Advances in Nursing Science
Vol. 32, No. 1, pp. 63–74

Nurses in the Nazi "Euthanasia" Program
A Critical Feminist Analysis

Susan Benedict, CRNA, DSN, FAAN; Jane M. Georges, PhD, RN

From 1940 to 1945, Nazi Germany conducted a program of killing institutionalized psychiatric patients. Known as "euthanasia," this killing program included the administration of lethal doses of medication given largely by nurses. The purposes of this article are to (1) describe the historical context in which nurses' participation in the Nazi euthanasia program occurred; (2) present a recently unsealed narrative testimony of a nurse accused of active participation in the euthanasia program; and (3) analyze this account from a critical-feminist perspective, with a focus on its epistemological salience for contemporary nursing. **Key words:** *critical theory*, *epistemology*, *euthanasia*, *feminist*, *Nazi*, *nursing history*

THIS ARTICLE is situated in the space between historiography and epistemology. We are undertaking a historiography, understood as a critical analysis of authentic historical source materials, of a narrative that has been sealed for more than 40 years. Building upon this historiography, we ultimately seek to address a question of enormous salience for contemporary nursing epistemology. What happens to nurses' "knowing" in the context of state-sanctioned violence? To what extent can our ways of knowing become overwritten or "patterns gone wild," as Chinn and Kramer[1] describe, when violence becomes normalized, even routinized? Drawing upon a recently unsealed narrative of nurses' participation in the Nazi "euthanasia" program, which killed tens of thousands of psychiatric patients in Germany during the years 1940–1945, we build on our prior work[2–5] examining the role of bio-power in shaping nursing epistemology to examine the implications for contemporary nursing. Specifically, this article seeks to (1) describe the historical context in which nurses' participation in the Nazi euthanasia program occurred; (2) present a recently unsealed narrative testimony of a nurse accused of active participation in the euthanasia program; and (3) analyze this account from a critical-feminist perspective, with a focus on its epistemological salience for contemporary nursing.

Author Affiliations: *College of Nursing, Medical University of South Carolina, Charleston (Dr Benedict); Hahn School of Nursing and Health Science, University of San Diego, San Diego, California (Dr Georges).*

The authors thank Traute Lafrenz Page, MD, who accompanied one author to the archives in Munich, Germany, and who graciously spent many hours translating the archival documents. In addition, the authors thank the staff of the Staatsarchiv München for their generous assistance in locating relevant documents and facilitating the petition to the German government for access to these documents.

Corresponding Author: *Susan Benedict, CRNA, DSN, FAAN, College of Nursing, Medical University of South Carolina, 99 Jonathan Lucas St, Charleston, SC 29425 (Benedics@musc.edu).*

HISTORICAL CONTEXT OF THE EUTHANASIA PROGRAM

With severe economic problems affecting Germany following World War I, psychiatric patients were moved into rural areas in an effort to decentralize the cost of care.[6] Instead of providing further support in community settings, psychiatrists created a 2-tier system with intensive therapy for acute cases and minimal therapy for chronic patients, coupled

with sterilization of those discharged from institutions.[7] Funding for psychiatric care was drastically reduced as the notion of providing even custodial care for "lives not worth living" was discredited through the publication of *Release and Destruction of Lives Not Worth Living* by Binding and Hoche[8] in 1920. This book—written by professors of law and of medicine—advocated the killing of the incurably ill and became a foundational text in the growing Nazi ideological movement.[9]

In the 20 years intervening between the publication of this book and the implementation of the euthanasia program, Nazism became the dominant ideology of Germany as Hitler and National Socialism came to power. Under the Hitler regime, an officially state-sanctioned goal was established of eliminating all who were living "lives not worth living," such as psychiatric patients who were unable to contribute valuable work to the Reich. Institutions for the mentally ill saw their budgets for food, utilities, and personnel cut even as patient occupancy increased.[7,10]

With the invasion of Poland by Germany in 1939 and the escalation of war, large numbers of wounded German soldiers were returned to the Fatherland. The reallocation of the institutional space, personnel, and supplies for the war effort gave a further impetus for the elimination of these long-term psychiatric patients in the context of Nazi ideology. By 1940, state-sanctioned euthanasia of mentally ill persons was codified in the T-4 euthanasia program.

THE T-4 EUTHANASIA PROGRAM

The organized program established by the Nazi government to "dispose of" mentally ill persons was termed euthanasia and was known by the code name of "T-4" after the address of the program headquarters at Tiergartenstrasse 4 in Berlin. Six centralized killing centers were established for mentally ill persons, 5 of which were at psychiatric institutions where inpatients were gassed in groups. In a very systematic manner, patients from other mental institutions throughout the Third Reich were transported to these centers to be murdered. Ultimately, an estimated 70 273 adult psychiatric patients were killed in the T-4 program.[11]

The T-4 euthanasia program ended on August 24, 1941, because knowledge of the killings was becoming widespread and, perhaps more importantly to the Reich, the goal of exterminating 70 000 nonproductive patients had been achieved. However, the termination of the gassing program did not end the murder of psychiatric patients in Nazi Germany. In fact, more patients were killed in the next phase of the elimination program, termed "wild euthanasia," than were killed in T-4.[12] Patients in this phase of the killings were no longer gassed in groups but were killed individually by nurses and physicians using lethal doses of medication.

WILD EUTHANASIA PROGRAM

In the so-called wild euthanasia program, individual physicians were authorized to put to death any and all patients whom they chose, without any prescribed criteria. It is important to note here that the physicians were granted authorization by the state to kill. However, they were not ordered to kill. The following quote by a witness to the wild euthanasia program gives the flavor of the context in which some of these decisions to kill were made, either for staff convenience or for the imposition of social control: "At first those patients were killed who gave a lot of trouble, who were rebellious. Their illness or age did not play a role. Sometimes patients were killed because they had started a romantic relationship with another patient."[13(p7)]

The majority of patients killed in the wild euthanasia program were those who were so mentally or physically incapacitated that they were not able to perform any kind of work at their institution. Thus, the notion of "useless eaters" was a central theme of the discourse surrounding the rationale for the killing of the persons with disabilities. In accordance with the National Socialist ideology of the

dominance of a perfect master race, the allocation of valuable resources during wartime, such as food to persons considered inferior, was deemed wasteful, thus providing a rationale for a policy of killing.[9]

THE MESERITZ-OBRAWALDE STATE INSTITUTION

Unlike the organized T-4 euthanasia program, these wild euthanasia killings were done on an individual basis, usually with an overdose of barbiturates or morphine and scopolamine. One of the main sites for these killings during the Third Reich was the state institution of Meseritz-Obrawalde located in the (then) German province of Pomerania.[14] Currently, Obrawalde is still an active psychiatric hospital with approximately 20 2-story brick buildings located on a college-like campus. The hospital now is known as Obrzyce and is located in the eastern sector of the town of Miedzyrzecz (formerly Meseritz) in Poland.

Obrawalde was a very self-contained microcosm in which everyone, including patients, was put to work. The institution had its own gardens, farms, and graveyard with patients providing most of the labor. Even Angora rabbits were raised for their fur.[15] Such self-contained asylums were a common model of psychiatric treatment in the Western world during the late 19th century and early 20th century. Within these settings, nurses often functioned in a closed system and participated in a range of practices including seclusion, electroshock therapy, and experimentation, sometimes in an unethical and abusive fashion.[16] At Obrawalde, this self-containment had 2 parallel consequences that facilitated the killings there: limitation of contact by the staff with outsiders and the further devaluation of any patient who was unable to work.

Under the administration of Walter Grabowski, an enthusiastic Nazi, euthanasia killings began at Obrawalde in 1942 and eventually included both inpatients and patients transported from other psychiatric institutions for the purpose of being killed at Obrawalde.[14] Because the patients in the outlying institutions had been subjected to radical decreases in their allotted resources at the institutions and care had been minimal, the patients often arrived in dire condition. Dr Hilde Wernicke, one of the physicians at Obrawalde, described one of these transports in her trial in 1945:

> At the beginning of 1942, the first trains with about 700 patients arrived at Obrawalde. At the end of the year and especially in 1943 these trains arrived more and more frequently. From all parts of Germany patients were abducted to be killed in Obrawalde. All the nurses and orderlies had to unload the patients. The ill persons were in horrible condition. Many were emaciated and they were very dirty. This condition contributed to the fact that the nursing personnel were able to distance themselves emotionally from those people who had been brought into such a condition beneath human dignity and that the personnel without any considerable pressure could be convinced to kill thousands of people.[10]

THE EUTHANASIA PROCESS AT OBRAWALDE

Hospitalized patients were selected for death by 2 physicians, Drs Mootz and Wernicke. These physicians would make rounds in their assigned wards and review the patients' charts, stopping occasionally to briefly examine some patients. Those who were severely ill or those who were less ill but unable to work were selected to be put to death. It is salient that the physicians did not do the killings; the actual killing process using medication overdose was performed by the nurses of Obrawalde.[15] Wernicke further testified:

> From the very beginning I refused to perform the killing myself. I was able to adhere to this position by saying that it would appear too obvious if I did it myself.[10]

The killings took place on specific wards of the different buildings. On these units, isolation rooms were designated as the "special" rooms for killing. If a selected patient was housed on another unit without a special

room, he or she was escorted by a caregiver to the unit equipped to accommodate the procedure.[14] In some cases, patients were given a sedative before being led into the special room. Once inside, the killing was done with an overdose of a barbiturate such as barbital (Veronal) or phenobarbital (Luminal) administered orally or, if the patient was unable or unwilling to take the oral medication, with an injection of morphine and scopolamine. At times, when medication was not available, an injection of air into the vein was given.[14] Dr Wernicke described the procedure for killing with oral medication overdose in exact detail:

> The killing with oral medication was in the following manner: One of the caregivers would hold the patient upright and the other would force the poison down the patient's mouth. When patients were found [to be] unusually restless, several caregivers had to be involved. If the patient refused to take the drink, one of the caregivers would speak in an assuring manner to the patient so that they would swallow the poison.[10]

The killings continued in this way until the day before the Soviet army arrived on January 29, 1945. The army found that the staff had fled and that approximately 1000 patients had been abandoned in Obrawalde. Stockpiles of more than 800 ampoules of morphine, 2000 ampoules of scopolamine, and syringes were discovered along with store rooms containing huge quantities of patients' clothing and shoes. There was a crematorium, an uncompleted gas chamber, and 2 mass graves with more than a thousand corpses in each.[17] Army pathologists established that 18 232 patients had died there over a 3-year period.[17]

IMMEDIATE DISPOSITION OF SELECTED OBRAWALDE PERSONNEL

Amanda Ratajczak, a nursing supervisor at Obrawalde, fled on January 29, 1945, but was captured by the Soviet soldiers in early March 1945. She admitted to killing more than 1500 patients herself. In fact, her last murders occurred just 1 day before the arrival of the Soviet army.[17] She was given a brief trial by the Soviets and was made to reenact the killings, demonstrating the medications and syringes. The Soviets filmed this reenactment. Following this trial, she and a male caregiver named Hermann Guhlke were executed by shooting on May 10, 1945.[17] Dr Hilde Wernicke fled Obrawalde with her friend, nurse Helene Wieczorek. They were arrested in August 1945 and were tried for murder in the first euthanasia trial before a West German court in March 1946.[17] Both were sentenced to death in Berlin and executed on January 14, 1947.[17]

NINETEEN YEARS LATER: THE NURSES' TRIAL

In marked contrast to the immediate sentencing and execution of these Obrawalde personnel, another 19 years would pass before the other nurses who participated in the euthanasia program would be brought to trial. In February 1965, 14 of the nurses of Obrawalde were put on trial for the murder of their patients in an event identified in the popular German press as the *Schwesternprozess* or "Nurses' Trial." The passage of 19 years was, no doubt, extremely important for the defense. The attorneys had the benefit of seeing successful defenses of others accused of euthanasia, and the defendants themselves had plenty of time to rationalize their actions and prepare plausible explanations. And, perhaps of equal if not greater importance, the German public's interest in the crimes of National Socialism had waned.[18] In fact, in a trial occurring in Frankfurt during the same year, one of the prosecutors stated, "The majority of the German people do not want to conduct any more trials against the Nazi criminals."[19(pxi)]

It was in this sociopolitical atmosphere that the court found that criminal action was not proven for some of the nurses, including Erna D., Margarete Maria M., and Meta P. Their statements that they had not realized that their patients were going to be killed could not be refuted in the trial. Ten remaining

defendants were found to have been "partakers in the killings, but the trial transcripts stated they

> in no case acted on their own. They simply followed the orders of their superiors *without identifying themselves with the activity* or approving of it. Because the accused followed the physicians' orders when executing the killings, they had no say-so in the action. They merely have to be looked at as *helpless* [authors' italics].[14(p710)]

Thus, all 14 of the nurses tried in the "Nurses' Trial" were acquitted on March 12, 1965. All files regarding these trials were sealed and placed in the Staatsarchiv München (State Archive of Munich) upon the conclusion of the trials. Originally, the files were sealed for a period of 80 years after the birth of the youngest defendant. To access these files before that date, the primary author (Benedict) had to go through a lengthy petitioning process of the German government and agree to not use the defendants' full names in publications.

THE CASE OF LUISE E.

Of these 14 nurses, Luise E. was the main defendant and was accused of participating in the killing of 210 patients. Because of her status as the main defendant, we have chosen her narrative to analyze as an exemplar of nurses' participation in the Nazi euthanasia program. Interwoven with her narrative, we provide an analysis of the epistemological themes of her discourse from a critical-feminist perspective. We consciously choose the critical-feminist perspective, understood as the rendering salient of power relations along the axes of gender, ethnicity, and class as a lens for our analysis. While a complete analysis of this narrative in the critical-feminist perspective (or any perspective, for that matter) is beyond the scope of this article, we choose to focus here on epistemology, understood as the nature of knowledge and its social construction. Thus, our approach to Luise's narrative is situated in the critical analytic tradition of nurse scholars in epistemology such as Carper[20] and Chinn and Kramer[1] who have used "ways of knowing" as a central trope in exploring the social construction of nurses' knowledge. We undertake this exploration of Luise's discursive patterns regarding who knew what during the mass murder of patients—and how they knew—as a backcloth for our examination of implications for contemporary nursing.

Biographical information

Luise E. was born on April 5, 1901, in Gumminshof. Her parents had been farmers. After attending school in Gumminshof, she began her nursing education at the Treptow psychiatric institution and stayed there following graduation in the early 1920s. Thus, her education in psychiatric nursing was typical for Germany at that time, and she was an experienced nurse by the time these events occurred. When the Treptow institution was closed in October 1941, she was sent to Meseritz-Obrawalde where she worked until the Soviet Army arrived on January 29, 1945.[21]

Luise's role in euthanasia

At Meseritz-Obrawalde, Luise E. was assigned to work in the quiet admitting ward. It was to this ward that patients arriving from other institutions were admitted.[21] Luise E. experienced her first case of euthanasia in the presence of Dr Wernicke in 1943.[21] The following is a narrative by Luise concerning her initial involvement. Throughout these narrative excerpts are from Luise, we have italicized selected words and phrases for analytic purposes.

> The actions of Dr. Wernicke *gave me the clear picture* that incurable sick patients were to be saved from their suffering by large dosages of Veronal. Neither *Dr. Wernicke nor any other person in Obrawalde ever talked to me* about euthanasia. I *never was told or sworn to keep these things secret*. There *never was a lecture* or other form of instruction about the subject. I thought *it was presumed that I agreed* with the practice of euthanasia.[21]

In a strangely telegraphic manner in which no words were ever spoken, Luise received a clear picture about what is about to happen to the patients and her role in it. She—and everyone else in the loop—*knows* about it. In a salient phrase, she says she has never been sworn to secrecy—a phrase usually associated with illegal or socially forbidden activities. There was no lecture or formal educational class that might give some gloss of professional respectability to these activities. The fact of mass murder was simply there, and everyone presumed that everyone else agreed to participate.

Later in her narrative, Luise did express conflict and even questioned the legality of—and possibly her culpability in—these killings. Despite the dire condition of some of the patients, Luise expresses a wavering sense of knowing who is—and is not—"human" in this context:

> . . . I had to fight severe inner battles when I was confronted with the problem of partaking in euthanasia. The way I experienced it at that time *it seemed more like killing human beings*.[21]

She seems to have lost her knowledge of who is—and is not—a human being in this social context. She goes on to explore the hegemony of "the law" in informing her knowing what was or was not allowed. Ultimately, she accepts the hegemony of physicians' ways of knowing what is legal and what is not:

> Was there any form of legislation which would allow such killings? I was never told that such a law existed. At another time, Dr. Mootz *assured me I should not worry at all about these things* because he would cover up for me. These remarks *gave me the idea that there was something legal* about the practice of euthanasia.[21]

In addition to relying on physicians' ways of knowing, Luise describes her deference to the ways of knowing displayed by her head nurse, Amanda Ratajczak.

> In the beginning of 1943. . .via my supervisor, Miss Ratajczak, Dr. Wernicke ordered me to administer 5 grams of Veronal. . . . Since Ratajczak *seemed to notice I was somewhat hesitant* she administered the Veronal herself. . .the Veronal was not sufficient, (and therefore) injections of morphine and scopolamine were prepared, and I remember that Ratajczak injected the patient. Two days later the patient died.[21]

A silent dialogue seems to be going on between staff nurse and supervisor, in which the supervisor knows what to do and demonstrates it to Luise, even to the point of showing her that sometimes multiple, repeated dosages are needed to achieve the desired outcome of patient death.

A tension between Luise and her nursing supervisor emerges, as Luise recalls that she was not always in agreement with the selection of those to be killed:

> I never had a good relationship with Ratajczak. She thought I did not tow the line satisfactorily, meaning that I did not do everything the way she wanted it. I was always convinced that the killings were *justifiable in some cases but not in others*. . .out of the 10 killings at which I was present, four or five were not justifiable in my opinion. Of course, I have to concede that *my opinion is that of a layman*. Ratajczak was *more liberal in her judgment* about which of the patients was to be killed. *She followed Dr. Wernicke's judgment unconditionally*. I myself had *to ponder seriously* about each case to judge the rightfulness of the killing.[21]

In an odd turn of phrase, Luise discounts her own ways of knowing and identifies herself as a layman, not privy to the level of knowledge possessed by physicians or nurse supervisors in the situation. Nevertheless, she ponders seriously about each case, implying that, after all, she does possess her own ways of knowing. She makes a clear distinction between her thinking response and the more unconditional response of her supervisor, Ratajczak. Later on, Luise comments on the process used by Dr. Mootz to make the selections:

> On the day before the killings, Dr. Mootz requested the history of the patients that he would name. . .Dr. Mootz would walk up to the patients' beds and look at them. He did not examine them. Afterwards he gave the order. So the order was given *only* according to the patients' history and the external appearance. . .in my humble opinion there was no justification for the killing in about

half of the cases. It was due to these cases which seemed to be not justified that I was constantly in such inner turmoil.[21]

Luise is therefore critical of Mootz's cursory selection process, which leaves the reader to wonder if she knew these patients in other, more personal ways—ways far beyond those accessible using only a written history and a quick glance. Did she as a nurse with years of experience in a psychiatric setting have a sense, perhaps, of the potential for connectedness with these patients who were being disposed of so casually? She goes on to describe the way in which the physician would give the actual order:

(Dr. Mootz's) orders sounded about like this: "Miss E., *let us take* about 5 grams of Luminal." At times some other sedative would be ordered, just whatever was available. *He did not say more*, nothing about how or when the medication should be administered. After this, Dr. Mootz would turn around and walk to the next bed.[21]

In a telling phrase, Dr Mootz issues a verbal order in the first-person plural ("Let *us* take. . ."), somehow including both himself and Luise in the statement. But immediately after his brief verbal inclusion of himself, he physically removes himself. He has now effectively erased himself from the context, leaving Luise to carry out an activity that has been left purposefully vague in its process and intent. Regarding these interactions with Mootz, Luise remarks that she fully knew what was being conveyed to the point of not needing any additional explanation:

More he (Dr. Mootz) never would say *but I understood what he meant*. Having taken orders for many years plus my previous experience with Dr. Wernicke, I was fully aware what these high dosages of barbiturates were meant to achieve. Dr. Mootz *did not need to say anything more*.[21]

In the course of describing the process of the killings, another group of knowers now emerges in Luise's narrative—the patients themselves:

There was a *special* room with two beds next to the ward of the severely ill patients. The *only purpose* of this room was to bring the selected patients into this place. . . . *I do not think that the selected patients or any other of the patients in the room were aware of the significance of transferring a patient to the special room*.[21]

Is she assuaging her own conscience by dismissing any possibility that the patients had knowledge of what was really happening? Or is she broadly assuming that persons with mental illness were incapable of interpreting the semiotics of being taken to a "special" room, from which no patient ever returns? Of course, we ourselves do not "know" exactly what these patients knew. What we do know is that many persons who were being transferred into "specially" designated locations for torture or killing by the Third Reich (eg, Auschwitz) report knowing *exactly* what was happening, regardless of their mentation status.[5] That Luise can so categorically assert that patients had no knowledge of their impending deaths in all cases seems suspect, particularly as she goes on to describe the process of killing patients:

If the patient was extremely *restless, which happened quite frequently,* three caregivers were needed for the procedure.[21]

The procedure for killing the patients was described by Luise in a very straightforward manner, including a description of how she and other nurses would sometimes talk soothingly to patients as they were in the process of killing them, thus creating a striking juxtaposition of "caring while killing" within her discourse:

In general, either the ward caregiver or I would sit the patient up in her bed, *put an arm around her and talk to her consolingly*. So one of us would hold the patient in an upright position and the other caregiver would hold the glass of medication. Then the patient either was able to swallow the fluid down on her own or it was given to her with a spoon.[21]

Luise's description of the killing process is remarkable on many levels. That she refers repeatedly to these patients with the feminine pronoun ("her") in this location is notable. In other parts of her narrative, she states that she had killed patients of both genders. That

she chooses to describe the routine or default process for killing a patient with feminine pronouns has a semiotic significance when viewed from a critical-feminist perspective. Was it more comfortable psychologically for her to cast her patients as females in her recounting of the actual procedure, with the killing of males (deemed "superior" to women in the Nazi ideology) now conveniently omitted? Or is there a possibility that, perhaps at some level, she felt a sense of identity with the female victims of a brutal ideological system, as she was being compelled to carry out its mandates?

Luise's narrative of this procedure sounds strangely familiar to contemporary nurse readers. The discursive elements (giving emotional support, using a helpful piece of equipment—ie, a spoon) that she includes are commonly present in our own nursing textbooks and protocols. Luise seems to express here that she knows what she is doing: she is a competent nurse, and this is how she carried out a procedure. That this procedure was essentially a murder has disappeared from her knowing. In marked contrast to the previously cited statement in which Dr Wernicke stated that caregivers would "*force* the *poison* down the patient's mouth,"[10] no words signifying violence are present here. Luise seems to be in a discursive space somewhere beyond good and evil or caring and violence. Violence can be made to disappear, if it is committed gently, caringly, as a "good" nurse should.

As she reflects on which patients whom it was acceptable to kill, a list of inclusion criteria she somehow knows begins to emerge:

> In my opinion, only those patients should have been killed who showed all signs of a very near end of their lives—*maybe about three weeks or less* until they would die, or other patients who had *so many deep bedsores* (decubitus ulcers).[21]

How she arrived at the seemingly arbitrary figure of 3 weeks' survival or the presence of multiple, deep decubiti as criteria for killing is not revealed. She continues to describe, however, how her knowledge of patients remained a source of conflict:

> I did not approve of killing patients who had totally lucid intervals between their attacks of insanity and those in whom I could see some hope for improvement. . .these were the cases which caused me the severe conflict that I have talked about.[21]

Strikingly, here she validates her ways of knowing as an experienced nurse. From her prior description of herself as "just a layman," lacking the knowledge possessed by her nursing supervisor and physicians, she describes herself as very capable of knowing which patients had a chance for improvement. In a subsequent statement[22] on August 23, 1961, Luise elaborated on the way in which she managed the conflict of killing these potentially improvable patients. In a clear manner, she describes the subsuming of her own knowing as a nurse into a hierarchical system in which she has been carefully socialized:

> When I did participate in those killings and thus acted against my inner attitude and conviction, I did so because *I was used to obeying strictly the orders of the physicians. I was brought up and instructed to do so*. As a nurse or orderly, *you don't have the level of education of a physician* and thus can't evaluate if the order of the physician is right. The *permanent process of obeying the order of a physician becomes second nature to the extent that one's own thinking is switched off*. . . .[22]

A paradox is here: she knows, but, at the same time, she *doesn't* know. The permanent social process of deferring to physicians renders her ways of knowing not just irrelevant in this context, but actually nonexistent. Her ways of knowing seem to exist at times, but at other times are totally obviated, as if they never existed at all.

This paradoxical knowing-while-not-knowing continues as a theme as Luise E. reflects on her faith tradition and spiritual values. She reflects on her own situatedness in the Protestant Christian tradition:

> I was and still am without interruption of the Protestant faith . . . the commandment "Du sollst nicht töten" (Thou shall not kill) is *truth* for me. When I did the killings, I must admit that *I offended*

this commandment. But as I expressed in my questioning, I didn't do it with a light heart, but *only after serious inner fights* did I obey the orders. . . . *I prayed to my God to forgive me* in such a case. In addition, I had to suppose that the ill people selected to be killed by the physicians were such seriously ill people that even in case of a mistake, *I had to see it as a release for them*.[22]

Thus, Luise has a certain knowledge of what constitutes an established truth in her faith tradition, consonant with the Protestant view of sacred scripture as a received text. But at the same time, it also appears to be for her a somewhat malleable truth. While she recognizes that she has transgressed a truth, her reframing of killing as a release from suffering creates a parallel truth that alleviates her culpability.

Throughout her narrative, Luise expresses a continual sense of being in a psychological no-person's land, a painful space in which she seems at times to know with a profound certainty. At other times, her knowing is erased by the superior knowing of the dominant persons in her context. She seems disconnected, adrift in a space in which everyone—and no one—knows what is going on. She is left hoping that a personal, connected, higher power ("*my* God") will show her a compassionate understanding, beyond the boundaries of scriptural commandments and a patriarchal, hierarchical system of power in which obedience to authority is second nature.

IMPLICATIONS FOR CONTEMPORARY NURSING

Ethical and political analyses of nurses' participation in the atrocities committed under National Socialism in Germany have only recently entered the scholarly literature beginning with the pioneering research of Dr Hilde Steppe[23] and her publication of *Krankenpflege im Nationalsocialismus* in 1989. Subsequent studies of nursing during the era of National Socialism have examined the roles of nurses in the euthanasia programs and in the concentration camps.[2–5] The relative scarcity of a nursing presence in the literature of this era, in marked contrast to that of physicians, is in itself a remarkable lacuna. Perhaps the traditional view of nurses as merely the robotic arms of physicians has rendered the consideration of nurses as moral agents not applicable in this context. Certainly, the court's 1965 finding that the nurses were *helpless* and followed the orders of their superiors "*without identifying themselves with the activity*"[14(p710)] reflects this view. Perhaps, also, the socially constructed concept of nurse in the Western tradition as akin to a maternal presence or angelic—in marked contrast to the construction of the physician/scientist as rational/technical—has rendered the presence of nurses in these atrocities unthinkable.

We seek to look beyond these notions of essentialism to examine Luise's actions—and ways of knowing—beyond the simple response of "she had no choice." As Eisenstein[24] notes in her critique of the use of gender at Abu Ghraib to promote a hetereosexist, normative agenda, gender is a crucial—and complex—factor in war. It *matters* that Luise E. was a woman, carrying out the brutal dictates of a fascist, imperialist/masculinist regime. We acknowledge that she may have had few other options in this context but to cooperate. What we wish to render salient are the ways in which power relations, particularly in a hierarchical, masculinist system, can potentially overwrite our ways of knowing, deforming, or even utterly erasing them. Like Luise E., contemporary nurses are situated in what Agamben[25] terms "zones of bio-power," understood as locations in which sovereignty—power over life and death—is enacted. Within these zones, participation in violence is a very real possibility for nurses, whether we inhabit explicit zones of bio-power such as Abu Ghraib or the more subtle zones of bio-power enactment such as hospitals or universities.

MIMESIS

As Ricoeur[26] notes, narration does not function merely as repetition. The very telling

of Luise's narrative functions to reveal new meanings to us as listeners, resulting in what Ricoeur[26] terms as *mimesis*, or the creative imitation of another's experience within our own. From a mimetic standpoint, Luise E.'s narrative presents us with some powerful implications for contemporary nursing epistemology. We reject the notion that nursing involvement in the activities of the Third Reich is something so long ago and far away that it constitutes an irrelevant narrative for contemporary nursing. Rather, we acknowledge that contemporary nurses continue to be situated in a biopolitical space that is fully part of the same European meta-narrative that informed Nazi Germany. As uncomfortable as this knowledge may be, the power relations that became the blatantly defining characteristics of the Third Reich—sexism, racism, and imperialism—continue to be a part of our discursive world. As Allen[27] states, the events and discourses that have brought us to this present moment in nursing "recede endlessly backward into a Eurocentric cultural context characterized by sexism, racism, and classism." Thus, Allen[27] asserts, we carry this context *within* us.

RESISTING THE OVERWRITING OF OUR KNOWING

Georges[28] states that nursing is currently in an especially critical space in regard to its growing awareness of bio-power in shaping its epistemology. While a growing awareness of the sociopolitical context in which nursing exists constitutes a salient feature of contemporary nursing scholarship,[28] we have yet to explore fully the ways in which biopower can—and does—overwrite our knowing. While a full exploration of the overwriting of Luise E.'s ways of knowing is beyond the scope of this article, we choose to focus our analysis here on a signal passage in her narrative. In a remarkable statement, Luise describes how during her killing of patients she would "put an arm around her (the patient) and talk to her consolingly." It is this juxtaposition of "killing while caring" that has, perhaps, a special salience as we reflect on the implications of Luise's narrative for contemporary nursing epistemology.

"CARING" OVERWRITTEN AS VIOLENCE

There exists in contemporary nursing literature a growing endorsement of the concept of caring as a defining focus for nursing. We do not disagree with this development per se. As nurses invested in holistic nursing, we are certainly supportive of the model developed by Watson[29] of nursing as a caring, biogenic praxis in opposition to an oppressive, biocidal one. We have no objection to such a stance. What we do object to is the overwriting of our knowing about caring—with consequent violence to ourselves and our patients—that can occur when a sexist, hierarchical discourse appropriates caring for its own purposes. For example, we have witnessed the reduction of caring to a prescriptive list of normative behaviors, such as smiling, eye contact, and appropriate touching, in some healthcare institutions. Of course, we do not object to nurses possessing interpersonal skills. What we do object to is the transformation of the powerful and complex concept of caring—by which we mean *connected praxis*—being reduced to behaviors enforced by institutions for the purpose of increasing patient satisfaction scores.

With such an appropriation, caring now becomes a twisted, deformed entity that can be used, almost as a weapon, as part of an apparatus of violence. As long as Luise E. speaks soothingly to her patients while she murders them, she is still a good nurse. Similarly, as long as we teach our students to render caring as the hallmark of nursing—*with caring now understood as personal kindness to patients ensconced in a brutalizing healthcare system*—we allow violence to continue. We perpetuate the overwriting of our knowing when we allow such a powerful—and potentially empowering—concept as caring to be reduced merely to a personal interactive

style, characterized by essentialist womanly attributes as a soft voice and smiling acceptance. Real caring does not consist merely of a kindly gesture in an otherwise heinous environment. It also consists of open protest that such environments even exist, the identification of the power relations that produce them, and the creation of alternative environments for health and healing. If Luise E.'s narrative teaches us anything, it is that the very heart and soul of nursing—our capacity for truly knowing our patients in a connected praxis—is *always* at risk for being hijacked into an apparatus of oppression to cover over violence.

A SHARED LEGACY

Like it or not, we share a legacy with Luise in a very deep way. The narrative of Luise E. makes us uncomfortable, and with good reason. We come from the same European meta-narrative of sexism, racism, and imperialism. We exist in a context of a healthcare system that increasingly casts patients in the role of budget line items in a corporate environment, thus dehumanizing them. We are situated in a place and time in which explicit zones of bio-power such as Guantanamo Bay are funded by our tax monies. These are obvious exemplars of social violence. But more subtly, and just as importantly, in our daily lives as clinicians, educators, and researchers, we face the risk of having what happened to Luise happen to us: knowing while not *really* knowing. We exist in an environment in which nurses can and do inflict suffering on other nurses, resulting in a pattern of oppression and violence against ourselves.[30] Thus, our ways of knowing—about ourselves and our patients—can be deformed and obviated in the service of violence. The narrative of Luise is both a warning and a lesson: the need for nurses to resist such overwriting assumes paramount importance, if nursing is to retain its humanity.

REFERENCES

1. Chinn PL, Kramer MK. *Integrated Theory and Knowledge Development in Nursing*. 7th ed. New York: Mosby-Elsevier; 2004.
2. Benedict S, Kuhla J. Nurses' participation in the Nazi "euthanasia" program. *West J Nurs Res*. 1999;21(2):246–263.
3. Benedict S. The nadir of nursing: nurse-perpetrators of the Ravensbruck concentration camp. *Nurs Hist Rev*. 2003;11:129–146.
4. Benedict S, Georges JM. An ethics of testimony: prisoner nurses at Auschwitz. *Adv Nurs Sci*. 2006;29(2):161–169.
5. Benedict S, Georges JM. Nurses and the sterilization experiments of Auschwitz: a postmodernist perspective. *Nurs Inq*. 2007;13(4):277–288.
6. Geary B. *Hitler and Nazism*. London: Routledge; 1993.
7. Burleigh M. Euthanasia in the Third Reich: some recent literature. *Soc Hist Med*. 1991;4:317–328.
8. Binding K, Hoche. *Die Freigabe der Vernichtung Lebensunwerten Lebens: ihr Mass Und Ihre Form*. Leipzig: F. Meiner; 1920.
9. Proctor R. *Racial Hygiene*. Cambridge, MA: Harvard University Press; 1988.
10. Statement of Dr. Hilde Wernicke, December 7, 1945, File TR 10/2584, Yad Vashem, Jerusalem, Israel.
11. Becker HJ, Lorent FR. *Trial Transcript. Landericht Frankfurt*. May 27, 1970:715. KS 1/69 (GstA).
12. Friedlander H. *The Origins of Nazi Genocide: From Euthanasia to the Final Solution*. Chapel Hill: University of North Carolina Press; 1995:151.
13. Statement of Walter Weyde in Hamburg on January 4, 1972. File TR10/22584, Yad Vashem, Jerusalem, Israel.
14. Sagel-Grande I, Fuchs HH, Rueter CF. *Heil- und Pflegeanstalt Meseritz-Obrawalde, Justiz un NS-Verbrechen*. Vol XX. Amsterdam: University Press Amsterdam; 1979:710.
15. Statement of Otto Freund. Staatsarchiv München, File number 33.029/3, December 4, 1962.
16. Nolan P. *A History of Mental Health Nursing*. Cheltenham, UK: Stanley Thornes; 1998:74–94.
17. deMildt D. *In the Name of the People: Perpetrators of Genocide in the Reflection of their Post-War Prosecution in West Germany*. The Hague: Martinus Nijhoff; 1996:65–66, 180.
18. Benedict S, Caplan A, Page T. Duty and "euthanasia": the nurses of Meseritz-Obrawalde. *Nurs Ethics*. 2007;14(6):781–794.
19. Arendt H. Introduction. In: Naumann B, ed. *Auschwitz*. New York: Frederick A Praeger; 2005: xi.

20. Carper B. Nurses' ways of knowing. *Adv Nurs Sci*. 1978;1(1):13–23.
21. Statement of Luise E. Staatsarchiv München, File Number 33.029/2, June 19, 1961.
22. Statement of Luise E. Staatsarchiv München, File Number 33.029/2, August 23, 1961.
23. Steppe H. *Krankenpflege im Nationalsocialismus*. Frankfurt am Main: Mabuse Verlag; 1989.
24. Eisenstein Z. Sexual humiliation, gender confusion and the horrors at Abu Ghraib. http://www.awid.org/eng/Issues-and-Analysis/Library/Sexual-Humiliation-Gender-Confusion-and-the-Horrors-at-Abu-Ghraib/%28language%29/eng-GB. Accessed January 6, 2009.
25. Agamben G. *Homo Sacer: Sovereign Power and Bare Life*. Heller-Roazen, trans-ed. Stanford, CA: Stanford University Press; 1998.
26. Ricoeur P. *Hermanetics and the Human Sciences*. Thompson JB, trans-ed. Cambridge: Cambridge University Press; 1981.
27. Allen D. September 11 and the eminent practicality of poststructuralism. *Nurs Inq*. 2002;9(1):1–2.
28. Georges JM. Bio-power, Agamben, and emerging nursing knowledge. *Adv Nurs Sci*. 2008;31(1):4–12.
29. Watson J. Caring theory as an ethical guide to administrative and clinical practices. *Nurs Adm Q*. 2006;30:48–55.
30. Giddings L. A theoretical model of social consciousness. *Adv Nurs Sci*. 2005;28(3):224–239.