties, many of them marked for death, entered Lyon (Vaughan 1942).

The April 27 report that appeared in the *Evening Standard* describes the experience of a Swiss physician who had been to the Russian front. Professor André Balser, in a report to the Swiss government, describes how he was attending to heavily wounded soldiers returning from the Russian front to Brest-Litovsk on a train. The train was halted in the countryside at the entrance to a tunnel.

The whole staff, conductors, nurses accompanying soldiers, etc., were summoned by the train commander, and were told to put on their gas masks and not to take them off before a special “air clear” signal would be given.

The whole thing was explained by the commander as an exercise. (When) Balser asked the commander, “What about the wounded?”, he was told “Don’t you know that they are in gas-proof compartments?” (*Evening Standard* 1942a)

The train stopped in the tunnel for half an hour. Afterward, Balser entered some of the train compartments to check on the wounded and found them all to be dead (ibid.).

Later in 1942, a newspaper article reported from Stockholm that a German radio broadcast was aired in an attempt to dispel rumors originating in Germany that the wounded were “quietly killed off by their own doctors”. The speaker stated that it was false that the wounded soldiers “being sent home via Norway on the hospital ship *Adolf Hitler* were mysteriously being disposed of en route whereas those transported on the hospital ship *Berlin* reached Germany.” The speaker explained that the soldiers “aboard the *Adolf Hitler* were seriously wounded and often died and were buried at sea” (*Evening Standard* 1942b).

### 5.6 TRANSFER OF EUTHANASIA PERSONNEL TO THE AKTION REINHARD DEATH CAMPS

When the T4 killing program ended in August 1941, the question arose about what to do with these “highly skilled” personnel with their unique expertise at murder. Viktor Brack wanted not only to put their experience to good use but to also have them available to start up a new
<table>
<thead>
<tr>
<th>Nurse</th>
<th>Euthanasia Hospital</th>
<th>Aktion Reinhard Camp</th>
<th>Trial/Verdict</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beulich, Max</td>
<td>Sonnenstein</td>
<td>Sobibor</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Blaurock, Kurt</td>
<td>Sonnenstein</td>
<td>Sobibor</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Bredow, Paul</td>
<td>Grafeneck Hartheim</td>
<td>Sobibor Treblinka</td>
<td>Killed in accident 1945</td>
<td>Clothing supervisor; shot prisoners for target practice – goal was 50 Jews per day.</td>
</tr>
<tr>
<td>Eisold, Johannes</td>
<td>Sonnenstein</td>
<td>Treblinka</td>
<td>Unknown</td>
<td>In charge of excavators at extermination site.</td>
</tr>
<tr>
<td>Felfe, Hermann</td>
<td>Sonnenstein Grafeneck</td>
<td>Treblinka</td>
<td>Sentenced to death; committed suicide.</td>
<td>Guard</td>
</tr>
<tr>
<td>Forder, Alfred</td>
<td>Sonnenstein</td>
<td>Treblinka</td>
<td>Guard</td>
<td></td>
</tr>
<tr>
<td>Grossman, Willi</td>
<td>Sonnenstein Hadamar</td>
<td>Treblinka</td>
<td>Guard</td>
<td></td>
</tr>
<tr>
<td>Horn, Otto</td>
<td>Sonnenstein</td>
<td>Treblinka</td>
<td>Supervised burning of corpses; reported to be a decent man.</td>
<td></td>
</tr>
<tr>
<td>Jührs, Robert</td>
<td>Hadamar</td>
<td>Sobibor</td>
<td>Acquitted</td>
<td>Guard</td>
</tr>
<tr>
<td>Klahn, Johannes</td>
<td>Sonnenstein</td>
<td>Treblinka Sobibor</td>
<td>Camp I</td>
<td></td>
</tr>
<tr>
<td>Matthes, Arthur</td>
<td>Sonnenstein</td>
<td>Treblinka Sobibor</td>
<td>Life imprisonment</td>
<td></td>
</tr>
<tr>
<td>Michel, Hermann</td>
<td>Grafeneck Hartheim</td>
<td>Sobibor</td>
<td>Wearing a white coat, he gave “welcoming speech” at Sobibor.</td>
<td></td>
</tr>
<tr>
<td>Möller, Max</td>
<td>Treblinka Sobibor</td>
<td>Ordinance guard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Novak (Nowak?), Anton</td>
<td>Sonnenstein Sobibor</td>
<td>Killed during revolt.</td>
<td>Supervisor of hair cutting</td>
<td></td>
</tr>
<tr>
<td>Schluch, Karl</td>
<td>Grafeneck Hadamar</td>
<td>Belzec</td>
<td>Worked as nurse after the war. Guard; accompanied Jews to the gas.</td>
<td></td>
</tr>
</tbody>
</table>

(continued)
“euthanasia” program after the war (Arad 1999). Thus, the first group of a few dozen men from the T4 program was transferred to Lublin in November and December 1941, and these were followed by more in early 1942. These men became members of the SS, wearing the uniform and holding rank. However, they were still accountable to T4 headquarters and were still eligible to take their vacations at the Attersee Lake in Austria, 50 kilometers east of Salzburg, the “euthanasia” staff’s rest and recreation site. Eventually, there were anywhere from twenty to thirty-five SS men at each of the “Aktion Reinhard” death camps, and the vast majority of these were from the “euthanasia” program (ibid.). (The name “Aktion Reinhard” was taken from that of SS-Obergruppenführer Reinhard Heydrich, instigator of the Final Solution discussion at the conference in Wanssee on January 20, 1942, who was assassinated in Prague on May 27, 1942.)

The Aktion Reinhard camps of Belzec, Sobibor, and Treblinka were established to implement the “Final Solution”: the plan to eradicate the Jews of Europe. These death camps were established in Eastern Europe and had as a single purpose the murder of the Jews. Many of the staff were Ukrainians who were joined by former T4 “euthanasia” personnel. Although a number of these men had worked as nurses and caregivers at the “euthanasia” hospitals, their work was quite different in the death camps.

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Euthanasia Hospital</th>
<th>Aktion Reinhard Camp</th>
<th>Trial/Verdict</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schwarz, Gottfried (“Friedl”)*</td>
<td>Grafeneck Bernburg</td>
<td>Belzec</td>
<td></td>
<td>Deputy commandant of Belzec</td>
</tr>
<tr>
<td>Seidel, Kurt</td>
<td>Sonnenstein</td>
<td>Treblinka</td>
<td></td>
<td>Supervised road construction.</td>
</tr>
<tr>
<td>Stadie, Otto</td>
<td>Bernburg</td>
<td>Treblinka</td>
<td>Sentenced to 7 years in prison; released because of poor health.</td>
<td>Administrative assistant to commandant</td>
</tr>
<tr>
<td>Steubel (Steubl?), Karl</td>
<td>Hartheim – senior male nurse</td>
<td>Sobibor</td>
<td>Killed in uprising.</td>
<td>Paymaster</td>
</tr>
<tr>
<td>Unverhau, Heinrich</td>
<td>Hadamar Grafeneck</td>
<td>Belzec Sobibor</td>
<td>Acquitted</td>
<td>Supervised victims’ undressing.</td>
</tr>
<tr>
<td>Zaspel, Fritz</td>
<td>Sonnenstein</td>
<td>Sobibor</td>
<td>Acquitted</td>
<td>Guard; supervised undressing.</td>
</tr>
<tr>
<td>Zirke, Ernst</td>
<td>Eichburg</td>
<td>Belzec, Sobibor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*“Medical practitioner”
At least two of these men, Arthur Matthes and Otto Horn, had worked at the Sonnenstein “euthanasia” center as male nurses before taking their killing expertise to Treblinka (ibid.).

Other than Irmfried Eberl, who was the first director of Bernburg and briefly the commander at Treblinka, no other SS physicians nor any female nurses were known to have worked at the Aktion Reinhard camps (Sereny 1974). Table 5.1 shows the nurses and caregivers who worked in the death camps. Even though there were small infirmaries or sick bays for the SS at the Aktion Reinhard death camps, the nurses and caregivers were assigned jobs quite different from patient care.

The death camps were precisely that. Their sole purpose was to kill as many Jews, in as short a period of time, as possible. Unlike the concentration camps, the only prisoners allowed to live were the few who were needed to support the SS staff and Ukrainian guards. As seen in Table 5.1, former nurses and caregivers were transformed from providers of patient care into cold-blooded murderers. Some actually returned to their nursing careers after the end of the war.

REFERENCES


Staatsarchiv München, untitled, file 33.029/8, no date given.


Wesse, H. Statement. 1946, File no. 10/2584, Jan 6, Yad Vashem. Jerusalem.
Until 1937, the Obrawalde hospital, near the town of Meseritz, belonged to the German state of Prussia, located in the border province of Posen/West Prussia. In addition to psychiatry, the many different departments in the hospital included internal medicine, neurology, and obstetrics. There were homes for children and the elderly, as well as for “crippled patients”. In 1938, the province of Posen/West Prussia was dissolved and the Obrawalde hospital was assigned to Pomerania. Today Obrawalde is known as Obrzyce and is located in the eastern sector of Międzyrzeć (formerly Meseritz), a part of Poland (Dramowicz 2004).

Obrawalde is still a functioning psychiatric hospital. Most of the buildings are still in use and, overall, the facilities have an atmosphere not unlike a college campus. Although there is a central administration building, the units for patients are two-story brick buildings that function quite autonomously, each with its own staff. Because of the distance between the buildings and their self-contained organization, it is easy to understand how events taking place in one building would be completely unknown to staff and patients in another. During the time of the killings, this was essential.

Following the change in administration in 1938, all general medical departments were abolished and Obrawalde became only a psychiatric hospital. In 1939, there were approximately nine hundred psychiatric patients in Obrawalde. Within a year, this number increased to more than two thousand with only three physicians to care for them (Sagel-Grande, I., Fuchs, H., Rueter, C. 1979), two of whom were over sixty-five years of age (Wernicke 1945). In 1941, Walter Grabowski, a former salesman, was appointed as administrative director of Obrawalde. He was regarded as an extreme National Socialist and was a friend of the Gauleiter of Pomerania Schwede-Coburg (Sagel-Grande 1979).

When Grabowski assumed the leadership at Obrawalde, he implemented a number of changes in the hospital that affected the nurses and caregivers. They often had to work fourteen hours a day and, toward the end of the war, had to dig ditches to protect the institution against the advancing Russian army (Sagel-Grande 1979). The caregivers on the wards were overburdened with the ever-increasing number of patients. Areas previously used as
living space for the patients were converted to wards, and beds were placed on top of each other. Medications and even cleaning supplies were in short supply. The well began to run dry (Wernicke 1945).

Grabowski was often rude and intimidated the hospital employees. The atmosphere among the employees became one of distrust (Sagel-Grande 1979). Within a year, Obrawalde became a place of immense misery. There were an enormous number of severely ill patients, in addition to less incapacitated patients who were required to work in jobs supporting the institution. The farm and gardens were especially vital as the nutrition of the ever-increasing number of patients was solely dependent upon Obrawalde’s own production (Wernicke 1945).

The killings at Obrawalde began under the supervision of Grabowski at the end of 1942. Included in those murdered were people who were already patients at Obrawalde and others who were transferred there to be killed (Sagel-Grande 1979). Transports arrived from other institutions in Germany. The arriving transports had patients who were half-starved, covered with excrement, and exhausted from traveling for several days. Many died in transit and others died soon thereafter (Wernicke 1945). Dr. Wernicke, one of the three staff physicians, testified that

the staff often had to work day and night with only a few hours of rest in order to take care of the arrivals. Because of the crowded conditions, it was almost impossible to fight problems like lice, scabies, dysentery, or at least to keep (these conditions) to a minimum. The fact that we managed in spite of the overcrowding . . . is due to the enormously hard work and dedication of the caregivers. (Wernicke 1945)

Patients were selected for death by the head physicians, Dr. Mootz and Dr. Wernicke. These doctors reviewed the patients’ files and briefly examined the patients. In addition to patients who were severely ill, there were those whose behavior was more normal but who were unable to work. The actual killings were left to the nurses and caregivers (Sagel-Grande 1979).

In the women’s portion of Obrawalde, the killings took place in Haus 1, 3 (children’s ward), 6, 8 (infectious diseases), 9, and 10. In the men’s part of the hospital, most of the killings took place in Haus 18 (ibid., 700–701). On these units, “isolation” rooms were designed to be killing rooms. The patients to be killed were taken into the isolation room before being administered the lethal medication. Patients from units without the special “isolation” room were transferred by the caregivers to units able to accommodate the procedure (ibid., 701).

Prior to being taken to the “isolation room”, some patients were pre-medicated with Veronal (Diethyl barbituric acid) or another sedative. Once in the room, in most cases, the killings were done with an overdose of a sedative such as Veronal or Luminal (phenobarbitone). Usually ten tablets (or the equivalent amount of powder) were dissolved in water and given to the patient. If the patient was unable or refused to take medication, an
injection of morphine and scopolamine was given. Occasionally, an injection of air into the vein was the mode of murder (ibid., 700).

The killing with oral medication occurred thus:

One of the caregivers would hold the patient upright, and the other would force the poison down the patient’s mouth. When patients were found unusually restless, several caregivers had to be involved. If the patient refused to take the drink, one of the caregivers would talk assuringly [sic] to the patient so that he or she would swallow the poison (ibid., 700).

The patients would soon fall asleep and usually die within half a day. Of course, those who were given the air embolus would die within minutes and those who received morphine and scopolamine would die within a few hours (ibid., 701).

In the early days of the killings, the caregivers had to remove the bodies themselves. Later, as the number of killings increased, a group of male patients, “the cemetery gang”, was organized. Bodies were taken first to the morgue and later buried in the institution’s own cemetery (ibid., 700).

The patients’ deaths were documented in a specially created office of the hospital. Here the death certificates were prepared and signed by the physicians. The true cause of death was not provided; rather, a common and plausible cause such as “stroke” was supplied. The number of patients murdered at Obrawalde between late 1942 and the arrival of the Russian army on January 29, 1945, is estimated to be about ten thousand. Included in this number may be some patients who died natural deaths (ibid., 700).

The following is a description of life as a patient at Obrawalde given by Otto Freund on December 4, 1964, at the Landesgericht in Frankfurt. Freund was born on January 22, 1915, in Bernburg, and at the time of his deposition he was residing in Frankfurt. Prior to being hospitalized in Obrawalde, he had been charged with desertion and theft and was kept under Paragraph 511 in a psychiatric institution in Osnabrück. When that hospital was subjected to repeated air raids, the patients were transferred to Obrawalde. According to Landesgerichts Rat Grabert, this statement by Otto Freund seems credible but “some reservation should be exercised regarding the dates and figures” because Freund “appears slightly retarded but not mentally ill” (the order of the statement has been rearranged for coherence) (Grabert 1962, 827).

When we left Osnabrück, we did not have any particular medical examination. I don’t ever remember having been examined by a physician who was not part of the institution. Patients who did not work in Obrawalde were killed by injections. Towards the end we were made to build a crematorium. Until that, the corpses were buried in mass graves. The graves were about as wide as a coffin and about two meters deep. Five to seven corpses were put on top of each other and
wrapped in black paper. Then we kept on digging and covered them with new earth. In this way, it went on. When relatives came to attend the funeral, the deceased was buried in a coffin with a trap door. These coffins were hinged on the bottom so that the body could be dumped from the bottom into the grave after the funeral and the coffin could be taken up to be reused. These funerals took place at 2 p.m. while those of patients who had no relatives attending were buried in the mornings. When relatives wished to bury the patients at home, the coffins were loaded onto railway cars, usually at 2 p.m. Once I helped and noticed eight coffins in a car... At noon when the field and farm workers had left, the corpses were taken out from Haus 18 for men and Haus 9 for women. I think there were about 40 corpses daily. The caregiver dealing with the corpses was small and had a beard. I cannot remember his name. All his workers were a bit crazy.

Head caregiver Weidemann and Dr. Mootz told us that we had to keep quiet about what was going on in the shop or elsewhere in Obrawalde. If we were found talking, we would be given an injection too. Weidemann gave the injections to the men in Haus 18. The women were given injections in Haus 9 but I do not know by whom...”Raddats” is a name I remember only because he was a friend of Schütte. He did have a seizure and like all who had seizures, he was given an injection.

The caregiver in our block was also the Nazi group leader in the village. He was a large man. I cannot remember his name. Maybe it was Wollenberg. I used to play chess with him.

We also built rabbit pens with the wood we received from the coffins. The name of the caregiver who was responsible for the angora rabbits was Schwarz. He and I escaped together when the Russian Army came... In the night when we had to escape from the Russians in January 1945, it was nurse Meina who let us out. (Freund 1962, 823–827)

Hedwig Neumann Vollheim, who worked as a laboratory and x-ray assistant at Obrawalde, provided a perspective in a statement to the Bavarian Criminal Police in Munich on February 10, 1960.

To answer the question when the killings began at Obrawalde, I will say the following: During the summer or fall of 1942, I happened to talk to the pharmacist named Winter or Winkler. Among other things, I asked him why there was so much morphine taken out lately. His answer was that all morphine went to Department VII where Dr. Mootz was the head physician. Later I asked my husband (a psychiatrist at Obrawalde, Dr. Vollheim) about it. From the way he reacted, I assumed that he was not aware of any of the killings. I must add that my husband was primarily a scientist and busy with other problems.

A few months later I had to go to the local police station to get an identification card. The police officer asked me how come there had been so many more deaths reported at Obrawalde and how come not
one of the death certificates had my husband’s signature. At the next medical conference, my husband mentioned the observations by the local police. The reaction of the other physicians was absolute silence.

Again a few months later, my husband was summoned to the local police where he was told it was not permissible to use just a stamped signature when signing a death certificate. They had to be signed by hand. My husband was quite surprised and asked to see some of these death certificates. They were indeed signed by using a stamp made from his signature. He proceeded to show these to Grabowski who told him he would get to the bottom of the issue.

The first time I heard about the killings at Obrawalde was in the fall of 1942. Patients as well as caregivers were talking about it. There was restlessness among the patients. A patient told me she had asked Dr. Wernicke where a certain patient, Mrs. K., was as she had heard someone had seen her in the morgue. Dr. Wernicke answered her: “If you keep asking about her you may end up there too.”

It was one of my duties to take photographs of patients who had been admitted to Obrawalde as well as also take photographs of those patients who had died on arrival. Supposedly these were patients who had been severely shocked by air raids in Berlin and who had died upon arrival or soon thereafter. Once—I think it was in the summer of 1943—I went again to the morgue to look for a patient to take a photograph. I saw so many corpses at that time—about 50—all placed on top of each other. I am sure that they had been killed.

To answer a question about the killings: I must say that I never was told officially about the killings. I never saw anything directly done. All I knew was through rumors from patients or caregivers. Officially euthanasia as practiced in mental institutions was never discussed with me. I think my husband too was never informed officially. At least he never talked to me about it. (Vollheim 1960, 12–17)

When the Russian army advanced on Obrawalde, Hedwig Vollheim and several other workers went as far as Paretz near Ketzin. There her husband was arrested by the Russians, and she never again heard from him nor was able to find out what had happened to him (ibid., 12–17).

A statement by Margarete Bruksch attests to Dr. Vollheim’s objections to the killings. She stated that she overheard a very heated conversation between Vollheim and Grabowski in which Vollheim stated that he did not agree with the killings and would not participate. Grabowski then threatened to fire him as medical director of Obrawalde (Bruksch 1960).

6.1 DR. HILDEGARDE WERNICKE

A central figure in the euthanasia program carried out at Obrawalde was Dr. Hildegarde Wernicke. She fled Obrawalde with her friend, Nurse
Helene Wieczorek, when the Russian army arrived in January 1945. She and Wieczorek went to Wernicke’s father’s home in Wernigerode, arriving there on February 3, 1945. In April of that year, Wernicke took over the practice of a local physician. She and Wieczorek were arrested on August 10, 1945, and she gave the following information in a sworn statement on December 7, 1945 (Wernicke 1945).

Born in Schleswig, Wernicke attended universities in Frankfurt and Marburg. She was twenty-eight years old when she began working as an assistant physician at Obrawalde in 1927 and within two years became the assistant medical director. She joined the NSDAP early, in 1933, because, as she testified, “all civil servants were urged to do so”. In 1937, she “had” to join the National Socialist women’s group and “was obliged to take on its leadership in Obrawalde” (ibid.).

I stress that I did it with a certain amount of urging. I was told that it was a duty for the war effort (Ibid.).

By the time the killings began in late 1942, Dr. Wernicke had been at Obrawalde for about fifteen years and was forty-three years old. She was unmarried and a Protestant.

Dr. Wernicke also agreed that the conditions at Obrawalde deteriorated greatly in 1939 when the institution was taken over by Pomerania. All of the special departments were dissolved, and the emptied buildings were sparsely prepared to admit psychiatric patients from other institutions. Yet, in spite of the increase in both patient numbers and acuity, the nursing and caregiving staff were only slightly increased and the number of physicians was not increased at all (ibid.).

The questionnaires required by T 4 (see Chapter 4) for the assessment of all psychiatric patients, which began in 1939, further contributed to the staff’s burden. Every patient was to be registered for the Reichsarbeitsgemeinschaft. Dr. Wernicke contended that the staff did not know the true purpose of the questionnaires at the time (ibid.).

As conditions continued to deteriorate, Wernicke became “disgusted with the situation” and stated that she asked for a transfer but was told that transfers were not allowed during wartime. She reported that she, as well as her colleagues, “suffered greatly” during this time, especially as rumors of patients being murdered became widespread.

There was no way to sound objections. Even old and trusted colleagues were done away with when they spoke up against the action (killing of patients). At times, it was rumored that a colleague ended up in a concentration camp because he had refused to let go of his patients. (Ibid.)

Also in 1939, incurable patients began to be transported to psychiatric institutions further east. If a patient was still able to work, it was
sometimes possible for one of Obrawalde’s physicians to object to the patient’s transfer, thus keeping him at Obrawalde. This practice of exceptions was soon halted, however. These first transports were via train and were escorted by caregivers from Obrawalde. The destination institutions for the early transports were provided. However, things soon changed—patients were transported by bus and the destination institutions were not given to the Obrawalde employees or the Obrawalde caregivers accompanying the transports. The accompanying “caregivers” were strangers to the Obrawalde staff. The beds emptied at Obrawalde by these transports were soon filled by patients from other institutions who were temporarily admitted before being transported elsewhere (ibid.). This, of course, was a part of the Nazis’ plan to keep families unaware of their relatives’ status and location so that visitation was impossible and the killings could be more easily covered up. “At that time, we did not know that these patients would be killed. I assumed that they would be slowly starved to death and I was very upset” (ibid.).

All children arriving at Obrawalde were on the lists to be killed. However, most of them were dead upon arrival or died soon thereafter due to the exhaustion of the trip. “The children arrived in such a poor state of nutrition that I asked the caregivers whether they had been fed at all as patients in Wittenau” (ibid.).

During the spring of 1943, Wernicke was to become one of the participants in the killing of the incurable patients.

It was a special duty due to conditions of war time. If I had refused to perform this task there would have been serious consequences. When I was not sure I would do it, I was told that there easily could be another physician taking my place. The idea of losing my job was frightening for me because I had no other income at all. Furthermore, there was a reason to be afraid for my life because it became certain that Grabowski had been informed about my angry outbreak about the present situation. I had said, “it is bestial what they are doing with our patients. If it is a law and it is necessary to kill them, it would be better to do it right here to spare them the misery of the transport. All in all, Himmler and those others at the top are crazier than our patients. It would be a good idea to bring them here and to institutionalize them so they could witness what is going on.” Such a remark could cost one’s life. I further showed my disgust for Himmler and the SS quite openly and opposed the smear campaign against religious beliefs which was rampant in Obrawalde since Grabowski had taken over. All of this caused me to fear for my life if I refused to take on this new responsibility and duty of my position.

I cannot agree that I acted criminally. My action was a response to orders from above. The “action” was in existence for over 3 years. One would not assume a public authority would be involved in a criminal
There was a law in existence but it could not be made public during war because of upsetting the general population. I did not doubt the truth of this answer. It appeared to have brought an increased number of requests by relatives of the patients—sometimes verbal and sometimes written—to help end the suffering of the patients with a merciful death. I was unable to obtain any additional information because Grabowski had threatened me with imprisonment or even the death penalty if I were to talk to anyone about our conversation.

From the very beginning I refused to perform the killing myself. I was able to adhere to this position by saying that it would appear too obvious if I did it myself. The selection of the patients who were to be killed should come from the Reicharbeitsgemeinschaft.

The patients were all incurable and in advanced stages of debilitation. I wish to stress this because I was accused of killing politically undesirable individuals who were sent to the institution under the pretense of mental illness. This (my killing of these patients) is impossible because of the patients’ histories and other existing reports including the physical examinations. It was my task to sift through the masses of the arriving transport patients and save from immediate death those who might improve or who were able to perform even minimal work. I can truly say that I did what I was able to do with this tremendous workload. I was taking care of 500—700 patients. I carefully read through every patient’s record and personally examined every patient. I took aside patients who had even a minimal possibility of improvement. Already I have described the state of the patients on arrival. I will have to add about their state of nutrition, especially during the last one-half year that all patients who were unable to perform any work were put on a so-called 2 form of maintenance which was a true starvation exercise. It was necessary in order to keep alive other patients who were able to work. So now only the truly suffering malnourished incurable patients were given the mercy injections. They soon would have died in any case.

I never asked my patients about their political beliefs, their religion or their race. They all seemed to me to be helpless poor human beings who I was responsible for. With my whole heart, I did everything to keep recently or newly afflicted patients and those with the potential for improvement alive. My patients were very attached to me and never even until the very last seem to be threatened by me. In fact, it became a problem when they had to be transferred to another ward.

. . . My part in the killing of incurable mental patients was a duty which I was unable to avoid unless I would be subjected to extremely severe punishment. I was afraid for political reasons. I was convinced of the lawfulness of my actions. I did not personally kill the patients because I refused to do so. With the best of my knowledge, I took care that only those patients were selected for whom death truly would
mean a salvation. I further saw to it that there was no threat or suffering would be involved once the decision to end a life was made.

I loved my patients very much and never mistreated them nor hit them. To the contrary, I always took good care in order to ease their difficult lot as much as possible (Ibid.).

According to Wernicke, there were still lists of patients to be killed when the Russians arrived in January 1945.

6.2 THE NURSE-DEFENDANTS OF OBRAWALDE

In 1964, fifteen of the nurses of Obrawalde who were accused of killing, or assisting with killing, patients hospitalized in the psychiatric hospital were to be tried for their actions. One nurse committed suicide before the trial. The following are the summaries of the accusations against them. Because more than twenty years had elapsed since the murders of the patients, none of the witnesses’ statements was judged by the court to be particularly valuable in further clarifying the circumstances surrounding the events. Thus the judgment was based upon the statements of the fourteen defendants.

6.2.1 Luise E.2

Luise E. learned of the murders of Obrawalde in 1943. At that time, Dr. Wernicke ordered Luise to administer 5 grams of Veronal to restless patients on Station 9U (the so-called restless ward [toestation]). Luise assumed that Dr. Wernicke was mistaken when she ordered 5 grams as that was ten times the usual dose (0.5 grams) for sedation and administered the customary dose. The patient calmed down, and the following day, Luise told Dr. Wernicke about the incident. Dr. Wernicke became very angry, screaming and yelling. She asked Luise if she did not understand that a doctor’s order was to be followed exactly. It became clear to Luise from this reaction that Dr. Wernicke had intended to have the patient killed with an overdose of the sedative Veronal. Luise decided to discuss the incidence with Dr. Mootz, who also worked on the women’s wards. Luise felt comfortable confiding in Dr. Mootz as they had worked together for about twenty years. Luise asked him if it could be possible that patients were being killed in Obrawalde. Dr. Mootz shrugged and explained to Luise that there were orders from the government to do so and that there was nothing he could do about it. Dr. Mootz explained that there was a law mandating this and that if there were further incidents, Luise should come to him. Luise had a second conversation with Dr. Mootz, but this revealed nothing further on the topic. Subsequently, Luise assisted in the killing of at least ten patients. These were severely ill patients selected by Dr. Wernicke, and the killings were done under the supervision of Amanda R. Dr. Wernicke ordered the specific dose
of Veronal to be dissolved in water for each patient. Some patients willingly drank the medicine; however, others had to be held down, requiring the assistance of many caregivers. Luise told these patients that Dr. Wernicke had ordered the medicine for them. If they refused to swallow, or if the oral medicine did not bring about the intended result—death—they were given lethal injections of morphine and scopolamine (Sagel-Grande 1979, 702).

In late 1943, Luise had to take over the position of head caregiver (oberpflegerin) at Station 6. While in this position, she took part in the murders of at least 110 severely ill patients. In the pretrial questioning, Luise E. stated that she had assisted in approximately two hundred killings in Haus G. It was later in the actual trial that she downgraded her complicity to 110 killings (ibid., 702).

These patients had been selected by Dr. Mootz after studying their files and seeing them during his rounds. It was Dr. Mootz who ordered the exact dosage of sedatives for each patient. In about two-thirds of the instances, it was Luise herself who administered the fatal dose; in the other one-third she assisted. All of the killings took place in the “isolation” room specially designed for the purpose. At least one other caregiver, including Anna G., Erna El., or Martha W. on occasions, assisted with each murder (ibid., 702).

6.2.2 Anna G.

Anna G. was born on November 28, 1897, in Charlottenhof. Her parents owned a small farm, and from the age of fourteen until she was eighteen years old, she helped on the farm. At age eighteen, she received some training in business and worked in retail for eight years. When she was twenty-nine, she began her psychiatric nurse’s training at Treptow. She joined the Nazi Party in 1935 but was never active. The psychiatric institution at Treptow became a military hospital in 1941. At that time, Anna brought the last of the patients to Obrawalde and began working there on a ward for nonacute patients (Sagel-Grande 1979, 696).

In 1943 or 1944, Anna was working at Station 6 O (oben—upstairs). Dr. Mootz was the physician, and Grunau, and later Luise E., were the head nurses on the unit. 6 O had two wards with non-acutely ill patients, one ward for severely ill patients, and a large room where patients ate their meals and stayed during the day. Occasionally transports of patients from other institutions would arrive and bring severely sick patients to this unit (Anna G. 1962).

The following was her testimony given on November 14, 1961, at the Landesgericht Traunstein:

Dr. Grabowski was greatly feared and there was talk that one might end up in a concentration camp if his orders were not followed. He was often seen in uniform. His assistant was an SS man, Mr. Herbert. Many people who belonged to this group left the church.
Euthanasia was practiced quite openly on Station 6 upstairs. I remember on the occasion of a birthday visit, I mentioned to Frl. (Luise) E. something like, “maybe one day we will end up in prison because of what we are doing here”. Otherwise I did not have any private conversations with Frl. E.

The first case in my memory when I partook in a killing was when Frl. E. called me to give her a hand. I was called into a small room. There was a severely ill woman about 40 years old. Frl. E. ordered me to dissolve the medication in water. From the dose, I knew it would be lethal. Frl. E. then gave the medication to the patient. I held on to the patient who was violently objecting to the drink. If she knew what it was that she was drinking, I do not know. Later I was ordered by Frl. Hirschmayer to check on the patient until she was dead. Later I learned that Dr. Mootz would point out certain patients during his rounds to the head nurse and he would request their records. Those were the patients to be killed. (Anna G. 1962, 401–414)

When asked by the interrogator why she assisted even after realizing the dose was lethal, Anna replied that “she was told to follow orders”. Since she had become an “official” in 1933, it was all the more her duty to follow orders. She also was afraid of Frl. E., Grabowski, and others. She said that she had to support her elderly father and was afraid she might lose her job. When she became aware of the killings there, she, like Luise, went to Dr. Mootz. He told her that it was required by law to kill all of the infirm mentally ill and that, as a public servant, she would have to do her duty just as he did (Sagel-Grande 1979, 703). Anna G. worked in Haus 6 O for four to six months. During that time, she was a participant in the killing of approximately twenty patients, mainly by bringing the patients to the small special room or by preparing the medication (Anna G. 1962, 401–414). She also had a role in selecting some of the patients for death by pointing them out to Dr. Mootz as he made his rounds. Her killings stopped when she was transferred to the pediatric unit in Haus 3 (Sagel-Grande 1979, 703).

At one time there was a patient who was working in the potato cellar. When she saw two other patients being brought to the small special room, she said, “Oh, my, you dear ones, what will still happen to all of us?” Anna told her, “Don’t worry, you are so hard-working that nothing will happen to you” (Anna G. 1962, 401–414).

Anna stated that she took part in the killings with Luise E. and Margarete R. She once witnessed an injection of air when she was holding the arm of the patient. She was “unable to recall the particular patient but thought it may have been a severely mentally retarded patient who was physically still quite strong.” Anna was unable to recall if Luise E. did air injections (ibid., 401–414).

In mid-1944, Anna was transferred to the pediatric department. Dr. Wernicke was the head physician for the department, and Dr. Schneider was
her assistant. Amanda Ratajczak was the head nurse. Anna was ordered to take children to the special room ten to twelve times (ibid., 401–414).

Later Anna worked on Ward 9, where the “restless”, mainly schizophrenic patients, were housed. All patients on this ward were heavily medicated. Here many killings took place, possibly more than on the other wards. Anna helped to bring them to the special room. She stated,

I do not know of any caregiver who refused to partake in these procedures. I also do not know of any caregiver who was sent to a concentration camp. My sister who was a protestant nursing sister (Diakonissin) refused to partake in anything. She had strong support from the motherhouse. Other caregivers did not have support like this. At times I thought to ask for a transfer but I was afraid of losing my job and I had to support my father. I was especially afraid of Grabowski—he even had the church of the institution closed. (Ibid., 413)

Gertrud G., Anna’s sister, was not a defendant in the trial but provided a statement. Her statement corroborated Anna’s. Gertrud, too, worked as a nurse at Obrawalde but was a member of a protestant nursing group, a Diakonie nurse. She stated that she was never approached about euthanasia and did not believe that it could happen. Had she thought it was true, she would have requested a transfer, which would have been a possibility because her contract was made by her motherhouse rather than individually. Gertrud did acknowledge that she was asked to bring five or six patients from her ward to another when requested by Drs. Wernicke or Mootz but she did not see anything unusual in the requests. In late 1944, she saw a mass grave at the institution’s cemetery and became somewhat suspicious (Gertrud G. 1962, 632–637).

6.2.3 Martha W.

Martha W. was born on July 24, 1908, in Gnesen and at the time of her trial was residing in Traunstein. She admitted to killing about fifty patients during her employment at Obrawalde. Martha also worked on Ward 6 O at Obrawalde at the time when Dr. Mootz was the physician and Luise E. was the head nurse (Martha W. 1962, 773–774).

Martha first learned of the killings when, in the presence of Grunau, Dr. Mootz ordered one of the patients to be killed by injection. When Grunau refused to take part in the killing, Martha also refused, stating that she would not need to take part because she was of a lower rank than Grunau. Dr. Mootz explained that the killings were ordered by law and, as a public servant, she could not refuse this duty. However, he did offer to try to have her transferred. In a few days, Dr. Mootz told Martha that he had been unsuccessful in arranging her transfer. In the months following this, Martha assisted in the killing of at least 150 patients. In some
instances, she prepared the medications and supported the patients as they were being given the lethal doses. In about fifty cases, she herself administered the medication, either orally or by injection, and in one case when the patient refused the oral medication, she administered it by enema. Martha is reported to have talked “sweetly and kindly” to the patients as they fell peacefully into their final sleep (Sagel-Grande 1979, 703).

Martha testified during her trial that

during his rounds, Dr. Mootz would point his finger at certain patients who were then taken into the special room. Usually there were one or two patients daily except Saturdays and Sundays. Many had been sent from other institutions and there were no records available. (Martha W. 1962, 461)

Martha was usually asked to bring the patients to the special room and to hold them when they were given the medication. She did not recall any patient being aware of the purpose of the medication (ibid., 461–465).

Martha recalled one incident when a farmer came to take his daughter out of Obrawalde because he needed her to work on his farm. The daughter had had religious delusions and had manic phases. The father was told that the daughter would first have to be sterilized. Following this surgery, Martha told the father to take his daughter as quickly as possible, and, in fact, Martha testified that she often advised visiting relatives to take their patient out of the institution as soon as possible (ibid., 461–465).

6.2.4 Erna E.

Erna E. was born on June 6, 1905, in Ottlotschin and received her psychiatric nurse’s training in Treptow. In 1941 she was transferred to Obrawalde, where she remained employed until the Russian army arrived in 1945 (Erna E. 1962, 546–550).

Erna E. worked upstairs at Station 6 of Obrawalde. Like Martha, Anna, and Luise, she administered lethal doses of sedatives or held patients while others did so. Erna E. was accused of participating in the killings of at least one hundred patients who had been designated by Dr. Mootz. She, too, had been informed by her supervisor that the killings were ordered by law and as a public servant she did not have the right to refuse to participate (Sagel-Grande 1979, 703). Her involvement consisted of bringing patients to the special room and undressing them as well as holding some while the medication was administered. At times she had to help carry the bodies to the cemetery (Erna E. 1962, 546–550).

Like Luise E., Erna E. admitted to participating in a higher number of killings during her pretrial questioning. She claimed she had admitted to this number because she was in poor health and because the police officer had suggested the number. During the main trial, she claimed she was
unable to give an accurate number of killings in which she participated, but she did not deny her participation in some (Sagel-Grande 1979, 703).

When asked why she did not refuse to participate, Erna answered that she never regarded the killings as something that was wrong because they had been ordered by her superiors. She stated that there was no alternative to following the orders (Erna E. 1962, 546–550). An unsuccessful pretrial motion to dismiss the arrest warrant against Erna was congruent with her later testimony. The requesting attorney, Dr. Eckhard Klein, objected to the arrest because “the accused Erna E. could not possibly have the mental awareness to look at her obedience to her superiors as wrong doings” (Klein 1962, 570–576).

6.2.5 Erna D.

Erna D. received her nursing education in Treptow and was transferred to Obrawalde in 1941. Her first assignment was in Haus 10, where no killings took place. Later Erna was transferred to Haus 5, where she worked with Anna G. and Dr. Wernicke (Erna D. 1962, 516–526).

Erna D. was ordered to bring an older patient with severe Parkinson’s disease to Haus 3, where she was taken into a small room and undressed. There Erna was asked to hold the patient’s hands by the caregiver Koslowski as the patient was administered a milky substance. The patient soon died (Sagel-Grande 1979, 703).

Erna occasionally had to bring patients to the special room or hold them when medication was given, usually from a normal-sized cup. Once she refused to give an air injection to a patient and was severely scolded by the head nurse, Amanda Ratajczak, who then proceeded to give the injection herself. Erna stated that she was always taught to follow orders—it was her duty to follow orders and she was afraid to refuse (Erna D. 1962, 516–526).

6.2.6 Gerta S.

Gerta S. was born on April 14, 1908, in Greifenberg, and, like Anna G. and Erna D., she was trained as a psychiatric nurse at the institution in Treptow. From 1941 until January 29, 1945, she worked on various wards at Obrawalde. In her testimony at the Landesgericht in Traunstein, she said that she had heard rumors early in her employment about patients being killed at Obrawalde. Additionally, she became aware of an increasing number of deaths when she noticed the many corpses in the morgue (Gerta S. 1962, 530–540).

Gerta’s first involvement in a patient’s murder was when Dr. Wernicke ordered her to inject 5 cubic centimeters (cc) of Luminal intramuscularly. Because Gerta knew the patient well, she checked the order with her superior and Dr. Wernicke, who repeated that 5 cc was the correct order because the
patient had had recent seizures. Gerta administered the injection but noticed that, by evening, the patient was still alive. The patient had been receiving Luminal frequently and had developed a tolerance for higher dosages. On the following day, Gerta found the patient (whose last name was I.) deceased in her bed. Who administered the fatal dose was unknown.

In another instance, there was a patient named Mina Bütow, to whom Gerta felt close. B. was about seventy years old and had tuberculosis and ascites. Before leaving for her vacation, Gerta pleaded with Dr. Wernicke to spare B., but, upon her return, Gerta found that B. was dead.

Gerta testified that she did not remember how many killings she had been present for or involved with. When asked why she did not simply refuse the orders, she stated that it would have been impossible and she was afraid she would end up in a concentration camp. When she was asked if it would have been possible that Dr. Wernicke had asked her to help with the killings because she was also a member of the NSDAP and the NS Frauen-schaft, Gerta insisted that it was her sense of duty to follow the orders of her superior and that she had been under the impression that there was a law requiring the killings.

During the trial, Gerta was asked about the relationship between Grabowski and E., and she replied that she had no knowledge. Additionally, she was asked about the whereabouts of Grabowski, and Gerta stated that she last saw him at the railway station in Meseritz with his horse-drawn cart (ibid., 530–540).

6.2.7 Margarete Ratajczak T.

Margarete, not related to the defendant Amanda Ratajczak, was born on June 21, 1922, in Bobelwitz. She worked from 1943 until early 1945 on Station 9, a unit for acutely ill psychiatric patients. She had been trained by Dr. Wernicke, who supervised her on Station 9, along with Amanda Ratajczak and the station caregiver, Waniczek. When the killings started on the unit, Margarete turned to both Dr. Wernicke and the head caregiver for advice. Both told her that the killings were legally ordered and as a public servant she would have to comply. She is reported to have talked kindly to the patients as they were being killed, thus “calming them and minimizing their misery” (Sagel-Grande 1979, 704).

Margarete admitted to having killed several female patients at Obrawalde during the time from 1943 to 1945. The killings were done with either injections of morphine with scopolamine, which were usually given intravenously but occasionally as intramuscular injections, or Luminal tablets dissolved in water and administered orally. Margarete remembers that often Amanda Ratajczak or Dr. Wernicke prepared the medication when she did the actual killings herself (T. Margarete Ratajczak 1962).

When questioned, Margarete was unable to recall the exact number of patients who she killed or assisted with killing. She estimated that she
killed about twenty patients and assisted with an additional two hundred. She denied having given any air injections, although she may have assisted with such (ibid., 761–776).

Margarete made the following statement:

It never occurred to me not to follow the orders given to us. Just as the soldiers on the front had to do their duty, so did we. To absolutely follow orders given by an attending physician is one of the most important duties of a caregiver. For this reason, the proviso if I would have also become a thief when it was ordered, is besides the point. The orders given to me were within the field of my work and my training (ibid., 761–776).

6.2.8 Meta Martha Margarete P.

Meta was born on August 27, 1911, in Mohro and at the time of her trial was residing in Lüneburg. She received her nursing education in Treptow and transferred to Obrawalde in August 1941 when Treptow was no longer a psychiatric hospital. At Obrawalde, she was employed on a women’s ward where Auguste Jeschke was the head caregiver. On this unit, she was attacked by a patient, and, after she recovered, she was transferred to Haus 5. There she worked with Ratajczak, Gertrud G., and Helene Klinner. Haus 5 had ambulatory patients who were able to work throughout the institution. Some were employed in the laundry, and others were involved with food preparation such as peeling potatoes and other vegetables. Others worked on Obrawalde’s farm and in the Angora rabbit breeding program, where they combed the animals and plucked the fur. Additionally, there was a large sewing department that employed some of the patients (Meta P. 1962, 678–683).

Meta herself usually worked outside. She never visited the morgue or saw anything unusual in the cemetery. However, she did notice the many transports that arrived, wondered where that many patients were being housed, and heard rumors among the other caregivers in 1943 and 1944 about the high mortality rate at Obrawalde (ibid., 678–683).

Meta testified that she was never asked if she would be willing to participate in the killings. She stated that she vaguely remembered being warned not to talk with any person outside of Obrawalde about things that occurred within the institution (ibid., 678–683).

While working as a nurse in Haus 5 in 1943 or 1944, Meta was ordered by the head caregiver to take a patient to Haus 3. Once there, the patient was placed in a special room where the caregiver K. attempted to administer a lethal dose of oral medication. Because the patient was extremely restless, K. asked Meta to come into the room and hold the patient’s arm so an injection could be given. When the patient quieted down sufficiently, another injection was given and caused the patient’s death (Sagel-Grande1979, 705).
Meta testified that as the injection was being given, the patient looked so directly at her that she thought she could never forget it. After the killing, Meta returned to Haus 5 and told the head nurse, either G. or K., that she would never take part in the transfer of a patient or any other attempt to kill since she “just did not have a heart for such things”. After that day, she was never asked to transfer a patient or otherwise participate in the killings (Meta P. 1962, 678–683).

6.2.9 Else T.

Else Martha Gertrud T. was born on August 14, 1920, in Treptow, where she received her nursing education. She was employed in Obrawalde from August 1941 until January 29, 1945, working in various wards (Else T. 1962, 684–693).

Else was employed in 1942 on the children’s ward in Haus 3. It was on this ward that she first heard about the killings at Obrawalde from the other caregivers who had observed that there were a large number of patients arriving in transports but none were leaving (ibid., 685–693).

Else is reported to have helped with the murder of a mentally handicapped five-year-old girl by holding her so that K. could give her a fatal overdose of a sedative. Else testified that the child had refused to drink the medication, so she held the child’s arms while K. gave the medicine with a spoon. Else left immediately afterward and stated that she did not know what the medicine was or if the child “fell asleep” afterward (ibid., 684–693).

Sometimes Else helped unload the patients who arrived by transport. These transports came from many different places. In some instances there were children who were in an extremely poor nutritional state, and sometimes patients died during the transport (ibid., 684–693). When Else was working in Haus 6 downstairs, she heard that killings were being done upstairs. Occasionally, Else had to go upstairs for an hour in the mornings before taking her work group out to the farm but never witnessed any murders (ibid., 684–693).

6.2.10 Berta H.

Berta Gertrud H. was born on April 2, 1899, in Gottersdorf and received her nursing education at Obrawalde. At the time of the trial of the Meseritz-Obrawalde nurses, she was residing in Hamburg. She was summoned to the police station in Hamburg on November 20, 1961, and provided the following statement:

I cannot remember when the killings began at Obrawalde. In the very beginning, patients were selected for transport and so were sent away. I think in Haus 8 the killings started during the summer or fall of
1943. At about this time, Dr. Wernicke and Amanda Ratajczak made rounds at Haus 8 and I went with them. At this time, Dr. Wernicke proceeded to tell us that there were orders from the Führer telling us that all hopelessly ill patients had to be eliminated. (These statements by Dr. Wernicke did not happen during meetings of the NS Frauen- schaft but during rounds.) To follow up with these Führer’s orders, we were to prepare the smaller room with only six beds for such purposes. Dr. Wernicke did not mention all the patients to be killed by name at that point. She only did so day-by-day, case by case.

I remember that I started to cry and told Dr. Wernicke: “Since we did not give life to the patients we have no right to take it!”. Dr. Wernicke then told me I could no longer be head caregiver and she ordered Mathilde K. to take my position. I remained with my decision not to kill patients. I have not been punished for this decision nor was I demoted from my position as head caregiver. The only difference was that I never was ordered to give injections or mix medications and make the patients drink them. I had the impression that Dr. Wernicke knew already before she made rounds which patients would be selected for the killing. I do not remember where the patients’ records were kept. I never got any orders about preparing medications or injections from Dr. Wernicke. All I was ordered was to see that certain patients would be transferred to the special room. I cannot remember how many patients were ordered to be transferred. It did not happen on every day’s rounds. I would venture to say that 80 to 100 patients were killed in Haus 8. The patients were told that they would receive some special treatment to help them. I do not remember any patient refusing to go to the special room.

I know that there were different methods used to kill the patients. At Haus 8, only Dr. Wernicke and Head Nurse Ratajczak used morphine with scopolamine or Luminal given intravenously. The other caregivers would dissolve Luminal or Veronal for oral use. I know Amanda Ratajczak would use air injections at times—maybe when no medicines were available. In these cases, a 20cc syringe was filled with air and injected into the patient’s vein.

Every Haus had a cupboard where all medications were kept. Only the physician and the head nurse had keys to this cupboard. No one else could get to it. I doubt whether there was any accounting of the amount of medicines used. Normally this would be one of my jobs. It is also possible that Grabowski did not want any account of the medications used to avoid questioning from some quarters.

After the transfer of the patient to the small room had been ordered, Amanda Ratajczak would announce what time she would come to see patients in the special room. At times she gave the medication by herself and at other times she ordered some of us to help her by holding the patient.

At the time I was convinced that it was wrong to kill patients. I could not help assisting in some cases and I convinced myself that I was not
doing the wrong thing since I had refused to be actively involved (Berta H. 1962, 693–704).

When Berta was asked if she knew the whereabouts of Grabowski, she stated that she did not. She stated that she had suffered from diphtheria at the time and had escaped to Hamburg via Denmark (ibid., 693–704).

6.2.11 Martha Elisabeth G.

Martha Elisabeth G. was born January 14, 1905, in Meseritz. She began her nursing education at Obrawalde in 1926 and worked in many different stations there until January 1945. During her deposition at the police station in Wasserburg on January 26, 1962, she stated that she first became aware of the killings when she heard a patient say to some of the other patients, “Down there people are dying.” Initially, Martha regarded it as just “a remark of a mental patient”, but when she told the head nurse Jeschke she remembered distinctly that Jeschke did not say a word (Martha G. 1962, 742–754).

Martha worked as a caregiver in Haus A I from 1941 until spring of 1943. After that, she worked as an assistant caregiver in Haus 8. Shortly after the killings started, she was ordered by Dr. Mootz to administer a tranquilizer to an agitated eighty-year-old woman. This injection was followed in about two hours by a second injection. The patient died within a few days, and Martha began to suspect that patients were being killed when another death occurred after receiving an unknown amount of Luminal. Martha went to the head caregiver, Jeschke, to discuss her suspicions, saying that she was a Catholic and could not burden her conscience any more (ibid., 742–754). She was informed that the killings were legally ordered and had to be done. In February 1943, Martha was ordered by Dr. Mootz to give an overdose of Luminal to a psychiatric patient who had bitten another patient. Martha questioned Dr. Mootz about the necessity of “burdening herself” with such an act, and he explained that the killings were a new law and she would have to obey. Martha then gave the lethal medication but again went to the head caregiver, Jeschke, and begged to be excused from having to do further killings. Following this, the killings were carried out by other caregivers. Martha transferred to Haus 8, and it was there that she heard it said for the first time: Killings were done to get rid of useless persons who ate meals but did not work. In Haus 8, Martha did not administer any overdoses but assisted others in murder by holding patients upright or restraining them so other caregivers, such as Amanda R., could give injections of morphine and scopolamine. Again Martha attempted to be excused from participating in these killings by appealing to Dr. Wernicke. She explained to Martha that these killings were legal, that she (Dr. Wernicke) alone took all responsibility for the killings, and that the killings were necessary to make room for wounded soldiers during these difficult war years. She did excuse Martha from actually administering the medications but did not release her from having to assist (ibid., 742–754).
Martha G. remained in Obrawalde until the Russian army arrived, and she witnessed and assisted in many more killings. Once the head nurse, Amanda Ratajczak, came to Haus 8, where Martha was working. Amanda was crying and said, “I have to come here and do it myself—in other houses they do it themselves”. Martha recalled that frequently tears were shed in those days because “no one knew how to get out of this” (ibid., 742–754).

Martha described how Grabowski initiated so-called roll calls when he first arrived at Obrawalde.

During these, he described how the soldiers on the front protected us so would we have to do our utmost. How patients in Obrawalde lived like in a palace and it was time to make room. Again and again he said that everyone must give his utmost and whoever was found slacking would be transferred. So it seemed normal to yield to the constant pressure from the superiors who it was believed knew what was right because they had a better education (Ibid., 742–754).

6.2.12 Edith B.

Edith B. was born on August 7, 1918, and received her training like many of the others in Treptow (B. Edith1962). She worked as a caregiver on Station 2 in 1943 (Sagel-Grande 1979, 705). During her interrogation in 1962, she made the following statement:

I always felt sorry for the patients. For one of our patients—a female patient from Hamburg who was very upset and disoriented due to the bombing in Hamburg—I smuggled letters to her husband out of the institution. This was certainly against the rule and I would have seen consequences if it had been discovered. At that time, I did not yet have the status of a public official but my attitude was the same. To us younger workers, the head nurse was something like a higher being and it was absolutely right to follow their orders.

I saw no connection between transferring a patient to a different room and killing them. I myself had absolutely no motive and no intention to transport any of our patients from life into death. I do not remember having been asked by anyone to keep events in Obrawalde absolutely secret. But I do remember how physicians and others stressed not to talk much about working conditions. (Edith B. 1962)

6.2.13 Margarete Maria M.

Margarete Maria M. was born June 26, 1910, and at the time of her interrogation on December 12, 1962, she was residing in Andernach. She received her nursing education at Obrawalde beginning in 1930 and successfully passed her examination in 1932. She remained an employee at Obrawalde until the advance of the Russian army in January 1945. Margarete stated that
she did not recall all of the different units on which she had been assigned. When many of the young male caregivers were drafted into the military, she was working with male patients. In 1941–1942, she was assigned to oversee patients who were working in the sewing department making fur garments for the German soldiers. Later she worked on a children’s ward that housed about thirty children and fifteen adult female patients.  

Once Margarete was assigned to accompany a transport of patients from Obrawalde to another institution near Gnesen. She recalled that she was quite surprised about the lack of accuracy of the other institution regarding the property of the patients and remarked that at Obrawalde every handkerchief and old hat would have been registered. She was aware of the “special room” where patients were brought to die and admitted helping to hold patients while the caregiver K. gave a cup of fluid to the patient. However, this took place in the ward and not in the special room. She denied ever giving assistance when injections were given. During her interrogation, she made the following statement (Margarete M. 1962):

I never was sure but I had to assume that my assistance when K. gave these liquids to the patients had to do with intent to kill the patient. But how could I resist? K. was my immediate superior and I was bound to obedience to her. I might have lost my job if I did not follow her orders. At that time, I had to take care of my grandparents because my mother had died in 1942 so I was the only one to take care of them. After my son was born, I tried several times to change my job and leave Obrawalde but they offered me half-time work and I would have otherwise lost my benefits as a civil servant.

I myself would never intentionally kill a patient. I took the profession of caregiving to help these poor people.

There also was a talk about a law that gave orders to kill patients. If it was not right to do it, how come no public prosecution was intervening? How come public health (officials) did not react? The increased number of deceased patients must have come to their attention. They always were active when epidemics occurred.

All in all, I have to say that everybody in Obrawalde was ill at ease. We caregivers were careful about what to say. All of us were afraid of being called to Grabowski’s office. In the town of Meseritz, there was much talk about what was going on in the institution but we caregivers were not allowed to talk about what was going on. I remember that it was not allowed to use the so-called “black path” which led sideways to Obrawalde from the outside so that outsiders would not be able to look inside the institution. (Ibid.)

6.2.14 Gertrud F.

Gertrud Krause F. was born on May 25, 1916, in the Labiau Kreis of East Prussia. She received her training as a caregiver in Obrawalde and worked
there from 1942 until 1945. Following the war, she went to Hamburg and studied the nursing of infants and children at the Children’s Hospital of Hamburg–Rothenburgsort. She passed her examination in 1947. During her years at Obrawalde, she was initially assigned to the animal “breeding department” established by Grabowski. In this department, mice and guinea pigs were bred for medical experiments and Angora rabbits were bred for their fur. She was transferred from the breeding department due to a conflict with another caregiver by the name of Hahn and was assigned to Station I. On this unit, twenty-five subacute male patients lived and worked. The head caregiver was Weidemann (Gertrud F. 1962).

During her time working in Station 1, Gertrud F. had to prepare certain medicines by dissolving powder in water. She also transferred patients to the “special room” and helped to undress them. This was always done, according to Gertrud F., in the evenings.

In the mornings, she had to transfer the corpses from the “special room” to the morgue on a flat cart. She was assisted in removing the corpses by patients.¹

In her interrogation, Gertrud F. admitted that she knew that the medications which she prepared were used to kill patients. When she realized this, she asked Weidemann not to “bother her”, and he promised that he would ask her only when he had absolutely “ran out of time”. He never asked her again. She reportedly asked to be allowed to leave Obrawalde three times and each time was turned down (ibid.).

During her 1962 interrogation she stated the following:

I am a religious person and believe in a God and in justice—without often attending church. My ethical striving has always been to not do injustices and to help others. That was the reason that I took on the profession of caregiver and to care for mentally ill persons in particular. At times when I observed and cared for severely ill patients who had no connection to their surroundings or to anything else, I looked upon their death as a salvation. I remember a few cases of multiple sclerosis. The patients were screaming in pain and asked to be relieved of their illness and their pain.

Because I did not have close contact with the killings at Obrawalde, I was not informed about the type of patients that were selected for the killings. At times I assumed that what was done was not right but I cannot say how high the percentage was of those murdered who were extremely ill.

I never had the intent to take part in the killings at Obrawalde. Preparing medicines from the patients was absolutely part of my job as caregiver. I cannot see how that makes me guilty of assisting in the killings. For many years, my only surrounding was the mental institution and we caregivers were trained in absolute obedience to our superiors
including the physicians and the director of the institution. Besides, I was the youngest caregiver on our ward. (Ibid.)

6.2.15 Hildegard Koschitzki

Hildegard Koschitzki (not a defendant in the trial), a caregiver, stated that she knew about the killings and, as a Catholic, considered them wrong but could not see any way to disobey orders. Once another caregiver overheard Koschitzki talking to another caregiver about the killings. Immediately afterward, Koschitzki was summoned to Grabowski’s office, where he threatened to send her to a concentration camp. Afterward, she reported that she lived in constant fear and anxiety. When she heard on the radio that the Russian army was advancing, she asked the caregiver Wieczorek, “What would it be like if the Russians occupied our area?” Wieczorek scolded her for having thoughts like this and threatened to tell Grabowski about it, saying that he would send her to a concentration camp. Koschitzki described her feelings about her involvement with the killings:

When I took the profession of caregiver, I did so in order to do good and help all patients. Out of this and my Catholic background, I considered the killings to be wrong. But I did not see that by transferring the patient into a different room or by helping to carry the corpses to the morgue that I was in any way assisting with the killings. I did it because some superior had ordered me to do it. We, as caregivers, were taught to follow orders always. Under the government of National Socialism, the drive to follow orders was even stronger. I did not see any possibility to not be obedient. (Koschitzki 1962)

THOSE WHO REFUSED

Elly Büchsenschuss began working as a caregiver at Obrawalde in 1942 following her treatment for a lung illness. She was assigned to Haus 17, which had ambulatory male patients who worked in either crafts shops or in agriculture. In the spring of 1944, she was asked by the head caregiver, Weidemann, to work in Haus 18. Because she had heard remarks about the killing of patients in Haus 18, she flatly refused to go. Weidemann then told her that the work in Haus 18 was less, and Büchsenschuss again refused, stating that she had never complained about the work in her current setting and was indeed happy there.

After further insistence by Weidemann to work in Haus 18, I told him frankly that there were killings going on there and how could I ever face my children at a later time if I had to admit that I had assisted
in the killing of patients. Furthermore, I had had a bout with a lung disease and did not want to expose myself to it. Weidemann just made a gesture with his hand and told me that I had to appear Monday morning for duty in Haus 18. Without further talking to Weidemann, I went to the head of personnel—I don’t remember his name—and told him that due to my previous lung problems, I didn’t want to work in Haus 18 where tuberculosis patients were housed. I did report to Haus 18 the next Monday in order to not be accused of disobedience. That same morning I was told to come to Weidemann’s office. He was there with the head caregiver S. and the head of personnel came later. Weidemann started to scream at the top of his voice that I had gone over him and that I didn’t want to be seen in the male department. He then ordered that I should immediately report to the head caregiver Jeschke on the station for female patients.

After that I worked on that unit supervising patients who worked outside the institution. Aside from my transfer to the “outside troupe”, I did not receive any consequences for my refusal. I remained in my position as caregiver and received the same salary.

I think it was the next day when Dr. Mootz reprimanded me for my refusal to work for Weidemann. Mootz also doubted that I had ever had a lung ailment. I told him to check with the home in Malchow/Mecklenburg where I had been sent for recovery. He never again mentioned it.

Much later I found out that there had been an administrative meeting and that my refusal to work in Haus 18 had come up. Apparently Grabowski made the point that since I didn’t belong to the National Socialist party, I could not be forced to work in Haus 18 because only members of the NSDAP were expected to take part in the kind of events that were going on in Haus 18. (Büchsenschuss 1962)

It is important to note here that there may have been other nurses and caregivers who refused to participate in the killings; however, because these individuals were not defendants or even witnesses in postwar trials, their stories remain unknown.

6.3 CONSEQUENCES

On January 29, 1945, the Soviet Army arrived at Meseritz. Many of the employees had fled, leaving behind about one thousand patients and workers to survive on their own (deMidlt 1996). The head nurse, Amanda Ratajczak, was found by the Soviets in early March. She admitted to killing over 1,500 patients herself, with the last murders occurring just one day before the arrival of the Russians. Amanda Ratajczak was given a brief trial by the Soviets and was made to reenact one of the killings. This process was
filmed. Sentenced to death, Amanda Ratajczak, along with the male caregiver, Hermann Guhlke, was shot on May 10, 1945 (Memorial Chamber at Obryzce 2005).

Wernicke, the head physician, and Helene Wieczorek, the station nurse, were sentenced to death in Berlin on March 25, 1946. The head male caregiver, Auguste Jeschke, died in prison in Waldheim in the Soviet zone after the end of the war, and Dr. Vollheim died soon after the war in Ketschendorf (Kühne 1962). The head male caregiver, Weidemann, committed suicide, as did the assistant department caregiver of Haus 3, Berta K. The director, Walter Grabowski, too, killed himself (Sagel-Grande 1979).

Käthe Kühne, a caregiver at Obrawalde, remained there until the Soviet army advanced, at which time she fled to Nauen. During the summer of 1945, she was taken from her home in Nauen by a Soviet soldier and imprisoned without being informed of the reason. Other medical personnel from Obrawalde also taken prisoner in Nauen were Auguste Jeschke, Elsa Reinsch, Margarete Loose, and Dr. Vollheim. After a few days, Kühne was brought to a prison in Potsdam. She was subsequently transferred to several internment camps, including Ketschendorf, Jamlitz-Mühlberg, and Buchenwald, ending up in Waldheim. Five years later, in 1950, legal proceedings were started against all 350 prisoners there. Each “trial” took about ten minutes. Kühne was sentenced to fifteen years in prison because she was a caregiver from Obrawalde who, having known about the killings, did not end her employment. She was released from the Hoheneck prison in 1954 as a part of a general amnesty. She never again worked as a caregiver because, after nine years in Soviet prisons, she had health problems and a “tendency to depression” (Kühne 1962).

Erna Standers, also a caregiver, was arrested in 1946 without explanation and transported to the prison in Potsdam. It was there that she learned that a former patient at Obrawalde had made accusations about the killings but had said only good things about her, thus leading to her release (Standers 1962).

6.3.1 The Trial of the Fourteen Nurses

At the conclusion of the trial of the fourteen nurses in 1965, the court found that the limited admissions of the accused could not be refuted. Because twenty years had elapsed, the nurses had had ample opportunity to be led by earlier statements of similar defendants in other trials. The court saw no possibility of removing existing doubts about the acts of the defendants. The accused claimed that they had not been aware that the administration of certain medications was meant to kill the patients. They stated that they did not realize that there were any selections of patients for murder and they did not realize that their participation would be criminal. The statements of each of the defendants are marked by a great deal of repetition.
Edith B., Erna D., Margaret M., Meta P., Gerta S., and Else T. claimed that they did not know that the patients that they had been “treating” were those who had been selected for death. This claim could not be refuted by the court. Each of these nurses had been involved in no more than three instances of assisting with the killings. In the final analysis, Erna D., Meta P., Else T., and Edith B. had each assisted in only one case and Gerta S. in three cases. Margaret M. assisted in two cases. The court was unable to exclude the possibility that although the defendants were seemingly aware of the purpose of their actions, there was a possibility that only later did they realize the true purpose of their actions and the consequences thereof. The court was open to the possibility that these nurses, in their minds, mingled actual events with later knowledge. This possibility is likely given that more than twenty years had elapsed. The court stated that simple-minded persons not accustomed to thinking—and all of the accused were deemed to be in this category—tend to fix events in their minds not as objective and clear but rather mingle them with insights that they have gained at a later date (Sagel-Grande 1979). Although this opinion of the court certainly helped the nurses as they sought acquittal, it also demonstrates the low regard for nurses—simple-minded and unaccustomed to independent thought.

It is worth comment that Obrawalde’s caregivers and physicians who were administered justice by the Russians fared far less well that those tried in 1965. Amanda Ratajczak was shot after a brief trial, Dr. Wernicke and Helene Wieczorek were hanged in 1946, and Käthe Kühne was imprisoned for nine years, despite denying that she ever participated in any activity that contributed to a patient’s death. She claimed that she had never brought a patient to the “special room”, prepared or administered any harmful medication, or even helped to hold down a patient when the lethal mixture was being given (Kühne 1962).

6.4 CASE DESCRIPTION:
LUISE E.—A NURSE ACCUSED OF KILLING

Luise Minna Mathilde E. was the main defendant in the trial of the fourteen nurses of Meseritz-Obrawalde. She was accused of participating in the killing of 210 patients. The following is from her deposition taken in the Bavarian State Office for Criminal Investigation, Wasserburg, Germany, on June 19, 1961.

Luise E. was born on April 5, 1901, in Gumminshof. Her parents had been farmers. After attending the primary school in Gumminshof, she worked for three years on her parents’ farm and also learned dressmaking. She began her nursing education at the Treptow psychiatric institution and stayed there following graduation. When that institution was closed in October 1941, she was sent to Meseritz-Obrawalde, where she worked until the Russian Army arrived on January 29, 1945.
At Meseritz-Obrawalde, Luise E. reported to the caregiver Jeschke, who assigned her to work in the “quiet admitting ward”. It was to this ward that patients arriving from other institutions were taken. Additionally, patients of private physicians were hospitalized on this ward. Patients who arrived by transport were assigned to wards by either Dr. Mootz or Dr. Wernicke. The “quiet admitting ward” was located downstairs in Haus 6. Upstairs was a ward for the “severely ill”. Nurses employed in that ward were Hirschmeier, the head nurse, and her assistant, W. Luise E. and G., also defendants in this trial, were also employed on that unit. There were only female patients in these wards. The head nurse on Luise E.’s ward was Guse or Gruse. Luise E.’s initial duty was to supervise the patients during the day while “work therapy” was going on. After about a year, in late 1942 or early 1943, she was made head nurse in the “restless station”. Dr. Wernicke was the only physician responsible for these patients, and it was under Dr. Wernicke that E. experienced her first case of “euthanasia” as previously described.

The actions of Dr. Wernicke gave me the clear picture that incurable sick patients were to be “saved from their suffering” by large dosages of Veronal. Neither Dr. Wernicke nor any other person in Obrawalde ever talked to me about euthanasia. I further never was told or sworn to keep these things secret. There never was a lecture or maybe some other form of instruction about the subject. I thought it was presumed that I agreed with the practice of euthanasia. My personal idea was that I would prefer such a mercy killing in case I had some terminal incurable disease—be it physical or mental.

Although this was my inner attitude, I had to fight severe inner battles when I was confronted with the problem of participating in euthanasia. The way I experienced it at that time it seemed more like killing human beings. Was there any form of legislation which would allow such killings? I was never told that such a law existed. At another time, Dr. Mootz assured me I should not worry at all about these things because he would cover up for me. These remarks gave me the idea that there was something legal about the practice of euthanasia.

A few days after the above-mentioned event, Dr. Wernicke came again and made rounds. It must have been in the beginning of 1943, I do not recall the exact date. Dr. Wernicke paused at the bed of one of the patients, a woman between 45 and 50 years. The patient was schizophrenic and was very heavy. Via my supervisor, Miss Ratajczak, Dr. Wernicke ordered me to administer about five grams of Veronal. After Dr. Wernicke left, the Veronal was taken from the medicine cabinet. I do not remember whether Ratajczak or I myself took it. The Veronal was dissolved in a glass of water. Since Ratajczak seemed to notice I was somewhat hesitant she administered the Veronal herself. The patient then was brought into a special room where she fell into
a very deep sleep. As far as I can remember, the Veronal was not sufficient. Since the patient was still asleep and unable to swallow, injections of morphine and scopolamine were prepared and I remember that Ratajczak injected the patient. Two days later the patient died.

I never administered Veronal or any other sedative by myself. It was impossible to do this because the patients were very restless and one person could not do it alone.

I am convinced the patients were aware of what was going on in the institution. They were together in one fairly large room often for a long period of time. They know each other and must have noticed how one or the other patient disappeared from time to time. In this connection, I would like to recount the following incident. One night two patients, both around 30 and both schizophrenic, made an attempt to run away. They hurt themselves during this attempt and were returned. They may have tried to run away because of fear for their lives. This event took place while I was on vacation. When I returned to work, orders had already been given to kill them. I know that both of them got the “proper” dosage of Veronal dissolved in water.

During the time from the end of 1942 and the beginning of 1943, it may have been roughly half a year, at least 15, at most 20, patients received Veronal or another sedative offered by Dr. Wernicke which resulted in their death. This was the time I worked on this particular ward. After this one-half year, I was transferred to take the place of Miss Grunan.

I was asked what I knew about how the relatives of the patients were informed, what cause of death would be given. I am unable to answer these questions since I had nothing to do with the notification of relatives or with the signing of the death certificates. I never received any instructions from Grabowski about these matters. Neither can I say how and by whom the corpses were removed or what arrangements were made about the burial.

I reported earlier that during the half year when I worked at the specific ward at least 15—not more than 20 patients—were killed by administering Veronal or morphine/scopolamine. This number should be quite correct. I can personally remember 10 killings quite exactly. The rest I know from very reliable sources.

I never had a good relationship with Ratajczak. She thought I did not “toe the line” satisfactorily, meaning that I did not do everything the way she wanted it. I was always convinced that the killings were justifiable in some cases but not in others. I felt the selection that Dr. Wernicke ordered was not done carefully enough. Out of the ten killings at which I was present, four or five were not justifiable in my opinion. Of course, I have to concede that my opinion is that of a layman. Ratajczak was more liberal in her judgment about which of the patients was to be killed. She followed Dr. Wernicke’s judgment unconditionally. I
myself had to ponder seriously about each case to judge the rightfulness of the killing.

When the head caregiver Grunau was transferred to Stettin, it seemed to be a good way to get rid of me. Without being promoted I had to take on the position of head caregiver which Grunau had left open. Three wards belonged to my field of duties: (1) the severely ill, (2) the quiet admission, and (3) the ward for patients in a reduced state of health. This latter ward was for patients who had been for a very long time in institutional care and showed obvious signs of physical strength. Only Dr. Mootz was responsible for the care of these patients. Dr. Wernicke did not work here.

In October 1941 when I was transferred to Obrawalde, the director of the institution was a physician, Dr. Banse. Soon after that—I do not remember the exact date—the director was Grabowski—an administrator. So the institution was no longer headed by a physician. Soon after that Dr. Banse left. I do not know the reason for his leaving.

Soon after Grabowski arrived there was much talk about his being very strict and about his intentions to bring many changes to the running of the institution. Rumor had it that he would bring tough regulations to the whole area of work therapy.

I only knew Grabowski from passing him in the hall—after all he was my director; otherwise I had nothing to do with him. So I cannot say anything about him during the first months I was working in Obrawalde. It was only later when I took over the job from Grunau that I witnessed the transports arriving from other institutions. Somehow I found out that most of the patients arriving in such a transport were to be killed and Grabowski was the one who ordered the killings. I cannot remember who had told me about this and I further do not know whether these orders originated from Grabowski or whether he received the order from some other place. No one among the caregivers talked about these matters. Also neither Dr. Mootz nor Dr. Wernicke talked to us about this.

I never received an order from or through Grabowski—neither directly nor indirectly. I myself have never spoken to him. What I know about him is hearsay from others. It was said that Grabowski yelled a lot at other personnel. Why or what for I do not know. Furthermore, it was said Grabowski was involved with euthanasia in other institutions. What I remember correctly was that they were other institutions somewhere in the east. The Director of Nursing Jeschke let it be known that Grabowski had been involved in the liquidation of Jews in the east.

The last time I saw Grabowski was the evening in January 1945 before the Russian Army marched in. He was giving a talk to the Volksturm [people’s troops] which consisted of a group of employees from Obrawalde. He ordered them to march against the Russian Army. The rest of the personnel were ordered to remain on the wards with the
patients. Whoever would try to run away would be shot on the spot. I later heard that Grabowski escaped in the western direction right after the talk. I never saw him again and know nothing about his fate. I do keep in contact with some employees from Obrawalde but no one was able to tell me anything about what happened to Grabowski.

Since I have been accused of saying or knowing so little about Grabowski, I would like to point out that Grabowski was a very high superior at Obrawalde and I never came personally in contact with him. All of my orders I received from Dr. Mootz or from Dr. Wernicke and sometimes from the Director of Nursing Jeschke. I have told everything I know about Grabowski and I am not holding anything back.

I shall state the following about the killings that took place during the time I was the successor of the head nurse Grunau.

Dr. Mootz was the one who gave the orders. On the day before the killings, Dr. Mootz requested the history of the patients that he would name. The records were located in the office of the ward. I had to find the histories of the patients and hand them to Dr. Mootz so he could look at them prior to his rounds the following day. He did not bring the records along when he made his rounds. Aside from Dr. Mootz, the head caregiver or her substitute would be present at the rounds. Mr. Mootz would walk up to the patients’ beds and look at them. He did not examine them. Afterwards he gave the order. So the order was given only according to the patients’ history and the external appearance. His orders sounded about like this: “Miss E., let us take about 5 grams of Luminal”. At times some other sedative would be ordered, just whatever was available. He did not say more, nothing about how or when the medication should be administered. After this, Dr. Mootz would turn around and walk to the next bed.

I always carried a notebook with me during the rounds and would write down which patients should get what medicine and how much. This was necessary to avoid any mix up or other mistakes.

After having been questioned, I state that not every patient whose records Dr. Mootz had requested was then killed. I must assume Dr. Mootz studied the patients’ records quite carefully. On the other hand, Dr. Mootz never gave orders to kill a patient unless he had studied the records. In my opinion, Dr. Mootz was very careful in his selection.

Although I have stated that Dr. Mootz took great care in his selection of patients who were to be killed, in my humble opinion there was no justification for the killing in about half of the cases. It was due to these cases which seemed to be not justified that I was constantly in such inner turmoil.

I just stated how the orders given by Dr. Mootz really contained only one sentence: “Miss E., let us take 5 grams of Luminal”. More he never would say but I understood what he meant. Having taken orders for many years plus my previous experience with Dr. Wernicke, I was fully
aware what these high dosages of barbiturates meant to achieve. Dr. Mootz did not need to say anything more.

There was a special room with two beds next to the ward of the severely ill patients. The only purpose of this room was to bring the selected patients into this place.

Although there was a fairly strict discipline among the nurses and caregivers and the head nurse had to supervise the other nurses or caregivers, I did not really have to give direct orders in these cases. The caregiver below me was about the same age as I was and was herself well aware of her duties. Either I myself or one of the other caregivers would follow the orders Dr. Mootz had given and also bring the patient into the special room. I do not think that the selected patients or any other of the patients in the room were aware of the significance of transferring a patient to the special room. Most of these patients were in a very poor state. They simply may have noted that someone was leaving the room.

Shortly after the patient was put to bed in the special room, they were administered the medication according to the order by Dr. Mootz. The remedies used were Luminal, Veronal, and morphine/scopolamine. I am absolutely certain no other remedies were used.

The remedies used for the killing never came from the central pharmacy. On the ward there was a medicine cabinet where these medicines were stored. The cabinet was regularly re-supplied so we always took it from there. Of course, there was strict accounting about the use of medication. Records were kept. There was the medication book where the amounts of medicine were reported as they were supplied by the central pharmacy. The physician checked the book and signed it. There was no keeping of records about medication taken from the medicine cabinet in the ward. So it was never recorded which and how much medicines were administered to a particular patient. The key to the medicine cabinet was given to the department head nurse. So I myself could not always have access to the cabinet.

The medicines necessary for the killings were taken from the medicine cabinet by the ward caregiver. I totally trusted these caregivers and never controlled the amounts taken from the cabinet nor did I count with them how many tablets were dissolved in water. I fully trusted all the caregivers working under me on the ward.

When asked how exactly the process of administering the medicines was taking place, my answer must be that it was very different in each case. The patients also reacted very differently in each case. The process was different according to the mental state of the patient. For instance, some of the patients understood that fact that they had to take some medication. Some of them were very eager to receive their medication. They seemed almost addicted and took all or any medication somewhat greedily. Other patients did not seem to know or to care
Susan Benedict

to take a drink. Others again assumed the fact that we picked them up and talked to them would indicate something pleasant—like being fed. Then there were those who were unable or refused to drink on their own. Those we had to spoon feed the medication.

In general, either the ward caregiver or I would sit the patient up in her bed, put an arm around her and talk to her consolingly. So one of us would hold the patient in an upright position and the other caregiver would hold on to the glass with the medication. Then the patient either was able to swallow the fluid down on her own or it was given to her with a spoon. If the patient was extremely restless, which also happened quite frequently, then three caregivers were needed for the procedure. At this point I would like to state that I was not all the time present at the procedure. At times it was done with the caregiver and I, other times the caregiver and another nurse, and sometimes the nurse and I were involved—just whoever happened to be on duty that day.

I have been asked to state how many patients were selected in the above described manner by Dr. Mootz and then were killed in the special room. It is very hard for me to come up with a number. I was working in this ward for about 1½ years. According to my memory, about six or seven patients were killed weekly. However, this number cannot simply be multiplied by the weeks. There was not always enough medication available. Luminal, Veronal, morphine, and scopolamine in large dosages could not be secured every week. A careful estimate would be about 200 killings ordered by Dr. Mootz with my participation. As mentioned above, I was not always present. Either I had different duties to fulfill or I was off duty or on vacation. So with careful consideration, I would estimate that Dr. Mootz had ordered all together between 300 and 350 patients to be killed in the area of my duties.

I have been asked whether Dr. Mootz could have ordered other caregivers to kill patients in my area of duties. I consider this to be impossible. It always was me or my immediate co-worker who was present at the rounds with Dr. Mootz when these orders were given.

I have mentioned during previous questioning that I myself thought there was a true justification for the killings only in about one-half of the killings ordered. In my opinion, only those patients would have been killed who would show all signs of a very near end of their lives—maybe about three weeks or less until they would die, or other patients who had so many deep bedsores (decubitus ulcers). They were suffering greatly and there were neither the necessary ointments and bandages nor any medication available for their condition. Or other patients who really were at the end of their human existence; they would eat their own feces and needed continual observation for those and similar acts. I did not approve of killing patients who had totally lucid times between their attacks of insanity and those where I could see
some hope for improvement. These were the cases which caused me the severe conflicts that I have talked about (Luise E. 1961).

The following are questions from the prosecution in Luise E.’s trial:

**Question:** During this investigation it has become obvious that you took part in the killing of patients even when you considered them unjustifiable. Did you refuse to partake in those cases?

**Answer:** In the beginning I talked to Dr. Mootz about the cases which I thought were not justifiable. Dr. Mootz did not listen to me. Since he insistently gave the orders, I had no choice but to follow them.

**Question:** You mentioned how those cases gave you severe inner conflicts of conscience. Did you talk about these problems to any other person?

**Answer:** I had to be very careful. It was not possible to just talk to anyone about these problems. I felt I was very much alone.

**Question:** At the beginning of this investigation you mentioned that you never heard about any special law which would make euthanasia legal. Did you think the killings which were ordered for you to execute could possibly be lawful and permissible?

**Answer:** To answer this question, I can only repeat what I said earlier. When I asked Dr. Mootz, he answered: I would have nothing to worry about. If necessary he would cover up for me. This morning at the beginning of the investigation, I was told I did not need to make any statements which may incriminate me as long as I was a witness in this case. I was further told that I did not need to make any statements at all to the police. I did not take advantage of my refusal to make any statements because I feel that I have not been guilty of anything. I further was informed about the consequences of making untrue statements in front of the judge. In this connection I would like to state that every thing I have said is the absolute truth.

In a stunning petition by K. Merkenschlager, an attorney representing Luise E. in 1965, the argument was presented that Luise E. could not possibly have killed 200 patients but, in fact, killed only 110.

The following figures should give evidence. Luise E. was working at Haus 6-O (upstairs) from the beginning of 1944 until January 29, 1945, about 54 weeks or 380 days.

1. There was not “treatment” on Sundays—54 days or on Saturdays—54 days.
2. There was one free day every 2 weeks—27 days
3. Church-related free days not falling on Sundays—12 days
4. Medication was not available—35 days
5. Vacation—35 days

Again: 380 work days minus 217 days left only 163 days when killings could have taken place. Luise E. did not necessarily take part in every one of these killings. Three caregivers were usually needed for every case: one for the actual injection or giving the oral medication and two for holding the patient down. So one can assume that if Luise E. took part in about 110 killings, she herself gave the injections or oral medications in about 75 cases and assisted in about 35 cases. She never gave any air injections. (Merkenschlager 1965)

Despite Luise E.’s own admission of killing patients, she was acquitted.

NOTES


Translation: “A criminal action is not valid if the perpetrator at the time of the criminal act is in a state of unconsciousness or is suffering from a state of pathological mental disturbance through which his ability to act out of his free will is out of the question” (translated by Traute Lafrenz Page, MD).

2. A condition for the author’s (Benedict) accessing the files related to the nurses’ trial was that the last names of the defendants not be divulged because the defendants were acquitted. These names, however, do appear in other publications. The names of other caregivers, nurses, and physicians are provided if either (1) they were found guilty, or (2) they were not defendants.

REFERENCES


Memorial Chamber at Obrzyce, Poland. 2005.


7 Klagenfurt
“She Killed As Part of Her Daily Duties”

Susan Benedict

7.1 KLAGENFURT

Located in the picturesque town of Klagenfurt, Austria, is an institution that rivaled Meseritz-Obrawalde as being a site for “wild euthanasia”. In particular, many of the killings took place at this state institution (Landeskrankenhaus) in the Siechenhaus.

A committee from the headquarters in Berlin visited Klagenfurt and filled out the Meldebogen (questionnaire) for each patient (see Chapter 3). The stated reason for the committee’s visit was the overcrowding of the institution with eight hundred beds. The staff was told that some patients would be transferred from Klagenfurt to other institutions to alleviate the problem. The questionnaires were completed without examining the patients. These questionnaires were then sent to the headquarters in Berlin for “evaluation” and were returned with a “+” for death and a “-” for life (Stromberger 2002).

During 1940 and 1941, three transports of patients left Klagenfurt for extermination. Early on, few of the personnel knew the outcome of the transports. Later, the knowledge became somewhat of an open secret (ibid., 41). After the first transport, the mayor of Ferlach posed an interesting question about former patients of Klagenfurt: “How come, in this city, three families received notice of the death of their relative from Neubrandenburg and not from Klagenfurt” (Niedermoser, n.d.). When more death notices arrived, it became clear to the personnel that patients were being transported to be killed at the receiving institution (ibid.).

Before the second transport, many patients had heard what was happening. The relatives of some of them were able, with the help of some of the caregivers, to get them discharged in time. However, for most there was no help, and by July 1941, there were only 250 of the original 800 patients remaining at Klagenfurt. In addition to more than five hundred psychiatric patients, approximately one hundred patients from the Siechenhaus were gassed (Stromberger 2002, 42).

Not all transports went smoothly. During the loading of patients at the train station for one transport, the patients were screaming and pleading
with the nurses, “Please, please, we don’t want to be gassed. We want to
die here. Please don’t send us to Germany.” But at this point, they already
belonged to Germany and the pleading was in vain (ibid., 42).

At Klagenfurt, as at other killing institutions, there were several secre-
taries employed just to manage the correspondence with the relatives of
the deceased patients. Because they wrote very sentimental letters, these secre-
taries were known as the “comfort scribes”. Not all correspondence went
smoothly. Once a woman living in the town of Klagenfurt received a letter
of condolence from the institution concerning the death of her cousin, and,
along with the letter, she received an urn that was supposed to contain his
ashes. Being curious about what was happening at Klagenfurt, she wrote to
the institution, saying that she had received the letter but not the urn. She
was immediately sent another urn (ibid., 43).

Another “mishap” occurred when a local farmer who was deaf was
forcefully admitted to Klagenfurt, where he was designated as “hereditar-
ily inferior”. He was placed on a list for transport to a killing site. Somehow
he was able to escape and returned home. Awaiting him there was an urn
purportedly filled with his ashes and a letter of condolence (ibid., 44).

As the practice of “euthanasia” became known to the public through
mistakes such as these, the effects were varied. One professor in the town of
Klagenfurt submitted a formal request to have his handicapped child killed.
A local physician complained that he didn’t dare to make house calls in the
rural areas because farmers had set the dogs after his colleagues when they
were hunting for more people to be “euthanasia” victims. One farmer in
the Lavant Valley was ordered to bring his six “retarded” children to the
institution. The farmer, being well aware of what would happen to them,
refused, saying that if that was what he wanted he may as well shoot the
children himself (ibid., 44).

Dr. Richard Paltauf, one of the physicians at Klagenfurt and the one who
conducted the postmortem examinations of those killed, stated that during
the Reichsärztesführung Dr. Conti’s visit to the hospital and the Siechenhaus
in May 1942, Conti made the following recommendation: “You should
not use morphine sparingly with these patients” (Paltauf 1945). The staff
understood this to mean that morphine was to be used freely on patients
with incurable diseases who were at the end state of their lives, but staff
did not interpret this as an indirect order to kill patients. Yet events took a
different turn.

The transports ceased and the killings began at Klagenfurt. The chief of
psychiatry, Dr. Niedermoser, did not have any of the murders committed
in the psychiatric wards of the hospital. Rather, he “referred” these cases
to the geriatric department, where the killings could take place without too
much notice. On average, three or four patients were killed weekly.

The physicians on the staff were told that a secret directive was in effect
that allowed for these killings. In fact, Dr. Niedermoser received a pam-
phlet with “all sorts of decrees” concerning the “treatment”, duty to report,
Susan Benedict

and other items regarding euthanasia. Additionally, it included orders to physicians and midwives to report deliveries of “malformations or idiots”. Unfortunately, Dr. Niedermoser burned the pamphlet before his interrogation (Niedermoser, n.d.).

7.1.1 Head Nurse Antonia Pachner

Born in 1891, Pachner attended Catholic schools. She began working in the obstetrical department of Klagenfurt in 1923 after completing a midwifery course. She later worked in the pediatric department (1931–1932) and then in the department for internal medicine (1932–1939). In September 1939, she was transferred to the Siechenhaus and made head nurse of both the front and back tracts. She was a member of the NSDAP (Nationalsozialistische Deutsche Arbeiterpartei, the Nazi Party).

The Siechenhaus had four hundred patients, two hundred of whom were bedridden. There were only fourteen caregivers and helpers to take care of them. All worked very hard, but there was not enough personnel to give every patient proper care. There was also never enough clean laundry for the many incontinent patients because the frequent air raids interfered with the delivery of the laundry. Stealing was common, with patients taking the belongings of other patients. Stealing by employees was not reported (Pachner 1945).

When questioned by the arresting officer, Pachner made the following statement:

> It is true killings of patients did take place in the Siechenhaus, in the back tract as well as the front. They were ordered by Dr. Niedermoser. There were different ways in which the orders were given and different reasons too—mentally inferior patients, epileptics, alcoholics, and incurable patients. Also there were patients who were not mentally ill but were so frail and old that they soon would have died anyhow. Some patients were having so much pain that they were continually screaming. For those it was a true mercy death. There were also those patients, often mentally retarded, who never would follow the rules of the house. They tried to run away and always were stealing from other patients. Then there were those who had been sent from Germany to be killed here. Also some patients who assumed that killings were going on and talked too much about it. Also old people who were incontinent and a real burden to caregivers. Those kinds of patients were reported to Dr. Niedermoser who then gave the order to kill the patient.

The killing of patients in the Siechenhaus had only started after transports were no longer going from Klagenfurt to Germany, to Linz, and to Bavaria. All together, three such transports were put together and sent from the Siechenhaus to Germany. The first one was in 1940 and the other two in 1941. They were sent away from Klagenfurt.
because more beds needed to be made available. No one ever returned. Relatives told us they had received notices of the death of the patient.

After July 7, 1941, no more transports were allowed to go out. The killings had to be done in the Siechenhaus. Before that date, very few killings had taken place. It was Dr. Niedermoser who selected the ones to be killed. He selected only those who had been bound to their beds for a very long time. It was really to shorten their suffering. I think there were not more than 3 or 4 killings during a month. These patients got a solution of 2% morphine, mainly orally, at times morphine injections. They would fall asleep for 2 or 3 days during which more morphine drops were given until they died.

These killings were done by the caregiver Ottilie Schellander. I was supplying the morphine. At times, when Schellander was absent, I myself would do the killings, but nobody else even knew about it.

The last killing took place in the middle of April, 1945. Dr. Niedermoser had ordered only Ottilie Schellander to do these killings. There was one other head caregiver, Egydius Santner, who was working in the men’s wards, who may have been designated by Dr. Niedermoser to perform these killings. Santner was later drafted and was a prisoner of war for a long time.

Other caregivers, including myself, did not receive orders to do any killings from Dr. Niedermoser. I had to transmit orders from Dr. Niedermoser to Ottilie Schellander. I would always do this by word of mouth.

It is possible that head caregiver Santner gave some orders to kill patients to caregiver Gisela Pressl. He told me so before he left for the army.

In some cases, I may have given orders to kill a patient to Paula Tomasch and Julie Wolf. I cannot remember giving orders from Dr. Niedermoser to Julie Wolf. I think she did not object but I think she never did more than 20 killings because most of them were done by Ottilie Schellander. I do not know why Julie Wolf denies having taken part in the killings. I am certain she did take part.

I thoroughly disliked the killing. I have performed killings but usually only when Schellander, Wolf, Pressl or Tomasz could not manage the patient alone or in case one knew the patient would refuse and fight back. As mentioned earlier, I never received direct orders from Dr. Niedermoser to kill anyone. Only in cases of very small children or infants, was I directly asked to do the killing, which I did. (Ibid.)

Pachner described the selection of patients as consisting of considering their medical history, looking at them and their suffering during rounds, and listening to the complaints about their behavior. All orders to kill were given verbally (ibid.).

The arresting officer noted that Pachner had given orders on her own initiative to kill patients at times when Dr. Niedermoser was not even in Klagenfurt. She acknowledged that she had given orders to kill patients but
denied that they were on her own initiative. She said that in Dr. Niedermoser’s absence, the killings that took place had been ordered by him prior to his departure (ibid.).

When questioned about others who had done the killings, Pachner described the following:

In the back tract of the Siechenhaus, aside from myself, the caregiver Schellander. She did most of the killings.

On the ground floor of the back tract, the men’s department, the head caregiver Santner. He was the only one who gave orders in the men’s department. I am sure he did some killings. Caregiver Pressl worked in the same department.

Julie Wolf only killed a few patients, maybe 20 or less.

Paula Tomasch is still working in Klagenfurt. She also only killed a few patients.

Anna Osterman helped with killing two patients. I had given her a mixture of morphine to give to these patients who were dying. I am sure she was not aware that it was meant to kill them.

Maria Binder gave morphine mixtures to I.Z. and B.A. Maria Binder is an old caregiver and must have been aware that repeated dosages of this mixture would help shorten the patients’ suffering.

Other killings in the front tract of the Siechenhaus were done by Egydius Santer including the killing of B.F. I myself have killed several infants and young children. Outside of these, there were no killings in the front tract. (Ibid.)

Pachner stated that Dr. Niedermoser never killed any patients himself.

The nationalities of the patients in the Siechenhaus were German and Austrian. Pachner described the procedure as follows:

There were three procedures: by an oral administration of Veronal and a mixture of cough syrup and Somnifen; by injection of morphine to the thigh or upper arm; or an intravenous injection of morphine. This was done rarely—only when there was a reason to speed up the process of dying.

In the beginning, the killings were always done by administering a mixture of Veronal or Somnifen in the ward where the patient was normally sleeping. Usually the patient would fall asleep after a quarter of an hour after he had taken the mixture. He would sleep for 24 hours or several days according to his general physical condition and never wake up. Death was then registered. At times, the patients would have foam around the mouth but not always. A few patients would vomit after digesting the mixture. Morphine injections usually were given when the oral mixture did not produce the wanted effect. Morphine injections were given when the Somnifen mixture did not bring on death or in cases where the patient refused to take the mixture.
Intravenous injections were rarely given. They were given when patients refused to take the mixture and the injection. Also in cases where one could expect much resistance or fight from the patient. Intravenous injections were done only by me; usually when the caregiver Schellander told me she was unable to use any of the usual methods. The intravenous injections were given under the pretext of a needed blood sample for a Wassermann Test. After the blood was extracted, the syringes were quickly exchanged and morphine was injected. Those patients died within 15 to 60 minutes (Ibid.).

The arresting officer asked Pachner if the number of patients killed between 1939 and 1945 was about 770, as reported in previous statements. She replied that this number did not include patients sent away on transports to be killed elsewhere; otherwise the number was close to accurate. No one could give a precise number, according to Pachner. After looking through the death registration book, Pachner listed 314 people, most of whom were killed by Ottilie Schellander; however, Pachner stated that these were not all who were killed, only the ones she could remember. Pachner was asked if Schellander liked to do the killings. She replied,

In my opinion, Schellander was very eager to please Dr. Niedermoser and so followed gladly any of his instruction. Niedermoser thought well of her and her work. I never heard her complain about all the killings she had to do so I do not know if she disliked doing it. Compared to an earlier time, Schellander was very nervous. She would cry easily. She was afraid of the bombing and ran to the bunker often before the others did. (Ibid.)

Pachner described what happened after the killings of the patients.

Every deceased patient in my department had to have a so-called “Post Mortem Report” completed before being sent to the mortuary. A head caregiver told me to fold over the left corner of this report in cases where the patient had received a lethal amount of medication. I always followed this order.

I am sure the prosector (one dissecting the body after death) knew about the killings in the Siechenhaus. Dr. Niedermoser must have informed him. Sometimes when the Post Mortem Report of a patient had not yet arrived, the following day at 8 AM the prosector, Dr. Paltauf, would ask the name of the deceased patients and whether he had died “with or without a corner”.

If there was not cancer or tuberculosis, the most common cause of death given was emphysema. Sometimes pneumonia was stated. The way Somnifen or morphine affected the patients was as follows: after the medicine was administered, the patient would fall asleep for several days and then he died. During that time, the lungs were affected.
or the patient got pneumonia. Dr. Niedermoser had given instruction to choose the medication so that the patient would die—but slowly. In that case, the prosector always could find a cause of death. When the prosector saw the left corner of the Post Mortem Report folder over, he did not have to look any more for a cause of death (Ibid.).

Pachner was asked by the arresting officer why she did not refuse the orders of Dr. Niedermoser to kill. She stated,

I am aware that the killing of patients is against the law and is not something any caregiver should see as within her duties. I am unable to explain why I did not refuse Dr. Niedermoser’s orders. I think I was afraid of being dismissed. Killings without orders from Dr. Niedermoser happened only in cases where caregiver Schellander did not dare to do it. For killings of the infants and small children, I did have general orders from Dr. Niedermoser. I never liked to do the killings but had to do them when Dr. Niedermoser explained to me that this or that patient needed to be killed and caregiver Schellander did not get around to it. I have known that the killing of patients, either upon orders or on my own initiative, was against the law. Supposedly, Dr. Niedermoser received the orders from Berlin to kill certain patients (Ibid.).

The questioning of Antonia Pachner was ended but then resumed on October 30, 1945. At that time, she was asked to identify from a list of patients who were killed those who did not have any “hereditary mental defect or illness” (ibid.).

Pachner then recounted a particularly harrowing incident of “correcting a mistake”:

I want to mention a case which happened in the autumn of 1944 in the Siechenhaus. The caregiver Julie Wolf telephoned the janitor to pick up a deceased patient. I saw her when she telephoned but cannot remember the name of the patient. Usually the janitor took a long time coming but in this case he came immediately. Shortly after this, the prosector told me I had sent a man who was still alive. Julie Wolf and I went straight over to the mortuary and found the patient still breathing softly. We took the patient back to the Siechenhaus and I scolded the caregiver Wolf about her sloppy work. Because the man already had a slip with the time of his death on his foot, rather than changing the slip, I gave him an injection of morphine whereupon he stopped breathing. I did this killing on my own but I am sure this was the only one I did without an order. (Ibid.)

This concluded the statement of Antonia Pachner.
7.1.2 Ottilie Schellander

Ottilie Schellander was one of the most active caregivers in the killing program. She considered herself to be a good and dutiful caregiver, and this belief was also held by her coworkers and superiors. “She killed as part of her daily duties” (Stromberger 2002, 46). She, along with the head nurse, Antonia Pachner, was assigned to the geriatrics unit, which was under the care of Dr. Niedermoser. Schellander had a very difficult background. Her father had committed suicide, and her brother was a patient in a psychiatric unit due to his experiences in World War I. He was later taken on a transport to his death—seemingly without anyone realizing it (ibid., 46).

Her colleagues were not in agreement about Schellander’s temperament. Some saw her as aloof and without feelings about her work and life in general. Others thought she actually enjoyed the killings. One of her closest coworkers, the director of the Geriatric Department, stated, “She never seemed to dislike the job or killing a patient” (ibid., 46). She received her orders to kill from either Dr. Niedermoser or Antonia Pachner.

It is true that I have been ordered to kill many patients. It is also true that some of these were not mentally ill or severely ill in other ways. They were just old and frail and helpless. However, those were not very many. . . . There were several reasons [why these patients were killed]. Some were incurable, some were totally incontinent, or were a great burden in other ways. But, as I mentioned, there were only a very few of these. It is true that I frequently pointed out those patients to either Dr. Niedermoser or to Head Nurse Pachner and that they then ordered the killing. It also has happened that we shortened the life of a severely ill patient in order to make room for other patients. (Schellander 1945)

Schellander described the order to kill as always being verbal and usually stated like “give something to him”. Usually Veronal or Somnifer were given, occasionally mixed with cough syrup. However, if these failed within the requisite time, Pachner order morphine injections, but this was rare (ibid.)

Most of the killings took place in the laundry-storage rooms on the first and second floors of the Siechenhaus. These rooms were purposely prepared to be the killing rooms by putting two beds in each. Niedermoser ordered absolute secrecy about the murders; however, the other caregivers and housekeeping staff slowly noticed what was happening (ibid.).

The murders began slowly in 1940 and soon picked up pace, with two or three patients being killed weekly. In addition to doing the killings herself, Schellander also ordered others to do them. In her absence, Paula Tomasch, Antonia Pachner, and Elfriede Melichen carried out the “duty”. Additionally, the head caregiver of the male patients, Egydus Santner, did a number of the killings before he was drafted into the army in 1942 (ibid.).
Schellander described a transport of sixty women who arrived in 1943, and only seven of them survived, although, as she reported, some may have died from natural causes. Also in 1943, a transport of children with tuberculosis arrived from Germany. All of these forty children were immediately killed with large doses of Somnifen (ibid.).

The murder of Maria S. occurred despite her being a very good worker. As Schellander described it, S. was sent to the back portion of the Siechenhaus as a punishment. After about an hour, she could not be found anywhere. Pachner advised Schellander to check the chapel because S. was known to be a very religious woman. Upon finding her in the chapel, Pachner took her immediately back to the laundry room and, in Schellander’s presence, without saying a word, killed her with an injection of morphine. Schellander reported that she would have tried to prevent this killing because S. was a good worker and a quiet person, but she did not dare to go against the will of Head Nurse Pachner. She would not have listened to me in any case. I myself did not help with this killing. I only helped to bring Maria Susnik back to the Siechenhaus because she refused to leave the chapel. At the time we brought her to the laundry, Head Nurse Pachner was very upset. (Ibid.)

During the questioning by the arresting officer, Schellander stated she was unable to remember how many patients she killed or any of their names. She also admitted that she had informed other caregivers about the killings but denied ever threatening anyone. She states that she had been accused of showing some enjoyment in the killing of patients. She responded,

That is not true. I was just doing my duty. (Ibid.)

Schellander was then told that, having been a caregiver at Klagenfurt for many years, she must have known that killing patients was against the law and most certainly not a part of her work. She stated,

I only came in 1939 to the Siechenhaus. Prior to 1940, I never received any order to kill a patient. I followed orders because I was always eager to do my duty and would never have dared to oppose an order.

I was made head caregiver in 1941. I do not know the reason. Very often patients who were dying were brought to the back tract of the Siechenhaus. I have often objected to every terminal cancer patient, every incontinent patient being taken there. Some patients were sent there for punishment. No one paid attention to my objections. It seems I received so many orders for killings of patients because my superior knew I would always do what I was ordered to do and did not dare to object. (Ibid.)

Schellander was arrested on October 24, 1945, at the age of forty-eight. She was charged with killing many patients at Klagenfurt during 1940–1945 (ibid.).
7.1.3 Gottfriede Melichen née Schellander

Gottfriede Melichen was the sister-in-law of Ottilie Schellander, who was her superior caregiver at Klagenfurt. In fact, Schellander got the position for Melichen in March 1943.

Melichen was born in 1907 near Klagenfurt. She was never a member of the NSDAP (Nationalsozialistische Deutsche Arbeiterpartei, the Nazi Party) but belonged to DAF (Deutsche Arbeitsfront, German Labor Front) and the NSV (Nationalsozialistische Volkswohlfahrt, National Socialist Peoples’ Welfare).

Melichen was arrested on November 2, 1945, and admitted to helping with the killing of patients at the Siechenhaus in Klagenfurt. She made the following statement:

On March 15, 1943, I was employed as a caregiver at the state hospital in Klagenfurt, more specifically at the Siechenhaus—Hintertrakt—women’s ward. From the beginning, I was not very happy with the work. My sister-in-law, Ottilie Schellander, had asked her superior to give me the job. My sister-in-law talked me into taking the job. I began working there under the direct supervision of my sister-in-law, Ottilie Schellander, and later on under Antonia Pachner.

It seems to me that other caregivers also soon were aware that in the Siechenhaus patients were being killed. For a while, in the very beginning, I did not know who was killing these patients. Soon after, I found out about the killings at the Siechenhaus. The women’s wards were at the Hintertrakt of the Siechenhaus and that was where my sister-in-law, Ottilie Schellander, and Head Nurse Pachner did the killings. These killings were kept secret and newly employed caregivers were not told about them. I think during the year 1944, when it became obvious that everyone knew about the killings, they did not keep it from me. By then, I knew when orders were given to bathe a patient and then put her to bed in the laundry room, that patient was going to be killed. Usually the house maids did the bathing of patients although at times I had to do it too. It happened sometimes that the patients were given a light form of sleeping pill. After the bath, the patient was put to bed in the laundry room. There either Schellander or Pachner gave them an injection. At times, both of them did it. It was an injection of morphine. If the patient did not die soon enough, an additional morphine injection was given. I myself was at times present when these injections were given. I myself never gave such injections. If anyone claims that I did so, then it is not the truth.

I have to confess that I really hated these killings. Quite often, I had to cry because some of those patients were quite dear to me. They were decent and liked to work. And I was sorry to see them go.

I was really very upset about the killing of Mathilde H. Mathilde H. was maybe a little stupid but you could not call her idiotic. You could
talk with her about everything. She was hardworking, always in a good mood. Often she sang some songs and so had a good influence on other patients. For a while she was working at the gate. There she sometimes talked too much and so was taken back to the women's ward. It had been known for quite a while that Mathilde H. was on the list to be killed. But Nurse Schellander was able—with all our pleading—to have head nurse Pachner postpone the killing. Then one day in the fall of 1944—I don't remember the exact date—when I was working with Head Nurse Pachner, she told me to bring Mathilde Hart to the laundry room today. I protested, saying “Please, not Mathilde!” But the Head Nurse insisted on her order. Together with Mathilde Hart, another patient was to be put to bed in the laundry room. I talked it over with the house maid, Mili (Ludmilla) Lutschounig, and told her I was not able to bring Mathilde H. to the laundry room. We both started to cry because she too was fond of Mathilde H. And we just did not bring Mathilde to the laundry room.

At that time, most of the patients were aware of the killings. They did not have any proof though. The same evening, Pachner went to the laundry room and did not see Mathilde H. there. She insisted that I would have to bring Mathilde at once. I just told her I could not and would not do it. But Pachner insisted that Mathilde should be brought there, especially since we were objecting. A little later, I saw the house maid, Ilse Printschler, going into the laundry room. I just ran away. I am certain Pachner killed Mathilde although I did not see it. In any case, she was taken away from the laundry room a few days later dead. Ilse Printschler told me Mathilde was crying a lot.

Furthermore, I had a hard time when Maria S. was killed. Maria S. was taken from the hospital to the Hintertrakt, the Siechenhaus. She was very religious; otherwise she was very quiet and a good worker. She certainly was no problem for the caregivers, although some of the patients complained about her at times. Sometime in May 1944, patients were yelling that Maria had run away. I quickly ran after her but could not right away locate her. Then I went to the chapel and there I saw the Nurse Schellander and Maria S. S. was kneeling at the altar and was singing some songs in Slowenisch. Schellander ordered me to get the Head Nurse which I did. Maria refused to come with us. She had to be carried back to the Siechhaus. As we got back to the first floor of the Siechhaus—at the laundry room—Head Nurse Pachner asked for the injection. I was shocked. I had thought we just would get Maria back to work. I left while Schellander and Pachner were busy with Maria. I think Maria S. was taken out of the laundry room the next day dead. Who killed her? I do not know. I guess Pachner because she ordered the injection.

If I remember correctly, I had to help Pachner in two cases of the killings. The first one was a male schizophrenic. I had to help to get his
hand out of his straightjacket so that she could get to his vein to give
the injection. I do not know the name of this man. In the same way, I
had to assist with the killing of a female patient. I have been present
a few times when Schellander gave the injections but I think I never
assisted her (Melichen 1945).

The arresting officer asked Melichen if the killings had been done by
people other than Schellander and Pachner. Melichen replied that she had
heard talk that the previous caregivers Gisela Pressl, Julie Wolf, and Paula
Tomasch had killed some patients on the lower floor of the Siechenhaus.
Melichen stated that she had never seen any of these nurses give any lethal
injections and that most of the killings were done by Schellander. She also
stated that some weeks there were two or three killings and sometimes
four. Other weeks there were none. The killings were usually done at the
beginning of the week (ibid.).

Melichen was handed the so-called Book of the Dead and was asked to
name the patients that she knew had been killed. She identified eighteen
patients that Head Nurse Schellander killed, one for stealing. Melichen
then identified twenty-one patients killed by Head Nurse Pachner (ibid.).

Melichen stated that she identified only the names of the patients that
she truly remembered who had been killed. These patients were killed in
the laundry room on the first floor of the Siechenhaus. She did not know
the names of the patients who were killed in the lower floor of the Siechen-
haus or on the male patients’ ward (ibid.).

Melichen was asked to describe the transports that came from Germany
to be killed at the Siechenhaus. She replied,

I think it was May or June 1943 when a transport with women and
girls arrived to be housed in the Siechenhaus. That was a transport with
about 60 patients. Later on, a transport with about 40 boys arrived.
The women and the girls were either imbecilic or crippled; some had
diseases of the lungs. Some of the people on these transports died a
natural death. Others were killed, most of them by Schellander. The
boys were sick or crippled. All of them had tuberculosis. Some of them
died a natural death and others were killed. (Ibid.)

The arresting officer asked Melichen why she refused to do the killings.
She replied, “I refused because my inner feeling was absolutely against it. I felt
sorry for those patients. I was appalled that one would kill a patient” (ibid.).

Melichen was asked if she thought that Pachner and Schellander enjoyed
doing the killings and if all of the killings had been ordered by Dr. Niedermo-
ser. The killings of H. and S. seemed to say they were not. She replied,

I cannot tell if Schellander and Pachner enjoyed the killings. I think
all patients who arrived from a transport and came to the Hintertrakt
were to be killed. Also patients who were transferred from the hospital to the Hintertrakt were to be killed. I cannot say whether Pachner did kill patients without proper orders. What was talked about was that S. and H. had been ordered to be killed. All the Head Nurse was able to do was to postpone the killings at times. (Ibid.)

When asked if she had been ordered to not talk about the killings, Melichen replied,

Ottile Schellander said to me, “You know if we talk about the killings, we will be in Dachau with one foot.” For this reason, I talked to no one about it. My mother, Agnes Schellander, also was living in the Siechenhaus. She had to stay there because her house was bombed out and there was no room for her at my niece’s. She arrived at the Siechenhaus on May 6, 1944 and died on April 15, 1945. The morning she died, my mother was a bit quarrelsome. I was not at the Siechenhaus the day she died. Ilse Printschler told me that the Head Nurse had given my mother some drops after which she died. They say she just quietly went to sleep. I have the strong suspicion that Pachner killed my mother but I have no proof.

There was also this problem of writing the patients’ histories. Dr. Niedermoser should have done it but he left it to Head Nurse Pachner. My mother was alert until the very end. My mother may have been killed for the one reason: she did not allow injustices. The moment she noticed some unjust action, she put in her opinion and became quite belligerent. It is a fact, patients have been killed when they were too troublesome or incontinent.

At the end, I would like to stress again that I never did anything to a patient which would have caused her death. Someone who would say I did is not telling the truth. I have told the truth and did not hold back anything. More I cannot say. (Ibid.)

The questioning of Gottfriede Melichen resumed on November 11, 1945. She was asked to describe how she assisted with some of the killings. She replied,

In some cases, Head Nurse Pachner ordered me to mix some Somnifén with cough syrup and give it to the patients who were to be killed. Sometimes it was Veronal in water so the patient could go to sleep and she could do the injection without trouble. Maybe it was in four or five cases where I did this. The deadly injections were done by Pachner. Only once, if I remember correctly, I was told to give an after injection to a patient who had been given the morphine injection but after some days the patient was still alive. Pachner handed me an injection for this purpose. I did not give the injection to the patient. I just emptied the
contents. The patient died anyhow after a while. I returned the empty syringe to Pachner. She never asked me what I had done. I cannot possibly remember the names of the patients to whom I have given the sleeping medication. In no case did I directly kill a patient. (Ibid.)

Melichen described her only other involvement with the killings to be limited to helping to hold patients. She was asked why she assisted in the killings because, as a grown and intelligent person, she would have known that to kill a human being was a crime and anyone assisting was also guilty. She replied that she knew it was a crime and she should not have followed the orders to help in the crime (ibid.).

Following this questioning, Gottfriede Schellander Melichen was arrested and taken to the Klagenfurt prison (ibid.).

7.1.4 Caregiver Ladislaus Hribar

Like the other caregivers and nurses, the head caregiver on the men’s ward, Ladislaus Hribar, was asked why he did not refused Dr. Niedermoser’s orders to kill. Hribar stated that Dr. Niedermoser had told him that an order had been issued from Berlin that was a command to reduce the patient load on the ward. In 1944, Hribar received about ten orders to kill but didn’t do three of them because he hated to do it and his conscience couldn’t bear it. The three who escaped death were not bedridden. When asked by Dr. Niedermoser why he didn’t follow orders, he told him that he really hated to do the killings and furthermore there had not been the opportunity. Niedermoser asked several more times but Hribar refused. He was not threatened or forced by Dr. Niedermoser. Hribar told the arresting officer that he hadn’t refused the earlier murders because, as a father of six children, he was worried about losing his job or—even worse, according to him—being sent to a concentration camp. However, he was never threatened with either of these consequences, but he asserted that they could have resulted (Hribar 1945).

Hribar had one additional comment that he wanted to add to his statement. He once asked Dr. Niedermoser why so many patients in the Siechenhaus were dying. Niedermoser stated that “he himself had to put on some brakes because the caregivers in the Siechenhaus were so radical about killing patients” (ibid.).

7.1.5 Caregiver Eduard Brandstätter

Brandstätter was arrested in Klagenfurt on November 7, 1945. He had been an employee of the Klagenfurt hospital for almost twenty years and was still working there as a caregiver at the time of his arrest. He described how the severely ill psychiatric patients were given repeated injections until they died:
In order to alleviate their pain, Dr. Niedermoser ordered frequent administration of Somnifen or injections of Monoskopia. After an injection, the patient would sleep for 7 to 10 hours. Some severely ill patients received a further injection upon awakening. Such repeated injections were ordered by Dr. Niedermoser in severe cases, patients who were screaming with pain. There were cases where the patient would receive an injection in the evening. In the morning, he would wake up, eat breakfast, and during rounds Dr. Niedermoser ordered another injection. The patient would wake up in the evening, start screaming with pain, and so received another injection. These cases were rare. I disliked having to give these repeated injections. I realized that the patients rarely could eat a meal because they were asleep all the time so they got weaker and weaker and finally died. Patients with these repeated injections would die between 4 to 14 days. I cannot say whether these patients died due to the injections or due to their illness. They all were severely ill and had to suffer so much. It is correct to say that these patients had to miss at least 2 meals daily so they got visibly weaker and weaker.

As I mentioned before, I really disliked having to give these repeated injections. But I could not do anything about it. I had no right to criticize the doctor’s orders. Once I talked to the head caregiver, Maria Cholowa, about it, telling her how I disliked these orders for repeated injections. She sort of felt the same way. I cannot remember how many orders Dr. Niedermoser gave for these repeated injections. I think during my time there, from 1941 until February 1944, about 10 or 14. In February 1944, I was drafted into the army and returned in June 1945 to my old job. Orders for “repeated injections” no longer existed in June 1945. Severely suffering and screaming patients still got some injections of pain medicine but only at night so other patients could sleep. (Brandstätter 1945)

Brandstätter told the court that Niedermoser never talked directly to him about any new regulation about lethal injections and he never ordered Brandstätter to keep the repeated injections a secret. The court asked Brandstätter why he didn’t refuse to do the repeated injections if he disliked them so much. He replied,

I did not refuse to follow these orders—I want to stress that there were very few of them—mainly because I felt I had no right to criticize orders a physician had given. I could see these repeated injections were too much for the patient but I did not dare to get into a dispute with Dr. Niedermoser. (Ibid.)

Brandstätter was asked if he knew about similar injections being given in other parts of the hospital. He replied that he knew of them in the women’s
ward because Maria Cholowa had once talked with him about them and how much she disliked following these orders.

Maria Cholowa never mentioned a number. She only mentioned how she disliked these killings. We also talked about what to do, how we could avoid this. But both of us had to agree that we did not have a right to debate this with Dr. Niedermoser or quarrel with him.

I have mentioned earlier that I only have been ordered to give these repeated injections in about 10 or 15 cases. I know that they resulted in the death of the patient. I want to stress thought that all these patients were at the end stage of severe illnesses, either tuberculosis or cancer. Some had to be fed by tubes. I have witnessed the sufferings of these patients and for this reason also did not counteract Dr. Niedermoser’s orders. I mentioned several times how it was against my better knowledge and that I disliked them intensely.

I only want to say that I was one of those caregivers who was committed to treat these poor human beings with all my love and good care. I always asked for the best diet for my patients. I was reprimanded by the administrator Auering because I demanded too much for my patients. During December 1943, a department of the hospital was hit by bombs and one of the incendiary bombs fell in one of the patients’ rooms. With the help of caregiver Hriba and under danger for my life, I transported these 7 patients out of their room to a safe place while the air raid still was going on. We then extinguished every incendiary bomb and kept that part of the hospital from being burned down. We had no orders for doing this, but Hriba and I did it out of love for our patients. There also were other bombs that hit the hospital, highly explosive bombs, while we were busy bringing our patients to safety.

I am accused of not having refused the orders to kill patients so I can only say again it was for me not possible to debate orders given by a physician. I also could see that all of those patients who were killed would have died within a short time anyway. (Ibid.)

### 7.1.6 The Trial of the Klagenfurt Personnel

During March and April 1946, thirteen staff members of Klagenfurt state hospital went on trial in the *Volksgericht Graz* (People’s Court) in Graz, Klagenfurt Senate. They included the following people:

- **Dr. Franz Niedermoser**  
  Physician  
  Forty-five years old
- **Antonia Pachner**  
  Head Nurse  
  Fifty-five years old  
  Accused of killing at least twenty patients, nineteen known by name
- **Ottilie Schellander**  
  Head Caregiver  
  Forty-eight years old  
  Accused of killing at least two hundred patients, eighty-eight known by name
Susan Benedict

- Paula Tomasch Caregiver Twenty-six years old
  Accused of killing thirteen patients known by name
- Juliane Wolf Caregiver Forty-one years old
- Maria Binder Caregiver Fifty years old
- Gottfriede Melichen Caregiver Thirty-nine years old
- Ilse Printschler House Worker Twenty-two years old
- Maria Hochmaier Caregiver Twenty-two years old
- Ludmilla Lutschounig House Worker Twenty-five years old
- Eduard Brandstätter Head Caregiver Forty-two years old
  Accused of killing 50–70 patients
- Maria Cholawa Head Caregiver Thirty-five years old
  Accused of killing at least thirty patients, fifteen known by name
- Ladilaus Hribar Caregiver Forty-three years old
  Accused of killing seven patients, three known by name

All defendants were accused of murder or assisting with murder (Niedermoser 1946).

The defendants, including Dr. Niedermoser and others, stated that they acted under orders and according to the law. They said they were not aware of any wrongdoing because they had received orders from a superior office to act in accordance with this law.

The chairman of the court, Dr. Karl Kugler, explained in depth how such a law could not have existed. Dr. Niedermoser claimed that he had been shown a copy of the law and this could not be disproved due to lack of evidence. Dr. Kugler found Dr. Niedermoser’s statement, however, to be quite believable because it was known that (1) the killings were ordered from central headquarters in Berlin, (2) that a commission had come from Berlin explaining such “orders for treatment of patients”, and (3) similar killings occurred not only in Klagenfurt but also in other psychiatric institutions.

Ministerial Director Franke had told him (Niedermoser) these orders for the killings had been due to a secret decree as preparation for a law in order to collect further experience. The statement further coincides with the report about the visit of Dr. Conti to Klagenfurt at the end of May, 1942. Dr. Conti, at that time, had asked whether the orders for the killing of patients had been carried out; there was such a law but it had as yet not been passed, but he [Conti] would take over the responsibility in the meantime.

The accused were unable to point out an existing law according to which their actions would have been within constitutional lawfulness. According to § 3 STG, no one can plead innocence due to ignorance of the law. However, it is necessary to examine to what degree the defendants mistakenly believed that such a law was in existence.
None of the defendants has any training in law. Most of them are rather simple people with little education. They felt to be under the intellectual authority of Dr. Niedermoser but he himself was under the impression that such a law was in existence.

As a National Socialist, Dr. Niedermoser was satisfied to think a law was in existence although all he was given to look at was some sort of a decree and the signature of the Führer. Although Dr. Niedermoser claims he did not totally agree—and even supposedly saved some patients from being killed—he never questioned the killing orders any further.

§ 134 STGB of the constitution clearly states the killing of any person is against the law. This never has been changed and therefore a discussion about whether a euthanasia law ever has been passed or not cannot be considered in any further discussion.

A further excuse used by the defendants is the fact that they acted on orders they had received. This is a fact and cannot be refuted. An order, however, does not excuse the execution of the order if the latter has an unlawful effect. § 535 and §560 of the STG explains this, although mainly in connection with soldiers. An order is never a justification for guilt. It may only be cause for mitigation. Even a soldier is allowed to refuse to execute an order if the order would result in an unlawful act. The defendants claim they were put into an emergency situation by the order. They were afraid of consequences which might ensue in case they did not execute the order. However, another employee, Josephine Messner, openly refused the order and nothing happened to her at all.

The court also wishes to point out that not every mental institution was used for the program of killing patients. The choice may have to do with the willingness of the personnel to partake in the program. In Klagenfurt, this willingness of the personnel resulted in the killing of about 400 human beings.

As caregivers, these human beings were entrusted to them as patients. The defendants therefore belong to a group of people that was obliged by their profession to look out for the well-being of the patients. Such duty is even stated in §358, §560, and §376 of the StG. where it is said that it would be punishable if a patient who is dependent on help would be refused his help. The defendants would have been punished if they neglected their care; if a patient had fallen out of bed in similar situations.

The act of the defendants according to §134, §135, Zl. 1 u. 3 StG have to be considered “treacherous murder”. All killings were done with poison. It is to be considered as treacherous murder because most of the patients had no idea and were rather expecting care and relief; most of them were neither physically not mentally able to give resistance. In most of the cases, the poison was mixed with sweet-tasting cough syrup. In one of the cases, the accused Schellander even added.
a toast: “To your health”. One of the patients who was selected to be killed left his drink standing without touching it and then another patient drank it and died. At times an injection was given under the pretense of drawing blood for a Wasserman test. All of these killings are typically treacherous killings. (Ibid.)

The following sentences were delivered:

Death by hanging
- Dr. Franz Niedermoser
- Antonia Pachner
- Ottilie Schellander
- Eduard Brandstätter

Fifteen years’ imprisonment
- Paula Tomasch
- Maria Cholawa

Ten years’ imprisonment
- Ilse Printschler
- Ladislaus Hribar

Acquitted
- Gottfriede Melichen
- Maria Binder
- Maria Hochmaier
- Ludmilla Lutschounig

The court made the following statement:

General humane laws have always ruled the relationship between human beings without specific penal interference. The relationship between human beings used to be guided by what was generally known as “humane” in the best sense—politeness, helpfulness, sympathy with those less fortunate were the ground rules. The dignity of man is founded on the respect a person will grant his fellow man, even if he may be his opponent. He grants it just because the other is a human being too. Once you treat a human being on principles of his economic value—when you treat man like an animal—when you butcher him just because to keep him is more expensive than to slaughter him—then you violate the law of human dignity and humaneness. This is what has happened in the Siechenhaus and in the mental hospital in Klagenfurt. 400 patients were killed there during the reign of the National Socialist government. (Ibid.)
The court found that the evidence against Niedermoser, Pachner, and Schellander was particularly incriminating because of the many repetitions of murder and because they “misguided” others to also kill. Extenuating circumstances for all defendants included not having prior criminal records, that they were following orders, and that they feared possible consequences if they had refused. Also, except for Brandstätter, all were openly admitting their actions. An additional extenuating circumstance for Dr. Niedermoser was the fact that he protected an anti-fascist, the witness Plattner, from the Gestapo. Paula Tomasch was described as mentally handicapped, which was considered an extenuating circumstance. An additional extenuating circumstance for Maria Cholawa and Ladislaus Hribar was that they attempted to not follow every order to kill a patient (Klagenfurt 1946). Cholawa and Hribar, unlike the others that were found guilty, were not sentenced to loss of all property because they “have to take care of innocent children” (Niedermoser 1946).

7.2 KAUFBEUREN

Just because the war in Europe ended in April 1945, the killing of psychiatric patients did not cease. In July 1945, American military members discovered that patients were still being murdered at the Kaufbeuren psychiatric facility in Bavaria, in the region of Swabia, 95 kilometers from Munich. The town of Kaufbeuren had a population of 13,381 in 1941. These killings took place less than one-half mile from the US military police headquarters. The last killing took place on May 29, 1945, thirty-three days after the American occupation of Kaufbeuren (Special Statement of Fact 1945).

On July 2, 1945, Major Marvin Linish and Captain Loyal Murphy of the Public Health Section of the US Army obtained “some information from a German doctor” and, accompanied by eighteen soldiers, went to Kaufbeuren. The hospital was located on an open road with “Off Limits” and “Lunatic Asylum” signs posted in English. It was a large complex with a capacity of three thousand patients, and was certainly the most outstanding landmark in the small town. It was built around 1900 and had a branch at Irsee, which was housed in a baroque monastery decorated with eighteenth-century frescoes. Many of the employees had worked at Kaufbeuren and Irsee for ten to twenty years, indicating that they were not brought in for the purpose of initiating the killings (ibid.).

At the Kaufbeuren facility, the two US Army officers asked to see the “second doctor in charge” and were

nonchalantly informed that he had hanged himself the night before. No one seemed to be aroused or emotionally upset at his violent end. Such was the callous attitude the doctors and nurses had for violent
death. Observers found, in an uncooled morgue, stinking bodies of men and women who had died 12 hours to 3 days before. Their weight was between 26 [57.2 pounds] and 33 kilos [72.6 pounds]. Among the children still living was a 10 year old boy whose weight was less that 10 kilos [22 pounds] and whose legs at the calf had a diameter of 2 ½ inches. Informant stated that tuberculosis and other diseases are rampant. Scabies, lice and other vermin were encountered throughout, linen was dirty and quarantine measures non-existent upon investigators’ arrival. (Ibid.)

The eighteen American soldiers who accompanied the two Army doctors to the site were so outraged by what they saw that they volunteered to serve on an execution squad for those culpable (New York Times 1945).

The servicemen especially noted the attitude of Dr. Ottmann toward the female patients in one ward. As the women stood, in military manner, upon Dr. Ottmann’s arrival, he pushed them aside to clear his way (ibid.).

Among those arrested was Dr. Valentin Faltlhauser, a sixty-nine-year-old civilian physician who was in charge of the facility. Others were three physicians and the food administrator, and Franziska Vill, who was the secretary to Dr. Faltlhauser and the mistress of Dr. Lothar Gärtner, the forty-three-year-old physician who had hanged himself with the cord of a bedside lamp (ibid.).

Sister Wörle, the head nurse on one of the children’s wards, confessed to having killed at least 210 children. She received a bonus of 35 reichsmarks (approximately $8.75) for these murders. She admitted this without coercion, asking the investigators simply, “Will anything happen to me?” Another nurse also arrested with Olga Rittler, “who, with a stony grin on her face, confessed to having ‘poisoned at least 30 to 40 persons’.’ When asked whether she was a Christian and believed in God, she answered cockily, ‘I am a Lutheran and this is a personal matter which does not concern you’” (ibid.). Interestingly, Olga Rittler’s husband was an official for the Führer Chancellery, holding the position of plenipotentiary for the eastern regions (ibid.).

There were two methods by which patients at Kaufbeuren were killed by the staff: overdose of medications and “scientifically directed starvation”. In the latter method, patients were assigned to receive either the rapid starvation diet, which killed patients within about three months, or the slow starvation diet, which took longer. The overdoses, as described by the head nurse, Wörle, consisted of intramuscular injections of scopolamine and doses of Luminal or Veronal given in food or liquid. Usually the oral overdose was first attempted, but if death did not occur within two to five days, injections of scopolamine would be given. The drugs were obtained from Berlin by Dr. Faltlhauser (ibid.).

The patients of Kaufbeuren were German nationals who came from all parts of the nation. It was the practice of the personnel to send a letter to
the patients’ relatives noting a turn for the worse shortly before the patients were killed. Immediately after the murders, the relatives were sent another letter saying that the patients had died and were buried, after being cremated, in the Kaufbeuren cemetery (ibid.).

The total number of patients killed at Kaufbeuren could not be determined because Faltlhauser and Reichert, the chief cashier, burned all of the papers prior to the arrival of the Americans. There were, however, records of the institution’s patient mortality rate from 1910 through 1944. Other than in 1917 (11.7 percent), the mortality rate did not exceed 10 percent until 1942 when it was 14 percent. Within the next two years, the mortality rate climbed to 25.6 percent in 1944. Another report documented that 260 children died in Kaufbeuren in 1945, 75 in 1944, and more than 60 in 1943 (ibid.).

In 1940, 211 men and 303 women, including 3 Jewish women, were transferred out of Kaufbeuren. One letter found by the Americans was a letter from the Landesfürsorge Verband Schwaben to the director of Kaufbeuren, Dr. Faltlhauser. It stated, “I beg to notify you that all the female patients transferred on 3 November 1940 from your institution have died at the institutions Grafeneck, Bernburg, Sonnenstein, and Hartheim” (ibid.).

Another letter written by the Gemeinnützige Krankentransport of Berlin on May 12, 1941, was directed to Faltlhauser and gave instructions for a transport. Patients were to be marked with adhesive tape pasted between the shoulder blades “bearing their names written in copy pencil. Simultaneously one piece of clothing must also be marked with the name. Two or three sandwiches for each patient and a few pitchers of coffee were also to be sent” (ibid.).

Other patients were transferred to be used as research subjects. A letter from the Bavarian State Ministry of the Interior stated the following:

In your letter dated 13–11–1942 [November 13, 1942], you requested that I dispatch to you suitable epileptics for the further carrying through of your research work. I have had the opportunity to discuss this matter with the Obermedizinalrat Drs. Faltlhauser and Pfannmuller [the chief physician at Egling-Haar]. Both are most agreeable to turn over to you suitable stock. For various reasons, primarily patients of the institution of Kaufbeuren are to be selected. If that institute does not have suitable material, I am also satisfied if patients from Egling-Haar are transferred to Günzburg for your research purposes. I beg you to keep in touch with Dr. Faltlhauser. (Ibid.)

Knowledge of the killings at Kaufbeuren was widespread in the town. The soldiers stopped one twelve-year-old boy in town and asked him what the buildings of the institution were and he replied casually, “Oh, that’s where they kill them” (ibid.).

Franziska Vill, Dr. Faltlhauser’s secretary and Dr. Lothar’s mistress, told the investigators that all employees were repeatedly given orders to keep
silent and were threatened with being sent to the Dachau concentration camp if they talked about the killings. She, however, also said that she thought it was extremely unlikely that anyone in the town of Kaufbeuren was unaware of what was happening at the institution (ibid.).

NOTES

1. Siechenhaus is a term that is no longer in common use. The original meaning could best be translated as “old folks’ home”. Comparable units are now referred to as geriatric units. Patients could be directly admitted to the Siechenhaus without being patients in the hospital. These were the “frail elderly” or those who otherwise couldn’t care for themselves.
2. Although Schellander described the use of morphine injections as rare, Melichen describes them as frequent. See Melichen’s statements.
3. Gottfriede Melichen denies the accusation that she killed any patients.
4. Ottile Schellander gave Melichen’s first name as Elfriede; however, in Melichen’s arrest report, it is stated as Gottfriede.
5. Deutsche Arbeitsfront (DAF) was established in 1933 as a Nazi organization that replaced all former labor unions, guilds, and professional organizations (Michael and Doerr 2002, 119).
6. Nationalsozialistische Volkswohlfahrt (NSV), National Socialist Peoples’ Welfare was a charitable organization founded on Nazi racial doctrine. It discriminated against asocials, “inferior races”, people with genetic conditions, and Jews. It assisted German mothers and children by promoting school health. It sent valuables that had belonged to people murdered by the Third Reich to Germany (Michael and Doerr 2002, 289).

REFERENCES

Klagenfurt 163


8 German Midwifery in the “Third Reich”

Wiebke Lisner and Anja K. Peters

8.1 INTRODUCTION

At the beginning of the twentieth century, midwifery in Germany was in a deplorable state, with low incomes, no social insurance, low social status, and little legal regulation. After World War I, the state of Weimar undertook a reform that can be interpreted as a step toward professionalization of midwifery, and stood in the context of the then current expansion and consolidation of the public health system. In the period of National Socialism (NS), with its dictatorial stateship (see Chapter 1), this process of professionalization was reinforced, and midwifery came under the newly promulgated Reichshebammengegesetz (Reich Midwifery Law) passed in 1938, marking an outstanding improvement.

The key element of state politics in the NS period was the racist population and health politics which tried to intrude into all spheres of daily life and were especially prevalent for social and health affairs. Therefore Adelheid von Saldern, author of “Innovative Trends in Women and Gender” describes racial engineering, referring to the concept of social engineering, as the core of the NS dictatorship (Saldern 2009).

In the first half of the twentieth century, births in Germany usually took place in homes and were attended by midwives.1 Midwives, therefore, played a key role in obstetrics. Since sexuality as well as pregnancy, birth and baby nursing were key elements at the crosspoint of regulating population and disciplining the individual body (Foucault 1977), after 1933 the reform of midwifery was intimately linked into the overall Nazi health and racist politics and into the broader concept of racial engineering.

The key value underpinning the midwifery profession in Germany was defined as “motherliness” (Mütterlichkeit). The role of the midwife, in practicing “motherliness” involved the provision of welfare services to her clients and the administering of education. The primary aim of midwifery, however, was to achieve good birth outcomes and a healthy mother and child.

The focus of the first section of this chapter is to explore how midwives adjusted their idea of Mütterlichkeit to the concept of racial engineering, and thus became part of the National Socialist’s biopolitical planning and
its implementations. A closer look is given to the involvement of midwives in the NS program of forced sterilizations and the “euthanasia” program for children (see Chapter 2), as two extreme actions undertaken by the NS-state to increase the number of “healthy” and “purebred” and decrease the number of those considered “unfit” and “not Aryan”. The aim is to show how midwives, as women on lower professional levels in the health system became an integral part of the Nazi regime. What kind of room for manoeuvre did they have as women working in a female-assumed sphere within the national socialist health system?

The second section of this chapter will introduce the chairwoman of the German Midwives’ Association and first president of today’s International Confederation of Midwives, Nanna Conti, to the reader. It provides an insight into the family system and social network of a key figure in the Nazi health system. The sources used offer many references for a context-sensitive analysis of Conti’s career in Nazi Germany. Contextualization can be regarded as one of the challenges of modern perpetrator research. Based on this, the significance of this study lies in the attempt to explain a female Nazi perpetrator’s actions (Peters 2010a).

8.2 MIDWIFERY BETWEEN MÜTTERLICHKEIT AND RACIAL ENGINEERING²:
Wiebke Lisner, translated by Rebecca van Dyke

In 1933, Professor Doctor Benno Ottow, director of the midwifery school in the Neukölln district of Berlin, called on general practitioners and midwives to “no longer judge nascent life solely in terms of the individual and isolated from the population as a whole,” but to see in it the “bearer of the survival and the future of the nation” (Ottow 1933, 162). In doing so, Ottow applied the principles of NS health policy to obstetrics. The aim of this health policy was to create a healthy, racially pure, and powerful Volkskörper (ethnic body). The creation of this body was viewed as necessary to the nation’s strength and racial superiority. During the NS period, health policy was oriented toward creating this body. As Winfried Süß specifies, the term Volkskörper described the collective model of a “hierarchically structured, racially homogenized production and reproduction community” (2003, 713). For those regarded as “valuable” members of the population, the NS Volkskörper model promised identity, security, and welfare and thus served, as did the Volksgemeinschaft (ethnic community), as an instrument of integration (Steinbacher 2007). The primary control elements were inclusion in and exclusion from the NS Volksgemeinschaft under the premise of racist politics. According to Michel Foucault (1977) the techniques of power subsumed under the concept of “biopolitics” for the regulation and control of population and life processes, as well as the alignment and adjustment of the individual body with or according to
specific norms, are characteristic of modernity. In this respect, biopolitical plans and implementation were not unique to NS. What was unique, however, was the joining of these with a racial policy that was raised to a national premise, a policy that became a defining element of health and social policy and unfolded its singular radical nature under the conditions of dictatorship (Raphael 2001). According to Thomas Etzemüller (2010) the “symbiosis of politics and science” opened up completely new opportunities for action to experts.

Adelheid von Saldern makes a case for extending the concept of social engineering for the period of NS and subsuming it under the term of “racial engineering” (2009, 87). The concept of social engineering was influential in Europe from the end of World War I until the 1960s. As Etzemüller writes, the use of social engineering represented “an attempt, alongside others, to deal with the consequences of modernity in which social relations were to be restabilized in the form of a community in order to fend off the allegedly threatening disintegration of society” (2010, 3). Accordingly, social engineering aimed for an optimization of society. In this respect, biopolitics can be seen as part of social engineering. Adelheid von Saldern defines social engineering as follows:

The concept of social engineering developed from modern sciences includes not only “politics from above”, but also self and group-cultivation according to social and political principles, norms and values. Social and cultural processes, including “self-cultivation” are linked to an interpretation of governmentality that focuses on manifold social practices within society, and not merely on top-down procedures. (Saldern 2009, 87)

In this sense, the definition of racial engineering as part of the concept of social engineering as done by Adelheid von Saldern for the period of the “Third Reich” enables integrating the process of the construction of the National Socialist Volkskörper into the concept of social engineering, while taking a particular look at the specifically NS element—namely, the primacy of racist policy. Research, biopolitical plans, and social processes, as well as collective and individual opportunities for action, can be made visible within the scope of racist policy and be interpreted as part of ambivalent modernity (Baumann 1995).

A primary starting point for the manifestation of biopolitics and racial engineering was the regulation of reproduction. The NS state took various measures to both prevent and promote childbirth. Those people who were regarded as having a “hereditary disease” or being “racially inferior” were to be prevented from reproducing while at the same time the birthrate of those considered “valuable”, “healthy”, and “powerful” was to be increased. The control, disciplining, and regulation of reproduction involved, first and foremost—if not exclusively—women and women’s
bodies (Bock 1993; Marßolek 1993). Thus, as Adelheid von Saldern concludes, racial engineering is “a gendered concept” (2009, 88). Moreover, pregnancy and birth, as central areas of the control of reproduction, belonged to the sphere of midwives’ work. In 1933, approximately 84 percent of all births were supervised by midwives acting autonomously. Thus, the profession obtained important biopolitical importance, and midwives were included in the process of racial engineering.

Ernst Puppel, director of the school of midwifery in Mainz, enunciated this when in 1934 he outlined what was required of midwives under NS at a conference in Hesse:

As obstetricians, we are standing . . . at the cradle of the nation. What is destroyed or even neglected here can never again be completely rebalanced. However, the enormous importance of these things does not become evident until you view the union of mother and child not as an individual, but as part of the whole to which we are all responsible, namely the German nation in its entirety. (Puppel 1934, 532)3

It was expected of both midwives and general practitioners that they maintain and improve the quality of the health and productivity of the Volkskörper. The point of reference of a midwife’s professional thinking and activity was to be the Volkskörper and not necessarily the health and needs of individual mothers and children. However, the demand for a shift in focus from the individual to “the nation as a whole” was at variance with the contemporary practice of midwifery. Midwives geared their professional conduct toward the personal situation of the individual woman observing her state of health while taking her social environment into account. The objectives on which the care relationship were based were to bring the birth to a favorable conclusion and maintain the health of mother and child. (Duden 2010). Thus the professional self-image of midwives was defined by the concept of Mütterlichkeit (Friedrich 1935). Unlike NS nurses, midwives were not to be “the Führer’s female soldiers” (Breiding 1998, 30) but instead, the “mothers of the nation” (Conti, Schulz, and Krosse, n.d., 7–9). The ideal midwife was the equivalent of the NS ideal mother: “racially pure”, genetically healthy, and politically responsible. Based on the concept of gender difference, the “ideal mother,” acting professionally and rationally, was to work in an “ideal sphere” designed specifically for her, managing the household and caring for her children full of self-sacrifice and with the awareness that she was not living and working for personal happiness, but for the welfare of the Volksgemeinschaft. (Haarer 1941; Wagner 1996). Motherhood experienced — to the extent that it applied to “valuable” members of the Volksgemeinschaft — an ideal reevaluation (Bock 1992; Reiter 1998). Bearing children was declared to be an important factor in the preservation of the Volksgemeinschaft. However, motherhood was not to refer solely to one’s own
child, but to the entire Volkskörper. In this respect, motherhood and tasks defined as “motherly” were de-privatized and politicized and thus experienced a reevaluation. At the same time, women classified as inferior were denied the right to motherhood (Wagner 1996). National Socialism was highly gendered, and Mütterlichkeit was the feminine principle that paralleled the male principle guiding the development of an NS “racially pure” ethnic community. This opened up gender-specific spheres of activity and participation for women (Frietsch and Herkommer 2009).

Thus, questions must be asked as to what extent midwives were included in the process of racial engineering, to what extent they were actively engaged in the processes, and to what level of negotiation and autonomy within those roles they could employ. The implementation of biopolitical plans, as well as the roles and actions of midwives within the context of racial engineering, can be examined through the case study of Lippe, a district that today belongs to North Rhine-Westphalia.

8.2.1 Practicing Midwifery in Lippe

The everyday and social milieu of a midwife, her biographical background as well as her experience, attitudes, and social networks, constituted the background of her actions (Saldern 1993). The private lives and everyday work of registered midwives took place in their respective working districts. The size of the district was measured in such a way that all of the women seeking help could be reached on foot or by bicycle. Hence, the midwife’s area of service was of a manageable size. Lippe makes for a suitable case study due to its limited territorial size, its political independence since 1947, and the richness of the available source material. With a population of approximately 175,000 in 1933 (0.4 percent of the entire German Reich population), the state of Lippe was relatively small (Fritsch and Tegtmeier-Breit 1994).

The midwife Bertha Vieregge was born in the mid-1880s in a Prussian city near the border with Lippe. After completing middle school at age fourteen, she worked for a farmer. When she was twenty-two she married a man from Lippe and moved with him to Lemgo, a city in the state of Lippe with a population of about 18,000. Bertha Vieregge completed her six-month training to be a midwife at the age of twenty-five, but did not begin practicing midwifery until six years later in the mid-1920s. At this point, her six children were between one and eighteen years of age. The Vieregge family owned no property but leased a garden where they grew vegetables and kept pigs. One of the older daughters tended to the household. On average, Bertha Vieregge supervised between twenty and thirty births a year. She stopped practicing in 1949 (Public Health Officer 1927; Calculation 1942–1945).

Vieregge’s life story is comparable to that of other midwives in Lippe at that time. The midwives were, on average, twenty-five to thirty years
old when they did their training. They had already performed some type of work after completing middle school at about fourteen years of age, and many were married and had children. Many of the midwives’ families secured their livelihood performing multiple jobs. The family’s total income was made up of what each family member earned and included the produce generated by the farms they frequently tended part-time in Lippe. The life patterns of midwives in Lippe exhibited parallels to those of the women they supervised—that is, the experience of pregnancy and birth united midwives with their clientele as did their membership in a similar social class, their educational background, and the type of work they performed before training to be midwives. What they also had in common was how they lived and the way they secured their livelihood (Klocke-Daffa and Lux-Althoff 1998). Connected to her clients through similar life experiences, the midwife was often a part of her district’s social community. Midwives operated accordingly in a close-knit network of personal and professional relationships.

Only very few midwives worked in a health area prior to their training, and traditionally, midwifery and nursing education were separate. As part of the Reichshebammengesetz (Reich Midwifery Law) passed in 1938, collaboration or overlap between the roles of midwife and nurse was even prohibited in 1939 (Verordnung zur Abgrenzung der Berufstätigkeit der Hebammen von der Krankenpflege 1939). Women completed their midwifery training at one of the state-run midwifery schools, which were affiliated with state women’s hospitals and university clinics. In 1921, Bertha Vieregge was able to complete her training within six months. In 1934 the training period was uniformly increased to eighteen months throughout the Reich. At the same time, “non-Aryan” women were excluded from midwifery training (Deutscher Gemeindetag 1934).

Like Bertha Vieregge, the majority of midwives in Germany were independent practitioners. In 1938 there were only 1,204 midwives employed in clinics across the Reich, whereas 22,449 were self-employed. Besides supervising and counseling women during pregnancy, childbirth, and the puerperium, midwives were often included in the infant welfare tasks performed by the local health authorities. In addition to obstetric duties, midwives also frequently performed social tasks, such as participating in baptisms or assuming responsibility for the well-being of the mother and child beyond childbirth and puerperal care. The registered midwives usually worked in the parturients’ homes, whereas from 1936 to 1943, about one-quarter of the childbirths assisted by registered midwives in Lippe took place in a clinic (Lisner 2006). In the homes during the supervision of pregnancy, childbirth, and the puerperium, they therefore had to adapt themselves to the circumstances for each respective home. For example, in each situation, they had to be able to deal with notions of order that were different to their own, close living quarters, and pets. Besides accommodating the parturients, they also had to accommodate their husbands,
relatives, and neighbors (Grabrucker [1989] 1996). Working in the parturients’ homes afforded midwives insight into their clients’ private lives. For example, the number of births and miscarriages experienced by the client, as well as details regarding the client’s sexual relationships, would not have remained secret. In this respect, the women were dependent not only on the midwife’s obstetric skill but also on her discretion, which was, therefore, an important quality for a midwife to possess (Case of midwife K. Croll 1924/1925). At the same time, the midwife was dependent on her clients and due to the proximity of their life-worlds, information about a midwife’s personal and professional life was also available to her clients. She was called on to assist childbirth only if she had a good reputation among the women in her district. In Lippe, which was predominantly Protestant, Bertha Vieregge was the only Catholic midwife. In 1933, approximately 94 percent of Lippe’s population was Protestant and only 0.5 percent Catholic (Reich Statistical Office 1933). Her religious affiliation as well as her status as a newcomer set her apart from other midwives in Lippe. This, as well as tensions between her and another midwife in Lemgo, which had been based on professional competition and economic differences, may have been the reason for her relatively small number of commissions. In 1935 Vieregge supervised only twenty-three births, while her colleague assisted in more than sixty (Yearly Health Report 1935).

8.2.2 Midwives and Midwifery during National Socialism

Beginning in 1933, midwifery experienced a reevaluation. The status of midwives who were “Aryan”, politically reliable, and efficient increased. The culmination of this professionalization was the enactment of the Reichshebammengesetz in 1938. For midwives, this law brought economic, social, and legal security that, compared with European standards, was unprecedented. At the same time, it excluded midwives who, in an NS sense, were considered to be politically unreliable, of Jewish origin, or inefficient. The Reichshebammengesetz, furthermore, introduced the mandatory enlistment (Hinzuziehungspflicht) of a midwife for every birth and miscarriage as well as ensuring that every midwife received a minimum income. This provided economic security, in addition to a restricted right of establishment (Zimdars and Sauer 1941; Tiedemann 2001). Thus, a governmental instrumentarium for the regulation of the number of freelance midwives was created. The goal was the optimum exploitation of the working midwives’ labor power as well as securing their sufficient income.

This was associated with larger working districts and higher numbers of clients. Consequently, it became less and less possible for unregulated midwives to practice, particularly in the country. (Lisner 2006). With the introduction of their mandatory enlistment, midwives gained a monopoly in obstetrics. Their activity was thus clearly distinguished from that of physicians and nurses, and their specialized knowledge was recognized.
The Professional Midwives Association, founded in 1933 and headed by midwife Nanna Conti, was given wide-ranging authority to regulate and control its members. Due to the *Reichshebammengesetz* stipulating mandatory membership in a professional association, this was applicable to all practicing midwives (Peters 2010).

An integral part of the reevaluation of the profession was its functionalization for Nazi health policy, as well as the implementation of the Nazis’ biopolitical plans. Beginning in 1933, midwives were included in the practice of racial engineering on different levels. It was not that new parameters of duties were created for this purpose, but that the state, as well as the Professional Midwives Association, extended the existing sphere of activity and advanced a politicization of the profession, aligning it with Nazi values.

The government and the professional midwives’ association expected midwives to educate their clients. Like doctors, they were to communicate material related to racial and population policy as well as Nazi ideology. In addition, they were expected to explain issues related to the care, raising, and feeding of infants as well as those related to household hygiene. In this regard, a midwife’s educational responsibility was oriented not toward the needs of women and their families but toward the goals of NS policy (Ottow 1933). The midwife’s influence could have a positive impact on mother and child, if, for example, she were advocating a healthy diet or good hygiene (Grabrucker, 1989, 1996). However, a midwife’s educational responsibility turned the interaction between her and her client into a control-related action. Furthermore, the mandate requiring midwives to pass on information to health authorities about families regarding, for example, their economic circumstances or their diligence turned them into discrete supervisory authorities.

Apart from their responsibilities to educate and control, midwives’ reporting duties were expanded in the period from 1933 to 1945. Besides reporting the illness or death of a woman who had just given birth, or a newborn, midwives were also required to report people who were considered “hereditarily diseased”, according to the *Gesetz zur Verhütung erbkranken Nachwuchses* (Law for the Prevention of Hereditarily Diseased Offspring, Gütt 1935). This law was passed on July 14, 1933 (see Chapter 2). The law regulated sterilization for eugenic reasons and constituted the basis for forced sterilization. Its intent was to prevent life that was classified as “undesirable” or “unworthy to live”. Doctors and all “of those concerned with the treatment, examination or counseling of people who are ill” (Ministerium des Innern 1934, 367) were obliged to notify public health officers of the birth of infants with hereditary diseases. Professional secrecy was suspended for this purpose (Vossen 2001). The local public health department comprised the institutional framework for registering people with hereditary diseases. The incoming reports were evaluated, and, if necessary, those affected were subjected to a genetic examination.
It was the midwives’ task not only to report a suspected “genetic disease” but also to promote acceptance of the law and provide counseling with the law in mind. Moreover, it could be assumed that public health officers asked midwives for information about people and families in their district (Ottow 1937a; Spranger 1936). Under the Gesetz zur Verhütung erbkranken Nachwuchses reports made by midwives could initiate proceedings for the performance of forced sterilization. In addition, the midwives’ reports, which they were compelled to submit for miscarriages, premature births, or stillbirths and for suspected abortions, served to complete the “genetic index” and thus recorded the population from racial and genetic perspectives. If illegal abortions were reported, this could initiate the prosecution of the affected women. Midwives effectively took on the role of policing both abortions and the births of children with disabilities. Consequently, they were included in the progressively radical processes of racial engineering that began prior to World War II.

8.2.3 The Inclusion of Midwives in the “Euthanasia” of Children

On August 18, 1939, about two weeks before the beginning of World War II, midwives received a decree mandating them to report malformed newborns and small children with disabilities to the public health officer, before their third birthday (Beddies and Hübener 2004). They received two Reichsmark for each report. The decree gave the following reason: “The early detection of pertinent cases is necessary for the clarification of scientific questions in the area of hereditary malformations and mental retardation” (Order of the Reich Minister of the Interior (IV b 3088/39—1079 Mi.) Meldepflicht über missgestaltete Neugeborene 1939). Reportable conditions were: “Malformations of any kind, in particular the absence of limbs, serious scissura of the head or the spine, and paralysis, including Little’s disease” (ibid.). Midwives were required to report such cases even if a doctor was present at the birth. The public health officers were not responsible for evaluating or reviewing the incoming reports, but were to pass them on directly to the Reichsausschuss zur wissenschaftlichen Erfassung von erb- und anlagebedingten schweren Leiden (Reich Committee for the Scientific Registration of Serious Hereditary and Constitutional Diseases). This was the code name of a committee located in Department IIB of the Führer’s Chancellery that planned and organized the registration, medical assessment, and murder of children with the symptoms defined by the Reich Ministry of the Interior (Topp 2004). The registration of children was especially important because the “euthanasia” organized by the Reich Committee concentrated primarily on children who did not live in an institution (Schmuhl 2009).

Based on the reports that were submitted, the Reich Committee reviewers decided on the admission of a child into one of the confirmed twenty-nine special children’s wards that had been set up in the spring of 1940
where children were mostly observed for a time and in part underwent therapy. If the children received a negative assessment after the period of observation, the Reich Committee issued an “authorization to kill” and the children were murdered by doctors or nursing staff, in most cases by means of an overdose of medication (see Chapter 5) (ibid., 42–50).

Within the scope of the so-called Reich Committee process, the murders were accompanied by scientific research. The children who were reported and admitted into a special children’s ward were, among other things, subjected to experimental therapy methods, vaccination experiments, and brain research (ibid.). According to information provided by Hans Hefelmann and Richard von Hegener, two of those responsible in the Reich Committee, approximately five thousand infants and small children were victims of “euthanasia” (Beddies 2009). Besides children with disabilities, those with behavioral disorders and so-called children in care, as well as the children of forced laborers, Jews, Sinti, and Roma, were murdered (Schmuhl 2009; Roer 1997). However, there was no clear distinction between the “euthanasia” of children and that of adults. According to recent research findings, 5 to 6 percent of the victims of the so-called Action T4, which ceased on August 24, 1941, and the “wild euthanasia” that continued under changed strategic conditions, were children and youths between the ages of three and twenty years. This corresponded to a total of 3,500 to 4,500 (Fuchs et al. 2004). The participation of midwives in children’s “euthanasia” primarily consisted, as was the case in their enforcing the Gesetz zur Verhütung erbkranken Nachwuchses, in fulfilling their obligation to notify the authorities. However, this was more comprehensive in that all disabilities then had to be reported regardless of their heritability (Grebe 1943).

In contrast to the Gesetz zur Verhütung erbkranken Nachwuchses, about which the midwifery journal reported in detail, the decree from August 18, 1939, was not mentioned. The government in Lippe classified it as highly confidential. Midwives were presumably informed verbally by public health officers about their new obligation to notify the authorities (Lippe 1939). It was not until August 1940, with the printing of a new decree dated July 1, 1940, that the specialist journal Die Deutsche Hebamme made it publicly known that midwives were obliged to notify authorities of malformed newborns. The new decree provided information about the establishment of the first special children’s ward in the state institute in Görden in Brandenburg. Public health officers were now obliged to arrange for the early admission of the child. Reports of “malformed” newborns were initially so scarce that with the decree dated September 20, 1941, the Reich Ministry of the Interior reminded public health officers “to ensure that the midwives conscientiously comply with the obligation resting on them to notify the authorities” (Klee 1983, 304). The midwives in the area served by the public health authority in Lemgo were initially reserved. By January 17, 1940, not a single midwife had reported a malformed newborn (Public Health Officer 1940). However, as the year progressed, the number of reports...
increased, and by December 1940, seven children had been reported. The midwives received two Reichsmark for each reported child (Public Health Officer in Lemgo 1940, 1941, 1942, 1943). Bertha Vieregge also reported a child with disabilities (Public Health Officer 1940). According to Bernd Walter (1996), from January 1940 to May 1944 the local health authority in Lemgo passed a total of twenty-seven reports to the Reich Committee. Of these, approximately nine to twelve were from midwives, but the files do not document any further reports from midwives after June 1942 (Public Health Officer in Lemgo 1940). The rest of the reports from Lemgo were from medical facilities (Walter 1996).

Ernst Klee (1999) described the repercussions of the reports, referring to the case of a girl named Ilse who was born on April 21, 1940, with Down’s syndrome and clubfeet. The day after her birth, the midwife reported her to the local health authority and received two Reichsmarks. The public health officer sent the report to the Reich Committee on May 8, 1940, which ordered that the child’s development be observed until October 1940. In October, the public health officer gave the desired report by pointing out the “physical appearance of Mongoloid idiocy”. On February 3, 1941, the Reich Committee sent the public health officer a letter informing him of the institution to which Ilse was to be admitted. On February 21, 1941, an occupational health nurse brought her to the Eglfing-Haar mental hospital. Her accommodation was paid for in equal parts by health insurance and by the Reich Committee. On April 5, 1941, Ilse was dead (ibid.). This example illustrates the procedure that began with registration of the child and ended with murder, as well as the uncritical cooperation by all of those involved. The midwife reported the child, which meant that it became a case to be reviewed by the public health officer. If the health officer confirmed the information from the midwife, the report was passed on to the Reich Committee, where the medical reviewers decided on the life or death of the child. The medical insurance companies ultimately financed the children’s murder in collaboration with the Reich Committee (Burleigh 2001).

The relatively low number of reports submitted by midwives active in the area served by Lemgo’s health authority indicated that they seldom had cause to submit a report. In 1939, for example, midwives in Lippe assisted in the birth of only five children with diseases or birth defects, which represented 0.2 percent of the total number of midwife-assisted childbirths (Yearly Health Report of Lippe 1939). Moreover, it should be taken into consideration that midwives did not always recognize disabilities, particularly if they were borderline cases, or did not want to recognize them. The midwife had to gauge whether she wanted to risk conflict with a child’s parents, which could possibly have a negative impact on her due to local social structures, or fulfill her obligations to the state. However, the extent to which midwives consciously refrained from reporting disabled newborns cannot be reconstructed. There is no indication in the files of reprimand or punishment of midwives for failing to report such cases to...
the authorities. This suggests that, as a rule, midwives complied with their obligation and that violations thereof could not be proven or were not consistently pursued (Walter 1996). Unlike nurses and doctors, midwives did not directly participate in the institutional murder of children (ibid.). They were responsible for reporting the children living with their parents—in the sense of a division of labor in crime—and thus contributing to the registration of the children.

Not all children were first centrally registered by the Reich Committee and then selected for “euthanasia”. Benno Ottow, writing about prematurely born infants in a 1940 issue of the midwifery journal, pointed out the possibility of doctors and midwives acting on their own authority:

Those who neglect or abandon a premature infant that may appear to be incapable of surviving but if still alive, can make themselves guilty of murder by negligence. It is good and useful to know this and to act accordingly, even though one in general will of course not doubt the responsible and correct conduct of doctors or midwives in pertinent cases. (Ottow 1940, 146–147)

Determining the ability of a child to survive was even in the NS period not up to midwives. They were obliged to do the best they could to keep mother and child alive and healthy.

In interviews, midwives nevertheless have implied that under certain circumstances, determining the ability of a child to survive was no longer a taboo issue in their practice. The former midwife Dorothee Wolter from Lippe reported, “I always said outright that this child can’t survive, didn’t I?” Interviewer: ‘And what did you do then?’ Dorothee Wolter: ‘Took it into the other room.’

In an interview, Maria Meurer, also a former midwife from Lippe, told of the birth of a child in the early 1940s with multiple serious disabilities: “And this child nobody wanted. . . . I kept it for six weeks. And it was in Niedermarsberg for 14 days, in Sauerland. It had a gas chamber then.” The first “special children’s ward” in Westphalia was set up in the Niedermarsberg/St. Johannisstift Catholic mental hospital in November 1940. There was no gas chamber present there (Berg 2001). It can be assumed that what Maria Meurer wanted to express with “gas chamber” was her awareness of the organized murder of children in Niedermarsberg or at least her suspicion of it. Unlike forced sterilization, the murder of children was not communicated publicly. However, it must have been obvious to midwives that the children admitted to the special children’s wards did not return home healthy but died within a very short period of time. Thus, when the child was admitted to the hospital, Maria Meurer knew that it would not receive the necessary care: “I said how I did it. . . . but if doctors say nothing will be done, forbidden is forbidden, isn’t it?” Maria Meurer could not assume the long-term care of the child. In addition, she came
under increased pressure because the doctors responsible for her working district pressed for the killing of the child. Maria Meurer recounts,

Dr. G. looked at it. He tells me: Miss Meurer, let it starve. I say: I’m the one suffering. . . . The doctor says: Make . . . (it so), then it can’t breathe. . . . . I say: What are you trying to say? I won’t do it if the child’s to die, if I’m to let it die. But I won’t contribute to its death. I’d be unhappy the rest of my life.

The death of the child was apparently not a taboo issue for either the doctors or the midwife. Yet what was important to Maria Meurer was not to be the one carrying it out. For her, the infant’s placement in Niedermarsberg was an acceptable solution. She silenced her conscience with the assurance that the child would not actively be murdered because of its disability, but that it would die due to a lack of care. The child’s parents, according to Maria Meurer, rejected it and thus responsibility for its life. In this case, she was free from conflict with the child’s parents when she reported it to the local health officer and took it to Niedermarsberg. Yet if parents accepted their child in spite of its disabilities, under certain circumstances the midwife was faced with a conflict of loyalty (Evangelische Gesundheitsfürsorge 1940; Stargardt 2006).

In the case described by Maria Meurer, however, all of those involved reacted in just the way the Nazi planners expected. Parents, immediate family, and doctors fulfilled the tasks they were meant to fulfill, with resistance and with a delay in time. The planners relied on — like Kurt Nowak writes — the passive acceptance of a psychological complicity that alternated between acceptance and rejection until the fact itself made further scruples irrelevant (1991). The fact that children were being murdered in a clinic under a doctor’s responsibility made it possible for family members and those involved to suppress their knowledge of the circumstances of the child’s death. Further aiding this suppression of knowledge was the fact that boundaries were blurred between active murder, facilitated death, and the failure to introduce life-sustaining measures (Walter 1996). These factors presumably played a part in Maria Meurer’s complicity with the process. In order to save the child, she would have had to openly express her rejection of the child’s death to the doctors, the public health officer, and the child’s parents, which she did not do.

8.2.4 Conclusion

Given their involvement in the social milieu of their districts and their expertise in obstetrics and women’s health, midwives held a position of trust. This enabled the low-threshold health-related and obstetrical care of women and children. At the same time, they were bound to governmental directives through their obligations towards the public health officers,
and also adhere to legal and working regulations. Thus, midwives fulfilled a dual mandate that, on the one hand, placed them under an obligation to the women and families in their districts and, on the other hand, bound them to state directives. Since the nineteenth century, this had been regarded as the ideal basis for entrusting midwives with governmental health-related and discipline-specific responsibilities (Burke and Kleine 2004). In Nazi Germany, however, midwives’ activities were oriented toward the Nazi Volkskörper.

Midwives profited twofold from the reevaluation and politicization of Mütterlichkeit, as it related to the National Socialist Volkskörper and was regarded as valuable. On the one hand, their area of competence was declared a primary issue in terms of national policy, and thus their activity received political attention and recognition. On another, their professional self-image, which was oriented toward the concept of Mütterlichkeit, was tied into biopolitical arguments, and midwives received governmental support for their interests in terms of professional policy. At the same time, all of those midwives considered inefficient or politically unreliable were excluded.

The connection to Mütterlichkeit, as well as the orientation of health policy toward the Nazi Volkskörper, resulted in midwives being included in the overall and radicalizing process of racial engineering, “from the prevention to the eradication of life unworthy to live” (Schmuhl 2009), as well as the promotion and increased efficiency of what was considered valuable. In doing so, midwives acted as a link between the population and the local health authorities. Thus, midwives could be active as multipliers of Nazi ideology, but also as government agents, taking part in recording population characteristics in their district. In playing a conciliatory role, they could also enable authorities to access families, helping, for example, to convince parents of the need to place their disabled child in a special children’s ward.

Midwives were supposed to act as mothers to “mothers-to-be”—that is, selfless and dedicated, but not exaggerated caring or sentimental and emotional. In addition to this, part of their duty was to continually bear in mind the well-being of the Nazi Volkskörper. This included orienting themselves toward a concept of care based on “motherly authority”, rather than on partnership or friendship. Having this authority, midwives made decisions for their clients, possibly after consulting doctors.

However, the involvement of midwives in the process of racial engineering failed due to their dual mandate. Locally, their actions were often guided by the social structures within their working districts. Biased by their existing connections to clients and by their own attitudes and values, midwives’ behavior was often contradictory. The case of Bertha Vieregge illustrates this. Thus, she fulfilled the obligation assigned to her within the scope of so-called children’s “euthanasia”. At the same time, despite the discrimination of the population classified as Jewish, she supervised the labor and puerperal care of a Jewish woman from her neighborhood.17 The
entrenchment of midwives in the milieu of their district in connection with the dual mandate constituted a specific sphere of action which midwives used in accordance of their personal attitude and their social and professional environment.

8.3 A FÜHRER FOR THE MIDWIVES—NANNA CONTI (1881–1951)\textsuperscript{18}

Anja K. Peters

As discussed, German midwives participated in the criminal demographic development policy of Nazi Germany as they kept a record of malformed newborns and their parents. Many of these babies were murdered in the child “euthanasia” program. One of the leading minds to be held responsible for this was *Reichshebammenführerin* (female Führer of the German midwives) Nanna Conti. This section offers a brief biography of Conti. It shows how the professional and political commitment of Conti from 1933 to 1945 was embedded in a context of familial, political, and environmental conditioning. It also introduces Professor Benno Ottow, who was one of the editors of the *German Midwives’ Journal* and engaged in the German sterilization policies of the Nazi era (Peters 2010a, b).

Conti was born on April 4, 1881, in Uelzen near Hanover. Her father, Dr. Carl Eugen Pauli (1839–1901), worked as headmaster of the local boys’ secondary school. He became well-known as an Etruscologist (one who studies the ancient civilization of Tuscany). In 1883 he lost his job following an extramarital affair and left Uelzen with his family. Conti’s mother was Anna Pauli née Isecke (1850–?), from Lębork near Gdansk. As many archival files were lost during World War II, it is difficult today to find historical data about her. From 1884 the family lived in and around Leipzig, where Conti’s father was once again employed as a teacher. Conti had two brothers, the younger of whom died in 1893. In 1895 the family moved once more, this time to Lugano in Switzerland, where Conti’s father had obtained yet another teaching post and continued his Etruscology.

Conti assisted her father in his research, learning to speak Italian fluently. She developed a love for Italy and Switzerland that would endure over her lifetime. In addition to her native German and Italian, Conti also spoke English and French, which enabled her not only to follow the International Midwives’ Congresses in London in 1934 and in Paris in 1938 but also to translate for German delegates and to read foreign professional magazines, which she summarized for German midwives.

In Lugano in 1898, Conti married Silvio Conti (1872–1964). She was not yet seventeen years old, while her husband was nineteen. During the following four years Conti gave birth to three children. In 1902 her marriage failed and she left her husband, moving to Germany, where she enrolled at Magdeburg midwifery school in 1904. In 1905 she began working as a freelance midwife in Berlin. As midwifery and nursing were (and still are)
strictly separate professions in Germany, Conti did not need to attend a nursing school before training as a midwife. Why she chose to become a midwife is as yet unknown. She was likely in urgent need of earning a living for her family and thus needed a respectable occupation to provide this.

Most midwives in Germany and Austria worked as independent practitioners as medical confinements tended to take place in the home. Maternity clinics and hospitals were used mostly in cases of risk or emergency. When Conti attended midwifery school, each German state had its own midwifery curriculum. Courses lasted approximately six months before the women were allowed to work as independent midwives. A fierce rivalry existed among midwives, the result of an increasing number of practitioners and a decreasing birth rate. Wages were so low that many lived in poverty, and the absence of an old age pension meant that many had to work until their death, or until they were too sick to work any longer. Under the leadership of Olga Gebauer, the first president of the International Midwives’ Congress, the midwives’ association fought for better training, adequate wages, and, most importantly, a law that would secure their being given preference over physicians in obstetrics (Szász 2006).

After World War I, the midwives’ organization split into several political wings and lobby groups reflecting the general political upheaval in Germany at the time. Contemporary reports show deep animosity between several key groups. Conti already appeared as one of the nationalist midwives, but remained in the background behind figures like Emma Rauschenbach (1870–1946).

Rauschenbach was chairwoman of both the Saxon Midwives’ Association and the largest Germany-wide midwives’ organization, Allgemeine Deutsche Hebammenverband (General German Midwives’ Association [ADHV]). After the Gleichschaltung (enforcement of standardization and elimination of all opposition within political, economic, and cultural institutions), she shared the presidency with Conti and Caroline Einstmann (1868–?) from Hanover, but was forced to retire when Conti dismissed her from all posts in 1939 (Sauer-Forooghi 2004). Einstmann was leader of the Hanoverian branch of the midwives’ organization. In the headquarters in Berlin she seems to have been responsible for administrative activities, but never played an outstanding role in the organization’s leadership.

We do not know much about Conti’s work as a practicing midwife in Berlin during the Weimar Republic. She was able to send her children to a grammar school, where they took their university-entrance diplomas. Her two sons, Silvio (1899–1938) and Leonardo (1900–1945), became a lawyer and a physician, respectively. Silvio would be appointed district administrator in Prenzlau near Berlin in 1933. He committed suicide in 1938, though the reasons remain unclear.

Conti’s daughter, Camilla (1902–1993), also attended university but left after a couple of months, perhaps because of financial problems. She married Doctor Robert Nissen (1891–1969), who became director
of the Westphalia State Museum in 1937. They do not seem to have been fanatic Nazis like Leonardo, but her husband’s career probably benefited from his in-laws’ influence. Camilla, in contrast with her brothers, did not appear in public.

Conti’s own interest in fascism and NS is said to have been influenced by the anti-Semitic and völkisch publisher Theodor Fritsch (1852–1933). Among several anti-Jewish pamphlets, he published the so-called Protocols of the Elders of Zion. Conti and her sons joined several extremely right-wing parties and organizations during the Weimar Republic until they became members of the NSDAP. One of these parties was the Deutschnationale Volkspartei (DNVP). The DNVP attracted especially Protestant, educated, and conservative middle-class women who were typically nationalistic and supporters of “racial hygiene”. Most of them were anti-Semites. Even if they themselves were also anti-feminist, they used the political opportunities of the Weimar Republic to spread völkisch ideas and to fight against the hated republic (Sneeringer 2007). Conti fitted perfectly into this profile. During the following years, she and her sons became more and more radical. She was admitted into the NSDAP, probably in 1930; thus, it can be assumed that she genuinely adopted the Nazis’ worldview.20

The Gleichschaltung ended the splitting of midwife organizations and reunited all groups under the roof of the ADHV, which was first renamed the Reichsfachschaft Deutscher Hebammen (Reich’s Association of German Midwives) and later renamed, in 1939, the Reichshebammenschaft (Reich’s Midwives’ Association). Renaming an established association gave the impression that the well-known and independent ADHV continued, especially as prominent ADHV leaders like Rauschenbach remained on the executive committee, but in fact it was supervised by the Reich’s Home Office and thus lost its organizational autonomy (Tiedemann and Huhn 2006; Tiedemann 2001). Conti was not elected as chairwoman by the midwives themselves, but appointed by the home secretary. According to the Führerprinzip (Führer principle), which implemented a strict hierarchy on all political levels, Conti herself appointed national midwife leaders. Conti was also leader of the Prussian midwives until 1940 and of the local, but important, chapter in Berlin. From 1939 when Rauschenbach was dismissed, Conti also acted as chief editor for midwifery affairs in the professional journal, together with Ottow and Professor Doctor Fritz Rott (1878–1959).21 As a high-ranking functionary in the German health system, Conti served on many committees and attended meetings and congresses. Speaking several languages, she also had access to international journals. From the existent sources it can be gathered that Conti was a nexus of authorization, influence, information, and insight into the Nazi system. Consequently, she must be held responsible for the involvement of German midwives in the Nazi race policies (Tiedemann and Huhn 2006).

Conti was very interested in demography and population movement. Her frequent articles about statistical research show her strong interest
in quantitative research and a broad mathematical understanding. She regularly read the British midwifery journal *Nursing Notes & Midwives’ Chronicle* (the *Chronicle*). In 1934 she quoted a report about birth rates, mortality, and sexual diseases in England and Wales. She analyzed the data from the *Chronicle* but, as with the mortality rates discussed earlier, concluded that she was not sure whether the statistical methods were the same as in Germany and therefore comparisons were questionable (Conti 1934). In 1935 she quoted a statistical report by the *Chronicle* about mortality numbers in Scotland. She copied in detail the statistical data that showed the health condition of mothers and the reasons for their death. They showed a direct relationship between hospital confinements and mortality (Conti 1935). This was an important argument for Conti, who also fought vehemently against the rising numbers of hospital confinements under the supervision of gynecologists in Germany. She was supported by her son Leonardo, but they were unable to turn back the clock.

In 1937 Conti again quoted the *Chronicle*, which she thought to be a very reliable magazine. The *Chronicle* wrote that confinements led by midwives showed a mother-mortality rate of 2 percent, in contrast to 5 percent in all births. The article continued that in the US, mortality occurred most often among upper-class women who mostly gave birth in hospitals under the supervision of a gynecologist. A similar mortality rate was seen in New Zealand, where, according to the *Chronicle* report, there were no midwives at all. Meanwhile, she noted that in England a new midwifery law was being prepared, which demanded that mothers should be allowed to choose their midwife, that midwives should be chosen according to knowledge and skill, and that obstetricians be allowed to select their midwife partner of choice (Conti 1936).

In Germany, midwives had fought for a federal midwifery law since the end of the nineteenth century. From 1933 to 1938, Conti, her son Leonardo, Rott, and Kurt Zimdars (1887–1982) worked intensively on a new bill, which was finally passed in 1938 as *Reichshebammengesetz* (see Section 8.2.2). It regulated midwives’ training and duties and gave women the right to be assisted by a midwife in labor. However, it went further than this by saying that every pregnant woman was required by law to call for a midwife. If not possible, she or the attending physician had to call for a midwife immediately after the baby was born. As a result of this law, since 1938 midwives have held the monopoly to attend every regular confinement in Germany and Austria. Seen as responsible for this rise of the role of the midwife, it is of little wonder that until the 1980s, high-ranking midwife functionaries ranked Conti among the heroines of German midwifery history.

In 1942, Conti wrote about “racial development in the USA”, strongly disapproving of Eleanor Roosevelt, who “liked acting as patroness of the black population and spoke at *Negerversammlungen* (Negroes’ meetings) (Conti 1942). Obviously, Conti also did not like that just 8 percent
of African-Americans were unable to read, that there were universities for them, and that efforts were made to fight tuberculosis and syphilis within the African American population. From Conti’s point of view, it was a waste of resources to engage so intensively on behalf of an “inferior” race. Other articles by Conti show her fear that the Neger would outnumber the “white race”. In an illustration of her anti-Semitism, she accused the Jews of supporting the Neger, stating that this support was not to be wondered at as Jews always deceived their host country (Conti 1942).22 She could be sure of approval for her opinion: “Already in 1919 Hitler himself had written that Jews were a ‘racial tuberculosis’ which would destroy their ‘host nations’” (Wehler 2010, 655).

In 1944, Conti quoted a report from a magazine, Deutsche Arbeit (German work), about the Indianerproblem (Indianer meaning native Americans) in Northern and Southern America. It said that while in the US native Americans were nearly exterminated, those in Mexico were very fertile and 59 percent of all Mexicans were Mischlinge (half-castes). Conti stated that the end of the “pure Whites” could be predicted there and that this was a warning to Germany. Only a Germany with many children would be able to withstand population pressures and attacks from the East (Conti 1944). Publications like this show clearly Conti’s deeply racist worldview.

Before World War II began in 1939 with the German attack on Poland, Conti corresponded with foreign colleagues and enjoyed the growing international network of midwives. From 1933 she traveled all over Europe and attended symposia, meetings, official celebrations, and of course the International Midwives’ Congresses in London (1934) and Paris (1938). The congress of 1936 took place in Berlin, over which she presided.

After the congress in London in 1934 it was unclear where the next one would take place. After some consideration, the German Midwives’ Association invited all members of the International Midwives’ Association (ICM) and associated organizations to Berlin. This congress opened on June 5, 1936, and was infused with a feeling of national hubris: “In 1936 the Olympic Games were to take place in August and the German people felt acknowledged and significant again after the disastrous and traumatizing end of World War I and the following political upheaval and chaos of the Weimar Republic” (Peters 2011a, 36–37). For Conti and the German midwives, it was an honor to host the ICM, bringing the congress back to its origins and to the home country of its first congress president, Gebauer (Peters 2011b).23

Conti opened the congress and welcomed over one thousand delegates and guests. She declared that this congress would focus not only on midwifery itself but also on those questions die sich mit den großen Fragen der Nationen berühren (which touch the big questions of nations): home and hospital confinements and mothers’ mortality. As these were topics of specific interest to Conti, it can be concluded that she deeply influenced the congress. A telegram was read aloud, sending kind greetings from the
German Midwifery in the “Third Reich” 183

leader of physicians in the Third Reich (Reichsärztesführer), Dr. Gerhard Wagner (1888–1939), and also from Adolf Hitler.

The delegations reported on their national midwives’ organizations before attending a reception hosted by the town of Berlin. On the following day the question of home versus hospital was discussed and national experiences exchanged. In the afternoon the midwives talked about their rights and duties in their home countries, and in the evening they were welcomed at a reception given by the home secretary, Wilhelm Frick (1877–1946). In his speech, Frick openly explained that Germany’s interest was to promote “valuable genes” and to avoid “inferior” offspring. He also argued that Germany was against war, because war would destroy the best and spare the weakest and consequently cause a negative selection. A further reception was given by Reichsfrauenführerin (Reich’s women’s leader) Gertrud Scholtz-Klink (1902–1999) (E. K. 1936).

The next morning started with reports on national strategies to increase birth rates, followed by a debate about the protection of mothers and children. In the afternoon Rauschenbach read a paper on midwives as counselors, and an evening theater performance was attended by seven hundred delegates. On June 9, 1936, the official delegates met. In the afternoon several hospitals and a Frauenmilchsammelstelle (milk bank) were visited. While the German midwives met on the following morning for their annual meeting, the foreign delegates were invited to visit a Frauenarbeitsdienstlager (labor service camp for women) and a Mütterschulung (mothers’ training course). On the last day, the midwives took a bus tour to Hohenlychen and Alt Rehse.

In Hohenlychen, Dr. Karl Gebhardt (1897–1948) was the leading physician at its sanatorium, which became famous during the Nazi period for its therapies for athletes and later for wounded soldiers. Gebhardt also became a leading physician in the SS and committed criminal medical experiments on imprisoned women in the concentration camp of Ravensbrück (Hahn 2008; Benedict 2003). Among his assistants were Dr. Percival Treite (1911–1947) and Dr. Herta Oberheuser (1911–1978). Treite, who was sentenced to death for mass murder but committed suicide, had been a scholar of Professor Dr. Walter Stoeckel (1871–1961), the leading German gynecologist of the first half of the twentieth century. In his autobiography, Stoeckel still regretted the suicide of his former scholar without distancing himself from the crimes Treite had committed. Stoeckel was also the mentor of Ottow. Oberheuser, the other assistant of Gebhardt, was also accused of murder and sentenced to prison. She had been arrested in Schleswig-Holstein, where in 1956 she returned to the village of Stocksee, where Conti had lived from 1945 to 1951. It is conceivable that the two women knew each other and were also in the same group of refugees from Berlin via Hohenlychen and Alt Rehse to Schleswig-Holstein in 1945.

An inmate of Ravensbrück was an Austrian midwife Josephine (Fini) Pöllinger. Pöllinger had been sentenced to prison for performing illegal
abortions. Norwegian resistance pioneer Sylvia Salvesen has given eyewitness accounts of Fini doing her utmost to help imprisoned parturients in the concentration camp to give birth. From a medical historian’s point of view, it would be interesting to find out whether Fini had lost her accreditation as a midwife due to her sentence. In that case it would have been illegal to call her for confinements. It would also mean that the camp physicians, nurses, and untrained staff who called her to attend to confinements instead of calling licensed midwives from outside the camp violated genuine national socialist law that required them to call for a licensed midwife for every parturient (Salvesen 1958). Further research regarding this matter would be necessary.

Alt Rehse, which was visited by seven hundred midwives from the ICM congress, is a small village in Mecklenburg where, in 1935, the Nazis built what they conceptualized to be an exemplary German village. Reorganizing its old estate, they also opened the Führungsschule der Deutschen Ärzteschaft (German physicians’ leader school), where leading physicians and junior doctors were trained in NS ideology. Lectures about “genetics, eugenics and racial hygiene” formed an important part of these courses. It can be assumed that nine thousand to ten thousand physicians took part in these training courses (Maibaum 2007). Because of the important role midwives played in implementing Nazi population policies and thanks to Conti’s influential connections, midwives were the only nonacademic profession who were invited to training courses held there. Conti attended every course until they were stopped in 1941, when Alt Rehse was used as a military hospital (Peters 2005).

At their meeting on June 9, 1936, ICM delegates had decided that the congress president would also preside over the ICM until the following congress, making Conti the first president of the ICM. She was awarded a silver badge by the Quaker midwife and international relief organizer Edith Pye (1876–1965) (Oldfield 2004). On this badge, the names of all national chairwomen were engraved. As the badge given at the congress was a provisional one, Conti received the actual badge during a ceremony at the children’s home at Borgsdorf near Berlin, whose matron had been a translator during the congress. After the award ceremony, she remarked that she was especially satisfied to see the growing understanding about Nazi Germany among the foreign delegates and was pleased to have shown them how deeply embedded the love for the Führer was among people. She closed with the words, “Mein Volk, mein Führer, wie dien’ ich Dir!” (My nation, my Führer, how I serve you!).

However, Conti was not just interested in Western health care. In 1935 she quoted a report in the International Nursing Review about midwifery in British Palestine. She reported to her German readers that until 1922, just a few trained Jewish midwives from Europe worked in Palestine while most pregnant women were attended by old women who were mostly Palestinians, Armenians, or Turks. She claimed that the Forderungen (demands)
German Midwifery in the “Third Reich” 185

of the Jewish midwives were too high for common women. It would be difficult to determine whether the fees of the trained European midwives really were too high for average wage earners, or whether she was employing an anti-Semitic cliché. Conti further explicated that in 1922 money was donated in honor of the wedding of Princess “Marie” (probably Princess Maria of York, who married Henry Lascelles in 1922), which was used by the British government to open a welfare institution for mothers in Jerusalem. Midwives were trained in this institution, as well as in a training school run by the Zionist women’s organization Hadassah (today’s Henrietta Szold School of Nursing) from 1925 (Conti 1935).

Conti was a keen supporter of breastfeeding and encouraged midwives to promote prolonged breastfeeding by all German mothers. As she was convinced that breast milk was the best for babies, she supported the Frauenmilchsammelstellen initiative, mentioned previously. Her dedication to the topic was acknowledged in the Swedish midwifery journal Jordemodern (Midwife). There, Swedish midwife Sara Toll described her impressions of a milk bank that she had visited during the Berlin congress, an institution supported by Conti herself. Toll described how mothers from all over Berlin donated their milk. She also described the processes by which it was sterilized and analyzed for quality. Toll was highly impressed by this visit and told her Swedish readers that only a few countries had achieved the same level in the care of mothers and babies as Germany and that the tour to the milk bank had produced the strongest impressions of the whole congress (Toll 1936).

Probably during the congress participants’ visit to Alt Rehse, Toll met the school’s principal, Dr. Hans Deusche (1891–1953), whom she married in 1937. In 1939, her husband wrote to Conti on behalf of one of his wife’s friends, the midwife Helene Bergquist (1895–1996), who wanted to gain experience working in Germany, being devoted to NS. Conti corresponded with both Ottow, chief physician at the gynecological hospital of Berlin-Neukölln, and his leading midwife, Margarethe Lungershausen (1892–1973), on Bergquist’s behalf. She thought that such a placement would help to spread the National Socialist ideology among European midwives (Peters 2010b).

Lungershausen led the section of hospital midwives in the German Midwives’ Association from 1940 to 1945. In 1945, after the fall of the Nazis, she fled to Denmark. She returned to Germany in 1948 and joined the reestablished Agnes-Karll-Verband (today DBfK), the largest independent nursing association in Germany and currently a World Health Organization collaborating center. Lungershausen, who had also trained as a nurse, became president of the organization in 1953 and published the organization’s magazine from 1949 to 1960. Her biography, her involvement in NS, and her postwar career have not as yet been researched (Tiedemann and Huhn 2006). Sources yet unpublished suggest that Conti had planned to install her as her successor in 1945, but that Lungershausen refused.
The German midwifery journal, first named Zeitschrift der Reichsfach- 
schaft Deutscher Hebammen (ZdRDH) and from 1939, Die Deutsche 
Hebamme (DDH), was Conti’s communication medium for reaching mid-
wives. The journal was a continuation of the journal of the ADHV. Until 
1943, all independent midwifery publications, inclusive of the Austrian 
midwives’ journal, had been merged in Die Deutsche Hebamme, which 
remained, under different names, the official journal of the DDH until 
2000. In 1939 it had a print run of nineteen thousand with 20–30 pages 
every two weeks, although its size and publication frequency fell in the 
following years due to shortages of raw materials during World War II 
(Tiedemann 2001).

The Nazis’ arrival to power in 1933 caused changes in the journal’s edi-
torship. Conti became involved in its production but Professor Dr. Siegfried 
Hammerschlag (1871–1948) and Dr. Marta Fraenkel (1896–1976) were 
dismissed. Hammerschlag was a well-known gynecologist who had writ-
ten the Prussian midwifery textbook and supported the midwives in their 
struggle for social acceptance for years, but being of Jewish origin, he was 
considered unacceptable for a National Socialist professional organization. 
He left Germany and immigrated to Persia (Peters 2010b).

Fraenkel was a physician of international reputation. She had worked 
for the hygiene department of the League of Nations in Geneva and was an 
executive of the famous Deutsche Hygiene Museum in Dresden. She was a 
Jew and thus lost her position; she emigrated first to Yugoslavia and then 
to Belgium, where she worked for Ligue National Belge Contre le Cancer 
before finally moving to the US. There she worked as a scientific assistant 
at the New York Welfare Council before she became a medical advisor to 
the US government in 1944. From 1949 she was a public health officer of 
the New York Department of Health and Hospitals. Today she has both 
a street in Dresden named after her as well as an assembly room at the 
Deutsche Hygiene Museum. Fraenkel exemplifies the “brain drain” from 
Germany in the 1930s caused by the Nazis’ anti-Semitic policies (Landeshauptstadt Dresden 2005).

Conti was probably well-acquainted with both Hammerschlag and Fraen- 
kel, and there are even rumors that she herself was well liked among Jew-
ish families during her work as a midwife practitioner. However, she was a 
convinced anti-Semite and began instead a seamless, deep, and productive 
cooperation with Hammerschlag and Fraenkel’s successor, Ottow. He was 
born on the island of Hiiumaa in Estonia, the son of a Baltic-German physi-
cian. In 1917 he achieved a doctorate degree at Tartu University and started 
working as a physician. He moved to Kiel in northern Germany, where he 
became a scholar of Professor Stoeckel. Stoeckel stated in his autobiography 
that Ottow was his most talented scholar in the field of urogynecology. In 
1932 Ottow became a member of the NSDAP. He actively applied for Ham-
merschlag’s post as senior consultant of the Landesfrauenklinik (State wom-
en’s hospital) of Berlin-Neukölln. Under his leadership the hospital became a
center for sterilizations because of eugenics. According to Ottow himself, he and his team performed 750 forced sterilizations between 1934 and 1936. Of these 750 patients, two women died due to an operation that offered them no personal therapeutic benefit. Ottow showed no regret for these deaths, but stated that the low mortality rate showed the harmlessness of the sterilizations. Approximately eighteen to twenty sterilizations were performed each day in the beginning of 1937. Ottow was not only one of the surgeons but also a member of the Erbgesundheitsgericht (hereditary health court) in Berlin. He was a convinced supporter of forced sterilizations of disabled women and girls (Ottow 1937b; Bremberger 2000).

Ottow actively supported the midwives’ organization. Along with his head midwives, Lungershausen and Conti, Ottow opened a school for midwifery leaders in his hospital in Berlin-Neukölln in 1941. This school was seen as an equivalent to the physicians’ school in Alt Rehse. When the house of the midwives’ association was bombed in 1942, Ottow offered them rooms in his own flat in the hospital. Conti stayed there when she was in Berlin, but in 1943 the hospital had suffered too much damage from bombing for work to continue. Patients were transferred to other hospitals—for example, to the psychiatric asylum at Landsberg. When asylums were chosen to host patients from hospitals in bombed towns, it usually meant that the asylum patients were sent to one of the “euthanasia” killing facilities like Hadamar or Bernburg. Therefore, it can be assumed that the patients at Landsberg were killed when Ottow’s patients moved into their rooms (Bremberger 2000).

Ottow fled to Schleswig-Holstein in 1945, as Conti did, and emigrated to Sweden in 1947. He received a recommendation from the famous Swedish physician Axel Höjer (1890–1974), who was not actually acquainted with Ottow. Höjer gave this recommendation because an Estonian physician, who knew Ottow from their time in the Estonian army during the Estonian war of independence of 1918–1920, had asked him this favor. Of course a recommendation by Höjer made it easier for him to get a Swedish visa. Interestingly, German troops fought against the Estonians and supported the Soviet Union, so presumably Ottow fought against Germany (ibid.).

From 1950 he worked at the Museum of Natural Science at Stockholm. Ottow never worked as a physician again but wrote on topics such as dinosaurs. He wrote about Karl Ernst von Baer (1792–1876), one of the leading embryologists of the nineteenth century and with Gustaf Retzius (1842–1919), one of Estonia’s most important natural scientists and a renowned anatomist and mastermind of scientific racism in Sweden. It can be assumed that Ottow remained not only devoted to his native country of Estonia but also convinced of eugenics and eugenic selection. He died in Stockholm in 1975. Ottow was never called to account for his participation in the Nazi sterilization program (ibid.).

Conti and Ottow’s supposed friendship, as well as her devotion to her son Leonardo and her close working relationship with both of them, leads us to
the conclusion that Conti was well-informed about Nazi sterilization policies and knew very well how the information collected by midwives was used. As mentioned previously, midwives were mandated to report all babies with genetic diseases and dysplasia from 1933 on. Subsequently, this information could have led to the sterilization of these children’s parents through the children’s euthanasia program (Benz, Graml, and Weiß 2007).

To analyze Conti’s biography and work it is also important to consider the life of her second son, Leonardo, as they made an effective pair in their work for German midwifery. Leonardo, a devoted Nazi from an early age, had a remarkable political career and became Reichsärzteführer (leader of physicians in the Third Reich) in 1939. However, he was unable to retain his influence and was outmaneuvered by Hitler’s personal physician, Karl Brandt (1904–1948), in the 1940s. In 1939, when the first meetings with Hitler about the “euthanasia” program took place, Leonardo belonged to the select circle of men who discussed the plans for the “mercy killing” of the incurable sick. Hitler himself was very keen on this topic but left the details to his subordinates. However, when Leonardo did not make progress, Brandt, with the assistance of Göring, Himmler, and Frick, used his chance to plot against him and also against Martin Bormann, the head of Hitler’s secretariat, both of whom they wanted to exclude from this influential task. In the end, Brandt, together with Philipp Bouhler (1899–1945), the head of chancery in Hitler’s personal office, became responsible for the “euthanasia” program. Still, Leonardo was involved in the planning. In December 1939 or January 1940, the first experimental killings of adults took place. Testimonies from the Nuremberg trials indicate that Brandt and Leonardo gave the first lethal injections themselves and also watched a group of patients being killed by gas (Graml and Weiß 2007). As Leonardo was Conti’s favorite son and they were close companions, it is difficult to imagine that he didn’t tell his mother about these “mercy killings”—maybe not the details, but at least the purpose behind the registration of “inferior” babies.

With respect to midwifery history, Leonardo is especially important as he did his best to pave the way for his mother in the Nazi party (Leyh 2002). As Reichsärzteführer, he didn’t fail to remind midwives of their duty to report babies who were deemed unfit. The midwives did not kill babies themselves, but the decision to allow a child to live or die was made upon their reports. Conti herself did not publish much about eugenics, and child “euthanasia” was never mentioned in the midwives’ magazine, but she frequently reviewed books by physicians about sterilization, genetics, and racial hygiene. Furthermore, lectures on these topics were a regular part of midwife meetings and also of the training courses in Alt Rehse, which were supervised by Conti.27 In summary, we can see that midwives played a role in the “euthanasia” programs and their Führerin, Conti, was largely responsible for the spreading and implementation of Nazi ideology.
Conti reached the climax of her career in 1938 when the midwifery law was passed. In the same year she had to confront the suicide of her first son, Silvio, and from 1942, the fall of her younger son, Leonardo, as he fought with Brandt for influence and power. As mentioned previously, Leonardo lost the power struggle (Schmidt 2008). It is yet to be assessed whether and how this conflict between Leonardo and the new figures in the Reich’s health system was reflected in the professional journal. It can be assumed that Conti remained loyal to Leonardo, but as she never had direct access to Hitler or even to his inner circle, her influence on personnel decisions in the upper echelons was probably insignificant. Even if she could have mobilized the midwives as a lobby group against Brandt, her power collapsed with the Tausendjährige Reich\(^2\) in May 1945.

In the spring of 1945, Conti and her family fled from Berlin via Hohenlychen and Alt Rehse to Stocksee in Schleswig-Holstein. There she remained in poor circumstances until 1951. Sources suggest that she retained her influence among midwives, but it is difficult to prove this as few records from the immediate postwar period in German midwifery remain. A former employee of the Reichshebammenschaft accused Conti of having embezzled money, but she was never called to account for this (Schumann 2009).

In the summer of 1951, Conti moved to Bielefeld, where Leonardo’s family lived. In January 1946, they had been given information that Leonardo had committed suicide in Nuremberg prison in October 1945. Conti’s grandson by Leonardo, Friedrich, had been a prisoner of war in a British camp, and Conti’s youngest granddaughter, Irmgard, had had to live with a foster mother in Munich, as the occupation authorities did not allow family reunification during the first years after the war. In 1950, however, the family started to recover. Irmgard Conti-Powell remembers the time of her grandmother’s death as follows:

> It was the two of us again [she and her mother], since my beloved Oma [granny] had died on December 30, 1951 . . . As word spread that Nanna Conti had died, condolence letters streamed in, not only from German midwives, but from midwives all over Europe. She had made lifelong friends and gained respect and admiration for her tireless efforts to make the profession of midwife not only respected but one that was officially acknowledged. (Powell 2008, 142)

The midwifery law from 1938 remained in place, minus its recognizable eugenic and anti-Semitic passages. The professional organization was reestablished in several states in West Germany, led by former peers of Conti, but even if Conti was still being praised in the 1980s, she is quite forgotten today. The ICM did not even remember their first president’s name until they were asked for information.
Conti’s biography, as known, shows a woman of strong intellect, assertiveness, *Mütterlichkeit*, and an enormous devotion to midwifery, but it shows also a convinced Nazi, racist, and anti-Semite who was willing to sacrifice supporters as well as parents and children if they stood in the way of the NS vision of a pure and healthy German race. Conti was one of those ideological brains behind the scenes who kept a murderous system running.29

NOTES

1. While 1933 on average about 16 percent of all German women gave birth in a hospital, in bigger cities the rate of births in hospitals was significantly higher: e.g. in 1932 in Berlin, approximately 64 percent of the delivered women gave birth in a hospital. Until the 1960s, in the Federal Republic of Germany, as well as in the German Democratic Republic, women routinely gave birth in a hospital (Schumann 2009).
2. This subchapter is based on my dissertation thesis, “Hüterinnen der Nation” *Hebammen im Nationalsozialismus* (Frankfurt, New York: Campus, 2006), which was funded by a stipend of the Heinrich Böll Stiftung.
3. Due to a readable text, all German citations are translated into English.
4. Her name has been changed.
5. In 1940, 20 percent of the registered midwives in Lippe were married to craftsmen and 28 percent to blue-collar workers; 22 percent were single, 74 percent married, and 7 percent divorced or widowed. In 1933, 28 percent of the midwife families had property or leased a garden; in 1940 it was 16 percent. A total of 76 percent of the households in Lippe had a large garden or productive agricultural land. The data on midwives in Lippe are primarily based on analysis of files in the Detmold State Archives (Lisner 2006).
6. In 1933 there were 101 registered midwives working in Lippe; in 1935, 6 were employed in one of the five clinics in Lippe with an obstetrics ward (Yearly Health Report of Lippe 1935).
7. The members of the “Reich Committee” were: Viktor Brack (chief administrator of Department II), Hans Hefelmann (director of the Central Office II b), Richard von Hegener (main department head in the Führer’s Chancellery), Herbert Linden (Reich Ministry of the Interior), the pediatricians Ernst Wentzler and Werner Catel, and the pediatric psychiatrists Hans Heinze and Richard von Hegener (Topp 2004).
8. Twenty-nine “special children’s wards” have been confirmed. It can be assumed that there were more (ibid.).
9. Topp (2004) and Hohendorf and Rotzoll (2004) demonstrate the close cooperation between the children’s clinic in Heidelberg, the “Reich Committee”, and the “special children’s wards”. They furthermore show that in the children’s clinic in Heidelberg, children were murdered or denied necessary therapy even without the authorization of the Reich Committee.
10. Statements for the “report premiums” paid are available for 1940. After 1941, there are only numbers indicating the total amount of the reports that were passed on (Public Health Officer in Lemgo, 1940, 1941, 1942, 1943).
11. Refusal by public health officers, doctors, clinic directors, and nurses also had no repercussions (Walter 1996, 691–692).
12. The name has been changed.
14. This and the following quotes: Maria Meurer (name has been changed), interview by Marianne Bonney, Detmold, ca. 1975. I would like to thank Mrs. Bonney for allowing me to use the interview.

15. For details on the “special children’s ward” in Niedermarsberg, see Berg (2001).

16. In other cases, parents had a hard time dealing with their children being admitted to a clinic. One set of parents in Halle lost custody of their physically disabled child because they did not consent to it being placed in a clinic (Evangelische Gesundheitsfürsorge 1940; Stargardt 2006).


18. This subchapter is based on the author’s “Nanna Conti—the Nazis’ Reichshebammenführerin (1881–1951),” Women’s History Magazine 65: 33–41. The original text was adapted and enhanced by including new biographical information on Benno Ottow.

19. She is mentioned as chairwoman for the branch “Hanover I” (Deutscher Hebammen-Kalender 1936). In 1933 it was announced she would lead the ADHV together with Conti and Rauschenbach (Allgemeine Deutsche Hebammen-Zeitschrift 1933). She was frequently named as addressee for administrative affairs, but already later in 1933 only Conti and Rauschenbach signed the announcement that the Reichsfachschaft Deutscher Hebammen had finally been founded.

20. Conti’s NSDAP membership card at the Federal Archives Berlin reads, “BArch (ehem BDC), NSDAP-Zentralkartei, Conti, Nanna.”

21. Fritz Rott was a well-known paediatrician, who supported the German midwives in their struggle for professional acceptance. He accelerated his professional career under the Nazi regime. For further information about Fritz Rott, see Schabel (1995).

22. In the original German text she used instead of this last phrase “always deceived their host country” a very biological phrase (den Wirtsstaat untergraben) that could not be translated into English (N. C. 1942, 279).

23. In 1900 a first International Midwives’ Congress had taken place in Berlin under the presidency of Olga Gebauer. A second international congress was organized in Dresden in 1911. Further congresses were hindered by the outbreak of World War I but restarted again 1923 outside Germany in Antwerp (Szász 2006).

24. Thanks to Dr. Sabina Arend for the valuable hint on that publication.

25. Also see A Drop of Milk (exhibition catalogue), ed. The Isaac Kaplan Old Yishuv Court Museum (Jerusalem, 2010).

26. Also see Hansson, Peters and Tammiksaar (2012).

27. The training courses were widely reported in the midwives’ magazine (Peters 2005). A transcript of the All-Prussian midwives’ meeting in 1939 gives a notion of the eugenic and Nazi instruction the midwives received (Oldenburg State Archive 1939). This file is a rare example as most files from the Reichsfachschaft were destroyed during an air raid and most Laender associations did not maintain an archive. Hence, information about German midwives before the 1950s has to be reconstructed from files scattered throughout Germany. The same problem applies to ICM files as they were brought to Berlin in 1940 and destroyed during the same bombing (Zur Geschichte der Internationalen Hebammenvereinigung 1954, 265–266). Käthe Hartmann (1896–1990), for several decades chairwoman of the Bavarian midwives’ association and also from 1957 to 1960 chairwoman of the West-German midwives’ federation, was a close acquaintance of Nanna Conti and deeply involved in the Reichsfachschaft’s policies but never called to account.
28. *Tausendjähriges Reich* = the Reich that would last for a thousand years; this metaphor was intended to demonstrate that the Nazi Reich was the continuation of the first German Reich (800–1806), founded by Charlemagne.

29. Unless otherwise noted, data in the second subchapter by Anja Peters has been quoted from the following texts: Peters (2005, 2008, 2011a).

REFERENCES


Case of midwife K. Croll (name has been changed) 1924/1925. File no: L 80 Ic, gr. XI, shelf 21, no. 17, vol. 5, Detmold State Archives. Detmold, Germany.


NSDAP-Zentralkartei, Conti, Nanna. BArch (ehem BDC). Federal Archives Berlin.


German Midwifery in the “Third Reich” 195


Yearly Health Report. 1935. L 80 Ic, gr. LIV, shelf 2, no. 4, p. 49. Detmold State Archives, Detmold, Germany.


9 From History to Memory
Using the “Euthanasia” Programs to Teach Nursing Ethics

Ellen Ben-Sefer and Dganit Sharon

9.1 INTRODUCTION

Despite the increase in courses, subjects, and classes related to the Nazi era, it is neither simple nor straightforward to teach and learn about this period for students of any discipline (Burke 2001). Deidre Burke (2001) asserts that most student encounters with knowledge of National Socialism, including the Holocaust, will take place in classroom settings and are delivered by teachers who have not been specifically trained nor supported in this goal. This difficulty also takes into consideration that the current generation of students will be the last to potentially engage with survivors, and most students tend to view this era as history with few implications for today. The meaning and relevance for their contemporary lives are not readily seen as obvious.

In some countries, in conjunction with classroom teaching, as a way to have students engage with concepts and history of the Nazi era, teachers incorporate museum trips and invite survivors to address students where possible, and in recent times, there has been a substantial increase in “heritage tours” in which students travel to the sites of death camps with teachers (Gilbert 1997). The most prominent perhaps is “The March of the Living”, an annual event at Auschwitz-Birkenau. All of these strategies are meant to engage students in learning about the Nazi era and integrate a number of lessons from its painful history. Such learning is just as important for nursing and midwifery students as for any other discipline.

These approaches may be helpful but not always practical and logistically feasible. The challenge for educators is not to shock and overwhelm students, nor to evoke a purely emotional response, but to help learners to relate to the events of National Socialism in a personal, meaningful, and human way—that is, to see victims, bystanders, rescuers, and perpetrators first as human beings, whose lives in many ways parallel our own, and by doing so, gain a deeper understanding of this history and its relevance to contemporary life. Understanding the inhumanity of many people during this era may also serve as a means to alert students to the dangers of contempt and hatred and enable students to feel a human link to victims of
other catastrophic events (Wilkanowicz 2005). Such understanding is an inherent part of the philosophies of nursing and midwifery.

Sacks (2005) points out a significant aspect of education about the Holocaust and the Third Reich. He distinguishes between history and memory, in which history is primarily someone else’s story, but memory is “my” story. History is the recollection of a past that is dead. Memory, on the other hand, is the identification with the past so that it becomes a part of our lives, and thus a part of our future (ibid.). This approach is of particular relevance to profession-specific education and fosters the goal of making history relevant to contemporary life, especially within a profession-specific context.

A profession can be seen as comprising a group of people who all share particular skills and knowledge that are applied in a specific context (Burke 2001). Specially tailored courses have been designed for various professions that seek to engage learners in a particular way and relate their professional development to the events of Nazi Germany. Within this profession-specific context, courses have been developed that are tailored to physicians, librarians, and accountants, among others, utilizing professionally appropriate material such as medical trial testimony and the study of the origins of racial hygiene policy for physicians, policies affecting literature and censorship in the Third Reich for librarians, and the confiscation of victims’ property and financial control and management of concentration camps for accountants and financial managers (Ehmann 2001).

Seminars and courses specifically designed for police, the military, and members of the judiciary follow similar patterns. Despite this plethora of profession-specific education, little to no attention has been paid to nurses and nursing education. Yet abundant evidence confirms the many roles nurses played as perpetrators in the T4 “euthanasia” program as well as their active participation in medical experiments in concentration camps. Nurses also participated in the Lebensborn program as part of Nazi racial hygiene policy, and in their public health roles they reported any children who were considered to be mentally or physically disabled and therefore unwanted in the new German racial order (Clay and Leapman 1995). While more research is required into the many roles nurses and midwives played as perpetrators, liberators, and rescuers in this overall period, it cannot be denied that a body of knowledge continues to grow with each year. Imber (2001) notes that the interdisciplinary approach to education affords students the opportunity to appreciate why and how the “euthanasia” programs and the Holocaust happened, and this applies to nurses and midwives as well as other professions.

Shirah Hecht (2009) has observed that educators face a difficult task. While striving to create a safe learning environment, educators must also encourage dialogue. Students must connect with the individuals and experiences that may make them intensely uncomfortable, and thus educators need to be flexible and willing to accept a broad spectrum of student responses. This has been particularly so in teaching nursing students and
nurses about the Nazi era. Significant issues related specifically to nurses and midwives, and especially their participation in the “euthanasia” programs, continue to be relevant to contemporary nursing practice. It is therefore puzzling that relatively few nursing or midwifery programs offer any education on this topic.

9.2 TEACHING ABOUT NURSING IN NAZI GERMANY

The professions of nursing and midwifery have a long and rich history, and study and scrutiny of the professions’ history afford students the opportunity to refine and enrich their understanding of these professions. Specifically, such study allows students to appreciate the ways that the past has influenced the nursing profession and consolidate a professional identity. In addition, knowledge and study of the profession’s history can help students develop critical thinking skills necessary in nursing (Madsen 2008). However, it seems that in recent decades, the study of the professions’ history has been relegated to a narrow scope, if taught at all, as courses that are more technologically or scientifically based are perceived as having greater value (ibid.). Moreover, in classes in which the history of nursing is still taught, programs tend to emphasize events or activities that emphasize “heroic nurses”, such as Florence Nightingale and Edith Cavell, and promote the image of the “good nurse” (Johnstone 1999). Consequently, there has been an ignorance of or a hesitation to approach the dark history of nursing and midwifery, which most certainly includes those who participated in the T4 “euthanasia” programs and Operation Reinhard murders of the Jews, in the “Final Solution” (see Chapters 5). Thus, any reference to nurse- or midwife-perpetrators of the Nazi regime is neither recognized nor seen as an important chapter of nursing or midwifery history that should be addressed in today’s nursing and midwifery education curricula.

The issues that are raised by discussing this important history include topics and troubling questions that are relevant in contemporary practice, such as ethical dilemmas, stereotyping, attitudes toward the mentally ill and disabled, and racism. Of particular import to nursing and midwifery is the attempt to understand the nature of care and caring practices and its perversion.

This history invariably raises questions that relate to the heart of nursing and midwifery practice by highlighting the danger of failing to see each individual as a valuable member of human society. The heart of nursing and midwifery continues to be care and caring practices, and it is fundamental for students to confront this history to develop insights into the causes and social constructs that enabled nurses and midwives to distort the goal of nursing practice and thereby harm and murder patients. In raising these issues, students are forced to confront their own values and beliefs, which may be an intensely uncomfortable experience. However, students who are exposed to this dark element of nursing and midwifery history will
be better prepared to face pressure to repeat violations of the trust that is central to any relationship between nurse and patient.

Johnstone (1999) noted that the majority of nursing history textbooks omit this dark episode. Thus, Johnstone concluded, in doing so, an image of nurses as “good women” who obey orders is perpetuated. This concept of obedience was a fundamental principle of at least some nursing leaders in the past. In the Anglo-centric world, the issue of absolute obedience to orders has been a central issue in nursing, and virtually all undergraduate programs address the importance of challenging orders when appropriate to patient care, ethical dilemmas that arise within such a context, and the importance of autonomous nursing decisions. Thus, the history of nursing’s participation in the “euthanasia” programs and the postwar defense of the nurses and midwives who were “following orders” is a stark example for contemporary students that illustrates the consequences in failing to question, challenge, and refuse orders, albeit in extreme circumstances. More emphasis needs to be laid on responsibility of their own actions and the need for confidence and courage to question orders, rather than simply following them blindly.

Nursing historians have specifically focused on the roles of nurse-perpetrators and have expanded knowledge to better understand nursing participation in medical experiments in Auschwitz, Bergen-Belsen, and Ravensbrück (Benedict and Georges 2006), as well as deepen insights and understanding of the nurses involved in the “euthanasia” programs. Lagerwey (1999), Steppe (1992), Benedict and Kuhla (1999), O’Donnell et al. (2009), Hoskins (2005), and Peters (2010) have advanced knowledge and fostered debate and ongoing research as more nurses focus attention on one of the darkest chapters of the professions’ history.

Currently, sufficient scholarship exists to provide a body of reliable research material for students. As more archival material becomes available and scholars scrutinize the role of nurses and nursing organizations in the Third Reich, it is apparent that a full semester course could easily be designed. However, in light of the worldwide nursing shortage and increasingly complex health care requirements and systems, it is not likely that such a course will ever be considered at the undergraduate level. At best, one class may be allocated, but in doing so, it enables nursing and midwifery educators to begin the process of introducing this content specific to nurses and midwives. This should not be considered sufficient but only a starting point, and one educational goal should be to encourage students to continue to learn, while at the same time fostering potential research students who will further examine the overall topic.

9.2.1 A Way to Teach This Topic

A research project originally undertaken in Australia and then replicated in Israel is an illustration of what can be accomplished even with limited classroom time in a nursing program. It enables discussion of problems
and dilemmas within an ethical context for both teachers and students. While this project was about nurses, its principles are equally relevant to midwives. However, only nurses were included in this study, so only nurses will be discussed here. The aim of the before and after study was to examine changes in knowledge of and attitudes about the role of nurses in the “euthanasia” programs of the Nazi era.

The goals of teaching nursing students about nurses and their active involvement in the “euthanasia” program are the following:

- To ensure that students are aware of this important historical event
- To enable students to appreciate that past events influence their current nursing practice
- To encourage students to learn more about this history
- To encourage future researchers to embark on historical projects that will further nursing knowledge
- To introduce students to the work of nursing historians and their methodology.

9.2.1.1 The Cultural Context

Culture and politics shape our knowledge, beliefs, and values and therefore deeply influence our exposure and ideas about history. With the exception of Germany, where students are taught the history of National Socialism and profession-specific education continues at the university level, most nursing and midwifery programs have failed to include this content in their course of study.

Just as cultural context shapes the student understanding in Germany, culture influences students in other settings. While the students in Australia and Israel were given identical readings, these cultural differences influenced all students and teachers. Both Australia and Israel are nations with a high proportion of immigrants, and students in both countries often struggle to develop fluency in a new language. Teaching style and goals also may differ considerably from the methodology experienced in their former home countries.

9.2.1.2 Significance of the Study for Nursing and Midwifery Students

Traditionally, nursing and midwifery have been viewed as caring professions, and thus it is hardly surprising that students may be disillusioned and shocked to learn about nursing and midwifery participation and involvement in torture, medical experimentation on human beings that was highly unethical, and the mass murder of patients, particularly the most vulnerable patients. In this instance, the vulnerable were children and adults who were physically and mentally disabled, during the period of National Socialist Germany between 1939–1945 (Benedict
The question that immediately arises is how nurses and midwives could willingly perpetrate such acts that trampled the foundations of their professions. What moral imperative enabled these nurses and midwives to justify such behavior? Equally important are the questions of motivation; what motivated them to cross the bounds of accepted principles and practices in nursing and midwifery? Trial testimony indicates little remorse on the part of at least some of the nurses; that is to say, they failed to see they had committed heinous acts (see Chapters 6 and 7). Discussions about the nurses’ testimonies regarding their feelings should lead students to question both obedience and remorse. Unfortunately, because they were not part of the postwar trials, nurses and midwives who did resist are seldom mentioned.

Andrew McKie (2004) notes that, when discussing nursing staff behavior during World War II as it appears in written texts, one question arises: How can we understand such an event as the Holocaust? One possible response is that we should try to understand events within their historical and political context. First, one must develop an ethical reflective narrative frame within a community of people. Fundamentally, the goal is to try to understand that behavior develops from collective values, tradition, and experience of people represented in these stories. Second, it is necessary to adopt an aesthetic approach in which the reader lives the story and develops a relationship with the text. In this case, the act of reading the material requires the reader to formulate some sort of action (Rosenblatt 1978). McKie refers to this concept as the ethic of responsibility. In the case he provides as an example, the reader is asked to identify with the needs of immigrants. Specifically, the reader must become engaged with the text and ponder these questions: What response that reflects ethical sensitivity is required of me? How do I grasp the concept of life? What community do I belong to? (McKie 2004). These questions and their discussion should lead students to refine their understanding of the purpose of nursing, moral values related to this purpose, and the importance of commitment to these values. Finally, reading the literature and testimony related to the T4 murders should lead students to appreciate the impact and influence of social pressures on the nature of the profession and their effect on decision making. In this instance, nursing decisions were made to accept orders without question and to fulfill them.

Reading this material also enables discussions of issues associated with compliance, both political and professional, divided loyalties, the many issues related to human rights, organizational ethics, professional and social responsibility, and the inevitable “slippery slope” that could see one slightly unethical action spiraling downward to more and more unethical decisions. Thus, it is clear that beginning study on the nurses and midwives involved in the T4 murders can give rise to important ethical questions and discussions that remain relevant to contemporary practice and will undoubtedly arise in many clinical contexts.
This process is illustrated by the required reading for students on the T4 murders. Students are initially asked to consider the social attitudes and values that motivated the nurses to participate in “euthanasia” and then think about the concept of euthanasia in contemporary practice. At this point, the emphasis is on social values and self-perception of the concept of life and euthanasia. Approaching the literature in this manner affords students the opportunity to become memory rather than history. Students are asked to refer to the values and professional ethics and the factors affecting the implementation of the T4 murders. For the Israeli students, the discussion takes place in the third year of study, and therefore they are familiar with the Code of Ethics of the International Council of Nursing (2011) as well as the Code of Ethics of the nursing profession in Israel (Israeli Nurses 2004). Furthermore, they have been exposed to principles and theories of bioethics. Likewise, the Australian students are well aware of the Australian codes of ethics for nurses and midwives (Australian Nursing and Midwifery Council 2012).

Based on social Darwinism, the “science” of eugenics garnered considerable interest in Europe and the US at the end of the late nineteenth century (see Chapter 2). Its basic theory held that the human race could advance and improve through destruction of its weakest members. This theory was applied rigorously under National Socialism in Germany with continual exhortation to the public through propaganda that eventually led to “euthanasia” and developed into mass murder and genocide under Nazi Germany (Benedict 2003). Hitler’s rise to power in 1933 began the process of implementation of policy designed to incorporate eugenic practices under the guise of “euthanasia”—namely, the elimination of those whose “lives were not worth living” and who therefore were not considered equal to other members of society. Among the first victims of this policy were children with disabilities.

As part of the discussion and debate of ethical issues that arise from involvement of the nurses, students are directed to express their opinions regarding the term “life not worth living”. In most cases, one important question that arises from the text of the required reading centers on the immediate tendency to give legitimacy to this assumption as it applies to people with severe disabilities—specifically, those who are dependent on others to perform basic life activities, people who are in a vegetative state, and the like. However, within an ethical context, these examples may lead students to express their views on termination of pregnancy. Within a human rights context, many students believe it is a fundamental right of the pregnant woman; however, this does not take into account the issue of fetal rights and may be further complicated by the issues and problems associated with a fetus that is likely to have developmental disabilities. Thus, the “life not worthy of living” becomes an ethical dilemma that questions whose rights prevail. Likewise, to use a modern day analogy, gender selection, or termination of pregnancy based solely on fetal gender, may also be
considered within the context of a “life not worthy of living”, as may termination of pregnancy for genetic abnormalities found in utero via prenatal screening programs. These examples not only are relevant to contemporary practice but also essentially mirror Nazi policy that favored the preferred Aryan infant, while those who failed to meet the criteria were deemed unworthy of life. Through this exercise students learn to think about the consequences of their actions and develop an understanding of the “slippery slope” argument. Even if the initial intention appears to be a good as a means to prevent suffering, the multiple dilemmas and consequences can be explored and lead to deeper insight of ethical questions that are integral to nursing practice.

9.3 DESCRIPTION OF THE STUDENT SAMPLE

A number of the Australian students had studied World War II during their primary and high school years, but not all students were familiar with the extent and scope of the Nazi era. Half of the cohort admitted that the material about the nurse-perpetrators was completely new to them. Not all students were familiar with modern European history, and even less so about the Third Reich and the Holocaust, and the history of the nurse-perpetrators is far from common knowledge, even among the more knowledgeable students. This is hardly surprising given the lack of knowledge and understanding about the role of nurses and midwives held by the world in general.

For many Australians, the war in the Pacific was far more relevant in the overall context of World War II than the war in Europe. This was equally so for the many Asian students who formed part of the cohort in the undergraduate program. Their understanding and knowledge were primarily focused on the invasion of Asian nations and the suffering under Japanese occupation. Nevertheless, prior to many of the classes, students who had traveled in Europe mentioned visits to the sites of the former death and concentration camps. Thus, the Australian cohort of students was far from homogenous in their backgrounds, knowledge, and exposure to this content, and similar inconsistencies are likely to be common in other countries.

It would be misleading to assume all Israeli students would be more knowledgeable than their Australian peers, although it is inevitable that life in Israel exposes all citizens to knowledge of the Nazi era and the Holocaust at some level. In fact, many of today’s students are grandchildren of survivors. The Holocaust is a compulsory component of school studies. It is not unusual to see groups of soldiers who are performing their compulsory military service on excursions arranged by the military to the largest Holocaust museum, Yad Vashem, located in Jerusalem. Most often, they are accompanied by an educator.

The relatively recent immigration of nearly one million new citizens from the Former Soviet Union (FSU) has influenced many aspects of life
in Israel, and educators must take into account their previous educations, cultural experiences, and expectations. Students from the FSU who arrived at a young age and were educated in Israel can be presumed to be more knowledgeable than their peers who arrived at a later age, who may know very little. Therefore, a breadth of knowledge of the Holocaust cannot be assumed in nursing students. Moreover, the student cohort in Israel is a mixed group of Jewish, Christian, Muslim, and Druze. Thus, like the students in Australia, they can be seen as diverse and bring different levels of interest, knowledge, and exposure to the topic. Approximately half of the Israeli students admitted that the topic of the nurse-perpetrators was new to them. Thus, it is indicative that general assumptions of student knowledge are not valid.

In light of these findings, no assumptions should be made about previous knowledge, nor that all students will have a broad understanding of the Nazi era, irrespective of the country or setting, even if it would seem at first consideration that they should, and teachers must consider these gaps in student knowledge. However, it cannot be disputed that such knowledge and exposure to the overall topic would be beneficial to the class.

9.4 THE TEACHING PROGRAM

In the six years since its inception, over one thousand nursing students at the University of Technology, Sydney, have been exposed to the teaching session during their undergraduate studies (Ben-Sefer 2006). A much smaller group of postgraduate nursing students has also had a four-hour seminar devoted solely to this topic. The invitation to include the master’s degree candidates was provided by the course coordinator after the inception of the undergraduate program. Undergraduate students in Australia were informed at the start of semester that the subject matter would be part of their course of study in children’s nursing, as developmental disability nursing is a component of the subject and it seemed the most appropriate stream of the curriculum in which to include the content. Postgraduate students were primarily from the field of mental health nursing, and, again, the content seemed appropriate to their specific discipline.

Undergraduate students were provided with a reading by Benedict and Kuhla, “Nurses’ Participation in the Nazi Euthanasia Programs of Nazi Germany” (1999), in advance of class. They were given questions to guide their reading and instructed to write answers to the questions in preparation for the class discussion. This preparation is necessary for undergraduate students who may not readily grasp why they are reading such material. The questions provide a basis for stretching their thoughts beyond reading history to applying the material to a contemporary context and how it might relate to their professional development. After the first year of teaching the material, it became obvious that many students wanted to learn
more and had no opportunity to do so. For those students, a reading list was compiled and additional supplemental articles provided. No student was forced to read more than the single required article.

Prior to the class, students were asked to consider the following:

- What social attitudes and values drove the actions of these nurses?
- Do you think attitudes and values have changed since then?
- What seemed the most important thing that you learned?
- How do you suppose this material relates to the practice of nursing in a developmental disability setting?
- What evoked the strongest reaction to some of the nurses’ statements?
- How does this material relate to contemporary practice?
- Are there any apparent links between contemporary beliefs and values in developmental disability that relate to Benedict and Kuhla’s article?
- Would you want to read more on the subject?

Postgraduate students were required to read several articles by Benedict, Lagerwey, and Steppe because it was presumed they could be expected to read at a higher level and could compare and contrast literature. Similarly to the undergraduate students, a number asked for additional reading, and a list was supplied for them as well.

In Israel, since 2009, the same article by Benedict and Kuhla has been supplied for undergraduate students at Schoenburn Academic College of Nursing, which is an affiliate of Tel Aviv University. Surprisingly, it is the first nursing program in Israel to introduce this content into its curriculum. For the majority of the Israeli students, English is a second or third language, but no material that is similar in style, content, and length exists in Hebrew. Similar to their peers in Australia, they were informed early in the semester of the required reading with questions translated into Hebrew for discussion. The class in Israel was taught within the framework of nursing ethics, which seemed appropriate to the content. The cohort in Israel is much smaller; thus far, seventy-seven students have taken the class.

Initially, no survey of student responses to the class or the material was conducted and only anecdotal responses were recorded; however, it seemed important to gauge general student reaction to the material and class, and therefore during one semester 168 Australian students responded to a brief questionnaire. Questions were kept to a minimum as a means of ensuring students would take the time to respond, although no student was forced to complete a questionnaire. The same questions were used with the smaller Israeli cohort, with a resulting sixty-six full responses. Some students chose not to respond to all the questions, and while it was obvious that the questionnaire should be refined, it seemed important to provide the same questions for both cohorts of students before any future revision that can help guide future curriculum changes (see Tables 9.1 and 9.2).
### Table 9.1
Survey of Israeli Undergraduate Student Responses to the Class (77 students)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading about the “euthanasia” program was completely new to me</td>
<td>8</td>
<td>16</td>
<td>6</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>I knew a bit about this prior to reading</td>
<td>30</td>
<td>18</td>
<td>7</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>I found the reading challenging</td>
<td>29</td>
<td>17</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>I could relate some of the issues to my own practice of nursing</td>
<td>25</td>
<td>14</td>
<td>12</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Most nurses know about this history</td>
<td>5</td>
<td>7</td>
<td>16</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Nurses should know about this historical aspect of nursing</td>
<td>33</td>
<td>25</td>
<td>31</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I felt upset and emotional in some of my responses to the reading</td>
<td>29</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>I would like to know more about this topic</td>
<td>29</td>
<td>16</td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 9.2
Survey of Australian Undergraduate Student Responses to the Class (168 students)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading about the “euthanasia” program was completely new to me</td>
<td>42</td>
<td>48</td>
<td>15</td>
<td>58</td>
<td>5</td>
</tr>
<tr>
<td>I knew a bit about this prior to the reading</td>
<td>6</td>
<td>59</td>
<td>22</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>I found the reading challenging</td>
<td>22</td>
<td>66</td>
<td>38</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>I could relate some of the issues to my own practice of nursing</td>
<td>23</td>
<td>92</td>
<td>38</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Most nurses know about this history</td>
<td>0</td>
<td>5</td>
<td>67</td>
<td>59</td>
<td>26</td>
</tr>
<tr>
<td>Nurses should know about this historical aspect of nursing</td>
<td>83</td>
<td>53</td>
<td>15</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I felt upset and emotional in some of my responses to the reading</td>
<td>49</td>
<td>63</td>
<td>26</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>I would like to know more about this topic</td>
<td>52</td>
<td>76</td>
<td>25</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
9.4.1 The Students’ Responses: Undergraduate

Both undergraduate student cohorts agreed that they found the required reading and classroom session disquieting and upsetting but deeply important. Almost 100 percent of the Israeli students agreed on this point. Contrary to the start of most classes, there was little chatter and a silence hung over the classroom as if students were not sure what to say. A brief overview of the Holocaust and the Nazi era began the session for Australian students, and this was followed in both Australian and Israeli classes with a short film clip from *Nazi Medicine: In the Shadow of the Reich* (Michalczyk 1997). This clip is specific to the nurses in the “euthanasia” programs.

Many students were angry and saddened to learn that nurses could commit such crimes, including murder. They were particularly distressed that the nurses justified their actions as caring behaviors and failed to see anything criminal in their conduct. Such responses were not surprising and were anticipated by teaching staff when students attempted to assimilate the perversion of trust and caring practices. Discussion began with the required questions, and it is notable that in every class, the initial silence gave way to lively debate and discussion in which students often challenged each other’s interpretation of the reading and began to relate the broad issues to their personal experiences. As students came to terms with this material, it was important for teaching staff to ensure that a climate of safety, support, and compassion prevailed, as students are apt to make personal revelations.

9.4.1.1 The Australian Students’ Responses

The following comments are from the Australian classes. One student rose and stated,

> I understand this. I understand what this is about. My family was murdered by the Khmer Rouge. None of you know what this is like, that the people you trusted could do these things to you. You go home to families at the end of the day. I only have a sister because everyone else was murdered. You don’t begin to know but everybody should learn about these things so they won’t happen again.

Predictably, the entire class was shaken by this revelation. Several students cried openly, and others rose to put their arms around the student and thank her for telling them. The students in this class were stunned and stated they would never see history in the same way again.

In another class a student commented,

> I wasn’t going to come to class today. I thought I would skip. I thought I knew everything about the Holocaust that there is to know. I thought
Ellen Ben-Sefer and Dganit Sharon

this was about the Jews. I’ve been to the Jewish museum so I thought I knew enough. I didn’t know until I read this that it has everything to do with me, the person I am, the nurse that I am going to be.

Yet another student admitted her prejudices in class, which she had kept to herself throughout the semester.

At the start of the semester, I was pretty sure what I thought about mentally handicapped (sic) people. Why don’t the mothers abort them? Why should everyone go through that pain and suffering? I couldn’t see that mentally handicapped (sic) people have a value too and we can learn so much from them. It’s taken this course and especially this class to see that. I’m so ashamed of the things I thought and to read this disgusts me because I probably wasn’t much better than these nurses. I have to wonder if I had been in their place if I wouldn’t have done the same thing and be convinced I was doing the right thing. I’ve learned my lesson. I’ve learned that I’d better speak up because that’s my job as a nurse. I have to speak up for people who don’t have a voice. If I don’t, I’m just as guilty as these nurses.

Still another student commented on the many documentaries she had seen on television and the meaning of history to her in a personal way.

My family and I watch The History Channel a lot. We like documentaries and there always seems to be some Nazi thing on. Almost every day. I couldn’t understand why. Not trying to be funny, but we sometimes call it The Hitler Channel. I’m just starting to understand and I never saw anything about this. Why not? We need to know. I never dreamed nurses could do such things and to so many people. Now I’m thinking they don’t show enough on television. I think we’re pretty lucky to have this class and I’m going to be watching with different eyes from now on.

In another class, students were challenged by another student’s revelation. Was it possible that they had tortured, tormented, or harmed a patient and rationalized their actions? Was it possible to convince themselves they had been agents of caring, while in fact, they had been the instigators of harm? Although several students recalled instances in which they insisted patients get out of bed to shower or mobilize, they began to question if it had been necessary and whether they were merely obeying orders. In each of these instances, the patients were experiencing pain and the students had failed to consider that the perception of the patient might have been one of causing more pain. One powerful revelation shook the entire class as the student related her experience with a terminally ill woman.

She was very sick, dying. The family was on the way down to see her for the last time and the doctor ordered me to give her another dose of
morphine. I never stopped to question the order, just did as I was told. It seemed sensible.

There were several seconds of silence before the student continued.

The patient died very shortly after I gave the morphine. She was dead by the time her relatives arrived. I never stopped to think about it. I only thought about it now. I think I killed that woman.

Students were stunned. The teacher leading the class reminded students that the discussion and personal disclosures were confidential in the sense that there would be no repercussions. Then the student was asked to think about how she would handle such a situation in the future. This is a key element of student learning: to allow the students to relate their experiences to events of the past and reflect on what has happened and how to respond in the future.

I learned something from reading about this. I thought it had nothing to do with me but it does. I should have questioned that order, it never occurred to me. I followed orders just like those nurses and the more I think about it, I killed that woman. She would have died anyway but that’s no excuse for my behavior. I will never accept an order without thinking again.

This student’s revelation and response were so powerful that other students began to agree that one lesson they have learned is to question more in the future and, if necessary, be prepared to take a stand. Consequently, one student’s interpretation and learning experience enable others to learn and see the relevance as well.

9.4.1.2 Israeli Students’ Responses

Students in Israel responded differently, and the following are their comments. One student stated,

I wasn’t born in this country. I came here when I was a teenager and finished with high school. I still can’t get used to being able to say what I want. I still feel like I have to look over my shoulder as someone in the back of the room is recording everything I say and how it will be used against me and my family. It doesn’t mean that I excuse these nurses for what they did, but I understand how that feels.

I came here from another country where you listened to the teacher and you didn’t ask questions. It’s hard to come here and do that—even when there are questions in your heart. This reading makes me see I have to ask questions, as hard as it is for me.

Another student commented on the perversion of care and caring and how it had been distorted by the nurses for their own purposes.
These people lied right from the beginning so right away they knew it was wrong. They didn’t care, no, that’s wrong. They cared, but about themselves. For the male nurses it was easy. My life or yours because if they refused they must have thought they’d be sent to battle so my life is worth more than yours.

Yet another student commented on stereotyping and its existence in contemporary practice.

I don’t care what anyone says. There are still stereotypes about mentally ill and retarded (sic) people. You don’t open your mouth in the hospital because you know what you’ll get. Why didn’t anyone question this? Maybe we’re just as bad. Okay, we don’t kill patients, but we don’t open our mouths, we’re just as cowardly.

A personal revelation from one student indicated that while many students and perhaps nurses and other hospital staff take care with their remarks, their thoughts may be quite different to those that are voiced.

Isn’t this what happens whenever you think you are better than someone else? And don’t we talk about patients who are a nuisance without thinking about why they are creating what we think is a nuisance? We think about ourselves, not other people. We think we’re better than other people; I mean, look at it. We walk in with those uniforms and even if we are the lowest on the hierarchy, we’re in those uniforms. We’re protected, like nothing can happen to us and we walk out the door at the end of the shift and they stay there sick. Do we think we’re better than other people? Do we think some people deserve care more than others? I think we don’t say it but think it and isn’t that how it starts? Isn’t that just as bad? You can control what people say but you can’t control what people think. Are we really in a position to think we are that much better? It’s frightening to think that. I’m the one saying it but I bet other people here know exactly what I’m talking about.

9.4.2 The Teachers: Australia

Results from both cohorts of students were similar. Australian students overwhelmingly believed that most nurses do not know about this period of history but should. In fact, one student mentioned an incident several months after the class. While on her clinical practice placement, she heard several staff nurses discussing a documentary they had seen and their lack of knowledge concerning the “euthanasia” programs. She entered into the discussion, telling them about the class and where to find more literature.
Moreover, a large majority answered that while it was upsetting to read, they would like to know more. Most significantly, a large percentage agreed that they could relate the issues to their own clinical practice and professional lives. The results from the Israeli students were similar, which indicates that such a program could be beneficial to any nursing student irrespective of the cultural background.

In the first year that the program was introduced in Australia, teaching was confined to two faculty members. Both had extensive teaching experience; one had a background in the Holocaust and Holocaust education, and the other had significant experience in child and family health nursing history. The two teachers met regularly prior to the class to discuss the material and postulate potential issues that could be raised and how to best address them. Following the success of the first year, additional staff members were incorporated in the teaching program. They were all briefed at the start of semester, provided with the article that undergraduate students would be required to read, and given additional material to supplement their knowledge. It was particularly gratifying that these teachers saw the class as a challenge and became actively involved in seeking additional literature and clarifying ideas prior to teaching the session. One teacher was the source of the film previously mentioned and was excited that she was able to contribute important material to the staff and students that would foster their learning and discussion. Another commented,

> I was a little concerned that students wouldn’t be able to handle this sort of material, that they were not mature enough in many ways. I can say this was the best class of the year. I cannot tell you how rewarding it was to guide students in questioning, challenging and debating each other and thinking about this terrible history and the shock when they begin to realize it is still relevant to them. This is the kind of class that makes teaching so worthwhile.

> It was interesting to watch the dynamics. How quiet all the students were at the start and the more they thought about the questions and were directed to them, the more they engaged with the material and the less they needed me. They were thinking, referring to particular quotes in the text, arguing and challenging each other. It gave them an opportunity to engage in a collegial debate with a maturity I didn’t know they possessed. For that matter, I’m not sure they realized they possessed this ability. This has also taught me that you have to have faith in students to be able to teach this material and sometimes they end up teaching the teacher. Isn’t that great?

Several weeks after the class, another teacher noted the following:

> I’m really surprised how this affected students. Even the ones that didn’t participate much in the discussion. I thought they weren’t
interested but it seems they needed time to digest the material. Some of them are still approaching me with questions. I think that’s a good thing because students tend to forget quickly and worry about exams and writing their essays but it signifies to me that they are still thinking about the issues discussed in class, so it hasn’t been quickly forgotten.

Another observation from a member of the teaching staff:

One of the things that seems to disturb students about this session is the lack of answers. I mean, students expect their teachers to have all the answers. They want answers. They want it to be easy and in this case, we don’t have the answers because this isn’t simple and there could be any number of responses. It disconcerts them but that isn’t a bad thing. It’s a much higher level of learning in my opinion; forcing them to seek answers to hard questions and not rely on a simple solution from a teacher. I do find this challenging; it’s intensely anxiety-producing for me as a teacher because I simply don’t know what any student might raise as an issue in class. I can’t predict so I can’t prepare; it forces me to be a better teacher in that sense. I have to listen very carefully and watch body language because I don’t know what any student might choose as a focal point for discussion that could be quite explosive and I have to decide to intervene or allow the students to manage the discussion. That’s a real challenge to me as a teacher and I have to have confidence in the students, which is not always easy for me. Yet, I have to say that some students raise issues I had not considered, so I learned from them, which is always exciting at some level.

9.4.3 The Teachers: Israel

In Israel, the teaching staff have a background in the Holocaust and related ethical issues in nursing practice. Like their Australian colleagues, they found the class a challenge. They found that as students warmed to the topic, they argued vehemently with each other and debated quite passionately. Because issues of racism and stereotyping are key issues that underpin the material, concern exists prior to every class that the debate could veer away from the topic into current political debate that concerns Israel, particularly with such a diverse student population. One faculty member stated,

I always worry about the issues of racism and what might happen in class. You cannot escape their importance in this article. I worry that non-Jewish students might not engage in debate and sometimes they don’t, but interestingly, they often do just as deeply as their Jewish counterparts and it is often the Jewish students who raise the issues of stereotyping and racism within Israel. Moreover, many of them reflect on the issue of following orders. This has a special context for many students who have served in the Israel Defense Forces and they try to
compare the issue of accepting and refusing orders both in a military and nursing context and mention their compulsory ethics courses for all soldiers.

In general, while the teachers involved in the program have been enthusiastic and positive, they acknowledged their concern at lack of preparation, particularly because it was not possible to completely prepare for each class and they must be willing to allow students the freedom to raise the issues they see as important, while balancing the need to guide the discussion with key comments and questions. They also recognized their limitations and the time constraints, which are inevitable in a short teaching session. To some degree, several of the teachers found this frustrating, while at the same time, a profound relief due to the intense nature of the material and discussion.

9.5 CONCLUSION

This program served an important purpose. It introduced nursing students to one aspect of National Socialism, with particular emphasis on nurses and wrongdoing. In working with students, it was clear that they required structured questions to help them understand the reading, but the experience enabled them to relate the past to their present and future, making history a part of their own memory. While there were flaws with the program, including lack of time to significantly delve into many aspects, it was a starting point for students, and provided them with thought-provoking material that continued to resonate with them long after they had attended the class. It also indicated that teachers required as much support and preparation as are feasible under the circumstances and constraints and that teachers must be open-minded and flexible and appreciate that issues and responses that they cannot anticipate may arise in class.

A full semester course would be beneficial to students in which they can explore nurse- and midwife-perpetrators, rescuers, and liberators in order to gain a broader insight into the Nazi era and the Holocaust and their direct relationships to the nursing and midwifery professions. More students should be encouraged to read, question, and pursue research into this underdeveloped field of nursing history. In teaching this program, students and teachers learn from the process, engage with others in a scholarly fashion, and ultimately achieve the goal of incorporating knowledge from the past to build a better future for the professions.

NOTES

1. See http://motl.org/.
2. These quotes were first published in Ben-Sefer (2006), and are reproduced here with permission.
REFERENCES


10 Changing Perspectives
From “Euthanasia Killings”
to the “Killing of Sick Persons”

Thomas Foth

10.1 INTRODUCTION

The previous chapters have provided an overview of the killings of more than two hundred thousand psychiatric patients during the Nazi regime (1933–1945). A growing number of studies demonstrate that events around the killings of patients are complex and interwoven with other events that at first glance seem to be independent of them. Although a brief summary is difficult to make without losing significant aspects of this research, this chapter critically discusses some explanatory approaches of the newer research in the field of “euthanasia” killings and highlights the fact that patients were killed before and after the Nazi regime. In writing about the role of nursing in these killings, some authors have blamed the crimes committed by nurses on a combination of different factors: their working conditions, the political conditions of the fascist system, the powerlessness of nurses, and their moral fallibility (due to the lack of ethical guidelines in nursing) (Benedict and Kuhla 1999; Gaida 2006; McFarland-Icke 1999; Schweikhardt 2008; Steppe 1991, 1992, 1993, 2000, 2001; Steppe and Ulmer 2001). In contrast, mechanisms existed that allowed nurses to perceive patients as having lives not worth living and thus as able to be killed.

A connection existed among scientific discourses of the times, political rationalities, economic calculations of the killings, and nursing. The Nazi regime was a blatant example of what Foucault called “biopower” (2003). The well-calculated killing of chronic, mentally ill patients was part of a huge biopolitical program that had a well-established “scientific” rationale for a recognized eugenic agenda. Nurses were a vital part of this program, supporting it in their everyday practice through the deliberate execution of patients. This chapter develops a theoretical framework that enables a new perspective on the killings of sick persons and the important role nurses played in these murders.

Certain patients were exposed to an increased risk of death much earlier than has been believed. Analyzing nurses’ and psychiatrists’ notes in patients’ medical records from before and after the Nazi regime demonstrated that no differences could be found over time in how the notes were
taken, nor were any differences identified in the content of the documenta-
tion on individual patients or in the treatments or therapies that they
received. As a result, suspicions arise that psychiatric patients were being
assassinated before and beyond the National Socialist–fascist period, a fact
supported by the research of other historians. This hypothesis implies that
the motivation for these killings has to be investigated within psychiatric
practice itself.

The next section provides a brief overview of the course of the killings of
patients during the Nazi regime, summarizing some of the significant older
research results in the field of the “euthanasia” killings and in the history
of the involvement of nurses in these killings. Specific emphasis is placed
on the interrelationships between the killing of patients and the Holocaust.
This section is followed by a short description of some of the more recent
explanatory approaches to the killings that some researchers have devel-
oped, but even these newer approaches focus exclusively on the killings
carried out under the Nazis. These explanations are inadequate to explain
the fact that sick persons were killed before and after the Nazi regime.
Based on this assumption, the last part of this chapter develops an alterna-
tive theoretical framework in order to analyze the killing of sick persons.
This framework enables one to understand the killings of sick persons as
not exclusively bonded to the Nazi regime but rather as consequence of the
logic of psychiatric practice as such. Nurses had and still have a strategic
position within this practice, and it is necessary to analyze this strategic
dimension of nursing and the interplay between psychiatrists, nurses, and
technologies to fully grasp what enabled these killings. This chapter is thus
a plea to expand the field of research from a focus on so-called euthanasia
killings to a broader analysis of the “murder of sick persons”.

10.2 KILLINGS OF SICK PERSONS DURING THE NAZI REGIME

10.2.1 The Coordinated Mass Murder of “Aktion T4” and
the Decentralized Patient Murder of the Second Phase

As the preceding chapters demonstrate, the killings of patients during the
Nazi regime must be divided into several phases. The first systematic mass
destruction under National Socialism was the so-called Aktion T4 (see
Chapter 5), which was a centrally coordinated mass murder of patients in
asylums as well as of residents in nursing homes for disabled people (Heil-
erziehungsanstalten). Between January 1940 and August 1941, a system of
selections, transports, and killing facilities assassinated more than seventy
thousand patients in gas chambers (Schmuhl 1987; Faulstich 1998; Ben-
zehnöfer 2001).

During and after this “gas-killing action”, an extensive but silent dying
took place in psychiatric hospitals, asylums, and nursing homes for disabled
people and individuals with mental illness. It was a matter of hidden, decentralized patient murders carried out through starvation, medication, and neglect. The scope of these murders has proven to be so extensive that research into them cannot begin to capture every detail. Since the beginning of this newer research in the field of euthanasia, which began in the 1990s, the number of victims has continuously escalated, with most recent attempts at quantification adding 150,000 to 200,000 people murdered under decentralized actions to the 70,200 victims of the *Aktion T4* (Faulstich 1998, 2000; Harms 2011).

### 10.2.2 Aktion Brandt

The killings that took place under *Aktion Brandt* evolved from 1941 onward. Officially known as “disaster medicine”, it polarized the scientific community around the question of whether nurses and physicians had intentionally assassinated patients in hospitals. Suspicions were raised that they were killing psychiatric patients in order to obtain hospital beds for physically injured war victims. From the summer of 1942 on, the escalating air war and the disaster management needed to care for war victims, which was initially the responsibility of regional offices, became reasons for the deportation and subsequent murder of patients. The progression of the war and the increasing threats to cities as targets of severe air raids influenced central planning, at least from 1943 on (Faulstich 1998). In the course of this operation, asylums in the particularly endangered regions—the metropolitan areas of Berlin and Hamburg, as well as the strategically important industrial zones of the Rhineland and Westphalia—were evacuated in order to make room for contingency hospitals for injured patients from these affected regions.

On July 7, 1943, the so-called barrack decree (*Barackenerlass*) allowed the construction of wooden barracks on the grounds of psychiatric asylums in order to obtain more space for psychiatric patients. Two months later the “double bed decree” (*Doppelbetterlass*) was enacted with the aim of doubling the space again by putting beds on top of existing patient beds. However, both decrees did not have the expected effects because of war conditions and the deficiency of construction materials (Faulstich 1998; W. Rose 2009). Furthermore, the influx of deported patients to the interim asylums continued and led to the overcrowding of these outlying asylums. The “solution” in this situation was to continue with the murder of patients, and most of them were killed through starvation and neglect.

### 10.2.3 Assassinations of Sick Persons outside the Aktion T4, the Second Phase, and Aktion Brandt

Other centrally ordered actions, other than under *Aktion T4*, also took place. Historians date the onset of the killing of children under the scope
of the order, Reichsausschuss zur Erfassung erb- und anlagebedingter schwerer Leiden (Reich Committee for the Registering of Hereditary and Congenital Illnesses), to the summer of 1939, before the start of the adult “euthanasia” killings. From the summer of 1939 until the end of the war, about five thousand children and juveniles were killed. Simultaneously, psychiatrist Paul Nitsche of Saxony developed his Luminalscheme, which killed psychiatric patients by sedative injection. In 1939 Nitsche, head of the Saxon asylums, ordered the psychiatrists under him to use more narcotics and sedatives in order to “guard the surroundings from outrages of sick persons” (Faulstich 1998). Nitsche’s scheme was combined with the concept of “systematic weakening” (Niederführung) of the patients, which meant enfeebling patients by starvation in order to use smaller amounts of Luminal to kill them (ibid.; Faulstich 2001). Both killing methods were practiced in Aktion T4 and during the war, and characterized a regionally initiated systematic extermination of patients that took place outside the zones designated for the centralized killing action. According to Heinz Faulstich, the Saxony asylum’s mortality rate “outside of Aktion T4” was higher than in all other regions in Germany (Faulstich 1998, 61).

This Saxon killing method, known as the “Saxon special path” in the “euthanasia” historiography, was copied by psychiatric hospitals in various parts of Germany and in countless numbers of other asylums in such places as Mesaritz, Hadamar, Eichberg, Uchtspringe, and the Steinhof in Vienna (Harms 2011). However, most of the hospitals preferred to kill their patients through starvation and drew on their experiences in the 1930s. Historian Hans-Walter Schmuhl (1987) observed that in 1938 patients were already being killed through starvation. Historian Ernst Klee (2009) contended that the starvation method as a war measure had also already been discussed in the Ministry of the Interior in 1937. Heinz Faulstich, also a historian, wrote that a decentralized form of starvation was already a general phenomenon in the asylums between 1933 and 1937 (1998, 318).

Other centralized plans were also carried out. The killing of one thousand to two thousand Jewish patients was centrally organized under a “special action” (Spezialaktion) in 1940 (W. Rose 2009, 100). In another, called “special treatment 14f13” (Spezialbehandlung 14f13), which was continued even after the stop of Aktion T4, around twenty thousand concentration camp inmates were killed in the facilities used by Aktion T4 (Faulstich 2000; Hohendorf 2008). Ultimately another one thousand people who were classified as “criminal mentally ill persons” and who were interned in psychiatric asylums according to Paragraph 42 of the criminal code became victims of the “extermination through working” program in different concentration camps. Even in European countries raided by Germany, mentally ill persons were killed. After its annexation, Poland, for example, became an experimental field for murders that paralleled the preparations of Aktion T4, and at least twenty thousand Polish psychiatric patients were shot, gassed, or starved to death. Together with their patients, many Polish psychiatrists and
nurses were killed as well (W. Rose 2009). Faulstich (2000) calculated that eighty thousand people died in Polish, Soviet, and French asylums. Unemployed personnel of the disbanded *Aktion T4* had found further work in the extermination camps in Eastern Europe.

### 10.3 Deaths in Psychiatric Hospitals Before and After National Socialism

However, if rising mortality rates within psychiatric hospitals are seen as a measure of intentional neglect of patients with potentially deadly effects, then in 1936 and 1937, respectively, the increase in deaths that occurred in most psychiatric hospitals within the German Reich cannot be detached from the “euthanasia action”, as Faulstich indeed concluded (1998, 609). The discovery of high mortality rates within psychiatric hospitals, asylums, and nursing homes before and after the time of fascism is a fact that has yet to attract significant historical attention. Faulstich, who published a detailed study on the killings of sick persons, shed light on killings before and after the Nazi regime. He assumed that the comparative neglect of this situation by historians is due to the attempt to come to terms with the atrocious crimes of the program of “euthanasia”. I believe, however, that the reasons for this neglect must be searched for in the models developed to explain the “euthanasia” killings. All of these models focus on the Nazi system of power and relate the killings to the specific circumstances that occurred under the Nazis. These models cannot explain, though, why the killings began before the Nazi regime and continued after the Nazis lost power, and this, I believe, is the reason why these killings have been ignored so far by historians.

It is an undisputed fact that during World War I, starvation prevailed within psychiatric hospitals. The controversial question remains, however, whether this starvation was intended or was simply a consequence of war and the general famine in Germany due to the continental blockade. Faulstich, who dedicated a large part of his book to this problem, assumed that the high mortality rates were apparently accepted due to the patriotic consideration that a lot of German soldiers lost their lives in the war (ibid.; Harms 1996). High mortality rates in the asylums are often linked to the so-called *Rübenwinter* (turnip winter—a synonym for the winter of 1916/17, when nothing other than turnips was available as food), as well as to the influenza pandemic of 1918. Mortality rates in the Langenhorn asylum in Hamburg, the focus of my research, nearly doubled in 1916 and nearly quintupled one year later, and prolonged starvation was identified as the reason why Langenhorn had more than 1,800 patients at the beginning of the war but only 1,300 remaining at its end (Foth, forthcoming; Böhme 1993). Historian Ingo Harms also demonstrated that for the Wehnen
asylum, the 1918 influenza pandemic did not play as dominant a role in the mortality rate as is generally thought (Harms 1996).

According to Klaus Dörner, reasons for the high mortality rates in asylums during the World War I could well have been due to an intentionally provoked shortage of food. The purposeful undernourishment of patients led to the death of seventy thousand inmates in the asylums through starvation, and during World War II, this method of reducing the asylum population was simply repeated (Dörner 2002). This hypothesis, however, supposed a top-down, state-organized action that led to the killing of as many victims as did Aktion T4 during the Nazi regime. Even though the intentional nature of these killings cannot be proven, the fact that mortality in nursing homes and psychiatric asylums exceeded that in the general population cannot be denied (Faulstich 1998).

The increase in mortality during the period of hyperinflation in 1923 was merely the peak of a famine that did not end with the World War I ceasefire but rather lasted late into the 1920s. Patients in psychiatric hospitals were hit especially hard. According to Faulstich, a general consensus now perceives psychiatric patients as victims. The economic misery that continued after the end of the war suspended their right to live (ibid.).

Faulstich’s 1998 study leaves no doubt that in the postwar period, deaths within psychiatric hospitals in all four zones of occupation did not come to an end, leaving the high mortality rates in need of explanation. Although the author relates these deaths once again to an avoidable lack of food, he rejects the idea that any occupying power was intentionally withholding food. He emphasized that food distribution was organized by and under the responsibility of German authorities.

10.4 EXPLANATORY APPROACHES

Most historians working in the fields of the history of medicine, and of nursing, focus on the killings (or what they refer to as “euthanasia”) under the Nazi regime, neglecting the fact that these events were taking place both before and after this time. Historian Hans-Walter Schmuhl (2010), for example, asserted that “after nearly three decades of intensive research we are far from a generally accepted interpretative model of the genesis of the ‘euthanasia’ program of the National Socialists”. Historian Uwe Kaminsky (2007) stated too that it would be an almost impossible endeavor to provide an overview of the development of the research in the field of National Socialist “euthanasia” and to give an account of the present state of research (a synopsis of the research can be found as well in Faulstich [1998]; an overview of the literature to the beginning of the 1990s can be found in Burleigh [1991, 1996]; a widespread bibliography can be found in Beck [1995]).
10.4.1 “Euthanasia” as “Final Solution of the Social Question”

Two main explanatory models exert considerable influence on the debate about the origins of the “euthanasia” programs. One approach, which incidentally could also be used for explaining the genesis of the Holocaust, can be found in the groundwork provided by Götz Aly and his collaborators. According to them, the “euthanasia” actions were planned and carried out mainly by a more or less homogeneous “expertocracy” legitimized under Hitler’s authority (Führerermächtigungen). These experts pursued a purportedly rational, economic, and demographic political program. The aim of the “final solution of the social question” was to select and exterminate the “useless” (Aly 1985, 1989, 1993, 1994, 1995). In Aly’s hypothesis, the rationale of the killings was based on the aforementioned plans of psychiatric experts to reorganize and “modernize” the German psychiatric system under a divided plan, which would provide “active” therapy for the treatable and concurrently would exterminate the nontreatable, unproductive, and chronically ill patients.

The explanation of euthanasia as the final consequence of a health and social policy in a capitalistic industrial society was most clearly developed by scholar Klaus Dörner. The National Socialists, along with members of the traditional bureaucracy and human sciences, saw using Germany as their “historic mission” to prove to “the rest of world once and for all that a society, once freed from its whole social burden by taking the painful risks of finally solving the social question—even if it meant losing a third of its whole population—would be able to set free the total potential of industrialization and become economically, militarily, scientifically, and certainly culturally invincible” (Dörner 2002, 60). According to Dörner’s hypothesis, industrialization in the nineteenth century was realizable only when a population was released from its obligation to care for family members. Hence a modern system of institutionalization and professionalization of care took place. “The onset of modernity around 1800 is not only characterized by the marketization of the economy and the industrialization of work but also by the elimination of caring for family members unable to work” (Dörner 2010, 44). The decoupling of economy and science from a religious and philosophical idea of what it means to be human enabled the perception that “up to a third of society was a drain on society and thus what to do with these people was seen as a question of financial costs” (Dörner 1989, 536).

Dörner’s position was close to that of sociologist Zygmunt Bauman (2008), who argued that the Holocaust was a symptom of this kind of rational modernity. Dörner’s model was sharply criticized by historian Dirk Blasius (1990), who focused on its teleological tendencies. In the end, Dörner’s explanation is based on a Marxist analysis of capitalism, and Schmuhl pointed out that in Marxist analyses, the social question of the nineteenth century was synonymous with the “labour question” of the proletariat.
Dörner’s model adopted the social question to the Lumpenproletariat, which in Marxist theory is the lowest, most degraded stratum of the proletariat, and described those members of the proletariat, especially criminals, vagrants, and the unemployed, who lack class consciousness (Schmuhl 2010). However, even if one concedes that regarding everything—even human beings—as objects of use is inherent in capitalism, nothing at all is explained. This is the Marxist idea of reification. Emphasizing the primacy of socioeconomic factors in this kind of historical analysis always produces the same results. Distinguishing between structures and the “rest” constructs the historical subject as a rational being and does not allow for “irrationality” or “free will”. This approach thus cannot explain why many assassinations were carried out in a more or less unorganized manner and independently from orders issued under the centralized planning actions.

10.4.2 “Euthanasia” and a “Developmental Biopolitical Dictatorship”

For a long time research assumed that there was a close interrelationship between eugenics and “euthanasia”. Schmuhl explained “euthanasia” as the endpoint in the radicalization of Nazi health policy on race and genetics and related it to the general political conditions under the “Third Reich”. The prehistory of the Nazi program of “euthanasia” can be found in the discussions on racial hygiene in the 1890s, in its apparent triumphal procession in science, society, and state during the time of the Weimar Republic, and, finally, in its elevation to state doctrine in 1933. The interconnections between government and party institutions enabled extraordinary, confidential, and even extralegal interventions that were justified by an apparently increasing threat of racial impurity (Schmuhl 1987). The succession of forced sterilizations, the abortions performed due to eugenic indications, and the “euthanasia” of children seemed to manifest this radicalization of eugenic ideas. This position was criticized by historians like Michael Schwartz and others, who emphasized that the concept of eugenics was politically polyvalent and adopted by different political parties and systems, implying that a categorical difference existed between eugenics and euthanasia (Schwartz 1996). An international comparison underlines this aspect: Eugenic movements existed in democracies—the US, Canada, Great Britain, Scandinavia, Switzerland, and others—and in authoritative states or dictatorships such as those found in National Socialist Germany or Stalinist Soviet Union (see, for example, Adams 1990; Kühl 1994, 1997; Roelcke 2007, 2002; Roelcke and Hohendorf 1993; Weingart 1995; Weingart, Bayertz and Kroll 1992).

Schmuhl (1997) later refined his thesis, underlining the interrelationship of eugenics and euthanasia on the same discursive level. He defined discourse as a “‘ruling mode of speaking’ that determines what can be talked about and in which language—and what supposedly should remain silent”
According to Schmuhl, it was apparent that since 1890, discussions about eugenics and the “extermination of life unworthy of life” were based on the same premises: “the categorization of humans and groups of humans according to their worth, the move to biologize the social, the absoluteness of the supra-individual community of origin, the abolishment of the idea of human rights anchored in natural rights, the exclusion of illness, disability, feebleness, old age, pain, and suffering from the *conditio humana*” (ibid., 68–69). Despite appearing to coincide with the theoretical perspective of this chapter, Schmuhl’s definition of discourse is imprecise and rough. Schmuhl is right in defining discourses as historically delineable possibilities of thematic speech, which define the borders of meaningful speech and coherent social acting. He nevertheless neglects the fact that language does not function merely as a mirror of reality but rather works in the construction of social reality and in the perception of what is perceived as “natural”, a second dimension because language is a medium that dictates its conditions on speech. Philosopher Michel Foucault argued that regimes carry (and disseminate throughout the space they occupy and the subjects they organize) their own truth, and that indeed, a regime of truth is a precondition of power (Brown 2008; Foucault 2007a, 2007b). It appears as if Schmuhl used the concept of discourse more in order to “prove” his original assumption that “euthanasia” was a radicalized form of eugenics. In the end, he remained within the more traditional framework of the history of ideas and insisted that socioeconomic conditions and the specific circumstances of World War II were decisive moments generating the mass assassinations of patients. At this point, Schmuhl is no longer arguing from a discourse theory perspective.

Schmuhl defined the “Third Reich” as a “developmental biopolitical dictatorship” aimed at controlling “birth and death, sexuality and reproduction, body and genetic dispositions” (2009, 10). The point of reference for this political entity was the collective subject of “people”, defined as a bio-organic body. The developmental biopolitical dictatorship was based on two pillars—one of health and heredity and the other of race. According to Schmuhl, these related streams were under scientific leadership that aimed to establish a stratified society. At its top would emerge a social egalitarian, biological homogeneous *Volksgemeinschaft* (or folk community) in which class disparities would be resolved. The relevance of the biosciences within the National Socialist state thus cannot be overestimated. As Schmuhl stated, the “scientists from these disciplines envisioned—even before 1933—a technocratic model of policy counseling through which ‘scientific expertise’ would dissolve politics into multiple factual constraints, political decision processes would become ‘rational’ solutions, with the consequence that science and technology would take the place of politics”. Schmuhl described this process as “reciprocal instrumentalization of science and politics” (2010, 9).

I also use the term biopolitic, but I am taking a more Foucauldian perspective than Schmuhl. Schmuhl loses some critical potential in his
understanding of the concept. The role of racism, for example, has a specific strategic function in Foucault’s conception of biopower, which becomes somewhat blurred in Schmuhl’s approach. Whereas biopower from a Foucauldian perspective is a particular mode of governing that is bound to multilevel technologies of power, Schmuhl’s conception of the term tends to reduce biopolitics to a biologized social. He reduces biopolitics to a kind of “social engineering” through eugenics. He and other historians have perceived the ideas behind eugenics and the actions of carrying out “euthanasia” killings as imposed by a coercive dictatorship and its technocratic elite. But as historian Michael Burleigh (1994) has emphasized, the procedures of sterilization and “euthanasia” were not always imposed top-down by a coercive state apparatus. And as my analysis elsewhere demonstrates as well, many German doctors and nurses made their decisions based on their own understanding of eugenics (Foth 2013). In the context of a widespread campaign of propaganda and public education, even parents often requested eugenic measures for their own children (Burleigh 1994). Canadian historian Robert Gellately takes this aspect as the focus of his book, Backing Hitler (2009). In it, he highlights the broad participation of Germans in Nazism and emphasizes that the explanatory model of the Nazi regime as a brutal police state, which forced its citizens into cooperation with the state, cannot capture its effectiveness. Based on an analysis of documents from the archives of the former Nazi Secret State Police (Geheime Staatspolizei, GeStaPo), Gellately argues that the police system could have functioned so effectively only because of the voluntary cooperation of Germans. It was not the case that secret police agents were everywhere; on the contrary, a low level of staff coverage made it impossible to control the population as a whole. Many police arrests were enabled only because many Germans voluntarily informed on their neighbors or acquaintances to the police (Gellately 2001). Gellately further contends that the Germans would have known everything about the crimes committed by the Nazi regime and concludes that most Germans agreed with these crimes (Schneider 2006). In discussing the “euthanasia” killings, Gellately emphasizes that most relatives of patients who were killed did not want to know too much about the killings and numerous German families were prepared to accept the murder of their closest relatives without protest, even with approval. By so doing, they created the psychological conditions for the genocidal policies carried out in the years to come. If people did not protest even when their relatives were murdered, they could hardly be expected to object to the murder of Jews, Gypsies, Russians, and Poles. (Gellately 2009, 107)

Biopolitics under the Nazi regime cannot be reduced to a simple killing of the unfit. As historian Robert Proctor highlights in his book, the Nazi’s attempt to defeat cancer was the most decisive and vigorous attack on the
disease then known to humankind; German cancer research was the most advanced in the world by the time Hitler assumed power in 1933, and the anticancer measures likely caused the disease to decline among the post-1945 German population (Proctor 1999).

Throughout the world over the course of the twentieth century, there was not a clear distinction between preventive medicine and eugenics, between the pursuit of health and the elimination of unfitness, between consent and compulsion. Sociologist Nikolas Rose emphasizes that even “under National Socialism . . . a coincidence between generalized biopower and dictatorship [developed] that was at once absolute and retransmitted throughout the entire social body . . . [which was] a complex mix of the politics of life and the politics of death” (2007, 58). Biopolitics under the Nazi regime entailed not merely the exercise of state power but strategies for governing life developed by many other authorities. Nazi doctors and health activists, not acting solely under the direction of a sovereign state, waged war on tobacco, sought to curb exposure to asbestos, worried about the overuse of medication and X-rays, stressed the importance of a diet free from petrochemical dyes and preservatives, campaigned for whole-grain bread and foods high in vitamins and fiber, and supported vegetarianism. (Ibid., 58)

My analysis elsewhere demonstrates that the decisions doctors and nurses made in regard to the killings of patients were not forced by the state or by a technocratic elite but rather were deliberately made by the psychiatrists and nurses themselves in the Langenhorst asylum, based on scientific categorizations and internalized normative conceptions (Foth 2009, 2011, 2012). This is an impressive example of what Foucault et al. (1993) called “self-techniques” and “self-regulation”. Understanding biopolitics as being composed of different power technologies and carried out by a multiplicity of authorities and experts independently from “state apparatuses” forces one to analyze the connecting lines between eugenics, euthanasia, and biopower in psychiatric practice as such. Furthermore, this perspective enables one to understand why the killings of patients were carried out independently of central planning, and why sick persons were being killed both before the National Socialists came to power and after the end of World War II.

Society under the Nazi regime must be analyzed as a society of regulation, and the decisive element in such a society is the norm. The norm operates, on the one hand, toward a body that power tries to discipline and, on the other hand, toward a population that power tries to regulate. A normalizing society is, according to Foucault, a society in which the norm of discipline and the norm of regulation intersect along an orthogonal articulation. To say that power took possession
of life in the nineteenth century, or to say that power at least takes life under its care in the nineteenth century, is to say that it has, thanks to the play of technologies of discipline on the one hand and technologies of regulation on the other, succeeded in covering the whole surface that lies between the organic and the biological, between body and population. (Foucault 2003, 253)

Biopolitics discovered population as a scientific and political problem, as a biologic problem of power engaged with collective phenomena that influence economy. These phenomena are random and unpredictable in detail, but they establish constants on a collective level, which can be detected at the level of populations. Biopolitics uses mechanisms that are very different to those used by the disciplines. First of all, it uses statistical surveys and global measurements, intervening on a global level by installing a regulatory mechanism and trying to establish a kind of homeostasis.

If the Nazi regime is analyzed from this perspective, it becomes a blatant example of modern population policy that was from the beginning connected to multiple detailed statistical surveys. During the Nazi regime, most of the data were evaluated with the newest technologies. The administration systematically used punch cards to enable the analysis of large amounts of data. Even the Holocaust was organized by using these technologies (and could not have been realized without this technological support), and the company IBM gained notoriety because it delivered the infrastructure enabling these data collections and analyses (Black 2002). The same is true for the organization of the killings of sick persons and the capturing of so-called hereditary risks. The former president of the German statistical society (Deutsche Statistische Gesellschaft), Friedrich Zahn, noted in 1940 that “statistics is closely related to the National Socialist movement”. As he continued,

The demographic policy enjoys the particular interest of the State. It is not anymore solely a quantitative population policy but rather has developed into a qualitative and psychological population policy and therefore demands from statistics increasing and deepened insights, which can be implemented using the energy of our Führer (Quoted in Aly and Roth 2005, 12, translation Foth).

Under the direction of the police, the health and welfare administration, and the statistical office of the German Reich, an efficient system of different registers, censuses, registration laws, and identification cards developed after 1933. All these measurements aimed to register and classify the population. In 1933 and 1939, population censuses were carried out, but they were not the only actions of registration: the work book (Arbeitsbuch) (1939), the health family register (1936), the obligation to register (1938), the German People’s Party (1939), and finally, the personal identification
number (1944) were the bureaucratic preconditions for a graded system of gratification and penalty, for selection and extermination. With the raw material of the population census from 1939, a register was installed for all non-Aryan peoples within the German Reich; it contained the names, dates, and places of birth, places of residence, occupation, and “grade of crossbreed”. The political office for matters of race (Rassenpolitisches Amt) of the German National Socialist Worker Party (NSDAP) began in 1934/35 to install a “register of asocial elements” (Assozialenkartei), followed in 1935/36 by the special register of Jews, Gypsies, and other “foreign ethnics” (Fremdvölkischer). From 1934 on, “hereditary sick persons” were registered by the health administration. Especially in the latter cases, nurses played a decisive role because they were mainly the ones who reported these persons (Gaida 2008). Historians Aly and Karl Heinz Roth described the effectiveness of statistics for population policy as follows:

Only through the work of statisticians with anonymous data do people become part of “problem areas” with their own so-called fertility probability, with their own probability of divorces, their own social behaviour, etc. Thus people are indexed by character profiles that can be differentiated endlessly and, even more important, can be randomly combined. Only then is it possible to further subdivide people in the process of population politic and social politic. By this means, it becomes possible to enact laws, decrees, and regulations for ever-smaller groups of people. These laws, decrees and regulations become less and less comprehensible and understandable (Aly and Roth 2005, 8, translation Foth).

This perspective enables one to integrate Nazism into the history of modern societies. Nazism was not a simple relapse into barbarism but rather used modern statistical methods in order to regulate the health of its population. The other side of a biopolitical society of regulation is that certain elements are excluded from the normal range of its population and defined as biologically dangerous—Foucault called this form of scientific racism state racism. Killing the other within a system of biopolitics becomes acceptable if a biological danger is targeted and if the elimination of this danger will strengthen the race; it is not a question of victory. In a normalizing society, race or racism is the precondition that makes killing acceptable. Darwin’s theory of evolution developed out of this background of biopower and became the means to imagine colonial relations, the necessity of war, criminality, and the phenomena of madness or mental illness. The concept of evolution became the frame through which to imagine killing and the potential of war. War not only eliminated the opposite race but also regenerated one’s own race through a selection of those battling for life. Seen from this perspective, psychiatry becomes one of the key sciences in biopolitics, because it is the psychiatric expert who is in charge of
demarcating the border between what has to be considered as normal and what must be defined as a biological danger to populations. Psychiatrists in Hamburg, for example, fought from the end of the nineteenth century on to be acknowledged as the sole source of expertise able to decide which individuals might present a danger to society (Foth 2013). Psychiatry’s decisive position in the governing of populations enabled the killing of psychiatric patients before and after the Nazi regime.

10.4.3 Potentials of the Theoretical Perspective

The potentials of the perspectives developed earlier can be summarized into three points. First of all, this view of National Socialism enables an integration of Nazism into the history of modernity. National Socialism was not a relapse into barbarism, but rather it used “modern” power technologies that were already in place before the Nazis came to power. The analysis of patients’ records, for example, demonstrates that the treatments or the therapies in the psychiatric asylum did not dramatically change. What happened in the asylum during the Nazi regime was already part of the everyday psychiatric practice before the Nazi regime. The changes concerned only the extent and the grade of organization of the killings. To analyze Nazism as a “modern” society means to acknowledge the dark side of modernity and to deny that there is always a positive connotation to modernity. Furthermore, this perspective makes it possible to integrate the National Socialist practices of domination and their legitimization on a historical curve and therefore enables one to describe modifications and discontinuities against a backdrop of continuity.

Second, the different forms of power as analyzed by Foucault—sovereign power, disciplinary power, and biopower—are identifiable within the Nazi regime. Even the positive, productive character of power understood as a self-subjugation of subjects under a regime of power is recognizable, for example, in the voluntary cooperation with the dictatorship of the National Socialists and the practices of denunciation. Nurses, too, voluntarily cooperated with the regime, and they were an important professional group of experts who carried out the biopolitical program of the Nazi regime. For example, the analysis of the nurses’ notes in the patients’ records highlights how important these notes were in the construction of patients’ identities and how this note taking was guided by scientific psychiatric classifications (Foth 2011, 2012). Nurses observed and reported in the first place about patients and their behavior, and further decisions about their fate were based on these notes. Another example is the denunciation of children with impairments because community nurses deliberately reported these children to the authorities with the clear knowledge that they would become victims of extermination (Gaida 2008).

The concepts developed by Foucault, the strategies and logics of power that he described, are useful for an analysis of the National Socialist
system. They allow a highlighting of the different facets of the regime and of the society.

Third, Foucault’s writings allow a concrete discussion about National Socialism, although they are not meant as an all-embracing analysis of Nazism. Nevertheless, a perspective on Nazism as a multifunctional power system that cannot be reduced to a single antimodern logic also allows for questioning events after 1945.

10.5 BARE LIFE

Against the backdrop of the theoretical considerations developed earlier, the psychiatrists and nurses exercised the sovereign right the moment they killed their patients. They exerted the right to make death and to let live. However, certain patients vegetated in the asylum under unbearable conditions before they were physically killed. Some patients had to live for years in these zones, where they were completely neglected. Patients from the Langenhorn asylum in Hamburg, for example, were often transferred to other asylums outside the city, where most of them met their death. The asylum of Lübeck-Strekenitz was assigned as a makeshift hospital for mentally ill patients from Hamburg, necessitating the removal of the mentally ill who had been hospitalized in Lübeck to create space for patients arriving from Hamburg. At the end of September 1941 more than six hundred patients were deported from Lübeck, nearly four hundred of whom had earlier been transferred from the asylum at Langenhorn. Even the top officials in Hamburg’s health administration—Kurt Struve, for example—did not have any idea where the Lübeck patients had gone. Some were transported to the asylums at Eichberg and Weilmünster, and some were transferred to Hadamar. All of these asylums were also used by Langenhorn to directly deport its patients. About four-fifths of the patients from Hamburg perished in these asylums under miserable conditions (Rönn 1991, 52). In the asylum at Eichberg, chaotic conditions prevailed; barely any physicians were on staff, and those that were on staff were likely to be addicted to morphine. There were only a few nurses, leaving most of the wards understaffed or “nurse-free”, and with the shortage of beds, many mattresses were placed on the floor. The patients had been abandoned (ibid.). These patients were socially dead (about the notion of social death see also Patterson [1982]) long before they were killed, and it seems as if they vegetated in specific zones within the asylum in which they were reduced to an animal-like state of life, or, in the words of philosopher Gorgio Agamben, these patients were reduced to “bare life”.

Agamben’s analysis is useful in thinking about the rendering of patients as invisible. Psychiatric practice must be analyzed as a form of disciplinary power that aimed to influence and transform patients at their very core. This practice was arranged around the absolute power of the psychiatrist
and could function only because it was a hierarchical power distribution in which the nurses had a definite strategic function. One important characteristic of this anonymous power (anonymous because it is a form of power that intervenes without emotions and is independent from the person who has it) is that it subjectifies the individuals in its reach by constructing an identity in the record and attaching this identity onto the person (Foth 2011, 2012). However, in all the records that were part of my research, we find at some point the exact opposite operation, which appears to be a paradox: specific patients suddenly disappeared into a zone of indifference because the notes suddenly broke off. In these zones it seemed as if anything was possible, because the little information that we have on them illuminates a severe intensification in the use of coercive means.

Using Agamben’s theoretical approach, it becomes possible to conceptualize the “zones of invisibility” as zones of banishment or “zones of exception”. In these zones the patient is held in a “relation of exception [which is an] extreme form of relation by which something is included solely through its exclusion” (Agamben 2005, 18). This again is exactly what happened to patients in Langenhorn because they were abandoned by psychiatric practice, but simultaneously it maintained control over their lives and even intensified corporeal interventions. Furthermore, as discussed earlier, from the end of the 1930s on, Langenhorn transferred thousands of patients to other asylums around Hamburg, where most were killed. It seems as if in Langenhorn certain areas existed that could be described as “zones of exception”, but these other asylums were nothing but “zones of exception”. Barely any information exists about what was going on in these asylums.

Agamben believed that the present was a catastrophic end point of a political tradition that had its origins in Grecian antiquity and that culminated in the Nazi extermination camps. For him, sovereign power was at the core of biopolitics, and the modern age does not mark a break with the occidental tradition (or the traditions in the Western world) but merely generalizes and radicalizes what was there originally (Lemke, n.d.). The production of a biopolitical body was the original purpose of sovereign power, whose inclusion into the political community was possible only if, at the same time, there were humans for whom the status of legal subjects was denied.

According to Agamben, it is necessary to examine the exception to understand the functioning of sovereign power, because it is in the exception that the nature of sovereign power will be revealed. Agamben explored the “states of exception”, where a sovereign declares a time or a place that the rule of law can be suspended in the name of self-defense or national security (Rabinow and Rose 2006). The sovereign decision over the exception is contained in the original juridical structure and principle in the Western world and is actualized through the declaration of the state of exception. The sovereign, who has the legal power to suspend the law, puts himself legally outside of the law; this is the paradox of sovereignty. The moment a
sovereign declares the state of exception, he does so by declaring that there is no existence outside the law. “I, the sovereign, who is outside of the law, declare that there is nothing outside of the law” (Agamben 2005, 15). The most prominent characteristic of the exception is that what is excluded in the exception is not, on account of being excluded, absolutely without relation to the rule (ibid.). What is excluded maintains itself in relation to the rule. “In this sense, the exception is truly, according to its etymological root, taken outside (ex-capere), and not just excluded” (ibid., 18, original emphasis). The exception is brought into being not by an interdiction but rather by means of a suspension of the juridical order.

According to Agamben, the act of banishment is the purpose of exception, which means that the banished are abandoned by the law. The original power of the law contains within it the possibility of abandoning life, but through this act, the law maintains control over life. Sovereignty then becomes the point where it is impossible to distinguish between law and violence; it is the threshold where violence transforms into law and law transforms into violence, and, at the same time, it is the threshold where nature and culture become indistinguishable. That is what characterizes sovereignty. For Agamben, the leading political differences since Grecian antiquity have been not between friend and enemy but the chasm between bare life (zoë) and the political existence (bios), or, in other words, between natural existence and the legal entity of human. Agamben used the term homo sacer, a figure from Roman law, to describe a human who could be killed without punishment because he had been banished from the legal political community and reduced to the status of a physical existence. While even a criminal had the right to reclaim certain legal protection, the homo sacer was completely without it. Once one was excluded from the legal community, one could not be prosecuted nor become a religious sacrifice. “Neither completely living nor completely recognized as dead, the homo sacer was a sort of ‘living dead’, one who did not have even the elementary right to die like a human” (Lemke, n.d., 18). A structural analogy exists between the sovereign exception and the homo sacer, in that they are two symmetrical extremes within the logic of sovereignty. A sovereign has the power to declare any person a homo sacer, but compared to a homo sacer, everybody could be a sovereign.

The state of exception was not an invention of totalitarian governments but rather developed from a democratic-revolutionary tradition (Agamben 2005). Every democratic constitution contains the possibility of declaring a state of exception.

10.5.1 Bare Life and the Camp

Concentration camps were one attempt to make this structure visible. The camp is the “hidden matrix” of political space. Agamben defined the camp as a space without legal subjects (bios); in the camp only “bare life” (zoë) existed. The paradigmatic figure of the camp is der Muselmann (Levi
Changing Perspectives 235

2008a, 2008b; Rousset 2008, 2005), a being from whom humiliation, horror, and fear has taken away all consciousness and all personality as to make him absolutely apathetic and degraded (Agamben 1998). These people not only were excluded from the political and social context they once belonged to but also no longer belonged to the world of humankind, not even to the precarious world of the camp detainees who had ceased to recognize them. They remained mute and absolutely alone (ibid.).

10.5.2 Critical Remarks

Agamben’s approach was criticized by a multitude of scholars (Aspe and Combes 2001; Butler 2004; Butler and Spivak 2007; Kiesow 2002; Lemke 1997, 2011, n.d.; Lemke, Krasmann, and Bröckling 2000; Negri 2008; Rabinow 1999; Rabinow and Rose 2006; N. Rose 2007; Zakravsky 2001, 2002). One of the main critiques focused on his notion of continuity, which proceeded from a fundamental continuity of biopolitical mechanisms whose foundation he found in the logic of sovereignty. He found a historical caesura in the modern era because “bare life”, formerly on the margins of political existence, increasingly shifted into the center of the political domain. Biopolitics therefore followed thanatopolitical rationalities and strategies. These assumptions were criticized by philosophers Paul Rabinow and Nikolas Rose, among others, who argued that exceptional forms of biopower can lead, “especially in conditions of absolutist dictatorship and when combined with certain technical resources, to a murderous ‘thanatopolitics’—a politics of death” (Rabinow and Rose 2006, 18), but that biopower in contemporary states takes a different form. This critique coincides with my perspective developed earlier, in which I tried to demonstrate that even under National Socialism, health policy cannot be reduced to thanatopolitic but must rather be analyzed as a complex interplay of different rationalities in order to govern the health of the population. Sociologist Thomas Lemke contended that Agamben’s notion of continuity between a “biopolitics situated in antiquity and the present is unconvincing” because the term “life” as it is used “in antiquity and modernity has little but a name in common, and this is so because ‘life’ is an especially modern concept” (Lemke 2011, 62). Only with the emergence of modern biology did the idea appear that life follows its own autonomous laws and is an area of study in its own right. The idea of hereditary dangers for a population, for example, was based on theories about degeneration and Darwin’s theory of evolution. Seen from this perspective, biopolitics is a historical phenomenon that cannot be separated from the development of modern states, the emergence of the humanities, and capitalist relations of production. “Without the bio-political project’s necessary placement within a historical-social context, ‘bare life’ becomes an abstraction whose complex conditions of emergence must remain as obscure as its political implications” (ibid., 63, translation Foth).
Nevertheless, Agamben’s distinction *bios/zœ* is illuminating without adopting his “diagnosis of Western history as a growing biopolitical nightmare” (Rabinow 1999, 16). His description of the camp seems especially helpful to better understand how zones of exception were erected and maintained within psychiatric asylums. Furthermore, Agamben’s approach enables one to understand the peculiar symbiosis between the psychiatrist, supported by the nurse, and the jurist.

10.5.3 The Psychiatric Asylum As a Camp

As mentioned earlier, the *Muselmann* in the concentration camps was excluded from the world of humankind, and even the camp detainees had ceased to recognize him/her—the *Muselmann* was absolutely alone. Dorothea Buck, a survivor of the psychiatric system, described her experience of exclusion.

In 1936, 71 years ago—at the age of just 19, I went through the most inhuman experience of my life in a psychiatric institution, against which even being buried alive during the 2nd World War paled into insignificance. I experienced the psychiatric system as being so inhuman, because nobody spoke with us. A person cannot be more devalued than to be considered unworthy or incapable of conversation. (Buck, n.d., n.p.)

As Agamben stated, what is excluded in the camp and, according to my perspective, in the psychiatric hospital, is included through its own exclusion. Both the camp and the psychiatric hospital were “a hybrid of law and fact in which the two terms have become indistinguishable” (Agamben 1998, 170). Both the camp and the psychiatric hospital were characterized by the fact that their inhabitants “were stripped of every political status and wholly reduced to bare life” (ibid., 171). The camp and the hospital became biopolitical spaces, “in which power confront(ed) nothing but pure life, without any mediation” (ibid., 171).

However, Agamben notes that the question of “how crimes of such an atrocity could be committed against human beings” is often posed (ibid., 171). This question is the starting point of many historical studies in nursing as well (Benedict 2003a, 2003b; Benedict, Caplan, and Lefrenz Page 2007; Benedict and Georges 2006; Benedict and Kuhla 1999; Berghs, Dierckx de Casterlé, and Gastmans 2007; Brush 2004; McFarland-Icke 1999; Steppe 1991, 1992, 1993, 2001). Nevertheless, I concur with Agamben that it would be more useful to investigate carefully the juridical procedures and deployments of power by which human beings could be so completely deprived of their rights and prerogatives that no act committed against
them could appear any longer as crime. (At this point, in fact, everything had truly become possible). (Agamben 1998, 171)

In the case of the killing of patients during the Nazi regime, the sovereign established a symbiosis not only with the jurist but also with the physician, supported by the nurse. Alfred Hoche, a specialist in criminal law, and Karl Binding, a physician specializing in ethics, attempted to legitimate in 1920 the extermination of “life unworthy of life.” Binding’s concept of “life unworthy of life” and “mercy death” reappeared in the Nazi regime. Masked as a humanitarian problem—against the background of a new biopolitical determination of the National Socialist state—the sovereign power practiced the power of decision over “bare life”. “Life unworthy of life” was not an ethical but rather a political term because it allowed for the possibility of a person being able to detach the bare life (zoe) from bios in another person.

The National Socialist government never adopted a law regarding its “euthanasia” program; it was simply based on a secret decree that never gained legal force. All physicians and nurses involved in this program were thus in a doubtful judicial position; it was a state of exception. The sovereign decision over “bare life” shifted away from political motivation and entered an ambivalent terrain wherein the sovereign and the physician, along with the nurse, began changing places. The precondition for these killings was that all murdered persons were judged as already having been excluded from the political community. They were living in a borderland between life and death, between interior and exterior, where they were nothing more than bare life. They were reduced to homines sacri, and in this “no man’s land”, the physician, nurse, and scientist were acting where, in former times, only the sovereign could act.

As already mentioned over the course of the chapter, the nurses carried out all interventions. Thus, they controlled these zones of exception, and, therefore, it can be concluded that they claimed sovereignty. As the sovereign stands above the law, so is bare life outside the scope of the law, but at the same time a part of it. In psychiatric practice, nurses and psychiatrists had control over life and death of their patients, even to the point of deciding who could be recognized as human.

This, then, was the actual mechanism that enabled the killing of patients, and it was a mechanism that existed as an integral part of psychiatric practice and not as an invention of the Nazi regime. This transformation of the psychiatrist from a representative of disciplinary power into a sovereign was central to the very core of psychiatric practice. Psychiatry could not exist without it, and it is the reason why the killings did not come to a stop after World War II. In Germany, psychiatrists and nurses did actually assassinate sick persons, but in many ways these persons were dead long before. Foucault emphasized that killing someone is not simply the physical extermination of the other but that there are also indirect forms of murder:
“The fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on” (2003, 256).

NOTES

1. Foucault used the terms biopolitics and biopower interchangeably in order to describe a particular power constellation of biopolitics. I therefore do not delineate between the terms biopower and biopolitics in this chapter.

REFERENCES


Foth, T. 2012. “Nurses, Medical Records and the Killing of Sick Persons before, during and after the Nazi Regime in Germany.” *Nursing Inquiry* 19 (2): 93–100.


11 Conclusion

Linda Shields and Susan Benedict

The topic of this book is both distressing and shocking. Since we began studying the role of nurses as killers, we have been told that this is not a suitable topic for study, that nurses “would never do those things”, and at times, despite concepts of academic freedom, employers (at times, and for one of us—LS) have found it hard to understand why we would study this, and have tried to put barriers in our way. Such ideas and behaviors have strengthened our resolve to continue. We strongly believe not only that this is a worthy topic for study but also that we are morally obliged to continue this journey. Our profession (and that of midwifery, too) cannot move forward and develop to its full potential unless such a dark side of its history is acknowledged and addressed. In 2011, the German Medical Association (Bundesärztekammer) (Livingstone 2012) apologized for the actions of physicians during the Nazi era. We suggest that it is time that German nursing and midwifery also do so through their respective organizations.

The book has revealed that nurses and midwives killed their patients, those who had come to them for care, and were complicit in some of the most egregious crimes in history. Some participated because they felt they had no choice; others did so believing that what they did was wrong, but they did it anyway. Still others genuinely believed that what they were doing was right. It is hard for us looking through the lens of history to understand. Across the world, in the twenty-first century, we come from a different worldview because many of us work under much easier conditions than did the nurses and midwives who committed these crimes. Many of us have received a much higher standard of education than was available to the nurses and midwives then, and certainly few of us have been subjected to the all-pervasive propaganda campaigns that so characterized the Third Reich. It is a brave person who would state, “I would never do those things,” without experiencing the prevailing atmosphere of the Nazi era. That is not to condone their actions. There were some who resisted. While we have not considered these in this book, we invite ongoing scholarship around nurses and midwives who did, indeed, resist and refuse to participate. Unfortunately, most of the stories of these brave resisters are lost to history because they were not a part of postwar trials.
In summary, Chapter 1 sets the scene for this whole story by providing background information about fascism, Nazism, the rise of Hitler, and the role propaganda played in the lives of all citizens of occupied Europe. Chapter 2 demonstrates how the ground was set for the development of killing as a method of negative eugenics, by exploring the rise of the eugenic movement, and its use, subversion, and application by the Nazis. Chapter 3 describes how nursing was structured in the Third Reich, demonstrating the power relationships within the bureaucracies of the nursing organizations, and how the law was adapted to fit the racial hygiene theories that abounded at the time.

Chapter 4 explains how psychiatric nursing worked, how those nurses were educated, and the work environments that fostered the need for obedience leading to complicity. The next chapters, 5, 6, and 7, are probably the most telling of the book, with use of trial transcripts of the few nurses who were tried for their crimes. It must be remembered that while this handful of individuals, with a small number of others, was caught and at least had to face justice, there were countless other nurses and midwives who were never called to account. Chapter 6 examines nurses at one of the killing centers, as a way of demonstrating how they justified their thoughts and actions. Chapter 7 continues this theme with exploration of nurses at two other killing hospitals.

While we know that nursing as a profession has often been ignored in the scholarship about health professionals in the Nazi era, midwives are even more neglected in the historical record. Chapter 8 is most important, as it tries to redress this omission. This is landmark work, beginning as it does an era of discovery and acknowledgment of the role of midwifery, and it is hoped that further scholarship will ensue. Chapter 9 takes a different approach by exploring what all this means for nurses and midwives today, and uses a recent research project with nursing students to demonstrate how this material can be effectively taught.

In Chapter 10, we find a theoretical explanation of why these crimes were committed, with a philosophical exegesis of the ethics and worldview of the time that allowed, indeed encouraged, nurses to become involved.

What are the lessons learned from the arguments presented here? Can we exonerate the nurses because they were caught up in the crimes of the Nazis? Can we understand when they say that they believed that what they were doing was the right thing?

One may question why this particular discourse is relevant today. After all, the Nazis disappeared in 1945, as did the crimes that they committed. Or did they? In the twenty-first century, health technology abounds, bringing with it many benefits. One can hardly question the advantages and lifesaving properties of organ transplants, and other complex surgical procedures. We have benefited from drugs that prevent lipid deposits in arteries and consequent fatal heart attacks, and older people remember
Conclusion

245

when antibiotics were not available and many children (and others) died each year from pneumonia. There is a perception that the modern world is free of the ethical dilemmas that the nurses discussed here faced, and accepted or ignored. We suggest, however, that some things never change, and dialogue about some present day nursing and midwifery actions is long overdue. An obvious choice for discussion is a practice against which bodies like the International Council of Nurses (2012) has fought robustly, that of nurses assisting with executions in countries that still have the death penalty. It is easy to see how this is wrong, and how a moral stance can be made against it. However, there are other areas that require scrutiny. In this discussion, we make no claims to support or refute the actions and factors we now present—for example, our discourse on euthanasia does not signify whether we agree with it. We present these ideas to illustrate that what the nurses in this book did may not be so removed from present-day nursing and midwifery practice, and we believe that any discussion around these topics is required.

Maternal-fetal screening services, variously known as prenatal diagnosis or pregnancy choice services, among other names, have, since the development of ultrasound as a screening tool during pregnancy, become commonplace. If a fetus is found to have a range of deformities, inherited diseases, or congenital conditions, mothers and fathers are given the choice of whether to continue with the pregnancy or have it terminated. While a condition known to be incompatible with life may be accepted as a reason for termination, sometimes terminations are being chosen for conditions that are far less severe, such as Down’s syndrome or cleft lip and palate. According to a report by the Nuffield Council on Bioethics (2006), in 2006 in the United Kingdom, approximately eight hundred thousand pregnancies were recorded, and thirty-five thousand screened women were told that their fetus was at risk of a serious abnormality. Figures for terminations of pregnancy in developed countries such as the United Kingdom, US, and Australia are difficult to find, and so it is not possible to know how many pregnancies are terminated each year.

Rationing of health care is a well-known term today. Escalating costs of health care and technology mean that some sort of reconciliation has to occur between what health care costs, what patients and clients expect, and what is deliverable within each country’s budget. Examples of where this has become a battleground can be seen in the US with President Barack Obama’s health reform, the Affordable Care Act (US Department for Health and Human Services 2012). In some Australian states, health budgets are being drastically cut and health staff in large numbers are losing their jobs in an attempt to balance governmental budgets (MacDonald 2012), while the National Health Service in the United Kingdom (Mason 2012) has struggled for years to provide the totally free at point of delivery health care that has become so much a part of the nation’s psyche.
Nurses and midwives are caught up in this. Many lose their jobs when health budgets are cut; others work under increasing pressure from managers and policy makers to cut corners and minimize the standards of care they deliver. Of course, those who suffer the most from such actions are ultimately the patients and clients of the health service. Under the Nazis, rationing of health services took a sinister turn, and people were killed if they were considered a burden on the state, and expensive to care for. Nurses and midwives need to remember this when faced with dilemmas around rationing of services and aim to find the courage to resist if asked to do inappropriate things that will not best serve their patients and clients.

In some countries around the world, voluntary euthanasia is legal (Bilsen et al. 2009). Nurses are legally involved in euthanasia in some countries, and have published on their involvement (Inghelbrecht et al. 2009; Dierckx de Casterlé et al. 2010). In most places, involvement is by choice and nurses can refuse to work in areas where euthanasia occurs. One could argue that there is a world of difference between the real euthanasia, or “mercy killing” of today, and the so-called “euthanasia” of the Nazis, which was anything but merciful. However, the ethical debate around euthanasia needs to be informed by the scholarship presented here, so that nurses can make valid conscience decisions about their willingness to work in areas where euthanasia is performed.

The International Council of Nurses (2012) strongly decries the involvement of nurses in torture, but evidence exists that nurses have been complicit in force feeding prisoners at Guantanamo Bay, which constitutes torture. In 2013, a report from the Institute on Medicine as a Profession revealed the actions of these nurses (Task Force 2013). Such modern day events indicate the importance of studying history of nurses and midwives in Nazi Germany.

There may be a long moral distance between the health professionals of Nazi Europe and the health world now. Nonetheless, we suggest that there is no room for complacency, nor is there any justification for thinking that such actions were only historical. In 2011, an American nursing student posted on Facebook a description of a young trauma patient who had sustained massive neurological damage. In response to this posting, a registered nurse provided advice on how to hasten the patient’s death by too slowly changing life-sustaining intravenous medications. Yet another nurse cheered on, “Do it, do it”. Apart from the obvious privacy rights of the patient, which were so badly abrogated, one could imagine the nurses in the Nazi killing centers cheering each other on in a similar fashion.

One important aim of this book is to prevent the Nazi crimes happening again. As with many studies of the Holocaust and the Nazi era, the keys remain education and exposure to the reality of what occurred. History has slipped from many nursing and midwifery curricula, and the history presented here receives little acknowledgment. Lobbying for the return of history

References:
Task Force (2013). "Guantanamo Bay Detainees: Medical and Ethical Concerns." Institute on Medicine as a Profession.”
as a permanent component of all curricula should be high on the agenda. The history of nurses and midwives in the Nazi era should be part of that. Ethics is taught in most nursing and midwifery courses, but, again, there is little taught about these very dark crimes. Only by exposing and discussing them can we be confident we are doing our best to prevent their recurrence.

Finally, it behooves us all, nurses and midwives alike, to remember the words of the Irish politician, Edmund Burke (1729–1797): All that is necessary for the triumph of evil is that good men do nothing.

REFERENCES


Glossary

Allgemeine Deutsche Hebammenverband General German Midwives’ Association
Bundesärztekammer German Medical Association
Berufsorganisation der Krankenpflegerinnen Deutschlands German Nursing Association
Caritas Schwesternschaft Caritas Sisterhood
cc cubic centimeter
cm centimeter
Deutsche Arbeitsfront German Labor Front
Diakonie Protestant Social Welfare Service
Diakoniegemeinschaft Deaconesses’ Fellowship
Dienstverpflichtung service obligation
Frauenarbeitsdienstlager labor service camp for women
Frauenmilchsammelstelle milk bank
Führermanifest Führer orders
Führerprinzip Führer principle (part of Nazi lore, that all is centered in the leader, or Führer)
Führerschule der Deutschen Ärzteschaft German physicians’ leader school
Gemeinnützige Krankentransport charitable ambulance service (belonged to Aktion T4)
GmbH (Gekrat) abbreviation for Gemeinnützige Krankentransport
Gesetz zur Verhütung erbkranken Nachwuchses Law for the Prevention of Hereditarily Diseased Offspring
Gleichschaltung enforcement of standardization and elimination of all opposition within political, economic, and cultural institutions
Heilerziehungsanstalten pedagogical institutions for disabled, such as blind, deaf, etc.
Kinderfachabteilungen pediatric department
km kilometer
Kanzlei des Führers, KdF Chancellery of the Führer
Kriminalrath criminal lawyer
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>KTI</td>
<td>Forensic Institute</td>
</tr>
<tr>
<td>Länder</td>
<td>a state of Germany</td>
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<tr>
<td>Landesfürsorge Verband Schwaben: State Welfare Union of Swabia (state as opposed to federal)</td>
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<tr>
<td>Landesgericht</td>
<td>State Court (as opposed to federal court)</td>
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<tr>
<td>Luminal</td>
<td>phenobarbital (Lopez-Munoz et al., 2005)</td>
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<tr>
<td>Meldebogen</td>
<td>registration form</td>
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<tr>
<td>Mischlinge</td>
<td>mixed race—people deemed to have both Aryan and non-Aryan parents</td>
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<tr>
<td>mm</td>
<td>millimeter</td>
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<tr>
<td>Mütterkreuz</td>
<td>Mothers’ Cross (an award given to women for producing many children, thereby supporting the growth of the nation)</td>
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<td>Mütterlichkeit</td>
<td>motherliness</td>
</tr>
<tr>
<td>Mütterschulung</td>
<td>mothers’ training course</td>
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<td>Nationalsozialistische Volkswohlfahrt: National Socialist Peoples’ Welfare Organization</td>
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<tr>
<td>NS Frauenschaft</td>
<td>National Socialist Women’s League</td>
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<tr>
<td>Negerversammlungen</td>
<td>Negroes’ [sic] meetings</td>
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<td>NSDAP</td>
<td><em>Nationalsozialistische Deutsche Arbeitpartei</em> (National Socialist German Workers’ Party, Nazi Party)</td>
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<tr>
<td>Obermedizinalrat</td>
<td>high medical rank in public health (honorary title)</td>
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<tr>
<td>Phenobarbital/one</td>
<td>a barbiturate drug (Lopez-Munoz et al., 2005)</td>
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<tr>
<td>Reichsärzteführer</td>
<td>Reich physicians’ leader</td>
</tr>
<tr>
<td>Reichsausschuss (RA) ß</td>
<td>German Reich Committee</td>
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<tr>
<td>Reichsausschuss zur wissenschaftlichen Erfassung von erb- und anlagebedingten schweren Leiden: Reich Committee for the Scientific Registration of Serious Hereditary and Constitutional Diseases</td>
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<tr>
<td>Reichshebammenführerin</td>
<td>female Führer (leader) of the German midwives</td>
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<td>Reichsgemeinschaft freier Caritaschwester: Imperial Association of Free Caritas Sisters</td>
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<tr>
<td>Reichskanzlei</td>
<td>Reich Chancellery</td>
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<tr>
<td>Reichsarbeitsgemeinschaft</td>
<td>Reich Working Party (usually followed by a title to denote the working party)</td>
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Reichsbund der Freien Schwestern und Pflegerinnen: Imperial Association of Free Sisters

Reichsbund Deutscher Schwestern: German Nurses National Socialist Imperial Association

Schwester: Sister (nursing title)

scopolamine: levo-duboisine and hyoscine, a drug used for treating addiction

Siechenhaus: geriatric unit

Somnifen: a barbiturate drug (Lopez-Munoz et al., 2005)

Schutzstaffel (SS): Protection Squadron

Stiftung: foundation

Sturmbann: SS and SA paramilitary battalion

Tausendjährige Reich: the Reich that would last for a thousand years

UNWCC: United Nations War Crimes Commission

US: United States of America

Veronal: a barbiturate drug

Volksgemeinschaft: people’s community

Volksgericht Graz: People’s Court (usually followed by a place name, as in this case—Graz)

Volkskörper: national body

Volkssturm: national militia, part of the German home guard

NOTES

1. Tausendjähriges Reich = the Reich that would last for a thousand years; this metaphor should demonstrate that the Nazi Reich was the continuation of the first German Reich (800–1806), founded by Charlemagne.

REFERENCES

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Dr. Susan Benedict’s interest in the roles of nurses during National Socialism resulted from a family trip to Germany. Her father, who had been a US Army medic during World War II, wanted to visit Dachau. At that time, there was an extensive exhibit about the medical experiments conducted in Dachau. Susan, along with her mother, who also was a nurse, wondered if nurses had been involved. This curiosity resulted in much independent study followed by a fellowship in medical ethics and the Holocaust from the US Holocaust Memorial Museum in Washington, DC. During that fellowship, Susan became acquainted with Dr. Henry Friedlander, who became her mentor for the study of nurses in the Nazi “euthanasia” programs, which was funded by the US National Institutes of Health, National Library of Medicine. Subsequent funding was obtained from the National Institutes of Health, National Institute of Nursing Research, and the Greenwall Foundation for further study of nurses during National Socialism and ethical dilemmas. Susan was mentored by Drs. Arthur Caplan and Karen Buhler-Wilkerson of the University of Pennsylvania during these studies.

She received her PhD from the University of Alabama in Birmingham and is currently a professor of nursing, director of Global Health, and codirector of the campus-wide Program in Interprofessional Ethics at the University of Texas Health Science Center in Houston, Texas, where she resides. She is a Fellow in the American Academy of Nursing (FAAN) and Vice-President of the Center for Medicine after the Holocaust.

Two additional people were both mentors and supportive friends: Traute Lafrenz Page, MD, and Helen “Zippi” Tichauer. Dr. Page was a member of the student resistance group in Munich, the White Rose, during World War II. She has traveled to numerous archives with Susan, explaining the nuances of the times, and serving both as translator and great traveling companion. Zippi is a survivor of Auschwitz, having arrived there in 1942 on the first transport of women from Bratislava. She currently lives in New York City. Zippi, too, has been a wonderful mentor and a teacher of the highest standards.
Contributors

Dr. Ellen Ben-Sefer was born and educated in the US. After completion of her Bachelor of Science in nursing from Boston University, she immigrated to Israel and as a nurse in Kibbutz Degania Bet. In later years, Dr. Ben-Sefer lived in Australia, where she completed a master of nursing in child and family health at University of Western Sydney and doctoral studies at Macquarie University, researching Westerbork transit camp, using health as a framework. Dr. Ben-Sefer’s dissertation was noted as being the first to explore a western camp from the inmate perspective. Dr. Ben-Sefer has had many years’ experience as both a clinical nurse and nursing educator, teaching for many years at University of Technology, Sydney, and Schoenburn Academic College of Nursing in Tel Aviv.

John S. Drummond is a recently retired senior lecturer at the School of Nursing and Midwifery of the University of Dundee, Scotland, UK. His interests lie in the important relationship between analytic and post-structuralist approaches to nursing philosophy, history, education, and research. He is cofounder of the International Philosophy of Nursing Society (IPONS).

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Jochen Kuhla began his education as a nurse in 1974 and specialized in intensive care nursing, and then entered the education sphere, working as a principal in a nursing school in Mosbach, Germany. One of his favorite
subjects was (and still is) the history of nursing. He then had a career change and became a software-consultant and trainer for the most important producer of medical-school-management software in Germany, Austria, and Switzerland. He now has a private practice as a software developer, and retains a strong interest in the history of nursing.

Dr. Mary Lagerwey is a professor at the Western Michigan University Bronson School of Nursing and College of Health and Human Services in Kalamazoo, Michigan. She teaches bioethics, nursing history, and qualitative methodology, and has served as chair of the Western Michigan Human Subjects Institutional Review Board (HSIRB) for several years. Lagerwey received a Bachelor of Arts in sociology from Calvin College, a BS in nursing from Grand Valley State, a Master of Science in nursing from Michigan State University, and a PhD in sociology from Western Michigan University.

Dr. Lagerwey’s publications and areas of research employ a sociologic approach to health care history and ethics, particularly in caring for vulnerable populations. Her book Reading Auschwitz was published as part of AltaMira’s Ethnographic Series. She has conducted extensive research on women and health care under the Third Reich. She is currently studying women and women’s organizations in the eugenics and progressive movements of the early twentieth century.

Dr. Wiebke Lisner’s PhD thesis examined midwifery during National Socialism, and was funded by a stipend from the Heinrich Böll Stiftung, Berlin. Her other research at the Institute of History, Ethics and Philosophy of Medicine at the Medical University in Hanover has included a study of politics in German and British medical journals from the interwar years till the 1960s, which was funded by the Deutsche Forschungsgesellschaft (DFG). In addition, she has coordinated the Midwifery BSc program at the University of Applied Science in Osnabrück, taught at the History Department of the University of Hanover, and taught history at the Midwifery School of Osnabrück. In 2012 she commenced a research project about midwives in the “Biopolitical Laboratory” of the Occupied East, exemplified by the “Reichsgau Wartheland”. This is funded by a stipend of the Deutsche Historische Institut Warschau (German Historical Institute Warsaw) and located at the History Department of the University of Hanover.

Dr. Alison O’Donnell is currently a lecturer in nursing with the School of Nursing and Midwifery, University of Dundee, Dundee, Scotland, UK. Her PhD from the University of Dundee examined the role that some nurses adopted during the euthanasia programs in National Socialist Germany, drawing on the work of the work of the French philosopher Michel Foucault. Dr. O’Donnell was awarded the Monica Baly Bursary from the
Royal College of Nursing History Society and a Carnegie Trust Travel Award, which enabled her to travel to Germany in May 2004 to visit the Hilde Steppe Archive, Frankfurt, the Hadamar Asylum, Hadamar, and the Ravensbrück Concentration Camp and Museum, Furstenberg.

Dr. O’Donnell teaches in a range of preregistration, postregistration, and postgraduate nursing courses. She supervises master’s degree students and recently has begun to be involved in the process of supervising PhD students within the University of Dundee. In September 2011, she was elected to the steering group of the Royal College of Nursing History of Nursing Society.

Anja K. Peters was born in Austria and educated there and in southern Germany. After completion of her training in pediatric nursing, she worked at Dr. v. Haunersches Kinderspital of Ludwig-Maximilians-University in Munich. In 2003 she completed a graduate degree in nursing and health—Dipl.-Pflegewirtin (FH)—at University of Applied Sciences in Neubrandenburg, Mecklenburg-Vorpommern. In her thesis she reconstructed the professional training courses for midwives at the Reich’s physicians’ leaders’ school in Alt Rehse, Mecklenburg-Vorpommern. She is a PhD candidate at the Institute for History of Medicine at Ernst-Moritz-Arndt-University Greifswald, researching the biography of Reich’s midwives’ leader Nanna Conti. Anja Peters has had several years’ experience as a lecturer in geriatric care, history of nursing and midwifery, and for unlicensed assistive personnel. In 2012 she was appointed as a Champion by Center for Medicine after the Holocaust (CMATH) in Houston, Texas. Anja K. Peters lives in Neubrandenburg.

Dr. Dganit Sharon is the head of the Nursing Department at Ruppin Academic Center, Israel. Dr. Sharon has a PhD in philosophy (Bioethics Program), from the Philosophy Department of Bar Ilan University, Israel, a Master of Arts in nursing from the Nursing Department of Tel Aviv University, Israel, and a Bachelor of Arts in nursing and registered nurse degree from the Hebrew University, Jerusalem, Israel.

In recent years, Dr. Sharon functioned as a nursing teacher, chairperson of the ethics committee, and clinical mentor at the maternity and neonatal faculty at Schoenbrun Academic Nursing School, Tel Aviv Sourasky Medical Center, Israel. Dr. Sharon was also a teacher at the Stanley Steyer School of Health Professions, Nursing Department, Tel Aviv University.

Dr. Sharon’s main academic and professional interests and activities include: nursing education, professional ethics, nursing ethics, professionalism, integrative medicine ethics, and maternity nursing. Among her academic and professional activities, Dr. Sharon is a member of the Israeli Nursing Ethics Bureau and the Ethics Committee of Physicians for Human Rights Association in Israel. Dr. Sharon also functioned as
a consultant for the Ethics Committee of the Israeli Organization of Classic Homeopathy and the Ethics Committee of Integrative Medicine.

**Dr. Linda Shields** is a professor of tropical health nursing in Townsville, Queensland, Australia, at James Cook University, and she holds an honorary chair in the School of Medicine at the University of Queensland. Her research interests include the history of nursing, health in tropical regions, the care of children in health services, in particular family-centered care, pediatric perioperative nursing, and ethical issues. Over her academic career, she has maintained a small clinical load in pediatric perioperative nursing, and in 2009 published the first book in that highly specialized area in about twenty years.

Professor Shields holds a higher doctorate—Doctor of Medicine, and PhD and master’s degrees from the University of Queensland, and belongs to the International Nurse Researcher Hall of Fame of Sigma Theta Tau International. She is a life member of the Australian College of Children and Young People’s Nursing, a fellow of the Australian College of Nursing, Australia, and a fellow of the Royal Society of Medicine (UK). She is a Champion at the Center for Medicine after the Holocaust in Houston, Texas, US.

**Dr. Murray Simpson** is a reader in the School of Education, Social Work and Community Education and the University of Dundee in Scotland. His extensive historical work has focused on the conceptual history of intellectual disability since the early nineteenth century. Dr. Simpson’s work over the past twenty years has focused primarily on the social constitution and significance of the category “intellectual disability”. Specific publications and projects have looked at intellectual disability in relation to adulthood, alcohol, offending, marriage and parenting, and day services. Continuing historical investigations have looked at the use of “moral governance” in the treatment of “idiocy” in the nineteenth century, the connections between discourses of idiocy and of colonialism, and these have led to a forthcoming book: *Speaking the Truth of Idiocy: Towards a Discursive Theory of Intellectual Disability*. He is a member of the Disability History Association and the British Sociological Association and is a fellow of the Royal Society of Medicine. Other current research includes evaluation of services caring for young families in difficulty, particularly relating to substance misuse.
This page intentionally left blank
Index

A
abortion, 70, 172, 184, 225
Affordable Care Act, 245
African-Americans, 182
Agamben, Giorgio, 232–6, 237, 238, 240, 241
air injection, 100, 107, 115, 118, 120, 122, 138
Aktion Brandt, 220
Aktion Reinhard, 100–103
alcoholic/ism, 6, 15, 19, 23, 142
Allgemeine Deutsche Hebammenverband (ADHV), 179, 180, 186, 191, 192, 194, 249
Alt Rehse, 183–5, 187–9, 194, 195
Altenkirch, Meta, 56
American Eugenics Society, 25, 50, 51
Anna G, 114, 115, 118
anti-Semitism, 3–5, 16, 17, 20, 23, 180, 182, 185, 186, 189, 190
Archduke Robert of Habsburg, 99
Aryan, 3, 4, 16, 50, 53, 63, 71, 165, 169, 170, 205, 230
asylum/s, 7, 27, 38, 49, 91, 92, 159, 187, 219–23, 228, 231–33, 236, 250
Auering, 155
Aufmann, Gustav Adolf, 87
Auschwitz, 10, 44, 198, 201, 216, 238, 241
Australia/n, 21, 31, 201, 202, 204–9, 212–14, 216, 245
Austria, 7, 79, 84, 95, 99, 102, 104, 140, 162, 163, 144, 179, 181, 183, 186
Banse, Dr, 133
Bare life, 232, 234–38, 242
Becker, Hans-Joachim, 72, 76, 78, 84, 86
Bellin, Emmy, 65, 66
Belzec, 101, 102, 103
Bergen-Belsen, 201
Bergquist, Helene, 185
Bernatot, 62
Bernburg, 94, 96, 102, 103, 107, 161, 187
Berta H, 121, 123, 139
Berta K, 129
Beulich, Max, 101
Binder, Maria, 144, 156, 158
Binding, Karl, 20, 21, 71, 72, 103, 237
biopower, 218, 227, 228, 230, 231, 235, 238, 241
bios, 234, 236, 237
birth defects/anomalies, 15, 174
Blankenburg, Werner, 80, 84, 86, 97
Blaurock, Kurt, 101
blind/ness, 14, 15, 76, 77, 249
Blum, Phillip, 63, 66, 68, 69, 103
Boeckh, Rudolf, 91
Bohne, Gerhard, 86, 97
Borkowski, Margerete, 66, 67
Bormann, Martin, 188
Bouhler, Phillipp, 83, 84, 188
Balser, André, 100
<table>
<thead>
<tr>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brandenburg, 77, 93, 94, 173</td>
</tr>
<tr>
<td>Brandstätter, Eduard, 153, 154, 156, 158, 159, 162</td>
</tr>
<tr>
<td>Brandt, Karl, 76, 83, 84, 94, 104, 188, 189, 196, 220</td>
</tr>
<tr>
<td>breastfeeding, 185</td>
</tr>
<tr>
<td>Bredow, Paul, 101</td>
</tr>
<tr>
<td>Britain, 5, 67, 225, 241</td>
</tr>
<tr>
<td>Brown Sisters, 40, 57</td>
</tr>
<tr>
<td>Büchsenschuss, Elly, 127, 128, 138</td>
</tr>
<tr>
<td>Buck, Dorothea, 236, 239</td>
</tr>
<tr>
<td>Burke, Edmund, 247</td>
</tr>
<tr>
<td>bus/busses, 87, 93, 97, 99, 111, 183</td>
</tr>
<tr>
<td>Bütow, Mina, 119</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>Canada, 225</td>
</tr>
<tr>
<td>carbon monoxide, 7, 93</td>
</tr>
<tr>
<td>caregiver/s, 41, 53–58, 76, 81, 86, 88, 98, 99, 101–103, 105–11, 114,</td>
</tr>
<tr>
<td>caring, 1, 8, 27, 28, 30, 39, 43, 44, 75, 76, 167, 177, 200, 202, 216,</td>
</tr>
<tr>
<td>209–11, 230, 234, 240</td>
</tr>
<tr>
<td>Caritas, 9, 20, 28, 29, 39, 40–42, 45, 249</td>
</tr>
<tr>
<td>Catel, Werner, 76, 77, 190</td>
</tr>
<tr>
<td>Catholic, 8, 9, 20, 27–29, 30, 31, 39–41, 50, 74, 123, 127, 142, 170, 175</td>
</tr>
<tr>
<td>child/ren, 1, 3, 6–8, 10, 13, 21–23, 27, 35, 37, 51, 58, 61, 62, 71–74,</td>
</tr>
<tr>
<td>166, 167–79, 182–84, 188, 190, 191, 199, 202, 204–6, 213, 220, 221, 225, 227, 231, 244,</td>
</tr>
<tr>
<td>245, 250</td>
</tr>
<tr>
<td>choice, 9, 11, 28, 45, 69, 70, 95, 137, 157, 181, 243, 245, 246</td>
</tr>
<tr>
<td>Cholowawa, Maria, 154–55, 241</td>
</tr>
<tr>
<td>Christian, 9, 17, 27, 30, 32–34, 44, 160, 206</td>
</tr>
<tr>
<td>communism, 3</td>
</tr>
<tr>
<td>compliance, 31, 91, 203</td>
</tr>
<tr>
<td>concentration camps, 40, 44, 61, 95, 103, 110, 114, 116, 119, 127,</td>
</tr>
<tr>
<td>153, 162, 183, 184, 192, 199, 205, 221, 234, 236, 238, 241</td>
</tr>
<tr>
<td>“conduct of conduct”, 35, 36</td>
</tr>
<tr>
<td>confessional hospitals, 32</td>
</tr>
<tr>
<td>Conti, Leonardo, 83, 141, 156, 179, 180, 181, 187–89, 194</td>
</tr>
<tr>
<td>culture/al, 4, 15–17, 19, 69, 166, 179, 202, 206, 213, 224, 244, 249</td>
</tr>
<tr>
<td>curriculum/a, 42, 43, 48, 51, 52, 55, 58–60, 68, 69, 179, 200, 206,</td>
</tr>
<tr>
<td>207, 246, 247</td>
</tr>
<tr>
<td>Czechoslovakia, 95</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>Dachau, 95, 152, 162</td>
</tr>
<tr>
<td>Darwin, Charles, 13, 14, 16, 18, 230, 235</td>
</tr>
<tr>
<td>Darwinism, 3, 16, 17, 25, 204</td>
</tr>
<tr>
<td>Davenport, Charles, 21, 51</td>
</tr>
<tr>
<td>Deaconess, 9, 11, 28, 30–33, 40, 41, 45, 57, 249</td>
</tr>
<tr>
<td>deaf/ness, 15, 77, 141, 249</td>
</tr>
<tr>
<td>death camps, 95, 100, 198, 102, 103</td>
</tr>
<tr>
<td>death penalty, 112, 245, 247</td>
</tr>
<tr>
<td>deformed/ity, 1, 14, 77, 95, 245</td>
</tr>
<tr>
<td>Deuschel, Hans, 185</td>
</tr>
<tr>
<td>Deutsch, Naomi, 51</td>
</tr>
<tr>
<td>Deutsche Hygiene Museum, 186</td>
</tr>
<tr>
<td>Diaconia Fellowship, 40, 41</td>
</tr>
<tr>
<td>dictator/ship, 3, 5, 24, 164, 166, 225–28, 231, 235</td>
</tr>
<tr>
<td>disabled/disabilities, 2, 3, 6–8, 18, 20, 27, 37, 48, 61, 69, 72–9,</td>
</tr>
<tr>
<td>87, 90, 94, 95, 172–77, 187, 191, 199, 200, 202, 204, 206, 207, 219,</td>
</tr>
<tr>
<td>226, 249</td>
</tr>
<tr>
<td>Dock, Lavinia, 51</td>
</tr>
<tr>
<td>doctor/s, 1, 6, 8, 13, 16, 20, 23, 25, 33, 38, 42, 53, 59, 67, 72, 74,</td>
</tr>
<tr>
<td>76, 77, 83, 91, 92, 94, 95, 100, 103, 104, 106, 113, 154, 159, 160,</td>
</tr>
<tr>
<td>165, 171–73, 175–77, 184, 190, 194, 196, 210, 227, 228</td>
</tr>
<tr>
<td>Doctors’ Trial, 67</td>
</tr>
<tr>
<td>Dörner, Klaus, 75, 223, 224, 225, 239</td>
</tr>
<tr>
<td>Down’s syndrome, 174, 245</td>
</tr>
<tr>
<td>Dresden, 39, 58, 96, 186, 191, 194</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>Eberl, Irmfred, 103</td>
</tr>
<tr>
<td>Ebrecht, George, 98</td>
</tr>
<tr>
<td>economy, 3–5, 19, 75, 224, 229</td>
</tr>
<tr>
<td>Edith B, 124, 130, 138</td>
</tr>
<tr>
<td>education, 9, 28, 30, 39, 42, 43, 49, 51, 52, 68, 69, 75, 118, 120,</td>
</tr>
<tr>
<td>121, 123, 124, 130, 157, 164, 169</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Index</td>
</tr>
<tr>
<td>Eglfing-Haar</td>
</tr>
<tr>
<td>Eichberg</td>
</tr>
<tr>
<td>Eimann, Kurt</td>
</tr>
<tr>
<td>Eisold, Johannes</td>
</tr>
<tr>
<td>elderly</td>
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<td>Else T</td>
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<tr>
<td>England</td>
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<tr>
<td>epilepsy/tic</td>
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<tr>
<td>Erna D</td>
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<td>Erna E</td>
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<td>Erna H</td>
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<td>Estonia</td>
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<td>ethics/al</td>
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<td>extermination</td>
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<td>F</td>
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<td>Facebook</td>
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<td>Faltlhauser, Valentin</td>
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<td>famine</td>
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<tr>
<td>Fascism/ist</td>
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<td>feebleminded/ness</td>
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<td>Felfe, Hermann</td>
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<tr>
<td>films</td>
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<tr>
<td>Final Solution</td>
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<tr>
<td>Fliedner, Caroline</td>
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<tr>
<td>Fliedner, Fredericke</td>
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<td>Fliedner, Theodor</td>
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<td>Forer, Alfred</td>
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<td>Freunde</td>
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<td>Fricht, Wilhelm</td>
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<td>Führer</td>
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<td>Führer principle</td>
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<tr>
<td>Fürst, T</td>
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<td>G</td>
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<td>Galton, Francis</td>
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<td>Gärtner, Lothar</td>
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<td>gas, gas chambers, gassings</td>
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<tr>
<td>Gebauer, Olga</td>
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<tr>
<td>Gebhardt, Karl</td>
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<tr>
<td>Geiger, Ferdinand</td>
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<td>genetic/s/ally</td>
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<tr>
<td>German Medical Association</td>
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<tr>
<td>German Miwives' Association (Reichshebammeschaft)</td>
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<td>German Nurses National Socialist Imperial Association</td>
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<td>German Nursing Association (BOKD)</td>
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<tr>
<td>Gerta S</td>
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<td>Gertrud F</td>
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<td>Gertrud G</td>
</tr>
<tr>
<td>Gestapo</td>
</tr>
<tr>
<td>Goebbels, Josef</td>
</tr>
</tbody>
</table>
Index

Göring, Hermann, 188
governmentality, 35, 45, 166
Grabert, Rat, 107, 139
Grafeneck, 68, 94, 96, 97, 101, 102, 161
Grossmann, 83, 101
Grunan, 132
Grunau, 114, 116, 133, 134
Guhlke, Hermann, 129
Gumbmann, Kathe, 63, 66, 68
Gypsies, 6, 19, 25, 88, 90, 227, 230
Hackbarth, Kathe, 65, 66
Haeckel, Ernst, 17, 20, 25
Hamburg, 12, 47, 79, 121, 123, 124, 126, 194, 195, 220, 222, 231–33, 239, 241
Hammerschlag, Siegfried, 186
Hart, Mathilde, 150
Hartheim, 95, 101, 102, 161
Haus, Friedrich, 87
Hefelmann, Hans, 76, 84, 173, 190
Heinze, Hans, 77, 83, 190
heredity/ary, 13, 15, 16, 18, 38, 50, 51, 73, 76, 141, 146, 166, 171, 172, 187, 221, 226, 229, 230, 235, 249, 250
Heyde, Werner, 83, 84, 86, 90, 92
Heydrich, Reinhard, 102
Himmel, Heinrich, 94, 111, 188
Hitler, Adolf, 4–6, 10, 14, 15, 18, 19, 23–25, 38, 40, 44, 49, 60, 69, 71, 72, 76, 83, 84, 86, 97, 98, 100, 182, 183, 188, 189, 204, 210, 224, 227, 228, 240, 244
Hoche, Alfred, 20, 21, 71, 72, 103, 237
Hochmeier, Maria, 156, 158
Hohenlychen, 183, 189
Höjer, Axel, 187
Holocaust, 1, 8, 10, 19, 40, 43, 48, 104, 198, 199, 203, 205, 206, 209, 213–17, 219, 224, 229, 238, 239, 242, 246
Horn, Otto, 101, 103
Hribar, Ladislaus, 153, 156, 158, 159, 162
Huber, Irmgard, 58, 60, 62, 64–69, 103
Hudson, Lillian, 51
hunger houses, 7
Huntington’s chorea, 15, 89

I

IBM, 229, 239
idiot/s, 14, 72, 73, 76, 80, 89, 142, 149
Imperial Association for Vocations and Professions in Social and Medical Services, 41
Imperial Association of Free Caritas Sisters, 40, 250
Imperial Association of Free Nurses, 41, 42
Imperial Association of Free Sisters, 40, 41, 251
Inner Mission, 9, 28, 29, 32, 37, 39
insane/ity, 14, 24, 69, 95, 136
International Confederation of Midwives, 165
International Council of Nurses, 204, 216, 245–47, 246
International Midwives’ Congress, 178, 179, 182, 191
intramuscular/ly, 118, 119, 160
Israel/i, 201, 202, 204–9, 211, 213, 214, 216

J

Jaworski, Leon, 65, 69
Jensen, Hermann, 39
Jerusalem, 185, 191, 205
Jeschke, Auguste, 120, 123, 128, 129, 131, 133, 134
Jews, 4–6, 8, 10, 19, 23, 25, 34, 43, 61, 67, 80, 88–90, 101–3, 133, 151, 152, 161, 162, 170, 173, 177, 180, 184–86, 182, 191, 200, 206, 210, 214, 216, 221, 227, 230
Jührs, Robert, 101

K

Kaiserswerth, 31, 33
Kalmenhof, 78–83
Karll, Agnes, 34, 47, 185
Kaufbeuren, 159–62
Kaufmann, Gustav Adolf, 87
Kaufmann, Kurt, 58, 65
Kilb, 56, 58, 59, 60
killing centers, 2, 23, 48, 58, 87, 93, 94, 98, 244, 246
Klagenfurt, 85, 140–63,
Klahn, Johannes, 101
Klein, Alfons, 62, 63, 65–67, 69, 97, 103
Klein, Eckhard, 118, 139
Klinner, Helene, 120
Kneissler, Paula, 68
Korsch, Edith, 68
Koschitzki, Hildegard, 127, 139
Koslowski, 118
Kretschmar, Gerhard Herbert, 76
Krimmel, Hedwig, 56
Kronberger, Mathilde, 122
Kugler, Karl, 85, 156
Kühne, Käthe, 129, 130, 139
Kupfer, Dr, 64
L
Landes-Heiltenstatt Institute, 61
Landsberg, 67, 187
Langenhorn, 222, 228, 232, 233, 241
Law for the Prevention of Offspring with Hereditary Diseases, 15, 38, 171, 249
Law for the Reorganization of Nursing, 42, 43, 45, 49
Lebensborn, 199, 216
Lemgo, 168, 170, 173, 174, 190, 191, 194, 195
Liebeneiner, Wolfgang, 74
Liesel S, 82
“life unworthy of life”, 1, 7, 71, 74, 103, 177, 226, 237
Linden, Herbert, 83, 84, 87, 90, 92, 190
Linsh, Marvin, 159
Lippe, 168–70, 173–75, 190, 193, 194, 197
Lohnauer, 95
Loose, Margarete, 129
Lorent, Friedrich, 84, 90, 104
Lübeck-Strecknitz, 232
Luise E, 113–17, 130, 131, 137, 138
luminal, 62, 78, 80, 106, 118, 119, 122, 123, 134–36, 160, 221
Lungershausen, Margarete, 185, 187
Lutschounig, Ludmilla, 150, 156, 158
M
Margarete Maria M, 124, 125, 139
Margarete R, 115
Margarete Katakczak T, 119, 120, 139
Margarethe S, 80, 81
Martha Elisabeth G, 123, 216
Martha W, 114, 116, 117
Marx/ism, 3, 224, 225
maternal-fetal screening, 245
Matthes, Arthur, 101, 103
medicine, 8, 20–23, 25–27, 32, 35, 38, 45, 48, 50–52, 60, 63, 68–70, 103–5, 114, 121, 122, 126, 131, 134, 135, 142, 145, 154, 194–96, 209, 216, 220, 223, 228, 238, 239, 241
Mein Kampf, 4, 10, 14, 25
Meldebogen, 87–90, 140, 250
Melichen, Gottfriede, 147, 149, 151–53, 156, 158, 162
Memmecke, 56
mental deficiency/retardation, 15, 24, 26, 69, 172, 146
mercy killing/death, 7, 8, 70, 76, 84, 99, 131, 142, 188, 237, 246
Merkenschlager, K, 137, 138, 139
Merkle, Adolf, 63, 66, 69, 103
Meseritz, 2, 10, 11, 44, 46, 105–40, 221, 238
Messner, Josephine, 157
Meta Martha Margarete P, 120, 121
Meurer, Maria, 175, 176, 191
Michel, Hermann, 101
midwifery/midwife, 1, 2, 8, 50, 77, 83, 142, 164–197, 198–204, 213, 216, 243–46, 247
milk bank, 183, 185, 249
Möller, Max, 101
Mongolism/oid, 77, 174
Morel, Benedict Augustin, 18
motherhouse, 8, 9, 11, 27–36, 45, 116
motivation, 65, 67, 203, 219, 237
Müller, Maria, 80–82
Munich, 75, 108, 159, 189
Muselman, 234, 236
Mütterlichkeit (“motherliness”), 164, 165, 167, 168, 177, 190, 250

Index

N
National Health Service (NHS), 245, 247
National League for Nursing, 51, 68, 69
National Socialists Sisterhood, 39, 40, 41
native Americans, 182
Nazi Party, NSDAP, 4–6, 22, 26, 40, 53, 56, 58, 60, 62, 65, 72, 73, 83, 84, 87, 97, 110, 114, 119, 128, 142, 149, 180, 186, 188, 191, 230, 250
Nazism, 2–4, 11, 25, 26, 38, 78, 104, 227, 230–32, 244
Nebe, Arthur, 92, 93
New Zealand, 181
Niedermoser, Franz, 86, 104, 140–47, 151–59, 162
Nitsche, Paul, 83, 86, 90, 92, 221
Nitze, Georg, 56
Novak, Anton, 101
Nuremberg, 26, 189; trial/s, 67, 188
Nursing Association for Reichssektion Public Health, 41

O
obedience, 3, 31, 33, 34, 36, 40, 42, 50, 63, 118, 125, 126, 128, 201, 203, 244
Oberheuser, Herta, 183
Obrawalde, 2, 10, 11, 105–40, 44, 46, 238, 242
obstetrics/ian, 105, 142, 164, 165, 167, 169, 170, 176, 179, 181, 190
Oels, Arnold, 87
Osnabrück, 44, 45, 107
Osterman, Anna, 144
Ottman, 160
Ottow, Benno, 165, 171, 172, 175, 178, 180, 183, 185–87, 191, 192, 194, 195

P
Pachner, Antonia, 142–53, 155, 158, 159, 162
Paltauf, Richard, 141, 145, 163
Pappenheimer, Ruth, 80
Pastoral power, 29, 32, 35, 36, 37, 45
Pauli, Carl Eugen, 178
perpetrator/s, 9, 28, 44, 67, 138, 165, 192, 198–201, 205, 206, 215, 238
Pfannmuller, 16
phenobarbitone/al, 78, 106, 250
Ploetz, Alfred, 13, 14, 16
pneumonia, 78, 80, 145, 146, 245
Poland, 5, 75, 84, 98, 105, 182, 221, 139
Pöllinger, Josephine, 183
prenatal screening, 205, 245
Pressl, Gisela, 143, 144, 151
Printschler, Ilse, 150, 152, 156, 158
Professional Midwives’ Association, 171
propaganda, 1, 2, 5, 6, 8, 11, 18, 23, 49, 50, 52, 84, 104, 196, 204, 227, 243, 244
Protestant, 8, 9, 20, 27, 28, 30, 33, 37, 39, 40, 41, 42, 50, 57, 74, 94, 110, 116, 170, 180, 249
Prussia/n, 54, 56, 98, 105, 125, 168, 180, 186, 191
prussic acid, 93
psychiatric nursing, 1, 2, 43, 45, 48, 49, 51, 52, 70, 114, 117, 118, 244
psychiatrist/s, 18, 20, 22, 24, 49, 50, 58, 108, 190, 218, 219, 221, 228, 231, 232, 236, 237
public health, 22, 38, 51, 52, 70, 83, 103, 125, 159, 164, 165, 168, 171–74, 176, 186, 190, 199, 250
public health nurses/ing, 30, 37, 51
Puppel, Ernst, 167, 195
Pye, Edith, 184
questionnaire/s, 31, 57, 58, 69, 86–88, 90, 91–93, 110, 140, 207

R
race, 3, 4, 7, 13, 16, 20, 22, 23, 25, 26, 38, 42, 50, 61, 70, 71, 88, 90,
112, 162, 180, 182, 190, 204, 216, 225, 226, 230, 250
racial biology, 29, 37
racial/race hygiene, 13, 14, 16–18, 20, 21, 23, 25, 37, 45, 103, 104, 180, 184, 188, 199, 225, 238, 244
racism, 1, 7, 23, 25, 26, 187, 200, 214, 227, 230, 241
Ratajczak, Amanda, 116, 118–20, 122, 124, 128–32, 139
Rauschenbach, Emma, 179, 180, 183, 191, 196
Ravensbrück, 40, 44, 183, 192, 201, 238
Red Cross, 9, 28, 29, 41, 43, 57
Reich Midwifery Law (Reichshebam-mgesetz), 164, 169, 170, 171, 181
Reichert, 161
Reinsch, Elsa, 12
Renno, Georg, 95, 98
resist/ors/ance, 7, 10, 20, 41, 104, 125, 145, 157, 162, 163, 176, 184, 203, 243, 246
Retzius, Gustaf, 187
Rittler, Olga, 160
Roma, 173
Roosevelt, Eleanor, 181
Rott, Fritz, 180, 181, 191
Ruoff, Heinrich, 60, 62, 64–67, 69, 103
Russia/n, 14, 58, 62, 63, 59, 95, 99, 100, 105, 107–10, 113, 117, 124, 127, 128, 130, 133, 227
S
Salvasan, Sylvia, 184
Santner, Egydus, 143, 144, 147
Scandinavia/n, 16, 21, 225
Schellender, Ottelie, 143–52, 155, 157–59, 162, 163
Schill, Meta, 56
schizophrenia/ic, 7, 15, 89, 116, 131, 132, 150
Schluch, Karl, 101
Schneider, Carl, 78, 115
Schneider, Willi, 86
Scholtz-Klink, Gertrud, 183
Schrankel, Agnes, 67
Schwarz, Gottfried, 102, 108
scopolamine, 78, 81, 93, 107, 114, 119, 122, 123, 132, 135, 136, 160, 251
Seidel, Kurt, 102
sexually transmitted diseases, venereal disease, 15, 20, 54, 59, 181
sick persons, 7, 10, 37, 217–42
Sinti, 173
slippery slope, 203, 205
Sobibor, 101–103
social hygiene, 16
Somnifen, 144, 145, 148, 152, 154, 251
Sonnenstein, 96, 101–3, 161, 239
Soviet, Soviet Union, 7, 67, 187, 128, 129, 205, 222, 225
Stadie, Otto, 102
Standers, Erna, 129, 139
Stangl, Franz, 95
Steinhof, 221
Steppe, Hilde, 1, 8, 11, 27, 28, 34, 38–40, 42, 46, 47, 50, 61, 63, 70, 97, 104, 201, 207, 217, 218, 236, 242
stereotype/ing, 16, 200, 212, 214
Steubel, Karl, 102
Stoeckel, Walter, 183, 186
Stosik, Anna, 98
Struve, Kurt, 232
Sturm Staffel (SS), 40
Sušnik, Maria, 148
Sweden, 187
Switzerland, 25, 178, 225
T
T4, 2, 7, 11, 45, 46, 48, 50, 60, 61, 66, 86, 87, 90, 92–97, 100–102, 173, 193, 199, 200, 203, 204, 219–23, 238, 239, 241, 242, 249
termination of pregnancy, 204, 205, 245
Third Reich, 1, 10, 11, 23–25, 45, 46, 48, 50, 60, 61, 68, 69, 103, 104, 162, 164, 166, 183, 188, 196, 199, 201, 205, 225, 226, 239, 242–44
Thomas, Judith, 62
Index

Thomas, Lydia, 67
Toll, Sara, 185, 196
Tomasch, Paula, 143, 144, 147, 151, 156, 158, 159
transport/s/ed/ing, 79, 86, 87, 93, 97, 98, 100, 106, 110–12, 114, 120, 121, 124, 125, 129, 131, 133, 140–43, 145, 147, 148, 151, 155, 161, 219, 232, 249
Treaty of Versailles, 4–6, 19, 20
Treblinka, 95, 101–3
Treite, Percival, 183
Treptow, 114, 117, 118, 120, 121, 124, 130
trial/s, 2, 26, 52, 58, 60–68, 84, 86, 87, 90–96, 98, 101, 102, 113, 114, 116–21, 127–31, 137, 138, 155, 199, 203, 243, 244
U
Uchtspring, 81, 221
United Kingdom, 14, 21, 245, 246
United Nations War Crimes Commission, 67, 251
Untermenschen, 6, 20
Unverhau, Heinrich, 102
“useless feeders/eaters”, 1, 7, 21
US (United States), 8, 9, 13, 14, 18, 21, 27, 28, 49–52, 58, 60, 62, 64, 67, 77, 95, 159, 181, 182, 186, 204, 225, 245
US Holocaust Memorial Museum, Xv, 1, 48, 60, 62, 70
V
Verberg, Reinhold, 87
Vienna, 221
Vieregge, Bertha, 168–70, 174, 177
Vill, Franziska, 160, 161
volk, 4, 18, 16, 17, 38, 50, 75, 184
Vollheim, Hedwig Neumann, 108, 109, 129, 139
Voluntary euthanasia, 246
von Baer, Karl Ernst, 187
von Galen, Clemens August Graf, 7
von Hegener, Richard, 78–80, 173, 190
W
Wagner, Gerhard, 72, 73, 183
Wahlmann, Adolph, 62, 64, 66, 69, 103
Wald, Lillian, 51
Waniczek, 119
Weidemann, 108, 126–29
Weiland, Christina, 66
Weilmünster, 232
Weimar, 2, 4, 17, 23, 49, 68, 85, 96, 164, 179, 180, 182, 225
Weimer, Isabella, 68
Weimer, Katharina, 56
Wentzler, Ernst, 77, 190
Wesse, Hermann, 79–83, 104
Wesse, Hildegard Irrmen, 81
Widmann, Albert, 92–94
Wieczorek, Helene, 110, 127, 129, 130
Wierig, 56, 60
Wiesbaden, 58, 62
Wild euthanasia, 60, 61, 105, 140, 173
Willig, Karl, 60, 62, 64–67, 69, 103
Wolf, Julie, 143, 144, 146, 151
Wolter, Dorothee, 175, 190
World War I, 2–6, 16–20, 147, 164, 166, 179, 182, 191, 222, 223
World War II, 5–8, 27, 28, 41, 43, 51, 72, 75, 172, 178, 182, 186, 203, 205, 223, 226, 228, 237
Wörle, Sister, 160
wounded soldiers, 75, 99, 100, 103, 104, 123, 183
Wrona, Anna, 81, 82
Y
Yugoslavia, 95, 186
Z
Zachow, Minna, 65, 66, 68
Zaspel, Fritz, 102
Zeitschrift der Reichsfachschaft
Deutscher Hebammen, Die
Deutsche Hebamme, 186, 192–96
Zielke, Christel, 68
Zimbars, Kurt, 181, 197
Zirke, Ernst, 102
zoë, 234, 236, 237