

**The boundaries of knowing:
Female nurses and ‘medicalised killing’ at the
*Landesheil- und Pflegeanstalt Eichberg****

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Abstract: *The architects of the Nazi euthanasia program were acutely aware of the moral dilemma that killing posed for institutional staff and implemented measures to reduce the strain on staff. The organisation of the killing program was a critical factor in the cooperation of nurses in the murder of institutional patients. This article examines how spatial boundaries within killing institutions and the secrecy surrounding the euthanasia program impacted on the behaviour of female nurses. These issues are examined through a study of female nurses who were involved in the killing of patients at the Landesheil- und Pflegeanstalt Eichberg, an institution that served as a ‘medicalised killing’ institution between 1941 and 1945. This article briefly outlines the history of the Nazi euthanasia program, the organisation of the killing operation at Eichberg and the role played by female nurses at medicalised killing institutions. The ways in which the organisation of the killing operation impacted upon the conduct of nurses and the strategies employed by nurses to reconcile their participation in medicalised killing are then examined in greater detail. The spatial boundaries within killing institutions and the secrecy surrounding the killings were important elements of the mechanics of the medicalised killing institutions. These spatial boundaries were reinforced by the hierarchical structure of killing institutions and the compartmentalisation of professional roles, which allowed nurses to shift responsibility for the killings.*

In October 1939 the National Socialists embarked upon the T-4 adult euthanasia program, a racial hygiene program that decimated the population of Germany’s institutions.¹ The misnomer ‘euthanasia’ was applied to this racial hygiene program in order to camouflage the killing operation. Rather than referring to the act of painlessly putting a person suffering from a terminal illness to death or a ‘mercy death’, in the context of the Nazi racial hygiene program the euphemistic term euthanasia meant the murder of those who were deemed ‘life unworthy of life’. Underlying the policy was the notion of negative human worth, i.e. the burden placed upon relatives or the community by the incurably ill and mentally defective – ‘ballast existences’ – and the threat they posed to the nation’s gene pool.² The National Socialists

opposed 'theories based on the equality of all men and on the fundamentally unlimited freedom of the individual vis-à-vis the State'.³ Nazi ideology presented a fundamental challenge to the rights of the individual. It is within the context of this social and political climate that the murder of those deemed to be a burden upon society became possible. The distinction between voluntary euthanasia and killing was erased and the rights of the individual were subordinate to the interests of the national community (*Volksgemeinschaft*).

A broad tension has developed in the historicisation of National Socialism and the Holocaust. Two major explanatory paradigms, generally referred to as functionalist and intentionalist interpretations, have emerged. The crux of this debate, as it relates to the issue of perpetrator behaviour, is the relationship between structure and human agency and how much weight is accorded to each. Key proponents of the functionalist approach, Raul Hilberg, Zygmunt Bauman and Christopher R. Browning, have emphasised how structural factors impacted on the behaviour of perpetrators.⁴ In more recent years the historiography of Nazism has taken what Neil Gregor has termed a 'voluntarist turn'.⁵ That is to say that there is an increasing body of historical scholarship that emphasises the wide number of organisations and a broad social spectrum of men and women who were actively involved in the crimes of the Nazi regime. A key proponent of the intentionalist approach, Daniel J. Goldhagen characterises the German population as 'an assenting genocidal community'.⁶ This trend has seen greater stress placed on the Nazi regime's criminal policies, which it is argued were well-known at the time and widely accepted by the German population.

Accounts of nurses' involvement in the euthanasia program draw upon functionalist interpretations and suggest that the organisation of the killing process was a key factor in perpetrator behaviour. Female nurses played a key role in the implementation of the Nazis' racial hygiene policies and were active participants in the murder of institutional patients under the auspices of the Nazi euthanasia program. The architects of the euthanasia program were conscious of the moral dilemma the killings posed for institutional staff and

implemented measures to reduce the psychological burden on them. Nursing historian Hilde Steppe emphasises, 'The perfection of the bureaucratic execution of the entire extermination program, based on the division of labour, offered each individual the possibility, by virtue of the drastically reduced latitude for acting and decision making, not to perceive the general picture'.⁷ This refusal to perceive the general picture helped nurses reconcile their role in the killing operation with their consciences. Steppe argues that nurses, for the most part, tolerated their own participation in systematic mass murder as part of their professional duties despite their moral objections.⁸ Following on from this point, historian Bronwyn McFarland-Icke argues that nurses' training and professional ethics militated against self-assertion and left them without discursive or organisational precedents for challenging those in positions of power.⁹ The organisation of the killing program was a critical factor in securing nurses' cooperation. The participation of nurses in 'medicalised killing' at the *Landesheil- und Pflegeanstalt Eichberg* (State Mental Hospital and Nursing Home; hereafter *LHPA*) provides an illustration of the ways in which the organisation of the killing operation impacted upon the conduct of female nurses.

This article focuses on the physical and psychological boundaries in killing institutions and looks to research from social psychology, sociology and philosophy to extend understandings of the conduct of nurses. Avoidance and self-denial (psychological denial) were key methods used by the nurses who worked at killing institutions in order to reconcile their role in the killing enterprise with their conscience. These psychological strategies were actively encouraged by the methods employed to murder patients, spatial segregation within killing institutions and the secrecy that surrounded the killing operation. Nurses transformed physical boundaries within killing institutions into psychological boundaries, denying knowledge of the killings and distancing themselves both physically and mentally from the killing operation. These boundaries were reinforced by the professional divide between the role of nurses and the role of physicians as decision makers, and the processes of authorisation within killing institutions.

The T-4 adult euthanasia program can be divided into two organisational phases. During the first phase of the adult euthanasia program patients were killed through mass gassing at six killing centres between October 1939 and August 1941.¹⁰ During this phase decisions about whether a patient should be killed were made centrally by medical 'experts' (*Gutachter*) on the basis of information provided by the patient's institution. Hitler halted the T-4 adult euthanasia program on 24 August 1941, by which time an estimated 70,000 patients were killed.¹¹ This halt was, however, merely a tactical retreat on the part of the organisers of the euthanasia program in the face of increasingly vociferous public protest over the killings. After a brief interruption in late 1941 the euthanasia program continued unabated on a greater scale until the end of the war and claimed the lives of an estimated 260,000 institutional patients.¹² With the aim of camouflaging the killing operation, Nazi officials switched from gassing patients to medicalised killing. Patients were transferred to institutions for medicalised killing where they were murdered through overdoses of sedatives or starvation over a long period of time. This second phase of the euthanasia program is referred to as 'wild euthanasia' because 'doctors – encouraged, if not directed, by the regime – could now act on their own initiative concerning who would live or die'.¹³ From 1942 onwards, euthanasia was integrated into the daily routine at killing institutions.

A report written by a planning commission in late 1941 noted, 'With few exceptions, death by euthanasia will hardly be distinguishable from natural death. That is the goal that is to be striven for'.¹⁴ This method of killing was designed to eliminate the visible aspects of the euthanasia program. Thus, medicalised killings were carried out within the walls of ostensibly 'normally' functioning institutions. Systematic mass murder masqueraded as medical care at such institutions. Historian Raul Hilberg has therefore argued, "Medicalized" destruction was in essence a destruction of medicine'.¹⁵ I will demonstrate that by blurring the boundaries between medical care and murder, medicalised killing also helped institution staff reconcile their involvement in the killings with the censoring gaze of their own conscience. Medicalised killing was used in conjunction with starvation diets, overcrowding, inadequate heating and clothing, and routine neglect, which all

contributed to a rise in infectious diseases and claimed the lives of many patients. The killing operation was also extended to a wider network of institutions in the second phase of the euthanasia program.

Female nurses at killing centres provided important logistical support to the killing operation during the first phase of the euthanasia program and their activities were inextricably linked with the killing operation as a whole. However, female nurses undertook tasks that were peripheral to the gassing of patients and there were no obvious causal links between these tasks and the deaths of patients. Moreover, spatial boundaries between the rooms where patients were killed and the areas of the institution where female nurses worked were established at killing centres. This spatial segregation allowed nurses to employ a strategy of avoidance and self-denial with respect to the role they played in the killing enterprise. I will show that similar measures were later implemented at medicalised killing institutions and that spatial boundaries were a key factor in the conduct of nursing staff at these institutions. The advent of the second phase of the euthanasia program marked a turning point for female nurses, as some female nurses made the transition from caregiver to single-handed killer. The duties nurses undertook at medicalised killing institutions included: taking patients to the room where they were killed; the preparation of the necessary medications; deceiving suspicious patients about the purpose of medications and injections; administering, often coercively, lethal doses of medications; and observing patients until the onset of death. In the event that patients had not died within a few hours, nurses also administered lethal injections of morphine–scopolamine or injected air into the patient’s vein in order to induce death. The key difference between the two phases in the euthanasia program was that some female nurses were drawn into active participation in the killings during the second phase.

The *LHPA* Eichberg was located west of Wiesbaden in the Hesse–Nassau region. Like other institutions in the region, Eichberg was at the forefront of the Nazi racial hygiene program. In the period 1935–39 a total of 301 people were sterilised at the institution.¹⁶ The institution also fulfilled a number of

roles within the euthanasia program. Eichberg served as a transit institution for the Hadamar killing centre during the first phase of the T-4 adult euthanasia program. Between April and August 1941, 2,019 patients passed through Eichberg on their way to Hadamar where they were killed through mass gassing.¹⁷ Institution staff made the transition from simply providing logistical support to carrying out killings after the establishment of a children's ward (*Kinderfachabteilung*) at Eichberg in early 1941.¹⁸ Between early 1941 and the end of the war, 430 children were killed at Eichberg under the auspices of the children's euthanasia program.¹⁹ Nurses also carried out the medicalised killing of adult patients at Eichberg after the commencement of the second phase of the adult euthanasia program. A total of 2,722 adult patients died at Eichberg during this period of 'wild euthanasia' between 1941 and 1945.²⁰ Foreign forced workers also figured amongst the victims killed at the institution during the latter stages of the euthanasia program.

The organisation of the killing operation at Eichberg was a key factor in the conduct of nursing staff. The organisers in charge of the euthanasia program at Eichberg sought to keep the circle of initiated staff to a minimum. Killings were carried out on a smaller scale at Eichberg, when compared with other medicalised killing institutions such as Hadamar and Meseritz–Obrawalde, and it was therefore possible for institutional director Dr Friedrich Mennecke and deputy director Dr Walter Eugen Schmidt to kill patients with the aid of a small core group of medical and nursing staff.²¹ The organisation of the children's euthanasia program at Eichberg illustrates how Mennecke and Schmidt worked with a small team of trusted staff members.²² Nurse Käthe K. was appointed as head nurse in the children's ward, although head nurse Helene Schürg was also responsible for nursing in the ward. Käthe K. recalled, 'I was called to the Director's office and was advised that a children's ward would be opened and I had to take over the ward because I was the only nurse who had trained in paediatric nursing.'²³ According to Käthe K.:

The other nursing staff and I were advised through a presentation by the head doctor Dr Mennecke that the sick children had to be separated from the healthy children. The parents of these children

should occupy themselves with the healthy children and the sick children would stay here.²⁴

Mennecke presented the establishment of the children's ward in a positive light claiming that the institutionalisation of physically and mentally disabled children would relieve the burden on the children's families. This explanation also omitted any discussion of the negative aspects of the racial hygiene measures. Käthe K. emphasised that '[Mennecke] said that the children would be "cared for"', implying that she was initially unaware of the plan to kill the children.²⁵ Even nurses like Käthe K. who worked closely with Mennecke and Schmidt were initially only given limited information about the planned measures. While it is unclear which staff members were informed of the plans to kill children suffering from physical and mental afflictions, it is likely that only senior medical and nursing staff were advised that the children would be killed and the true purpose of the children's ward was concealed from most staff members at the institution. The remaining staff members were provided with minimal information about the children's ward. The records of the Frankfurt *Staatsanwaltschaft* (state prosecutor's office) and the Eichberg trial show that at least twenty other male and female nurses worked at Eichberg between 1941 and 1945. The involvement of only a small circle of trusted staff in the killings and the secrecy that surrounded the killing operation was a key organisational feature of the killing operation.

The boundaries of knowing and the nurses' lack of first-hand knowledge of the killings were key factors in the conduct of many nurses at killing institutions. The fact that only a core group of staff members were informed of the intention to kill mentally and physically disabled children enabled other staff members to avoid knowledge of the killings. According to one staff member, 'With few exceptions none of us knew what was done by Dr Schmidt and the other accused [Helene Schürg, Margarete F. and Käthe K.] and, certainly to a lesser degree, Dr Mennecke.'²⁶ A number of nurses worked with Käthe K. in the children's ward for varying periods of time. Dr Elizabeth V. recalled, 'The nurses who worked [in the children's ward] under Käthe K. were, as far as possible, kept out of the occurrences in the ward.'²⁷ At Eichberg the killings

were carried out by Schmidt and his small circle of close assistants out of sight of other staff, while many other nurses remained in the position of relative outsiders.²⁸ Of course, after the war many Eichberg staff members denied knowledge of the killings in order to exonerate themselves from wrongdoing and the majority of those who worked at the institution escaped prosecution. There is, however, a certain degree of truth in such statements and this claim points to the psychological strategies employed by nurses at the time. The denial of knowledge provided a psychological escape route for nurses who were not directly involved in the killings. By limiting the number of nurses who were directly involved and concealing the killings from other institution staff, Schmidt was able to secure the continued participation of those staff members who did not participate directly in the killings. Nurses who were not directly involved in killing patients provided logistical support by transferring patients to the rooms where other staff members killed the patients. These nurses found it easier to reconcile their involvement in the euthanasia program because they did not witness the killing of patients and were not directly involved. Nevertheless, the tasks these nurses undertook were inextricably linked with the killing enterprise. Spatial segregation in killing institutions and the secrecy surrounding the killings encouraged those who were not directly involved to simply turn a blind-eye to the killings.

Similar to the first phase of the euthanasia program, spatial boundaries within killing institutions were a key aspect of how the killings were organised at medicalised killing institutions during the second phase of the euthanasia program. According to Helene Schürg, 'The injections were usually given in the bathroom or in a separate room in the ward so that others could not see the incident.'²⁹ The staff members who carried out the killings made efforts to prevent their colleagues witnessing the killings. This practice encouraged nurses who were not directly involved in the killing of patients to simply avoid the killings. Nurse Franziska P., for example, distanced herself from the killings:

I did not, however, concern myself with these matters because everyday after the end of work I went to Kiedrich where I live and

hence I had little contact with the other staff outside work... Apart from this, in my ward, the women's observation ward, patients were never killed.³⁰

Franziska P. took solace in the fact that the killings were not carried out in the ward where she worked and employed a strategy of avoidance during her working day. The fact that Franziska P. did not live at Eichberg meant that she could escape the institution after completing her daily duties and put the thoughts of the killings out of her mind. Franziska P. also avoided contact with other staff members and the inevitable conversations about the deaths at the institution, which might have confronted her with evidence of the killings and compelled her to reflect critically upon what was going on at the institution. However, despite efforts to distance other staff from the killings, nurses who worked alongside those who carried them out could not avoid knowledge of the killings. For example, nurse Anne K. recalled hearing a child crying in the room at the rear of the children's ward. Anne K. wanted to attend to the child but 'was prevented [from entering the room] by nurse Käthe K. in a very harsh manner with the threat that she would report her to Dr Schmidt.'³¹ While Anne K. did not witness the killing of the patient, Käthe K.'s suspicious behaviour led her to conclude: 'Things were not all above board.'³² The accounts of nurses at Eichberg have shown that staff were aware that patients were being killed and those who were not directly involved in the killings simply avoided the areas of the institution where the killings were carried out and tried not to think about what was going on at the institution.

The repression of knowledge played an important role in the conduct of many nurses at Eichberg. Despite the evidence that lay before them, many nurses were gripped by denial. Nurse Katharina S. first became aware of the rumours about killings at Eichberg while working at a nearby institution, though she denied knowing about the killings after she began working at Eichberg. Katharina S. recalled a case where a patient died suddenly:

I did not perceive anything with respect to the killing of patients. I recall the case of Frau S. who was transferred [to another ward] in the

evening around 7 o'clock and half an hour later she was dead... the woman did not give the impression that she would die so soon... In any case, I did not believe in both these cases that [the patient] died of natural causes.³³

Although acknowledging the suspicious circumstances surrounding the deaths and admitting that she did not believe that the patients died of natural causes, Katharina S. nevertheless maintained that she did not notice anything with regards to the killings. Some staff members denied that they were aware of the killings, but these accounts show that there were ample signs for staff members to develop their own suspicions, even when they were not confronted with unequivocal evidence of the killings. Another staff member recalled, 'This talk that comparatively a lot of patients died suddenly, although they still seemed capable of living, generally circulated amongst the staff.'³⁴

Rumours about the killings abounded amongst Eichberg's staff and patients and the killings were evidently an open secret. For nurses who were not directly involved awareness of the killings remained ambiguous and this lack of clear-cut evidence could justify their failure to act. These nurses made a critical distinction between suspicion and knowing. McFarland-Icke emphasises that 'nurses' strategies for avoiding knowing, deferring, and suppressing their own moral reflection were not spun out of thin air but rather were allowed, and at times encouraged by the institutional environment in which they found themselves.'³⁵ While nurses were confronted with evidence of the killings, the lack of conclusive proof meant that they could remain in a state of perpetual ignorance. The nurses' 'uncertainty' meant that they could try to explain away the deaths at the institution rather than face the harsh reality that patients were being killed. The boundary between suspicion and knowing ensured that nurses who were not directly involved in the killings could continue with their work without questioning the role they played in the killing operation.

For nurses who were directly involved in killing patients, it was clearly more difficult to deny the relationship between their duties and the deaths of

patients. The psychologist Stanley Milgram has emphasised the inverse ratio of readiness to cruelty and proximity to victims.³⁶ Yet nurses who carried out medicalised killings did not enjoy the comfort of a buffer between themselves and their victims. The absence of a barrier between nurses and their victims raises important questions about how these nurses coped with their involvement in the killings. The following description of the method used to kill children at Eichberg applies equally to adult patients:

To my knowledge it was less common for Dr Schmitt (sic) to kill the children through a lethal injection than it was for the nurse Käthe K. to kill the children by administering strong doses of Luminal. It was said amongst the nurses that Käthe K. dissolved the Luminal in sweetened water and gave the solution to the children to drink.³⁷

This account of how the killings were carried out at Eichberg shows that certain nurses worked closely with Dr Schmidt in the implementation of the killing operation. Staff mixed sedatives with the patients' food every morning and night and after a few days the patients would lose consciousness and would develop pneumonia, bronchitis or other fatal breathing irregularities.³⁸ One nurse recalled that once sedatives were administered the patient was 'unconscious for three or four days and then slowly passed away.'³⁹ This method of killing made it easier to conceal the truth from work colleagues. For those who were directly involved in the killings, this method also made it easier to reconcile the killing with one's own conscience. Some nurses referred to medicalised killings as '*einschläfern*' or 'putting a patient to sleep.'⁴⁰ This euphemistic term connotes a peaceful and painless death, and, more importantly, masks the nurses' murderous deeds. In contrast to murdering a patient by shooting them, as was the case with the killings committed by members of the mobile killing squads (*Einsatzgruppen*), the causal link between the administering of lethal doses of medications and the patient's death was blurred because a number of hours usually lapsed before patients died. Medicalised killing therefore had much less immediacy than other methods of killing.

Nurse Käthe K. stressed that the children at Eichberg were seriously ill. When asked whether children's lives were ended prematurely, nurse Käthe K. replied, 'I certainly had the impression that the children's suffering was relieved, but [their lives were] not ended prematurely.'⁴¹ However, the testimony of one Eichberg doctor contradicts this claim; 'The children could have lived longer. Whether they could live for much longer? Down's Syndrome patients can live to twenty years of age.'⁴² Even nurses who were directly involved in the killings tried to convince themselves that the patients were gravely ill and that their own actions were not the cause of the patients' death. The killings seemed less objectionable because they came in the guise of medical interventions, such as the administration of medication. Medicalised killing blurred the boundaries between killing and therapeutic or palliative interventions, and therefore allowed those who were involved in the killings to employ a strategy of self-denial and to hide behind the façade of care giving.

Female nurses Helene Schürg, Käthe K. and Margarete F. were implicated in the investigation into the euthanasia killings at Eichberg and were amongst the former staff members who were indicted by prosecutors in 1946.⁴³ Margarete F. objected to her arrest: 'I hereby declare that I am not guilty. I only fulfilled my duties as a nurse at the *Landesheil- und Pflegeanstalt* from 21.8.1922 until my dismissal on 27.7.1945 and acted upon the orders of the doctors in charge.'⁴⁴ Like so many nurses who participated in the euthanasia program, Margarete F. argued that she was just following orders. Käthe K. similarly asserted, 'I never administered any tablets without an order from the doctor.'⁴⁵ Käthe K. expressed the conviction that she was innocent, 'I did nothing that I should feel guilty about.'⁴⁶ While acknowledging the high mortality rate in the children's ward, Käthe K. claimed, 'It never occurred to me that [patients were being killed] because we had severely ill children.'⁴⁷ The nurses' testimony suggests that as nurses they carried out Dr Schmidt's orders unquestioningly and without critical reflection upon the intentions behind those orders. This raises an important question, could we expect nurses to reflect critically upon the orders they were given by their superiors?

Prosecutors asked Schmidt to what extent head nurse Helene Schürg was able to judge the intended effect of the roughly twenty therapeutic methods he employed and, more specifically, whether the dosage of sedatives administered to a patient would induce sleep or bring about the patient's death. Dr Schmidt replied, 'In general, of course [Schürg could determine the intended effect]... I employed many very new methods. In some cases she might not have been aware.'⁴⁸ Senior nurses like Schürg, Margarete F. and Käthe K. had many years experience in nursing and were therefore well aware of the potentially lethal effects of high doses of sedatives or morphine–scopolamine. Käthe K.'s assertion that she did not realise that Schmidt intended to kill the patients is clearly exculpatory and is not credible. The defence used at her trial perhaps reflects her own self-denial at the time. This self-denial was a psychological mechanism used to cope with her participation in the killings; it was surely easier to administer lethal doses of medications to patients if you could convince yourself that you were simply giving a patient something to help them sleep or ease their pain.

The nurses' testimony also reveals that they felt that they were absolved from responsibility for the killings because they were following the orders of institutional doctors. Emphasising the hierarchical institutional order and arguing that they were bound to follow the doctor's orders, nurses played down their scope for action and deferred responsibility for the killings. Nurses who worked at killing institutions emphasised the boundary between their own responsibility and the responsibility held by institutional doctors. Research into perpetrator behaviour has exposed the courtroom apologia of those who faced prosecution. The German penal code stipulated that first degree murder must be the product of base motives (hatred, bloodlust, greed etc.) thus many perpetrators argued at their post-war trials that they were merely following orders. Donald Bloxham observes, 'The plea "I was only following orders" formed the basis for one of the most enduring stereotypes of German behaviour in the Nazi era, but also of perpetrators of war crimes and crimes against humanity everywhere.'⁴⁹ Like other groups of perpetrators, nurses who were prosecuted after the war claimed that they were only following orders and were not responsible for the killings they carried out. While the

claim that 'I was only following orders' is clearly exculpatory and judicial testimony should not simply be taken at face value, a closer examination of the processes of authorisation reveals much about the psychological strategies used by those who participated in the killings.

Spatialisation was reinforced by the institutional framework in which nurses worked. A salient feature of killing institutions, and medical institutions more generally, was their rigid hierarchical structure. Above all, institutional doctors required obedience from staff. As subordinates within the institutional hierarchy, nurses were accustomed to obeying orders and, therefore, proved to be receptive to the order to kill patients. 'The most horrifying evil in human memory', contends the sociologist Zygmunt Bauman, 'did not result from the dissipation of order, but from an impeccable, faultless and unchallengeable rule of order.'⁵⁰ The system of order and obedience was at the heart of the killing enterprise. It is precisely because order was maintained and staff followed orders that killing institutions were so efficient. Nurses argued that they were not in a position to stop the killings or even contravene orders. In taking the view that orders could not be disobeyed, nurses claimed that their scope for action was almost negligible. The psychologist Herbert C. Kelman argues, 'The processes of authorisation... define the situation as one in which standard moral principles do not apply and the individual is absolved of responsibility to make moral choices.'⁵¹ Within such an explanatory framework perpetrators are reduced to an instrument of an outside will. Many nurses believed that authorisation exonerated them for their involvement in the killings and this enabled them to placate their consciences. Nurses' superiors sought to disarm nurses' moral inhibitions against killing by allowing them to shift responsibility. In exchange for obedience without question the authorities accepted full responsibility for the nurses' actions. This implicit contract underpinned nurses' participation in the euthanasia program and was an important factor in securing their participation in the killing enterprise. The compartmentalisation of professional roles and the professional divide between nurses and physicians and the processes of authorisation allowed nurses to shift responsibility for the killings.

At the heart of the killing operation was a moral vacuum. This moral vacuum is illustrated by the ways in which institutional staff shifted blame for the killings. The testimony of staff shows that from physicians to nursing staff, no staff member accepted the act of killing patients as their own. Physicians who sanctioned the killing of patients passed on the order to kill to nursing staff and therefore later argued that they were not responsible as they did not carry out the killings. On the other hand, nurses blamed their superiors for the killings arguing that they were only following the orders of their superiors. The philosopher John Lachs has pointed to the mediation of action (the phenomenon of one's action being performed for or by someone else) and the paradox of the moral vacuum:

The result is that there are many acts no one consciously appropriates. For the person on whose behalf they are done, they exist only verbally or in the imagination; he will not claim them as his own since he has never lived through them. The man who has actually done them, on the other hand, will always view them as someone else's and himself as but the blameless instrument of an alien will.⁵²

Drawing on Lachs' paradigm, Bauman argues that the increase in the physical and/or psychic distance between the act and its consequences achieves the suspension of moral inhibitions and quashes the moral significance of the act and thereby pre-empts all conflict between personal standards or moral decency and immorality of the social consequences.⁵³ All staff at killing centres contributed to the killing enterprise to varying degrees; however, staff at all levels of the institutional hierarchy ultimately shifted responsibility for the killings and no individual took responsibility for the collective enterprise. The part each individual played in the killing operation was therefore stripped of any moral significance, and thus the mediation of action enabled nurses to reconcile the killings with their conscience.

The organisers of the Nazi euthanasia program adopted key measures to alleviate the psychological burden of the killing operation on institutional staff,

elements of which can be seen during both phases of the euthanasia program and across all killing institutions. Spatial boundaries within killing institutions, the secrecy of the killing operation and the direct involvement of only a small circle of staff meant that many nurses could avoid knowing the terrible truth. These nurses used the psychological strategies of avoidance and self-denial to cope with the euthanasia measures that were carried out at Eichberg. Only a small proportion of Eichberg's staff killed patients single-handedly, although the remaining staff members were invariably aware of the killings. For many staff members who were not directly involved in the killings it was simply a case of 'out of sight and out of mind'.

Nurses also translated the spatial boundaries within killing institutions into psychological boundaries thereby detaching the tasks they performed from the murder of patients. These psychological boundaries enabled nurses to silence the voice of their conscience. While the institution's rumour mill ensured that Eichberg's staff had their suspicions that things were amiss at the institution, the fact that knowledge of the killings was for many staff members based on rumour and suspicion rather than first-hand knowledge meant that staff did not feel obligated to speak out and could always justify their inaction. Medicalised killing blurred the boundaries between medical care and murder and enabled nurses who were active participants in the murder of patients to employ a strategy of self-denial by convincing themselves that they were not responsible for the deaths. Through a strategy of self-denial nurses were able to dispatch the lives of patients with a clear conscience. This strategy of self-denial was reinforced by the professional divide between doctors and nurses and the authorisation of the killings, which eroded nurses' sense of personal responsibility. Boundaries – both physical and psychological – operated on a number of levels at killing institutions and enabled nurses to reconcile their involvement in the killings with their conscience.

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This article has been prepared in accordance with the conditions of the archival access granted by the Hessisches Hauptstaatsarchiv Wiesbaden (HHStAW), and the German data protection legislation. The patients and staff members discussed in this article are, with few exceptions, referred to with first names and the initials of their surname only in order to protect their anonymity.

¹ The program was named after the address of the villa at Tiergartenstraße 4 in Berlin-Charlottenburg where most of the T-4 administration was housed.

² There is a significant degree of debate amongst historians with regard to whether economics or racial ideology was the primary motivation behind the euthanasia program. Götz Aly and Michael Burleigh argue that economic imperatives were the key factor in the killing operation. Götz Aly, Peter Chroust, and Christian Pross, *Cleansing the fatherland: Nazi medicine and racial hygiene*, John Hopkins University Press, Baltimore, 1994; Michael Burleigh, *Death and Deliverance: 'euthanasia' in Germany, c. 1900–1945*, Pan Books, Oxford, 2002. Henry Friedlander, in contrast, argues that Nazi racial policies were underpinned by a belief in the inequality of man that 'produced theories that pointed to the inferiority, degeneracy, and criminality of the handicapped and of members of different races.' Henry Friedlander, *The Origins of Nazi genocide: from euthanasia to the final solution*, University of North Carolina Press, Chapel Hill, 1995, p.xiv.

³ Hans Globke, co-author of Nuremberg Race Laws, quoted in Claudia Koonz, *The Nazi Conscience*, Belknap Press, Cambridge Massachusetts, 2003, p.163.

⁴ Raul Hilberg, 'The Nature of the Process', in Joel E. Dimsdale (ed.), *Survivors, victims, and perpetrators: essays on the Nazi Holocaust*, Hemisphere Pub. Corp., Washington, 1980, pp.25-6; Zygmunt Bauman, *Modernity and the Holocaust*, Cornell University Press, Ithaca, New York, 1989; Christopher R. Browning, *Ordinary Men: Reserve Police Battalion 101 and the Final Solution in Poland*, Aaron Asher Books, New York, NY, 1992.

⁵ Neil Gregor, 'Nazism – A Political Religion? Rethinking the Voluntarist Turn', in Neil Gregor (ed.), *Nazism, War and Genocide*, Exeter University Press, Exeter, pp.1–21.

⁶ Daniel Jonah Goldhagen, *Hitler's willing executioners: ordinary Germans and the Holocaust*, Abacus, New York, 2001, p.406. Goldhagen's study was first published in 1996.

⁷ Hilde Steppe, "Mit Tränen in den Augen zogen wir dann die Spritzen auf...", in Hilde Steppe (ed.) *Krankenpflege im Nationalsozialismus*, Mabuse-Verlag, Frankfurt am Main, 1989, p.164.

- ⁸ Hilde Steppe, “Mit Tränen in den Augen zogen wir dann die Spritzen auf...”, p.164.
- ⁹ Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany: moral choice in history*, Princeton University Press, Princeton, NJ, 1999, p.261.
- ¹⁰ Mass gassing centres were established at Grafeneck in Württemberg, Brandenburg on the Havel (near Berlin), Hartheim near Linz (Austria), Sonnenstein in Pirna (Saxony), Bernburg on the Saale (Saxony) and Hadamar (Hesse).
- ¹¹ It is commonly accepted that the sermon given by Clemens August Graf von Galen, bishop of Münster, in protest against the euthanasia program played a significant role in the ‘halt’ to the killings; however, Michael Burleigh argues that the killings were halted because the program had reached its initial target figure of one chronic patient per thousand inhabitants of Germany by the summer of 1941 and because the experienced T-4 killers were needed to carry out the Holocaust. Michael Burleigh, *Death and Deliverance*, pp.173–4.
- ¹² Hans-Walter Schmuhl, ‘Die Patientenmorde’, in Klaus Dörner and Angelika Ebbinghaus (eds), *Vernichten und Heilen: der Nürnberger Ärzteprozess und seine Folgen*, Aufbau-Verlag, Berlin, 2001, p.297.
- ¹³ Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, Basic Books, New York, 2000, p.96.
- ¹⁴ Quoted in Götz Aly, ‘Medicine against the Useless’, in Götz Aly, Peter Chroust and Christian Pross (eds), *Cleansing the Fatherland*, 1994, p.35.
- ¹⁵ Raul Hilberg, *Perpetrators, victims, bystanders: the Jewish catastrophe, 1944–1945*, 1st ed., Aaron Asher Books, New York, NY, 1992, p.66.
- ¹⁶ Horst Dickel, ‘Alltag in einer Landesheilanstalt im Nationalsozialismus – Am Beispiel Eichberg’, in Christina Vanja and Martin Vogt (eds), *Euthanasie in Hadamar: Die nationalsozialistische Vernichtungspolitik in hessischen Anstalten*, Eigenverlag des Landeswohlfahrtsverband Hessen, Hessen, 1991, p.105.
- ¹⁷ Horst Dickel, ‘Alltag in einer Landesheilanstalt im Nationalsozialismus’, p.105.
- ¹⁸ HHStAW Abt.461, Nr. 32442/4: LG Frankfurt, Verfahren Schmidt, Schürg, Senft, 4KIs 15/46 (Ss 92/47) Eichberg trial, testimony Käthe K.
- ¹⁹ Horst Dickel, ‘Alltag in einer Landesheilanstalt im Nationalsozialismus’, p.105.
- ²⁰ Henry Friedlander, *The Origins of Nazi genocide*, p.159.
- ²¹ For example, estimates of the number of patients who perished at Meseritz-Obrawalde during the second phase of the euthanasia program range from 6,991 to more than 10,000. Henry Friedlander, *The Origins of Nazi genocide*, p.159.
- ²² Schmidt later took over the position of acting director when Mennecke was drafted into the *Wehrmacht* (army) in late 1942.
- ²³ HHStAW Abt.461, Nr. 32442 /1: Staatsanwaltschaft (StA) Frankfurt, Verfahren Schmidt, Schürg, Senft, 4KIs 15/46 (Ss 92/47) Eichberg trial, interrogation of Käthe K., Eichberg, 27 July 1945.
- ²⁴ HHStAW Abt.461, Nr. 32442 /1: Eichberg trial, interrogation of Käthe K.

- ²⁵ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony Käthe K.
- ²⁶ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Anna H., Eichberg, 15 March 1946.
- ²⁷ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, statement provided by Dr. Elizabeth V., Eichberg, 2 August 1945.
- ²⁸ Bronwyn McFarland-Icke, *Nurses in Nazi Germany*, p.232.
- ²⁹ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Helene Schürg, Frankfurt, 3 May 1946.
- ³⁰ HHStAW Abt.461, Nr. 32442/2: Eichberg trial, statement made by nurse Franziska P., 22 May 1946.
- ³¹ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, statement provided by Dr. Elizabeth V.
- ³² HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Anne K., Eichberg, 9 August 1945.
- ³³ HHStAW Abt.461, Nr. 32442/2: Eichberg trial, statement made by nurse Katharina S., Eichberg, 22 May 1946.
- ³⁴ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of nurse Adam S., Eichberg, 29 March 1946.
- ³⁵ Bronwyn McFarland-Icke, *Nurses in Nazi Germany*, p.248.
- ³⁶ Stanley Milgram, 'Some Conditions of Obedience and Disobedience to Authority', *Human Relations*, Vol. 18, 1965, pp.62–5.
- ³⁷ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Johann M., Eichberg, 27 July 1945.
- ³⁸ Michael Burleigh, *Death and Deliverance*, p.106.
- ³⁹ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Anne K., Eichberg, 3 May 1946.
- ⁴⁰ HHStAW Abt.461, Nr. 32061/46: LG Frankfurt, Verfahren gegen Kneissler, Zachow, Korsch, Gumbmann, PKs 1/47 Grafeneck, Hadamar, Irsee trial, testimony of Hadamar nurses Edith Korsch and Minna Zachow, 9 January 1948.
- ⁴¹ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony of Käthe K.
- ⁴² HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony of Dr. Leopold C., former Eichberg doctor.
- ⁴³ For an account of the Eichberg trial see Fritz Bauer and C.F. Ruter, *Justiz und NS-Verbrechen*, Vol. 1, University Press Amsterdam, Amsterdam, 1968; Dick de Mildt, *In the name of the people. Perpetrators of genocide in the reflection of their post-war prosecution in West Germany: the "Euthanasia" and "Aktion Reinhard" trial cases*, Martin Nijhoff, The Hague, 1996.
- ⁴⁴ HHStAW Abt.461, Nr. 32442/1: Eichberg trial, interrogation of Margarete F., Wiesbaden, 8 February 1946.
- ⁴⁵ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony Käthe K.

⁴⁶ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony Käthe K.

⁴⁷ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony Käthe K.

⁴⁸ HHStAW Abt.461, Nr. 32442/4: Eichberg trial, testimony Dr. Walter Eugen Schmidt.

⁴⁹ Donald Bloxham, *The Final Solution: A Genocide*, Oxford University Press, 2009, p.264.

⁵⁰ Zygmunt Bauman, *Modernity and Holocaust*, p.151.

⁵¹ Herbert C. Kelman, 'Violence without Moral Constraint: Reflections on the Dehumanisation of Victims and Victimisers,' *Journal of Social Issues*, Vol. 29, 1973, p.25.

⁵² Quoted in Zygmunt Bauman, *Modernity and the Holocaust*, p.25.

⁵³ Zygmunt Bauman, *Modernity and the Holocaust*, p.25.