In early October of 1939, designated by the government as the year of "the duty to be healthy," Hitler authored a secret memo certifying that "Reichsleiter Bouhler and Dr. Brandt are hereby commissioned to allow certain specified doctors to grant a mercy death [Gnadenstod] to patients judged incurably sick, by critical medical examination." By August 24, 1941, when the first phase of this "adult operation" was brought to an end, over 70,000 patients from more than a hundred German hospitals had been killed, in an operation that provided the stage rehearsal for the subsequent destruction of Jews, homosexuals, communists, Gypsies, Slavs, and prisoners of war.

**Historical Background**

The idea of the destruction of "lives not worth living" had been discussed in legal and medical literature long before the Nazi rise to power. In the late nineteenth century, scholars writing for the British *Westminster Review* had debated the merits of destroying the insane in order to relieve society of "this terrible burden." In 1912, at a meeting of the Hungarian Psychiatric Association, a Dr. Namenyi recommended that "useless idiots" be killed according to the principle of euthanasia. Euthanasia has, of course, meant different things to different people. The word originally simply meant "an easy or gentle death"; the English use of the word in this sense dates back at least to the seven-
prompted a nationwide debate on when—if ever—a physician was justified in taking life. Ewald Meltzer criticized Hoche and Binding's proposal, linking it with the morality of the "breeding state"; the Weimar Reich Health Office included a review of Meltzer's book in its files on racial hygiene. Heinrich Hoffmann and Max Nassauer both advocated "dying help" (Sterbebhilfe) for the incurably sick; I. Malbin defended the destruction of "lives not worth living" as a natural practice common to peoples throughout history. In 1922, Ernst Mann published a novel portraying the destruction of the poor as a means of eliminating poverty. In 1925 E. Kirchner linked Hoche and Binding's proposal with Nietzsche's view that "the sick person is a parasite of society"; he also noted that the Lengnitz town council in the early 1920s had recommended the formation of a commission to determine whether money might be saved by eliminating the insane. Two years later, Kirchner applauded Hoche and Binding for their "creative solution" to problems posed by Plato, Thomas More, and Nietzsche.

Calls for euthanasia (in the various senses of the term) were not restricted to Germany. In 1932 Kilcock Millard, president of Britain's Society of Medical Officers, proposed legislation regulating voluntary euthanasia. In 1935 a number of British physicians formed the Voluntary Euthanasia Legalization Society, headed by Lord Moynihan, president of the Royal College of Surgeons. In 1936 the Euthanasia Society submitted a bill before the House of Lords to allow voluntary euthanasia, and over the next five years (1936–1941) the British Medical Journal carried on a lively debate over this question. A not uncommon view in this debate was that euthanasia should be considered an option for the (otherwise healthy) mentally retarded.

The facile language used in such debates often sounds strange to the modern ear. Consider the following extraordinary assertion by the philosopher Bertrand Russell, taken from his 1927 Marriage and Morals: "It seems on the whole fair to regard negroes as on the average inferior to white men, although for work in the tropics they are indispensable, so that their extermination (apart from questions of humanity) would be highly undesirable." Though Russell's remarks are not made in the context of the euthanasia debate, they do reveal how broadly nets were cast over questions of who will live and who will die.

American discussion of the "euthanasia question" peaked (predict-
ably) in the period 1936–1941. As in Britain, most advocates claimed that people should have the right to choose when or how they want to die. Euthanasia was primarily intended to help guarantee the rights of individuals to what we today would call death with dignity. Many American advocates also argued that euthanasia might be a good way to save on medical costs. Dr. W. A. Gould, for example, in the *Journal of the American Institute of Homeopathy*, defended euthanasia as one way of resolving economic difficulties; he asked his readers to recall in this context the “elimination of the unfit” in ancient Sparta. Some offered more radical suggestions: in 1935 the French-American Nobel Prize winner Alexis Carrel (inventor of the iron lung) suggested in his book *Man the Unknown* that the criminal and the insane should be “humanely and economically disposed of in institutions supplied with proper gases.” W. G. Lennox, in a 1938 speech to Harvard’s Phi Beta Kappa chapter, claimed that saving lives “adds a load to the back of society”; he wanted physicians to recognize “the privilege of death for the congenitally mindless and for the incurable sick who wish to die; the boon of not being born for the unfit.” Lennox was astute enough to perceive that “the principle of limiting certain races through limitation of off-spring might be applied internationally as well as intranationally. Germany, in time, might have solved her Jewish problem this way.”

American support for the concept of euthanasia dwindled in the early 1940s, after rumors of German exterminations began to filter into the American news media. The issue was not entirely dead, however. In 1942, as Hitler’s psychiatrists were sending the last of their patients into the gas chambers. Dr. Foster Kennedy, professor of neurology at Cornell Medical College, published an article in the official journal of the American Psychiatric Association calling for the killing of retarded children aged five and older—children whom the author called “those hopeless ones who should never have been born—Nature’s mistakes.” Kennedy cited Justice Holmes’s remarks (made originally in support of sterilization, not of euthanasia) that “three generations of imbeciles are enough,” and he was apparently not alone in this opinion: a 1937 Gallup Poll showed that 45 percent of the American population favored euthanasia for defective infants. After the war, physicians accused of having organized the euthanasia operations were able to point to America to argue that the idea of destroying inferiors found supporters outside Germany.
open resistance anticipated from the church would not play the part that it might in other circumstances."

The association of euthanasia and war was not fortuitous. If the healthy could sacrifice their lives in time of war, then why should the sick not do the same? This was Hoche and Binding’s argument, and it became a fashionable one among the Nazis. One American writer recognized this thinking as early as 1941, when he pointed out that the handicapped and mentally ill “were not killed for mercy. They were killed because they could no longer manufacture guns in return for the food they consumed; because beds in the German hospitals were needed for wounded soldiers; because their death was the ultimate logic of the national socialist doctrine of promoting racial superiority and the survival of the physically fit.” The Nazis made this link explicit. On August 10, 1939, when Nazi leaders met to plan the euthanasia operation, Philipp Bouhler, head of the Party Chancellery, declared that the purpose of the operation was not only to continue the “struggle against genetic disease” but also to free up hospital beds and personnel for the coming war. The underlying philosophy was simple: patients were to be either cured or killed. Accordingly, Leonardo Conti, Wagner’s successor as Reich Health Führer, allowed individuals capable of productive work to be excluded from the operation.

The concept of sacrificing the less than physically fit reverberated through other areas of Nazi legal and medical policy. In March 1937 the Frankfurter Zeitung reported on the case of a farmer who had shot to death his sleeping son because the child was “mentally ill in a manner that threatened society” (gemeinschaftsgefährlich geisteskrank). The father was charged with murder and brought to court, where he defended his action on the grounds that the son had become (among other things) a financial burden to the family. The prosecutor asked for the death penalty. Karl Astel, president of the Thuringia Health Office, came to the father’s defense and influenced the court to grant a reduced sentence of three years in prison. The mental condition of the murdered son played an important role in the decision.

The destruction of life not worth living was also glorified in Nazi literature and art. In 1936 the ophthalmologist Helmut Unger published his widely read novel Sendung und Gewissen (Mission and conscience), which told the story of a young woman who, suffering from multiple sclerosis, decides that her life is no longer worth living and asks to be relieved of her misery. Her husband, a doctor, recog-

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Figure 35. Gerhard Wagner and Adolf Hitler at the Nazi Party Congress in Nuremberg in 1935, at which Hitler discussed with Wagner the “euthanasia” of the mentally ill. From Deutsches Ärzteblatt, 65(1935): 913.

Figure 36. “The Prussian Government Provides Annually the Following Funds for: a Normal Schoolchild (125 RM); a Slow Learner (573 RM); the Educable Mentally Ill (950 RM); and Blind or Deaf-Born Schoolchildren (1,500 RM).” This illustration depicts the burden of maintaining the socially unfit. From Volk und Rasse, 8(1933): 156.
izes her plight and agrees to give her poison. In a grand act of humanity, the husband gives his wife a fatal injection of morphine, while a friend of his (also a doctor) accompanies the act with soothing and romantic music at the piano. The doctor, Terstegen, is accused of murder and brought to trial, where he refuses to let his colleagues invent an alibi for him, because he is convinced he has done no wrong. "Would you," asks Terstegen, "if you were a cripple, want to vegetate forever?" He is finally acquitted on grounds that his act constituted an act of mercy; in a critical scene, the words of the Renaissance physician Paracelsus are recalled: "medicine is love."23

Unger's novel was important in helping to prepare the ground for the euthanasia program. In the fall of 1933, Gerhard Wagner ordered the book made into a movie designed to dramatize the plight of the incurably ill. The film (Ich klage an!) was released in Berlin in the early war years, where it was a great success.24

Humanistic propaganda notwithstanding, the argument for the destruction of life not worth living was at root an economic one. In 1934, for example, the journal Deutsche Freiheit in Saarbrücken published a small pamphlet by Dr. Heilig, a representative of the Nazi Physician's League for Altena and Lüdenscheid. In his pamphlet, Heilig argued:

It must be made clear to anyone suffering from an incurable disease that the useless dissipation of costly medications drawn from the public store cannot be justified. Parents who have seen the difficult life of a crippled or feeble-minded child must be convinced that, though they may have a moral obligation to care for the unfortunate creature, the broader public should not be obligated . . . to assume the enormous costs that long-term institutionalization might entail.25

Heilig also stated that 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.

Heilig's comments are typical within the Nazi medical profession. Popular medical and racial hygiene journals carried charts depicting the costs of maintaining the sick at the expense of the healthy (see Figures 36 and 37); schoolbooks asked students to calculate the costs of maintaining the frail and invalid. Adolf Dorner's 1935–36 high school mathematics textbook, for example, included the following problems:

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Figure 37. "You Are Sharing the Load! A Genetically Ill Individual Costs Approximately 50,000 Reichsmarks by the Age of Sixty." This poster, from an exhibit on racial hygiene produced by the Reichsnährstand, illustrates the burden of the mentally ill on the healthy German population. From Walter Gross, "Drei Jahre rassenpolitische Aufklärungsarbeit," Volk und Rasse, 10(1935): 335.
Problem 94
In one region of the German Reich there are 4,400 mentally ill in state institutions, 4,500 receiving state support, 1,600 in local hospitals, 200 in homes for the epileptic, and 1,500 in welfare homes. The state pays a minimum of 10 million RM/year for these institutions.
I. What is the average cost to the state per inhabitant per year?
II. Using the result calculated from I, how much does it cost the state if:
   A. 868 patients stay longer than 10 years?
   B. 260 patients stay longer than 20 years?
   C. 112 patients stay longer than 25 years?

Problem 95
The construction of an insane asylum requires 6 million RM. How many housing units @ 15,000 RM could be built for the amount spent on insane asylums?\(^{26}\)

Such problems did not remain in the realm of theory. After the war, documents presenting detailed calculations of the “savings” achieved through the euthanasia operation were found in a safe in the castle at Hartheim (one of six euthanasia institutions equipped with gas chambers). Euthanasia officials calculated that the “disinfection” (murder) of 70,273 individuals in the course of the operation had resulted in savings of the following food items (in kilograms):

<table>
<thead>
<tr>
<th>Item</th>
<th>Savings (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread</td>
<td>4,781,339.72</td>
</tr>
<tr>
<td>Marmalade</td>
<td>239,067.02</td>
</tr>
<tr>
<td>Margarine</td>
<td>174,719.23</td>
</tr>
<tr>
<td>Schmalz</td>
<td>5,311.40</td>
</tr>
<tr>
<td>Coffee substitute</td>
<td>79,671.38</td>
</tr>
<tr>
<td>Sugar</td>
<td>185,952.86</td>
</tr>
<tr>
<td>Flour</td>
<td>156,952.86</td>
</tr>
<tr>
<td>Meats and sausage</td>
<td>653,516.96</td>
</tr>
<tr>
<td>Potatoes</td>
<td>19,754,325.27</td>
</tr>
<tr>
<td>Butter</td>
<td>50,485.49</td>
</tr>
</tbody>
</table>

Altogether, the euthanasia operation had saved the German economy an average of 245,955.50 RM per day (88,543,980.00 RM per year); if one assumed an average institutional life expectancy of ten years, the Reich had been saved expenses in excess of 880 million RM. Officials also noted that by the end of 1941, 93,521 hospital beds had been freed up by the operation.\(^{28}\)

Even before the euthanasia operation, other aspects of Nazi social policy reflect this same philosophy. In 1933, the first year of Nazi government, expenditures for the handicapped and invalid were drastically cut. In 1933 German medical insurance companies paid 41.5 million RM for invalids—10 million less than in 1932, in the depths of the recession.\(^{29}\) Many homes for the elderly or infirm closed in the early years of the Nazi regime; the total number of nurses caring for the ill dropped from 111,700 in 1933 to 88,900 in 1934. According to the Statistische Reichsamt, the number of hospitals and other medical care institutions fell from 3,987 in 1931 to 3,219 in 1935; the number of beds per 1,000 population fell in the same period from 5.7 to 4.5.\(^{30}\)

These policies were supported by Germany’s most prominent racial hygienists. Othmar von Verschuer, for example, attacked Germany’s entire system of socialized medicine on the grounds that it interfered with the natural tendency for individuals to sort themselves out according to “inner genetic potential.” Verschuer argued that socialized medicine could seriously impair the racial hygiene of a people, and that the German state had been far too eager to support “the weak, the laggard, and the inferior.”\(^{31}\) Fritz Bartels, Gerhard Wagner’s right-hand man in the Nazi Physicians’ League, phrased this in even stronger terms. He accused Marxists in the “14-year humiliation” (14 Jahre Schmach—Nazi language for the Weimar Republic) of having built “palaces for the mentally ill,” “wonderful parks and gardens” for those inferior beings that inhabit Germany’s mental institutions. Bartels noted that this would soon have to stop. This, after all, was the lesson of history: “From time immemorial, the nation has always eliminated the weak to make way for the healthy. A hard, but healthy and effective law to which we must once again give credence. The primary task of the physician is to discover for whom health care at government expense will be worth the cost.”\(^{32}\) For the Nazi medical philosopher, support for the mentally ill was simply not worth the cost. In the course of the thirties, funds allotted to care for the mentally ill gradually fell, reaching 40, 39, or even 38 pfennig per person per day.\(^{33}\) It was not such a large step from here to remove all care entirely.

The Child-Murder Operation
The program to destroy lives not worth living began in a relatively innocuous fashion. In the fall of 1938, a father by the name of Knauer wrote to Hitler asking that his child, born blind, retardated, and with-
out an arm and a leg, be granted a “mercy death,” or euthanasia. Hitler instructed his personal physician Karl Brandt to determine in consultation with the child’s physicians whether or not the facts were as stated in the father’s letter. Brandt was instructed that if the report proved to be accurate, then he was empowered to allow the physicians to grant the child euthanasia. Werner Catel, the physician in charge of the child, agreed to allow the child to die a “mercyful death.”

The case of Knauer provided a model on which other euthanasia actions would be carried out. In May 1939, only a few months later, Brandt notified Hans Hefelmann that Hitler had asked him (Brandt) to appoint an advisory committee to prepare for the killing of deformed and retarded children. Hitler’s Chancellery was to be directly responsible for the operation; but to maintain secrecy, the project was organized under the cover name Committee for the Scientific Treatment of Severe, Genetically Determined Illness (Reichsausschuss zur wissenschaftlichen Erfassung von erb- und anlagebedingter schwerer Leiden). Members of the committee included Karl Brandt, Helmut Unger, the pediatrician Ernst Wenzler, the psychiatrist Hans Heinze, and the pediatrician Werner Catel. The entire process of euthanasia was to be conducted under the strictest secrecy (Geheime Reichssache); Hefelmann, in testimony after the war, noted that only those physicians from whom a “positive attitude” could be expected were asked to participate in the operation. 34

On August 18, 1939, just fourteen days before the invasion of Poland, the Committee for the Scientific Treatment of Severe, Genetically Determined Illnesses produced a secret report, delivered to all state governments, asking that midwives or doctors delivering any child born with congenital deformities such as “idiocy or Mongolism (especially if associated with blindness or deafness); microcephaly or hydrocephaly of a severe or progressive nature; deformities of any kind, especially missing limbs, malformation of the head, or spina bifida; or crippling deformities such as spastics [Littleschen Erkrankung]” register that child with local health authorities. The ostensible reason given for this registration was “to clarify certain scientific questions in areas of congenital deformity and mental retardation.” 35 The order also required that doctors with any child in their care up to the age of three and suffering from any of these infirmities report this child to local health offices; doctors throughout the Reich were sent elaborate questionnaires for this purpose. Registration orders were published in many medical journals; the ailments listed in the orders were simply added to the list of other things requiring medical notification—such as venereal disease, births and deaths, childbed fever, certain contagious diseases, and genetic illnesses falling under the Sterilization Law. 36 Midwives were paid 2 RM for every registration.

Questionnaires returned by physicians or midwives were assembled in Berlin at the desk of Hans Hefelmann, business director of the operation. Hefelmann sent the questionnaires to Professors Catel, Heinze, and Wenzler to be sorted for “selection” (extermination). Children slated to die were marked with a plus sign; children allowed to live were marked with a minus sign. Decisions were made entirely on the basis of these questionnaires; those doing the selection never examined the children in person or consulted the families or guardians. Children marked with a plus sign were ordered into one of twenty-eight institutions rapidly equipped with extermination facilities, including some of Germany’s oldest and most highly respected hospitals (Eglfing-Haar; Brandenburg-Görden; Hamburg Rothenburg and Uchtspringe; Meseritz-Obrawalde, among others). Parents were told that the transport was necessary to improve treatment for their child. 37

Methods of killing included injections of morphine, tablets, and gassing with cyanide or chemical warfare agents. Children at Idstein, Kantenhof, Görden, and Eichberg were not gassed but were killed by injection; poisons were commonly administered slowly, over several days or even weeks, so that the cause of death could be disguised as pneumonia, bronchitis, or some other complication induced by the injections. Hermann Pfannmüller of the hospital at Eglfing-Haar slowly starved the children entrusted to his care until they died of “natural causes.” This method, he boasted, was least likely to incur criticism from the foreign press or from “the gentlemen in Switzerland” (the Red Cross). 38 Others simply left their institutions without heat, and patients died of exposure. Nazi medical men could thus argue that their actions were not technically murder, for they were simply withholding care and “letting nature take its course.” 39 Parents were informed with a standardized letter, used at all institutions, that their daughter or son had died suddenly and unexpectedly of brain edema, appendicitis, or other fabricated cause; parents were also informed that, owing to the danger of an epidemic, the body had to be cremated immediately.
provided letterhead for operations correspondence; the Charitable Foundation for Institutional Care was responsible for arranging financial details; and the Nonprofit Patient Transport Corporation was responsible for transporting patients to extermination institutions. Each organization was subordinated to the Committee for the Scientific Treatment of Severe, Genetically Determined Illness, the body established in the summer of 1939 to administer all euthanasia operations. The operation was given the code name T-4, derived from the address of the Nonprofit Patient Transport Corporation, located at Tiergartenstrasse 4 in Berlin.

In October 1939 the first euthanasia applications were sent to psychiatric institutions, where they were evaluated by forty-eight medical doctors—including most notably Werner Heyde, Friedrich Mauz, Paul Nitsche, Friedrich Panse, Kurt Pohlisch, Carl Schneider, and W. Villinger. For their services, the physicians received five pfennig per survey if they evaluated more than 3,500 applications per month, and ten pfennig if they evaluated fewer than 500 per month. From a total of 283,000 applications evaluated, roughly 75,000 patients were marked to die.

The first executions of adult mental patients were carried out during the military campaign against Poland. On January 9, 1940, Dr. Hildebrandt, the future head of the Office of Race and Settlement, reported to Himmler the “elimination [Beseitigung] of approximately 4,400 incurable mentally ill from Polish insane asylums,” and further, “the elimination of approximately 200 incurable mentally ill from the asylum at Konradstein.” Most of these were simply shot, as part of the cleanup work of Einsatzgruppen deployed by the Security Service (SD) close behind advancing German armies. Patients were also killed in certain parts of Germany near the front—especially in Pomerania (near Danzig)—and in West Prussia. At about the same time, physicians began to develop techniques that could be used to destroy the entirety of Germany’s mental patient population. In early January 1940, Brack, Brandt, Conti, and Bouhler met in the psychiatric hospital at Brandenburg, near Berlin, to conduct the first large-scale test of adult euthanasia. August Becker, a chemist employed by the Reich Criminal Police Office, described this first “experiment” as follows:

I was ordered by Brack to participate in the first euthanasia trial run in the Hospital at Brandenburg, near Berlin. It was in the first part of January 1940 that I traveled to the hospital. Special apparatus had been constructed for this purpose at the hospital. A room, similar to a shower
with tile floors, had been set up, approximately three by five meters and three meters high. There were benches around the edge of the room, and on the floor, about ten centimeters above the ground, there was a water pipe approximately one centimeter in diameter. In this tube there were small holes, from which the carbon monoxide gas flowed. The gas containers were outside the room and were already attached to one end of the tube. In the hospital there were already two crematoria ovens ready to go, for burning the bodies. At the entrance to the room, constructed similar to that of an air-raid shelter, there was a square peep hole through which the behavior of the subjects [Delinquent] could be observed. The first gassing was administered personally by Dr. Widmann. He operated the controls and regulated the flow of gas. He also instructed the hospital physicians Dr. Eberl and Dr. Baumhardt, who later took over the exterminations in Grafeneck and Hadamar. At this first gassing, approximately 18-20 people were led into the "showers" by the nursing staff. These people were required to undress in another room until they were completely naked. The doors were closed behind them. They entered the room quietly and showed no signs of anxiety. Dr. Widmann operated the gassing apparatus; I could observe through the peep hole that, after a minute, the people either fell down or lay on the benches. There was no great disturbance or commotion. After another five minutes, the room was cleared of gas. SS men specially designated for this purpose placed the dead on stretchers and brought them to the ovens. At the end of the experiment Viktor Brack, who was of course also present (and whom I'd previously forgotten), addressed those in attendance. He appeared satisfied by the results of the experiment, and repeated once again that this operation should be carried out only by physicians, according to the motto: "The needle belongs in the hand of the doctor." Karl Brandt spoke after Brack, and stressed again that gassings should only be done by physicians. That is how things began in Brandenburg. The carbon monoxide used in this and subsequent operations (or "disinfections," as they were commonly known) was recommended for use by toxicologists at the Reich Criminal Police Office's Institute for Criminal Technology. After taking the gold out of the teeth, the bodies were sent to be burned in newly installed crematoria. The Brandenburg experiment served as a model for subsequent executions. Hospitals at Grafeneck, Bernburg, Sonnenstein, Hadamar, Brandenburg, and the castle at Hartheim near Linz were all specially outfitted with gas chambers disguised as showers and crematoria to burn the bodies. Young, inexperienced doctors were chosen to run the facilities. The original intent of those who planned the euthanasia operation was to scale it according to the formula 1,000:10:5:1—that is, for every 1,000 Germans, 10 needed some form of psychiatric care; 5 of these required continuous care; and among these, 1 should be destroyed. Given a German population of 65-70 million, this meant that 65,000-70,000 individuals should have been included within the operation. And in fact the program kept closely to this schedule. By the end of August 1941, when the gassing phase of the operation was stopped, 70,273 individuals had been killed. The committee responsible for overseeing the operation kept meticulous records, and today we have an accurate account of how many were killed, and where.

<table>
<thead>
<tr>
<th>Killing stations</th>
<th>Period of operation</th>
<th>Numbers killed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grafeneck</td>
<td>Jan.-Dec. 1940</td>
<td>9,839</td>
</tr>
<tr>
<td>Brandenburg</td>
<td>Feb.-Sept. 1940</td>
<td>8,601</td>
</tr>
<tr>
<td>Bernburg</td>
<td>Jan.-Sept. 1941</td>
<td>10,072</td>
</tr>
<tr>
<td>Hadamar</td>
<td>Jan.-Aug. 1941</td>
<td>18,269</td>
</tr>
<tr>
<td>Hartheim</td>
<td>May 1940-1941</td>
<td>13,720</td>
</tr>
</tbody>
</table>

It is important to recognize the banality of the operation. In 1941 the psychiatric institution at Hadamar celebrated the cremation of its ten-thousandth patient in a special ceremony, where everyone in attendance—secretaries, nurses, and psychiatrists—received a bottle of beer for the occasion. Operations on such a scale are not easy to keep quiet. Rumors had begun to spread in 1940 that children were being killed. Some people began to notice identical form-letter death announcements appearing in newspapers; others complained when they were notified that their child had died of "appendicitis," even though the child's appendix had been removed years before. Suspicions also began to grow (especially around the hospital at Hadamar) that homes for the elderly were going to be emptied; some elderly began to refuse commitment to rest or retirement homes. In the spring of 1940, after a number of parents complained that their children had been killed, state prosecutors filed charges of murder against the directors of two institutions. Charges were quickly dropped, however, when the courts were informed that Hitler himself had guaranteed the immunity of all persons involved. Subsequently procedures were developed to prevent such difficulties. Martin Bormann ordered that letters notifying parents of their child's death be varied in both form and content. Himmler suggested showing films on heredity and mental disease in order to
quell the "ugly public opinion" that had grown in the mountainous area surrounding the extermination hospital at Grafeneck; such films had been used since early in the regime as part of an effort to harden public attitudes against "weaker" elements in the population. The regime also took more forceful steps. Parents who resisted turning over their children to the hospitals were declared incompetent and deprived of custody. In other cases, reluctant parents were sent to forced labor camps, and their children were placed in the custody of the state. By the summer of 1941, protests (especially from the Catholic church) had become sufficiently frequent to cause a certain amount of concern among those administering the operation; on August 24, 1941, Hitler ordered Brandt to stop gassing patients in psychiatric institutions. By this time, however, the original goal of eliminating 65,000–70,000 patients had already been achieved.

The killings continued, however, throughout the war and even for some time after. After the fall of 1941, the character of the euthanasia operation changed dramatically. Until August 1941, the program had been centrally administered through Hitler's Party Chancellery. Beginning in 1942, responsibility for administering euthanasia was shifted away from the Chancellery and back to individual hospitals. The methods of killing also changed. Whereas earlier killings had been primarily by means of gas chambers, killings after the fall of 1941 were achieved through a combination of injections, poisonings, and starvation. Euthanasia took on less the character of a single, Reichwide "operation" and more the character of normal hospital routine.

This routine character of euthanasia operations continued in at least one instance for some time after the end of the war. Peter Breggin, in his article "The Killing of Mental Patients," has described his interview with Robert Abrams, a twenty-four-year-old soldier, reporter, and public relations officer at the time of the American occupation. According to Abrams:

It was a full three months after the start of the occupation when a German doctor told a story that no one could at first believe. The doctor had returned home from the war to discover that the state hospital near his village was exterminating its mental patients, and that this was going on unabated within a few hundred yards of an American M.P. unit. The chief psychiatrist of the hospital had actually been arrested as a Nazi, but the remaining doctors, nurses, and attendants in the hospital had continued on quietly with their murder of the inmate population.

Breggin continues:

On July 2, 1945, Abrams and a carload of soldiers entered the town, Kaufbeuren, and saw the institutional buildings in the distance... The third doctor in command was now the chief and he told Abrams that the last child patient had been killed on May 29th, 33 days before the occupation of the nearby village. The last adult had died twelve hours before Abrams' arrival, and only the drawn guns of the Americans had put an end to the "destruction of useless eaters."

Doctors were never ordered to murder psychiatric patients and handicapped children. They were empowered to do so, and fulfilled their task without protest, often on their own initiative. Hitler's original memo of October 1939 was not an order (Befehl), but an empowerment (Vollmacht), granting physicians permission to act. In the abortive euthanasia trial at Limburg in 1964, Hefelmann testified that "no doctor was ever ordered to participate in the euthanasia program; they came of their own volition." Himmler himself noted that the operations undertaken in psychiatric hospitals were administered solely by medical personnel.

Two further dimensions to this situation have emerged from recent research. First, most of those physicians who did object complained primarily that the operation was not, strictly speaking, legal. In the early years of the program, some of those administering the operation (Brack and Lammers, for example) were sufficiently concerned about this complaint that they drew up plans for a euthanasia law with the help of several of Germany's racial hygienists (such as Fritz Lenz). One version of the law, drafted in 1940, included the following provisions:

1. Anyone suffering from an incurable illness that leads to strong debilitation of either oneself or others can, upon explicit request of the patient and with permission of a specially appointed physician, receive dying help [Sterbehilfe] from a physician.
2. A patient who, as a consequence of incurable mental illness requiring lifelong care, can, through medical intervention and without his knowledge, have his life terminated.

Proposals for establishing a euthanasia law were widely discussed, and yet the law was never passed. The decision was made instead to keep the question of euthanasia a "private matter"—between doctors and their patients. The killings were performed contrary to German law, though authorized by government officials; Hitler assured those
responsible for administering the program that he would bear full responsibility for all that was done.59

The West German historian Götz Aly has shown that in many cases, parents of handicapped or retarded offspring were eager to rid themselves of the stigma of having “defective children.” Many parents wrote to hospitals to ask if their child could be relieved of his or her misery and be granted euthanasia. The euthanasia operation was not an entirely unpopular program; in fact, it appears to have received a broad level of public support throughout the country.60 Nazi authorities anticipated this before the onset of the program. In 1920 Ewald Meltzer had surveyed the parents of 162 handicapped children, asking whether they would be willing to have their child put to death, and if so, under what circumstances. A surprisingly large number of the respondents advocated some sort of euthanasia for their children: 119 (73 percent) said yes, with various degrees of qualification; only 4 rejected the suggestion under any circumstance. Meltzer’s survey was cited by Nazi authorities exploring how to administer the child-euthanasia program: when Hitler’s personal physician Theo Morell helped draw up plans for the operation in the summer of 1939 he referred to Meltzer’s survey, noting that many of those who said yes had also expressed the hope that they would never be told the true cause of their child’s death. Nazi physicians used this to justify disguising the true nature of the operation from the parents or guardians of the victims.

Similarly, the elimination of the adult mentally ill was not an entirely unpopular program. By the end of the thirties, propaganda bodies had whipped up such fear and hatred for the mentally ill—one Bielefeld physician compared the genetic defective to a “grenade” waiting to explode61—that the elimination of these people seemed a logical or even humane measure. Support for the euthanasia of the mentally ill was apparently one reason that steps were taken, in the spring and summer of 1939, to coordinate a single, nationwide euthanasia program: as Aly has shown, Nazi authorities formulated standardized procedures for killing mental patients partly out of fear that, in war conditions, individual Gauleiter might begin destroying patients on their own.62

The Medicalization of Anti-Semitism

Historians exploring the origins of the Nazi destruction of lives not worth living have only in recent years begun to stress the links bet-

tween the destruction of the handicapped and mentally ill, on the one hand, and the Jews, on the other. And yet the two programs were linked in both theory and practice. One of the key ideological elements was the “medicalization of anti-Semitism”—the view developed by Nazi physicians that the Jews were “a diseased race,” and that the Jewish question might be solved by “medical means.”63

According to Walter Gross, head of the Office of Racial Policy, it was first with the Nuremberg Laws of 1935 (and especially the Blood Protection Law) that the explicit link was made between the genetically healthy (Erbgesunden) and the German blooded (Deutschblütigen). The 1933 Civil Service Law (which excluded non-Aryans from government employment) was primarily a “socioeconomic,” not a “medical or biological,” measure; according to Gross, it was not until the Nuremberg Laws banned marriage and sexual relations between Jews and non-Jews that German racial legislation was put on a “biological basis.” All subsequent legislation in the sphere of race and population policy, Gross claimed, was based on this distinction between “healthy” and “diseased” races.64

The Nazi conception of healthy and diseased races was at one level expressed in metaphors of the Jew as “parasite” or “cancer” in the body of the German Volk. One physician phrased this in the following terms: “There is a resemblance between Jews and tubercle bacilli: nearly everyone harbors tubercle bacilli, and nearly every people of the earth harbors the Jews; furthermore, an infection can only be cured with difficulty.”65 Peltret also contrasted the “biological” character of National Socialism with the “pathological” character of communism and the “artificial” (künstlich) character of imperialistic fascism.

Nazi physicians also claimed, however, that Jews actually suffered from a higher incidence of certain metabolic and mental diseases. In his speech before the 1935 Nazi Party Congress at Nuremberg (the same meeting at which Hitler proposed the murder of the mentally ill), Gerhard Wagner argued that for every 10,000 inhabitants in the Reich, there were 36.9 mentally infirm among the Germans and 48.7 among the Jews. Wagner cited the “interesting figures” of the “Jewish doctor Ullmann,” documenting the fact that between the years 1871 and 1900 the relative proportions of Jews and Germans in psychiatric institutions rose from 29:22 to 163:63. Interesting as well, Wagner noted, was the fact that Jews showed a higher rate of sexual deficiency, expressed, for example, in the blurring of secondary sexual characteristics. This, he affirmed (citing the “Jewish doctor Piltz”),
explained not only the higher incidence of homosexuality among the Jews but also the prominence of female Jews in “masculine pursuits” such as revolutionary political activism. Wagner concluded that Jews were “a diseased race”; Judaism was “disease incarnate.”

Wagner was not of course the first to make such claims. Nazi medical theorists were able to draw upon a broad body of literature documenting differential racial susceptibilities to disease. In 1902, for example, Alexander Pilcz had reported in one of Austria’s leading medical journals that Jews suffered disproportionately from acute psychosis and insanity and were especially susceptible to psychoses of a “hereditary-degenerative nature.” A Dr. Rajanski noted that the 1871 German census showed that Jews were nearly twice as likely to suffer from mental illness as Christians; and in Vienna, a Dr. M. Engländer presented statistics to demonstrate the higher incidence of idiocy, myopia, glaucoma, diabetes, and tuberculosis among Jews than among non-Jews, attributing these higher rates to poor nutrition and inbreeding. Much of this research was published in Jewish journals: Dr. L. Silvagni, for example, in the 1902 Jüdisches Volksblatt, reported a higher incidence of nervous disorders, gallstones, bladder and kidney stones, neuralgia, chronic rheumatism, and brain malfunction among Jews (but also reported a lower susceptibility of Jews to lung infections, typhus, various fevers, syphilis, and alcoholism. Gerhard Wagner cited these and other articles as evidence for his claim that Jews suffered from many diseases that non-Jews did not have, and concluded that the interbreeding of Jews and non-Jews therefore posed grave risks to German public health. Wagner argued that if Germans continued to allow the mixing of “Jewish and non-Jewish blood,” this would result in the spread of the diseased genes (krankhafte Erbanlagen) of the “already bastardized Jewish race” into the “relatively pure European stocks.”

The study of the racial specificity of disease was to become one of the chief priorities of biomedical science under the Nazis. Otmar Freiherr von Verschuer, director of the Frankfurt Institute for Racial Hygiene, was one of the leaders in this effort. In his 1937 book on genetic pathology, Verschuer identified more than fifty different ailments suspected of being genetic in origin. He also classified diseases according to how common they were among particular racial groupings. Measles, Verschuer argued, was rare among Mongols and Negroes; myopia and difficulties associated with giving birth were more common among civilized than among primitive peoples of the world.

He produced evidence to show that Jews suffered more from diabetes, flat feet, staggery (Torsionsdystonie), hemophilia, xeroderma pigmentosum, deafness, and nervous disorders than non-Jews; both Jews and “coloreds” (Farbige), Verschuer wrote, suffered higher rates of muscular tumors. Interestingly, tuberculosis was the only disease Verschuer listed as less prevalent among Jews than among non-Jews. To explain this, Verschuer added an adaptive story. Jews, Verschuer claimed, have for centuries lived in the cities. Their long-standing urban life has led them to develop resistance against diseases commonly found in cities (such as tuberculosis) and to become susceptible to ailments such as flat feet.

Nazi physicians sometimes speculated that Jewish racial degeneracy might be explained in terms of the supposedly hybrid character of the Jewish race. In 1935, for example, Dr. Edgar Schulz of the Office of Racial Policy published an article demonstrating higher rates of insanity (manic depression and dementia praecox), feeblemindedness, hysteria, and suicide among Jews than among non-Jews. Schulz claimed that these and other disorders arose from the fact that Jews were not, strictly speaking, a single race but rather were an amalgam of Negro and Oriental blood. As a result of this “impure” racial constitution, Jews suffered “tensions and contradictions” that became manifest as disease. This phenomenon was supposedly observed not just among Jews but among any population that experienced racial mixing. The anthropologist Wolfgang Abel in 1937 thus described the Rheinlandbastarde as suffering from a host of racial maladies—including tuberculosis, rickets, bad teeth and gums, gout, flat feet, bronchial problems, and nervous disorders such as nail biting, eye twitching, speech defects, and crying in the night. Eugen Fischer’s early studies of the “Rehboother bastards” were supposed to have proved that children of interracial marriages scored lower on standardized tests than their classmates.

Racial scientists were remarkably creative in their attempts to explain the odious effects of racial miscegenation. Wilhelm Hildebrandt, for example, in his 1935 Racial Mixing and Disease, argued that the maladies produced by racial miscegenation were a product of the fact that different races have different life spans and that bodily organs therefore mature and degenerate at different rates. If a long-lived person were to mate with a short-lived person, then the various organs might mature and die at different rates, disturbing the “equilibrium” found in relatively pure races.
Interestingly, differential racial susceptibility to disease was one topic Jews were permitted to write about, even at the height of the Nazi regime. In 1937 Drs. Franz Goldmann and Georg Wolff presented statistics demonstrating lower rates of infant mortality and tuberculosis among Jews than among non-Jews. These authors, writing for Germany’s officially sanctioned Jewish body (the Reichsvertretung der Juden in Deutschland), also pointed out that Jews suffered higher rates of mortality from diabetes, diseases of the circulatory system (especially arteriosclerosis), and suicide. From 1924 to 1926, suicide rates among Jewish men were 20 percent higher than for non-Jewish men (the difference between Jewish and non-Jewish women was even higher—30 percent); by 1932–1934, the Jewish suicide rate was 50 percent higher than the non-Jewish rate.

There is evidence that some Nazis did recognize that differences in susceptibility to disease might be due to social rather than racial causes. In 1940, for example, Martin Stämmler and Edeltraut Bienck analyzed demographic shifts among Jewish and non-Jewish inhabitants of Breslau in the period 1928–1937. Stämmler and Bienck noted that Jewish birthrates had declined considerably over this period, and that consequently the proportion of elderly was higher among Jews than among non-Jews. This fact, the authors said, helped account for the higher rates of mortality Jews suffered from disorders such as cancer, diabetes, and circulatory failure; it also helped explain the lower death rates from tuberculosis and infectious diseases, ailments that commonly strike the young. They also noted that Jewish mortality rates had risen dramatically over this period: from 14.2/1,000 in 1928 to 21.2/1,000 in 1937. As the British Medical Journal pointed out, however, nowhere in their analysis did Stämmler and Bienck discuss the role of state violence or the barbarities of the concentration camps in producing these statistics.

The interpretation of the Jewish problem as a medical problem was to prove useful in Nazi attempts to find a “final solution to the Jewish question in Europe.” In the early months after the invasion of Poland in 1939, Nazi officials turned to medicine to justify the concentration and extermination of the Jews. Just how this was done illustrates something not only about the role of medical ideology in the persecution of Germany’s minorities, but also about how the concept of the Jew as “disease incarnate” began to take on the character of a self-fulfilling prophecy.

Genocide in the Guise of Quarantine

On September 1, 1939, Hitler’s armies invaded Poland on the pretext of retaliation for an attack on a German border station by Polish troops—an attack we now know to have been staged by SS guards disguised as Polish officers. Shortly after the occupation of Poland, SS officers were ordered to confine all of Poland’s Jews into certain ghettos, including first and foremost, the traditional Jewish ghetto of Warsaw.

In territories occupied by the German army, Nazi medical authorities used the danger of disease as a pretext to justify a series of repressive measures against the Jewish population. In Warsaw, when the Nazis established a separate section for Germans on the city’s streetcars, the Nazi-controlled Krakauer Zeitung explained: “The separation of the Germans from the Poles—and particularly from the Jews—is not merely a question of principle; it is also, at least as far as Warsaw is concerned, a hygienic necessity.” When the Nazis banned Jews from unauthorized railway travel in occupied Poland, Nazi newspapers printed headlines announcing: “Germ-carriers Banned from Railways.” Hygiene was commonly listed as the reason for excluding Jews from a wide range of activities in the Generalgouvernement.

One of the most brutal forms of persecution for which hygiene was used as a pretext was the confinement of Jews to the ghettos. In February 1940 more than 160,000 Jews from the areas surrounding the industrial town of Lodz (renamed Litzmannstadt after German occupation) were rounded up and forced into one small part of the town. The original intention was to remove all Poles and Jews, thereby leaving the town entirely “German.” When this proved impractical, Nazi authorities decided to confine the Jews to the northern part of town and to regulate all trade or interchange between the Jewish and non-Jewish sectors. On April 30 the Jewish quarter was sealed off and surrounded by a wall, similar to the one being erected around the Jewish ghetto in Warsaw. German newspapers reported that the ghetto in Lodz was the “most perfect” of all the settlements established by the Germans in occupied Poland; one author called it the “purest temporary solution to the Jewish question anywhere in Europe.” Similar ghettos were subsequently established on a smaller scale in Cracow, Lublin, Radom, and other parts of occupied Poland.
In each of these cases, hygiene was preferred as one of the principal grounds for concentration. The establishment of the Jewish ghetto at Lodz, for example, was justified as a measure necessary to protect against the dangers of epidemic disease. And soon after concentration, of course, Jews in these ghettos did begin to suffer from higher rates of infectious disease. These outbreaks of disease allowed Nazi medical philosophers to justify the continued concentration of the Jews in terms of a medical quarantine. Medical police powers were often invoked for such actions: on December 1, 1938, the German government had granted health authorities broad powers to confine anyone suspected of being a carrier of infectious disease. This allowed officials to confine individuals to a certain area or to transport them to hospitals or other “appropriate” areas. The measure was most commonly used for tuberculosis victims, but it was also used for racial deportations.

It was in the Warsaw ghetto, however, that the Nazis were able to realize to the fullest their prophecies of “Jewish disease.” Shortly after the invasion of Poland, German radio stations carried a report of an associate of Goebbels who had recently returned from a visit to Warsaw and Lodz. The author of this report described the Jews of the ghettos as “ulcers which must be cut away from the body of the European nations”; he claimed that if the Jews of the ghettos were not completely isolated, the “whole of Europe would be poisoned.”

Before the war, the population of Warsaw was approximately 1.2 million including 440,000 Jews, two-thirds of whom lived in the ghetto in the northwest part of town. When Nazi occupation forces began forcibly concentrating Poland’s rural Jews into the ghetto, the effect was to create a breeding ground for disease. The crowded living conditions were exacerbated by shortages of food and clean water. In 1940 and 1941, as the number of Jews arriving in the ghetto grew from 500 per day to over 1,000 per day, diseases began to break out, soon reaching epidemic proportions. The world medical press was not unaware of these conditions. The July 6, 1940, issue of the British Medical Journal reported: “Typhoid fever is still raging in Warsaw, where there are from 200 to 300 cases every day. Fully 90 percent of the victims are Jews. The German authorities have increased the number of disinfecting stations from 212 to 400, but have made no attempt to eradicate the source of the disease by clearing out the worst part of the ghetto, where tens of thousands of Jews are confined under pestilential conditions.”

The situation was to become much worse. Before the war, mortality in the ghetto due to all causes had been about 400 deaths per month. By January 1941, nearly 900 people were dying every month, and death rates were increasing week by week. By March the number of deaths had grown to 1,608 per month, and in the single month of June 1941, 4,100 people died from infection and disease, compounded by starvation, physical abuse, and lack of adequate medical supplies. According to Wilhelm Hagen, the German commissioner of the ghetto (a Dr. Auersbach) sabotaged efforts on the part of well-meaning German doctors to alleviate the situation by his order to block shipment of food and medical supplies to the city. By the end of 1941 official rations had been reduced to bread worth about 2,000 calories per person per day, and many were receiving even less than this. Hunger and epidemic disease reinforced each other as mortality rates from tuberculosis alone rose from 14/100,000 in 1938 to more than 400/100,000 in the first quarter of 1941. The case was even more dramatic with typhus. In the single month of October 1941, health authorities responsible for the Warsaw ghetto recorded 300 deaths from typhus—nearly as many as from all causes combined before the German occupation.

Epidemics that raged inside the Warsaw ghetto in 1941 and 1942 provided Nazi occupation forces with a medical rationale for the isolation and extermination of the Jewish population. On October 29, 1940, the Hamburger Fremdenblatt noted that 98 percent of all cases of typhoid and spotted fever in Warsaw were to be found in the ghetto. In the spring of 1940 non-Jewish doctors were barred from treating Jewish patients; on March 12 the Krakau Zeitung explained this ban as follows: “This decree is based on the fact that infectious diseases, particularly spotted fever and typhoid, are widespread especially among the Jewish population. When Jews suffering from those diseases are treated by non-Jewish doctors—doctors who are at the same time treating the sick of other races—there is a danger of their transmitting diseases from the Jews to the non-Jewish population.”

In the first months of the German occupation of Poland, traffic between Jews and non-Jews in and outside the Warsaw ghetto was not restricted; Germans and non-Jewish Poles were allowed to enter the ghetto. After 1940, however, contact with Jews was declared a “threat to public health”; Jews trying to escape from the ghetto were shot on the grounds they were violating the quarantine imposed by
the Nazis. Years later, long after the war, when the Nazi chief of police for Warsaw was brought before a West German court to be tried for ordering the shooting of Jews trying to leave the ghetto, defense attorneys argued that this action had been a “necessary precaution” to preserve the quarantine.\(^{92}\)

Criminal Biology

Criminal biology was to forge a further link in the medical solution to the Jewish question. According to the psychiatrist Robert Ritter, the “urgent task” of criminal biology was “to discover whether or not certain signs can be found among men which would allow the early detection of criminal behavior, signs which would allow the recognition of criminal tendencies before the actual onset of the criminal career.”\(^ {93}\) Such efforts were not, of course, the invention of the Nazis. Criminal biologists had tried, at least since Cesare Lombroso's *L'uomo delinquente* in the late nineteenth century, to construct a medical-forensic system linking moral, criminal, and racial degeneracy. Crime, in this view, was a disease; criminality was linked with certain physical manifestations such as facial shape or body hair. (Lombroso's work was rarely cited by Nazi criminal biologists, probably because of his Jewish ancestry.)

In the twentieth century, spurred by advances in genetics and hopes for eugenics, criminal biology became an important research priority in the German scientific community. Concerns on the part of criminal biologists were close in many ways to those of the racial hygienists. Criminal biologists argued that crime is both genetically determined and racially specific; they worried that criminals were reproducing at a faster rate than noncriminal elements of the population (see again Figure 1). In the Nazi period, government statistics offices attempted to determine what proportion of murderers (for example) were genetically defective: in 1938 government statisticians provided data to show that, whereas in 1928–1930 only 14.5 percent of all murderers were genetic defectives (*erblich belastet*), by 1931–1933 this proportion had supposedly grown to 20.1 percent.\(^{94}\) Twin studies here again provided the vital empirical link between theory and policy: racial theorists argued time and again that studies of identical and nonidentical twins proved that crime was the product of hereditary disposition and not just social environment.\(^{95}\) Racial hygienists in the Nazi period drew important political implications from such studies: at the

fourth Congress of Criminal Biology at Hamburg in June 1934, Rainer Fetscher predicted that a thorough implementation of the Sterilization Law would lower criminality as a whole by 6 percent and “moral” (sexual) crimes by 30 percent.\(^ {96}\) Fetscher himself had begun in 1927 to construct a comprehensive “criminal biology map of the Free State of Saxony” (*Kriminalbiologische Kartei des Freistaats Sachsen*),\(^ {97}\) which he later used to identify individuals for sterilization.

Interest in criminal biology accelerated with the rise of the Nazis. By 1935, legal and medical journals were regularly reporting that crime and other “antisocial behavior” were genetically determined racial characteristics. J. F. Lehmann's *Monthly Journal of Criminal Biology and Penal Reform* had, since 1904, pioneered the study of the “genetics” of crime; after World War I, many other journals followed suit.\(^ {98}\) By the mid-1930s most German universities offered instruction in this area—often in conjunction with courses on racial hygiene.\(^ {99}\) The German government supported research in this area in several ways. In October 1936 Justice Minister Franz Gürtner ordered the establishment of fifty examination stations throughout Germany to explore the genetics and racial specificity of crime. The main targets of these stations (modeled on similar institutions existing since 1923 in Bavaria) were individuals under the age of twenty-five serving long-term prison sentences; everyone serving a three-month sentence or longer was required to be examined. In addition, larger criminal biology research stations (*Kriminalbiologische Sammelstelle*) were established at Munich, Freiburg-Breslau, Cologne, Münster, Berlin, Königsberg, Leipzig, Halle, and Hamburg to evaluate the effects of various measures on the incidence of crime—especially the 1935 Castration Law.\(^ {100}\) In 1939 the *Deutsches Ärzteblatt* reported Himmler's orders that henceforth, examination of the genetics and genealogy of criminal suspects was to become a routine part of criminal investigations.\(^ {101}\)

Criminal biologists also addressed the Jewish question. The conceptual link here, as one might imagine, was the theory that Jews were racially disposed to certain forms of crime, just as they were racially disposed to certain kinds of disease. One should recall that “disease” for the Nazis was often broadly construed to cover not just physical disorders but also behavioral and cultural maladies. Johannes Schottky, for example, in his 1937 book *Race and Disease*, argued that Jews were racially disposed to suffer disproportionately not
just from flat feet or gout but also from mental disorders such as feeble-mindedness, hysteria, various sexual disorders, and pathological drives for recognition and power. It was not a large step from here to argue that Jews were racially disposed to commit certain forms of crime. Indeed, Fritz Lenz had put forth this thesis in his textbook on human genetics, written with Erwin Baur and Eugen Fischer. One of the distinctive racial qualities Lenz attributed to the Nordic man was a certain sense of “foresight,” a quality that, according to Lenz, led the German (unlike the Jew) to respect the life and property of others. Lenz presented statistics to buttress this point. For the decade 1892–1901, he listed as follows the relative incidence of crime (per 100,000 population) among German Catholics, Protestants, and Jews.

<table>
<thead>
<tr>
<th>Crime</th>
<th>Catholics</th>
<th>Protestants</th>
<th>Jews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offenses in general</td>
<td>1,361</td>
<td>1,112</td>
<td>1,030</td>
</tr>
<tr>
<td>Minor assaults</td>
<td>67</td>
<td>54</td>
<td>44</td>
</tr>
<tr>
<td>Grievious bodily harm</td>
<td>314</td>
<td>186</td>
<td>75</td>
</tr>
<tr>
<td>Fraud</td>
<td>68</td>
<td>58</td>
<td>113</td>
</tr>
</tbody>
</table>

From such statistics, one might think it difficult to argue that the Nordic was less prone to crime. Lenz, however, asserted that these data disguised what was really going on. If one compared Jews, not with the non-Jewish population as a whole, but with those parts of the non-Jewish population of similar economic status, then one would find (Lenz claimed) that violent crimes were “no less common among Jews than non-Jews.” Lenz was willing to take other parts of his statistics at face value, however: “Fraud and the use of insulting language really are commoner among Jews”—as is “the circulation of obscene books and pictures” and “the white slave trade.”

Nazi medical authorities followed this lead. Gerhard Wagner, in the same speech in which he attacked the “exorbitant costs” of supporting the mentally ill, declared that the incidence of criminality was higher among Jews than among non-Jews, as was the incidence of bankruptcy (fourteen to thirty times higher for Jews), distribution of pornography (“exceptionally Jewish”), prostitution, drug smuggling, purse snatching, and general theft. Wagner and other Nazi medical leaders were able to cite the work of Lenz and others in the racial hygiene community in support of this thesis.

Science thus conspired in the solution to the Jewish question: Jews were racially disposed to commit crime, as they were racially disposed to suffer from a host of other diseases. By the late 1930s, German medical science had constructed an elaborate world view equating mental infirmity, moral depravity, criminality, and racial impurity. This complex of identifications was then used to justify the destruction of the Jews on medical, moral, criminological, and anthropological grounds. To be Jewish was to be both sick and criminal; Nazi medical science and policy united to help “solve” this problem.

The Final Solution

The German census of May 17, 1939, revealed that there were 330,892 Jews in Germany (now including Austria); there were in addition 72,738 “half-breds” (Mischlinge erster Grad), and 42,811 quarter-Jews (Mischlinge zweiter Grad). In six years of Nazi rule, the number of Jews in Germany had fallen by 390,000. For those remaining, a variety of “solutions” were proposed, and medical doctors were among those leading the search for solutions.

Publicly, Germany’s medical journals made it clear that Jews were to have no place in the New German Order. Dr. W. Bormann, for example, writing in the Arzteblatt für den Reichsgau Wartheland, declared that the “retrieved” German territories of the occupied East were to be settled “exclusively with German men.” On November 23, 1939, when laws were passed requiring Jews in occupied Poland to wear the yellow star, Germany’s foremost medical journal justified this as necessary “to create an externally visible separation between the Jewish and Aryan population.” The journal argued further that in order to establish a “geographical” separation between the races, there were two possible solutions: the creation of a separate Jewish state and confinement to a ghetto. The latter solution was preferable, because “it could be implemented more rapidly and with greater effect.” The Deutsches Arzteblatt reported with satisfaction that, as a result of Nazi policies, areas of mixed Polish-Jewish population had already begun to disappear, and Jewish businesses were gone. Furthermore,

for the first time in centuries, the Jew has been forced to change his lifestyle; for the first time, he is required to work. For this purpose, Jews have been organized into forced labor brigades. At the head of each of these brigades there is a Jew who supervises his racial comrades and is
Brack's new plan was simply another version of the plan to induce sterilization by X-rays. Jews were to be radiated with sufficient quantities of X-rays (500–600 roentgen for men; 300–350 roentgen for women) to destroy the reproductive capabilities of the testicles or ovaries. This, Brack suggested, might be best achieved by having individuals stand in front of a counter where they would be asked to fill out a form; an official standing behind the counter would operate the apparatus, administering to the genitals a dose of radiation for the time it took to fill out the form (two to three minutes), thereby castrating the individual. With twenty such setups, Brack figured that one could sterilize perhaps 3,000–4,000 people per day.\(^\text{115}\)

Sterilization was ultimately rejected as a solution to the Jewish question. The decision to destroy Europe's Jews by gassing them in concentration camps emerged from the fact that the technical apparatus already existed for the destruction of the mentally ill. In the earliest phases, both the children's and the adult euthanasia operations were to be administered only to non-Jews: Jews were explicitly declared not to deserve euthanasia.\(^\text{116}\) But the operations were eventually extended to Jews, and in mass fashion. On August 30, 1940, the Bavarian minister of the interior ordered all Jewish patients in psychiatric hospitals to be transported to the hospital at Eglfing-Haaf, near Munich; a memo of December 12 that year justified this move on the grounds that the mixing of German and Jewish patients posed “an intolerable burden on both nursing personnel and the relatives of patients of German blood.” In fact, Jewish psychiatric patients from the hospital at Berlin-Buch had begun to be rounded up and sent to gas chambers at Brandenburg since earlier that summer (June 1940).\(^\text{117}\) In early September 1940, 160 Jewish patients at Eglfing-Haaf were filmed as part of the propaganda film Scum of Humanity (Abschaum der Menschheit). On September 20 these patients were sent to Brandenburg, where they were gassed on September 22.

In early 1941 the Reich Ministry of the Interior ordered that all Jews in German hospitals be killed—not because they met the criteria required for euthanasia, but because they were Jews.\(^\text{118}\) The Jews were not the first group to be singled out for extraordinary euthanasia. Criminals in Germany's hospitals had already been disposed of by this time; and in the course of 1941 a number of other groups would fall within the shadow of the program. On March 8, 1941, Werner Blankenburg wrote to local Gauleiter asking that all “aso-
ministering euthanasia. From July 1944 through the spring of 1945, for example, 400 Russians and Poles were gassed in the psychiatric hospital at Hadamar—now with years of experience in execution by gas chamber.  

It is important to realize today that for Nazi physicians no sharp line divided the destruction of the racially inferior and the mentally or physically defective. The physicians responsible for administering the euthanasia operation in German hospitals (T-4) were also responsible for formulating criteria and administering the first phases of the destruction of the Jews and handicapped in Germany's concentration camps (14 f 13). When cross-examined after the war at the Nuremberg trials, physicians pointed out that they did not always distinguish whether certain exterminations were for racial, political, or medical reasons. The testimony of Dr. Mennecke, questioned by the defense attorney for Karl Brandt, made this clear:

**Attorney:** When was the decision made to exterminate individuals based on racial and political considerations? Had this already been decided by the time you first visited a concentration camp?

**Mennecke:** No.

**Attorney:** When was it then?

**Mennecke:** As far as I can remember it first began in Buchenwald or Dachau.

**Attorney:** How was it done prior to this? What was your task in the concentration camps?

**Mennecke:** The examination of certain prisoners with respect to the question of psychosis or psychopathology.

**Attorney:** So it was a question of mental illness?

**Mennecke:** A medical question.

**Attorney:** And later it became a political and racial question?

**Mennecke:** Yes. That is, alongside the political and racial question I also had to make purely medical judgments.

**Attorney:** So, you had two kinds of cases: the mentally ill, which had to be evaluated according to medical criteria, and those which had to be evaluated according to political and racial criteria?

**Mennecke:** One simply cannot distinguish the two, Herr Attorney. The two cases were simply not divided and clearly separated from one another.  

American army officials discovered shortly after the war that concrete plans for the final solution (Endlösung) of the Jewish problem in
Europe were made at a luncheon organized by SD chief Reinhard Heydrich at Wannsee castle (near Berlin) on January 20, 1942. At this meeting thirteen high-ranking Nazi and Reich government officials were shown photostatic copies of a letter from Hermann Göring charging Heydrich with the task of finding a “final solution to the Jewish question.” Records from the meeting were discovered in the files of the physician Philip Hoffmann, head of the SS Race and Settlement Office.\(^\text{123}\)

We also know that Germany’s political elite discussed these issues openly well before final plans were made. On January 20, 1939, for example, Hitler announced in his infamous speech before the Reichstag: “Today, I will once again be a prophet: if international financial Jewry inside Germany and abroad should manage to force the people of the world once more into a world war, then the result will be not the ‘Bolshevization’ of the earth, and thereby the victory of Judaism, but rather the destruction of the Jewish race in Europe.”\(^\text{124}\)

Hitler repeated this promise several times in subsequent years;\(^\text{125}\) his underlings made similar claims. On March 23, 1941, for example, Himmler presented a report to Hitler announcing that “the very idea of Jews I hope . . . to see fully extinguished” (Der Begriffe Juden hoffe ich . . . völlig auslösch zu sehen). Four months later, on July 31, 1941, Hermann Göring entrusted Heydrich with “the solution of the entire Jewish question in the German sphere of influence in Europe.” And on November 16, Alfred Rosenberg announced at a press conference the intention of the government to find a final solution to the Jewish question.\(^\text{126}\)

Earlier than this, it is possible to find numerous references from German doctors to the need for a solution to Germany’s Jewish problem. In 1939, for example, Edith Löhlöffel, editor of the women doctors’ journal, praised Hitler for the reunification of Austria and Germany, and for his “elimination [Ausschaltung] of all foreign races from Germany.”\(^\text{127}\) Reich Health Führer Leonardo Conti, in a speech before a meeting of government physicians on December 14–15, 1938 in Berlin, announced it was the intention of the government to find a final solution (endgültige Lösung) to the Jewish problem in Europe.\(^\text{128}\) In 1938 Walter Gross announced that the work of the Office of Racial Policy would not be finished until “the disappearance of the last Jew from our Reich.”\(^\text{129}\)

Discussion of the Jewish question was a common feature in several of Germany’s medical journals in the Nazi period. Popular medical journals discussed the history of the Jews, in some cases complete with pictures portraying the exodus of the Jews from Egypt, the problems of Zionism, and so forth.\(^\text{130}\) In the early war years the Deutsches Ärzteblatt carried a regular column on “Solving the Jewish Question,” which reviewed current attempts at solutions not just in Germany, but in Romania, China, Japan, Italy, and other countries.\(^\text{131}\) The journal worried that Britain was building “an army of 100,000 Jews in Palestine,” an army that “could and would be used against the Germans.” It reprinted Hitler’s words (in boldface) that another war in Europe would mean not the “Bolshevization” of the earth, but the destruction of the Jewish race in Europe.\(^\text{132}\)

Racial hygienists also carried forth this banner. Otmar von Verschuer described in his textbook the need for a “complete solution of the Jewish question” (Gesamtlösung des Judenproblems).\(^\text{133}\) On March 27–28, 1941, at opening ceremonies for the Institute for Research on the Jewish Question (Institut zur Erforschung der Judenfrage) in Frankfurt, Eugen Fischer and Hans F. K. Günther were guests of honor at a meeting where possible solutions to the Jewish question were discussed.\(^\text{134}\) At this meeting Walter Gross reviewed the shortcomings of previous efforts in this regard (emancipation, persecution, partial annihilation, and so forth) and claimed that a final solution could come only with the complete “removal of Jews from Europe.”\(^\text{135}\) Racial hygienists appreciated Nazi efforts to solve the Jewish question. In 1944, not long after he accepted Josef Mengele as his scientific assistant, Verschuer proudly claimed that the dangers posed by Jews and Gypsies to the German people had been “eliminated through the racial-political measures of recent years.” He also noted in this context that the purification of Germany from “foreign racial elements” required a larger effort extending across the entirety of Europe.\(^\text{136}\)

In November 1942 the Informationsdienst des Hauptamtes für Volksgesundheit der NSDAP, a journal published by the Reich Health Publishing House, noted in the “Confidential Information of the Party Chancellery” there had appeared a paper (no. 881) titled “Preparatory Measures for the Final Solution of the European Jewish Question.”\(^\text{137}\) Copies of this journal were circulated within the medical faculties of certain universities (for example, Giessen); one can only wonder what crossed the minds of these professors upon seeing the title of this paper.\(^\text{138}\)

The continuities linking the various phases of the Nazi’s program
to destroy lives not worth living were both practical and ideological. In the fall of 1941, with the completion of the first major phase of the euthanasia operation, gas chambers at psychiatric institutions in southern and eastern Germany were dismantled and shipped east, where they were reinstalled at Belzec, Majdanek, Auschwitz, Treblinka, and Sobibor. The same doctors and technicians and nurses often followed the equipment. Germany's psychiatric hospitals forged the most important practical link between the destruction of the mentally ill and handicapped and the murder of Germany's ethnic and social minorities.

Sexual and Racial Pathologies

It was not just the Jews or the mentally or physically handicapped, but other groups as well that were stigmatized as "sick" and "degenerate" by German racial scientists. Jews, Gypsies, communists, homosexuals, the feebleminded, the tubercular, and a wide class of "antisocials" (alcoholics, prostitutes, drug addicts, the homeless, and other groups) were all marked for destruction.

Consider the case of homosexuals. By the 1930s Nazi medical leaders could draw upon a sizable literature documenting the supposedly pathological character of (male) homosexuality. In the first (1904) volume of the Archiv für Rassen- und Gesellschaftsbiologie, Ernst Rüdin argued that homosexuality was a genetically determined "diseased form of degeneracy." In 1924 Dobrovsky published an article claiming that gay men showed abnormal gum and tooth development; an article by Arthur Weil in the same year purported to discover distinctive bodily deformities in homosexual men. Nazi racial hygienists built upon views common in pre-Nazi research. In the summer of 1934, Professor Lothar Tödla of Munich argued that homosexuality was a "moral pathology" and advised that Germans use "all possible means to suppress such sick perversions in the body of our people."

By the mid-1930s physicians in Germany were united in arguing that homosexuals posed a threat to public health. Physicians writing in Germany's leading public health journal, Der Öffentliche Gesundheitsdienst, regularly described homosexuality as a "pathology" and homosexuals as "psychopaths." The magnitude of the threat was not something to be taken lightly: in 1938 the Office of Racial Policy reported that Germany was faced with an "epidemic of some 2 million homosexuals, representing 10 percent of the entire adult male population."

The most common theory of homosexuality advanced under the Nazis was that homosexuality was an inborn, biologically determined disorder. In 1939, for example, a physician by the name of Deussen published an article titled "Sexual Pathology" supporting this view in the journal Progress in Genetic Pathology. Deussen cited Theobald Lang's work purportedly showing that the sisters of male homosexuals tend to exhibit particularly "masculine" characteristics; this led both Deussen and Lang to accept Richard Goldschmidt's theory of the male homosexual as a "genetic female." Interestingly, belief in a genetic basis of homosexuality was not confined to the political Right. In 1937 the socialist physicians' Bulletin in exile published an article claiming that homosexuality was "inborn, and hence not subject to the free will of the individuals who come into the world with this inversion." The journal advocated abolishing section 175 of the Prussian criminal code criminalizing homosexuality.

In light of such arguments, some Nazi physicians disputed the claim that homosexuality was a genetic disorder. In June 1938, for example, a physician writing for the Office of Racial Policy characterized homosexuals as "weak, unreliable, and deceitful"; they were typically "servile and yet power hungry, .. incapable, in the long run, of functioning in a positive manner in society as a whole." This author argued that homosexuality was not, however, a genetic disease: the view that homosexuality was inherited simply played into the hands of those who wanted to assert that homosexuality was not a matter of choice. This was the argument "upon which the entire ideology of homosexuality is based"—namely, that these people "cannot do otherwise." The author estimated that although perhaps only 2 percent of all homosexuals were actually "genetically sick," these people exerted an enormous influence in society: "40,000 normals—whom one might well expel from the community—are in a position to poison 2 million citizens." Homosexuals, in this author's view, were like the Jews: they build a "state within a state, they are state criminals. They are not 'poor, sick' people to be treated, but enemies of the state to be eliminated!"

Homosexuality was illegal in the Weimar Republic; the Nazis, however, imposed a series of new and far more repressive measures against this group. On the night of June 30, 1934, most of the (largely homosexual) leaders of the SA (including, most notably, Ernst Röhm)
were assassinated, in what subsequently became known as the Röhm putsch or “night of long knives.” The Röhm putsch marked only the first phase of the Nazi persecution of homosexuals. Beginning soon after the Machtsgreifung, Nazi officials had begun to construct an inventory of all representatives of the so-called third sex; these lists were subsequently used to “cleanse” the German population of these people. In the mid-1930s, thousands of individuals identified as homosexuals were arrested and sent to concentration camps, where they were detained so as not to “infect” the broader population. Thousands of camp inmates wearing the pink triangle were ultimately sent to the gas chambers, as part of the attempt to rid Germany of this “pathology.”

Other groups were singled out for destruction, and here again the cooperation of medical personnel on both ideological and practical levels was crucial. Beginning early in the Nazi regime, the Reich Health Office began constructing elaborate genealogical tables of all Gypsies in Germany. In 1938 public health authorities were asked to register with the police all Gypsies and Gypsy “half-breeds,” based on information gathered from genealogical tables or genetic registries. This information was then used by police authorities to round up Gypsies for deportation. An article in the Deutsches Arzteblatt described some of the tasks faced by the physician in sorting out the Gypsy question:

Experience gathered thus far in the struggle against the Gypsy plague [Plage] reveals that half-breeds are responsible for the largest fraction of criminal offenses among the Gypsies. It has also been shown that attempts to make the Gypsies settle down have failed, especially among the purest strains of this race; this is because of their strong wander instinct. It has thus become necessary to separate pure and half-breed Gypsies, for the purpose of coming to a final solution of the Gypsy problem [endgültigen Lösung der Zigeunerfrage]. Toward this end, the SS Reichsführer and chief of German police [Heinrich Himmler] has issued elaborate instructions. In order to achieve this goal, it will be necessary to determine the racial affiliation of all Gypsies living in the Reich, also that of all people living like Gypsies.

This article specified that all Gypsies were to be registered with the Reich Criminal Police Bureau, in a special division created for this purpose (the Reichszentrale zur Bekämpfung des Zigeunerwesens).

Gypsies, like Jews and homosexuals, were often described by Nazi medical authorities as a “health risk” to the German people. Otmar von Verschuer claimed that 90 percent of Germany’s 30,000 Gypsies were “half-breeds,” and that most Gypsies were “asocial and genetically inferior.” In 1944 medical authorities in Bulgaria “ascertained” that Gypsies, by virtue of their migrant lifestyle, were responsible for spreading infectious diseases; Bulgarian authorities ordered all Gypsies to give up their wandering lifestyle and settle in a single location. Medical involvement in the destruction of the Gypsies was also more direct. In the winter of 1941–42, Dr. Robert Ritter, a prominent German criminal biologist, participated in a conference at which the drowning of Germany’s 30,000 Gypsies by bombardment of their ships in the Mediterranean was proposed. Ritter ultimately became one of the chief organizers of the genocide of this group. Beginning in the mid-1930s, he received funds from the German Research Council (DFG) to research the Gypsy question at his Racial Hygiene and Population Biology Research Division within the Berlin Health Office. On January 20, 1940, Ritter reported to the DFG that the Gypsy question could be solved only “if the majority of asocial and useless Gypsies can be rounded up and put to work in special camps, where they can be prevented from any further reproduction.” He helped prepare evaluations (Gutachten) used for identifying Gypsies to be destroyed; on January 31, 1944, Ritter reported that he had recently completed evaluation of 23,822 Gypsy “cases.”

The campaign against tuberculosis took on a similar—if more controversial—character under the Nazis. Even before their rise to power in January 1933, the Nazis claimed that the eradication of tuberculosis was one of their highest goals. Opinions were divided, however, on what the appropriate attitude toward the disease should be. Some complained about the exorbitant costs associated with treating the disease. F. Koester, for example, writing in Germany’s leading tuberculosis journal, stated in 1938 that care for Germany’s 400,000 tubercular cost the government 4 or 5 billion RM annually. Others expressed doubts whether it was a good idea even to try to eradicate tuberculosis, given that this would eliminate an important means of “natural selection.” Tuberculosis had been recognized as an infectious disease since Koch’s discovery of the tubercle bacillus at the end of the nineteenth century, yet many also recognized that infection with the bacillus was not a sufficient condition for someone coming down with the disease. People knew that one had to be in a weakened physical state to contract the disease—but opinions differed on the nature or origins of this state. Many argued that the “white plague”
was largely the product of nutrition, living space, or working conditions; others argued that although environmental factors were important, one’s physical or racial constitution was the crucial variable. Followers of Kretschmer’s *Konstitutionslehre*, for example, argued that those with the *leptosome* body type were especially susceptible to the disease, and concluded that such individuals should be advised not to go into nursing or medicine (where they were more likely to be infected). Fritz Lenz argued that members of the Nordic race (or light-skinned individuals more generally) were particularly resistant to the disease; Hans Luxenburger postulated a correlation between schizophrenia and TB.¹⁵⁸

Even prior to 1933, the widespread conception of tuberculosis as a genetically inherited disease¹⁵⁹ prompted many to call for the isolation of those with the disease from the “genetic stream” of the population. Alfred Grothahn, as early as 1915, advocated celibacy for the afflicted; others proposed that the actively tubercular not be allowed to obtain a marriage license. Still others argued that tuberculosis should constitute grounds for eugenic sterilization—a proposal that F. Redeker criticized as early as 1931 as “only the most recent demand in the fool’s paradise [Wolkenkuckucksheim] of eugenics.”¹⁶⁰

After 1933, health officials stepped up their struggle against the disease. Despite continued calls for sterilization or marriage bans (and even some calls to promote the breeding of the “muscular” over the “leptosomal” body type in the German population),¹⁶¹ tuberculosis was never included within the sterilization or marital health laws. TB did, however, become the most common ground for abortion in Nazi Germany, and health officials initiated a massive campaign for early detection of the disease, along with obligatory chest X-rays for everyone in the SS, the army, the SA, and workers in the armament industry.¹⁶² On December 1, 1938, the Order for the Struggle against Contagious Diseases required that all cases of tuberculosis be registered with state health authorities; the order also allowed the forcible confinement of individuals with the disease.

During World War II, the struggle against tuberculosis took on a more urgent nature, especially in occupied territories. On May 1, 1942, the Gauleiter for the Wartheland region in occupied Poland wrote a letter to Himmler suggesting that Poland’s 35,000 incurable and infectious tubercular be exterminated, and that preparations for this operation be made as soon as the region’s remaining 100,000 Jews were destroyed. Reinhard Heydrich approved the operation in a letter of June 9, 1942, on the condition that health authorities could determine which cases of the disease were incurable. Kurt Blome, head of Germany’s medical postgraduate education program and now deputy chief of the Nazi party’s Office for Public Health, was asked to explore the alternatives open to German authorities to deal with the matter. Blome distinguished three possible options: “special treatment” (Sonderbehandlung—Nazi language for extermination); isolation of the severely infected; or creation of a special reserve for all tubercular. Blome estimated that the first of these options—the one favored by Heydrich and Himmler—would take six months to complete. He also cautioned, however, that the operation would have to be kept secret; if the operation were to become public, Germany’s enemies would be able to mobilize the “doctors of the world” against Germany, and opposition would be even greater than to the euthanasia operation. Blome therefore recommended the creation of a reservation, comparable to a leper colony.¹⁶³ It remains unclear today how far plans for such a colony were ever put into effect.

The Medical Experiments

No account of the Nazi destruction of life not worth living would be complete without at least a brief examination of the role of physicians in the notorious medical experiments of the 1940s. Evidence that physicians participated in experiments in the concentration camps was presented in the “doctors’ trial” in Nuremberg in the spring and summer of 1947. At the trial, physicians from the concentration camps in Dachau, Auschwitz, Buchenwald, and Sachsenhausen were accused of having forced prisoners to drink seawater, to suffer extremes of cold or low pressure, or to undergo bone or limb transplants that often ended in death or crippling mutilation. The experiments were undertaken not out of sadism, but to gain knowledge about certain conditions faced by German military men. Prisoners were immersed in ice water to discover how long German pilots, downed by enemy fire, could survive in the icy waters of the North Sea; they were forced to drink seawater to determine how long a man stranded at sea might survive without fresh water; they were subjected to mutilating limb transplants to improve techniques that might prove valuable in genuine military emergencies; and they were wounded or injected with infectious bacteria to determine the effectiveness of new antibacterial drugs.
The medical experiments were begun in conjunction with a series of new priorities established by the Nazi regime in the war years. Plans for the occupied East (the so-called Generalplan Ost) involved a dual strategy of “negative demography” and “racial resettlement.” According to these plans, 8 million Germans would resettle the occupied territories over thirty years; this program would be combined with sterilization and other more drastic means of removing local non-German populations. Several of the experiments undertaken in Germany’s concentration camps were designed to devise techniques for controlling fertility in the newly conquered eastern territories. Carl Clauberg, for example, experimented with ways to induce sterility; Horst Schumann explored new techniques for castrating men. Hundreds of people were mutilated or killed in the course of these experiments, which lasted from 1942 through the end of the war.

A further priority that emerged during the war was to find new means of combating infectious diseases faced by troops moving into Africa or southern and eastern Europe. Spotted fever, for example, became a problem during the invasion of the Soviet Union; in response, Professor Gerhard Rose ordered tests of new vaccines against the disease in the concentration camp at Buchenwald. Rose’s experiments (which proved fatal for many of the subjects involved) were planned in consultation with Germany’s chief medical authorities—Leonardo Conti, Hans Reiter, and Ernst Grawitz—in the hope that such experiments might help to solve problems facing German armies. Other, less fatal, methods were also tested: at the SS hospital in Dachau, Ernst Grawitz tested homeopathic preparations to see if they were effective in combating infection (he found they were not).

One of the supervisors of medical experiments at Dachau was Hans Deuschl, a personal friend of SS chief Himmler and head of the Doctors’ Führer School at Alt-Rehse. In 1940 or 1941, Deuschl left Alt-Rehse to take up war duties on the eastern front, where he was appointed chief of health affairs in Estonia. As an SS man and longstanding leader in the Nazi Physicians’ League, Deuschl reported directly to Himmler. In a letter of January 24, 1942, he wrote to Himmler asking for permission to deal “radically” with an epidemic of spotted fever that had broken out among a group of Russian prisoners of war in Estonia, near Fellin. Deuschl noted in his letter that 1,400 Russian prisoners of war had fallen ill, and only about 25 percent were capable of work. In view of this situation, he advised that “radical measures” be taken: half the Russian prisoners were to be shot, so that the remaining half could be given twice the previous rations. Deuschl commented that this would also reduce the danger of epidemic disease in the camp—an important benefit, given that the summer months would bring a renewed risk of dysentery and typhoid. Deuschl made the premise upon which his decision was based quite clear: “I would rather see the death of 500 Bolshevist beasts (who will probably eventually die anyway—of hunger, cold, or disease), than see one German soldier—or even one Estonian soldier—perish from epidemic disease.” Himmler wrote back, granting Deuschl permission to implement his “radical measures.”

In the summer of 1943, Himmler asked Deuschl if he would be willing to supervise a series of medical experiments at Dachau; Deuschl accepted the offer. Dachau was the first concentration camp to engage in human experimentation. In 1939 Sigmund Rascher had begun a series of experiments on blood-clotting factors; in subsequent years he helped to organize the infamous low-pressure and cooling experiments, sponsored in conjunction with air force medical bodies. In these experiments, prisoners (primarily Russian prisoners of war) were submerged in ice water or subjected to low pressure for hours at a time, often until death. The purpose was to discover how long pilots forced to bail out over water or at high altitudes could survive in conditions of extreme cold or low pressure. As of July 1943 there were (according to one observer) “three to five” separate sets of experiments running at Dachau.

Deuschl was chosen by Himmler to supervise the experiments, partly because he had been a long-time personal friend. Himmler doted on Deuschl, sending him flowers, china, cognac, fresh fruit, and chocolates during the war, when these were difficult to obtain without special connections. In 1943 Deuschl was able to acquire a house in Starnberg, a small town in the foothills of the Bavarian Alps (the house had recently belonged to a Jewish family). Deuschl’s rewards were political as well as pecuniary: in January 1944 he was named mayor of the town.

Personal reward was only one of several reasons physicians became involved in the experiments. At the Nuremberg trials, physicians justified their participation in the experiments on a variety of grounds. Karl Gebhardt carried out a series of experiments with sulfonamide, in his words, to clear himself of suspicion in the death of SS General Reinhard Heydrich. Others argued that prisoners were
being sacrificed to help save the lives of other, more “valuable” individuals. If concentration camp prisoners were condemned to die anyhow, what harm could there be in using them in this way? Furthermore, those who survived the first run of “terminal” experiments were supposed to be granted a stay of execution. (Physicians at the camps admitted, however, that this did not apply to Poles and Russians; nor is there evidence that Jews or Gypsies were ever granted such a reprieve.) Physicians compared their work with medical experimentation in other countries, at other times. Defense attorneys after the war were able to cite instances in the United States in which experiments had been performed on unwilling or unknowing human subjects.  

Perhaps the most common argument was that such experiments were done on orders “from the professors in Berlin.” This of course was a convenient excuse. Physicians claimed that if they had disobeyed orders, then they themselves might have become victims. There is, however, little evidence that physicians ever refused to participate in Nazi programs; those few who did (in the euthanasia operation, for example), do not seem to have suffered for their refusal. As noted earlier, physicians were never ordered to participate in the experiments; those who participated did so because they were given the opportunity and volunteered.

It is curious that, immediately after the war, people were eager to argue that Nazi medical experiments “were not even good science.” The American prosecutor at Nuremberg, for example, felt compelled to point out that Nazi medical experiments were “insufficient and unscientific,” “a ghastly failure, as well as a hideous crime.” One is almost left with the impression that if such experiments had been “good science,” this would somehow make a difference in our attitudes toward them. And yet the cruelty of an experiment is not lessened by its scientific value. Furthermore, Nazi experiments were not entirely “insufficient and unscientific,” in the restricted sense of these terms. The experiments were undertaken by trained professionals; the results were presented at prestigious conferences and scientific academies. Karl Gebhardt and Fritz Fischer, for example, ordered a series of experiments whereby women were infected with gas bacilli, staphylococcus, or malignant edema to determine the effectiveness of new drugs produced by the German pharmaceutical industry. Gebhardt and Fischer presented the results of these experiments at a May 24–26, 1943, meeting at the Military Medical Academy in

Berlin; prominent German physicians (such as Ferdinand Sauerbruch) participated in discussions of the experiments, which had been performed at the concentration camp at Ravensbrück. Results of these and other camp experiments were published in scientific books and articles. German industry also profited from the experiments: the firm Behring-Werke, for example, used concentration camp prisoners to test new vaccines against spotted fever; Bayer Pharmaceutical Company purchased female experimental subjects from Auschwitz (for 700 RM each) in order to perform experiments on this “captive population.”  

Part of our revulsion for Nazi medical experiments stems from the fact that they violated a relationship of supposedly unique confidence and trust. In the Nazi period, the doctor-patient relationship was exploited to achieve goals that would have been difficult to attain by other means. At Buchenwald, for example, 8,000 Russian prisoners of war were executed in the course of supposed medical exams; unsuspecting prisoners were taken to an examination room, where they were told to stand in front of a device apparently designed to measure their height. Prisoners were then shot in the head from a secret cavity built into the device. (This device can still be seen as part of the exhibit the East German government has established among the ruins of the former concentration camp.) The traditional doctor-patient relationship was exploited in other ways as well. SS troops suspected of disloyalty were executed under the guise of medical treatment through intravenous injection of phenol or gasoline. Phenol and gasoline left odors on the body, however, which caused problems with high-ranking Nazis whose bodies had to go on public display at state funerals. Nazi physicians thus developed methods of execution that would simulate “natural causes” of death. For example, Professor Heissmeyer, one of Karl Gebhardt’s associates at the SS hospital in Hohlenlychen, developed a technique to induce acute and fatal miliary tuberculosis by intravenous injections of live tubercle bacilli. Sigmund Rascher at Dachau developed cyanide capsules that could be used either for executions or for suicides.

It is possible of course, in hindsight, to separate analytically the sterilization program (eugenics), the destruction of the mentally ill (euthanasia), and the destruction of Germany’s racial minorities (the final solution). The fact is, however, that each of these programs was seen as a step in a common program of racial purification. Medical
journals used the expression “life not worth living” to refer to those sterilized under the 1933 Sterilization Law,\textsuperscript{176} to those killed in psychiatric hospitals, and to those killed in concentration camps.

If we want to understand the logic of the Nazi racial program, then it is not possible to draw a sharp line between what happened before and after 1939. Nor is it possible to maintain that Germany’s biomedical community restricted its participation only to the earliest or more “theoretical” phases of this process. Physicians played an active role in both the theory and the practice of each phase of the Nazi program of racial hygiene and racial destruction.

In this light, we can appreciate the conclusion reached by Max Weinreich in his \textit{Hitler’s Professors}:

It will not do to speak in this connection of the “Nazi gangsters.” This murder of a whole people was not perpetrated solely by a comparative small gang of the Elite Guard or by the Gestapo, whom we have come to consider as criminals . . . the whole ruling class of Germany was committed to the execution of this crime. But the actual murderers and those who sent them out and applauded them had accomplices. German scholarship provided the ideas and techniques which led to and justified this unparalleled slaughter.

[Those involved] were to a large extent people of long and high standing, university professors and academy members, some of them world famous, authors with familiar names.\textsuperscript{177}