

# Useless Eaters: Disability as Genocidal Marker in Nazi Germany

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The methods used for mass extermination in the Nazi death camps originated and were perfected in earlier use against people with physical, emotional, and intellectual disabilities. This article describes the historical context of attitudes toward people with disabilities in Germany and how this context produced mass murder of people with disabilities prior to and during the early years of World War II. Several key marker variables, the manipulation of which allowed a highly sophisticated Western society to officially sanction the murder of people with disabilities, are examined. Important implications must continually be drawn from these sad events as we work with people with disabilities at the dawn of a new century.

*Would you, if you were a cripple, want to vegetate forever?*

—Dr. Tergesten, in the propaganda film *Ich Klage an!*

(*I Accuse!*, 1941)

Even given the passage of time and the necessary exposure of many people to commonly known historical events about Nazi Germany, some facts are more familiar than others. Historically, the focus has remained on the state-sanctioned genocide of the war years, which resulted in the extermination of Jews and to a lesser extent other populations, such as the Gypsies, political prisoners, and homosexuals (Yahil, 1987). In secular terms, images of death camps and the Nuremberg Trials represent the nadir of a humanitarian conflagration that began with the invasion of Poland in 1939 and ended with Germany's surrender and political and physical partitioning in 1945.

However, relatively little attention has been paid to significant precipitating historical events that served as a catalyst for what later became known as the Holocaust. These events, rooted in powerful societal and scientific perceptions of difference with parallel extensions in state policy and action, were intensified and codified with the rise of National Socialism and Hitler's assumption of power in 1933 (Aly, Chroust, & Pross, 1994; Friedlander, 1995). Official notions of difference, which would later find their most diabolical expression in the murder of the Jews, were first expressed in state-sanctioned killings of children and adults with a wide range of physical, emotional, and intellectual disabilities.

I draw on the relatively few but important sources available in English to illustrate a neglected historical aspect of perceptions of people with disabilities for several purposes. First, I provide a description of the historical context under-

girding perceptions of and attitudes toward people with disabilities in Germany and how this context produced mass murder of people with disabilities prior to and during the early years of World War II. Second, I examine several key marker variables, the manipulation of which allowed a highly sophisticated Western society via state law and policy to sanction the murder of people with disabilities. Third, I provide a brief synopsis of implications that can be drawn from this conflagration that influence work with and on behalf of people with disabilities in the 21st century.

## People with Disabilities in Germany: Historical Underpinnings

The idea of societies disposing of people with disabilities was hardly new at the dawn of the 20th century. There is ample evidence that both medical and legal debates across Europe, including in Germany in the 19th century, included fatal solutions for inmates of asylums and others with physical, emotional, and intellectual disabilities. These historical attitudes gathered momentum, however, in the late 19th and first half of the 20th centuries.

### *Treatment Prior to World War II*

Along with the rest of Europe after the Enlightenment, Germany sought to address difficult issues related to people with disabilities. As in the United States, late-19th-century German efforts to meet the needs of this population consisted largely of custodial care either privately by family members and church

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institutions or in state asylums. These efforts were reflected in a significant increase in the number of publicly sustained German asylums, which increased from 93 in 1877 to 226 in 1913 (Burleigh, 1994). There was also a concomitant increase in the number of private institutions providing various levels of residential care to those with a wide spectrum of disabilities. This state of affairs remained relatively stable until World War I.

The outbreak of war in 1914 precipitated significant changes for people with disabilities across Germany. The logistics and material requirements of fighting a major conflict soon had social and economic repercussions among all sectors of the population. For asylum inmates, the most debilitating outcome was the wartime rationing of food. Caregivers, despite their best efforts, were unable to compensate for their patients' nutritional losses. At the Berlin-Buch asylum, for example, the average daily caloric intake for inmates decreased from 2,695 in 1914 to 1,987 by January 1918 (Burleigh, 1994). Unable to supplement their meager rations via hoarding or purchases on the public black markets, inmates soon deteriorated. In addition, most asylums strictly adhered to cost-cutting measures of less heating and clothing. Medicine, a critical need for the war effort, was relatively scarce for those in custodial care. These high levels of deprivation and neglect, along with overcrowding and poor sanitary conditions, soon led to marked increases in communicable diseases and elevated mortality rates. The relatively stable pre-World War I annual institutional mortality rate of approximately 5.5% escalated to 30% by the end of the war. In real terms, by 1918, more than 140,000 people had died in psychiatric asylums across Germany (Burleigh, 1994).

The privations of the war had a marked effect on perceptions of disability among institutional caregivers and the public. Caregivers generally acknowledged the deplorable state of affairs in asylums but also understood the necessity of shifting resources to those able to conduct the war effort. Among the general public, the war effort's reallocation of resources also highlighted the divide between those who were healthy and able to contribute and survive unaided, and those with disabilities, who could not. Thus, by the end of World War I, an implicit but palpable public perception of higher economic worth was attached to people without disabilities, and lesser worth was attributed to people with disabilities. Later, the economic worth of human life under the Nazis proved a key distinction for creating and sanctioning genocide against people with disabilities.

By 1918, a trend toward institutional contraction emerged. Many private and public asylums had closed. Others were transformed into convalescent homes for injured soldiers or hostels for refugees. Still others stood empty as supporting funds were redirected to convalescing patients with predictable recoveries who would again enter the workforce to help the country recover economically. Also, asylum populations remained low because of the now exorbitant cost of admitting

and caring for new patients. These circumstances soon generated various models of cheaper outpatient treatment that controlled expenses and bolstered progressive social reforms attempting to soften the image of asylums as nothing more than prison warehouses.

Societal tensions generated by deprivation, war, and notions of peoples' relative worth based on their ability to contribute to society continued to affect people with disabilities in institutions across Germany until the late 1920s, precipitating rapid and radical attitudinal changes even as the medical and psychiatric communities continued to struggle with custodial issues related to asylum inmates. It was clear, however, that extensive and expensive care could not be expended on people who could not immediately aid Germany's economic recovery. In practice, this meant that among asylum inmates, attempts were made to distinguish those who could be at least partially rehabilitated (the "curable") from those who could not (the "incurable"). By this time, two perceptions were firmly fixed among German medical professionals and laypeople alike. First, even the much lowered number of asylum inmates had to be further reduced in the long term, given the country's restricted economic outlook. Second, because many of those with disabilities were now more visible through outpatient programs, their infirmities and their sometimes inappropriate or undesirable behavior were often considered a threat to public decency and social order. Accordingly, inappropriate public behavior by people with disabilities was often dealt with in terms of legal action and through the criminal justice system, thus melding disability and criminality in the public mind. Professional and public debate had raised the imperative of social control to prevent the proliferation of asylum inmates, including those with disabilities, whose characteristic behaviors were now firmly perceived to be at best undesirable and at worst criminal.

The identification of many more people with disabilities in outpatient care and the consequent necessity that at least some proportion of these persons needed inpatient care led to a renewed expansion of institutionalization. By 1929, the number of psychiatric patients in all levels of care had almost doubled from the years immediately following World War I. Economic considerations were exacerbated by the Depression beginning in 1929, and inpatient populations grew rapidly as many families of previously deinstitutionalized persons, no longer able to support them, returned them to private and state-run facilities. It was at this point that the seeds of genocide were sown among professionals and ordinary German citizens alike. The juxtaposition of severe economic constraints, crowded asylums, the attachment of levels of economic viability to human worth, and the sense that people with disabilities formed a burdensome and often criminal element in society all significantly added fuel to ethical debates concerning euthanasia and sterilization. By the late 1930s, there was open discussion among many asylum administrators about actually killing inmates.

### *Euthanasia and Voluntariness*

Historically, euthanasia has meant a voluntary request for death without suffering by the patient. However, in the 17th century its meaning was modified to grant the right to *alleviate suffering* exclusively to physicians. While the meaning and implications of euthanasia changed somewhat over time, it was universally accepted that the act of euthanasia was always voluntary. That is, when individuals exercised their right to voluntarily choose the timing and the manner of their death as a means of ending their suffering, it was a physician's responsibility to assist them (Proctor, 1988). However, in the 1890s the meaning of euthanasia in Europe, and especially in Germany, came to include two other aspects. First, the notion of a voluntary "right to die" was extended to mean that in some instances the request for euthanasia could be made by persons other than the suffering patient. Second, the extraordinary levels of care accorded the terminally ill and asylum inmates again raised the issue of negative human worth and underlined the possibility of involuntary euthanasia; that is, the economic burden that terminal illness or caring for the insane placed on families, caregivers, and the community was a factor to consider in decisions for euthanasia. In one sense, therefore, the debate quickly shifted from the idea of a "gentle death" itself to who would request or abet the patient's demise. Subsequent branches of the debate took up the notion of suffering among humans as comparable to that of animals and the implication that in certain instances humans could be disposed of in the same way—quickly and painlessly. The distinction between voluntary euthanasia and involuntary killing was thus effectively eradicated, and an ominous term was coined for the first time: "life unworthy of life."

In 1920 the concept of living beings not worthy of the life they embodied gained impetus with a tract published by two university professors, Karl Binding and Alfred Hoche. *Permission for the Destruction of Life Unworthy of Life* articulated key implications for people with disabilities. Binding and Hoche called for the killing of people with disabilities, whom they viewed as "incurable idiots" having no will or sense of living. Killing them, therefore, was hardly involuntary euthanasia, that is, the imposition of others' will upon them. This shifted the burden of human existence from simply being alive to requiring an explicit justification for living. For Binding and Hoche, therefore, the right to live was to be earned, not assumed. One earned the right to live by being a useful economic contributor to society. Chief among the individuals they saw as being useless were those who seemed to have little or no human feeling, or in their terms, "empty human husks" whose only societal function was the consuming of precious resources while contributing nothing to society in return. In Binding and Hoche's terms, they were "useless eaters" whose "ballast lives" could be tossed overboard to better balance the economic ship of state. In speaking of those with disabilities, and explicitly advocating involuntary euthanasia, Binding and Hoche wrote,

Their life is absolutely pointless, but they do not regard it as being unbearable. They are a terrible, heavy burden upon their relatives and society as a whole. Their death would not create even the smallest gap—except perhaps in the feelings of their mothers or loyal nurses. (Burleigh, 1994, p. 17)

Furthermore, Binding and Hoche drove home the economic argument by calculating the total cost expended in caring for such people. They concluded that this cost was "a massive capital in the form of foodstuffs, clothing and heating, which is being subtracted from the national product for entirely unproductive purposes" (Burleigh, 1994, p. 19).

Binding and Hoche's polemic was furiously debated across Germany. One strident critic of the Binding and Hoche position was Ewald Meltzer, the director of an asylum in Saxony, who held that many of his charges did indeed have the ability to enjoy life inasmuch as their disabilities would allow. In an attempt to support his belief, Meltzer surveyed the parents of his patients to ascertain their perceptions of disability and euthanasia. To Meltzer's astonishment, the survey results showed a widely held contradiction among the parents that although they had strong emotional ties to their children, they simultaneously expressed, with varying degrees of qualification, a "positive" attitude toward killing them. In fact, only a handful of respondents completely rejected all notions of euthanasia (Proctor, 1988). The results of this survey were a harbinger of future public and official perceptions and actions toward people with disabilities. Meltzer's survey was later used as a major rationale for the killing of thousands of people with disabilities under the National Socialists, whose long-held social perceptions of difference coupled with official state prejudice delineated a series of genocidal markers that doomed significant numbers of people with disabilities during the Nazi era.

### **Genocidal Markers of Disability**

Scientific research of the late 19th century was overshadowed by Darwin's ideas of biological determinism, including its most radical form, eugenics, which had begun to establish genetic markers predictive of physiological characteristics. The fate of people with disabilities in Germany may be understood by examining a similar series of genocidal markers, with corresponding sequelae, which determined the real-world fate of "useless eaters."

#### *Marker 1: Darwinism and the Biology of Determination*

Nineteenth- and early-20th-century Germany, like the rest of the Western world, had been significantly influenced by two powerful scientific impressions. First, the prominence of the biological sciences had been established by the revolutionary

ideas of Charles Darwin, who provided reasonable explanations for distinct differences among many observed natural phenomena. Darwin and his contemporaries focused on inequalities within all living species, including humans. Darwin's ideas of evolution emphasized the struggle for survival and the notion that only the strongest and most able of any species would survive as genetic progenitors of future generations, thereby safeguarding the health, and ultimately the endurance, of that species. In short order, these ideas were applied to humans in the form of Social Darwinism, which held that in humans, both biological and social traits were passed from one generation to the next.

Thus, as scientists busied themselves with measurement, classification, and definitions based on physical, biological, and social similarity and difference, they not only reinforced popular social prejudices but enshrined them as irrefutable scientific fact. By the early 20th century, scientists had amassed a great deal of pseudodata portending to show differences between individuals, genders, and ethnic groups by rank ordering any population trait from superior to inferior. For example, individuals were judged as superior based on their race (White, with northern Europeans deemed superior to southern Europeans and Slavic ethnic groups) or their wealth (wealth was superior to poverty). In addition, levels of socially appropriate behavior (law-abiding, self-regulating, restrained, and conformist) were judged superior to socially inappropriate behavior (criminality or antisocial behavior; Friedlander, 1995). These and other classifications soon precipitated both informal social changes and more formal legal measures. Darwin's ideas gained widespread acceptance in Germany, where they nudged the predisposed intelligentsia toward accepting social inequality as presumptive long before Hitler's National Socialist party swept to power in 1933.

Second, an offshoot of Darwinism, Social Darwinism, held that not only biological traits but also social characteristics and their resultant behaviors were genetically determined. Social Darwinism's ideas of difference, therefore, in the form of eugenics, appeared to have immediate and effective application for a number of societal problems, such as "hereditary" social traits (e.g., socially inappropriate or criminal behavior). Here the rationale was simple: All visible traits of human difference were genetically determined. Thus, just as eye and hair color were genetically determined, so were drunkenness, sexual promiscuity, and other socially inappropriate behaviors. A simple extension of these perceptions led to the idea that an effective way of controlling or eliminating these problems was by sterilization, incarceration, or death.

Having established the concept of social heritability and its consequences for individual inequality, similar rankings of desirability were soon applied to entire groups of people, including grouping people by class. That is, the more "inferior" (i.e., lower class) the person, the more likely they would be to engage in undesirable social behavior (e.g., sexual promiscuity) and often criminal behavior (e.g., prostitution). This logic was then used to extrapolate that because many individuals from

impoverished backgrounds committed undesirable social and criminal acts, and far fewer from among the wealthy, the entire lower class was characterized by criminality. People with disabilities, many of whom displayed inappropriate behavior or abnormal physical appearance, were among the groups of people thus classified. Based on these perceptions of difference, the next logical step was to control and eventually eradicate undesirable biological and social differences through eugenics.

### Marker 2: Eugenics

The term *eugenics* was coined by the naturalist and mathematician Francis Galton in 1881. Eugenics was described by its leading American proponent, Charles Davenport, as "the science of the improvement of the human race by better breeding" (Friedlander, 1995, p. 4). The eugenicists believed Mendelian laws governed the heredity of human physiological traits (Darwinism) and social traits (Social Darwinism). Genetics, therefore, could be manipulated to enhance social ends. This assumption encouraged research on the transmission of social traits and the classification of individuals, groups, and whole societies on a scale of human worth.

Predictably, the results of these efforts isolated individuals and groups of people who appeared to have less intelligence, higher levels of antisocial behavior, and, therefore, by definition, less human worth than those higher up on the ability and prosocial behavior scales. In turn, the emphasis on human worth by rank allowed the eugenicists to study different segments of the scale. More often than not, they chose to study the lower end, including study of individuals with lower intelligence and those they considered socially deviant. Eugenics captured the imagination of researchers in Europe, England, and the United States. In the United States, politicians purportedly promoting the public good were quick to recognize eugenics as a powerful tool for shaping public opinion against people with disabilities. Such awareness fueled laws in many states for the involuntary sterilization of people with disabilities, the most famous case perhaps being that of a Virginia woman with mental retardation, Carrie Buck, named in the 1927 landmark *Buck v. Bell* case (Winzer, 1993).

Prior to World War I, the German eugenicists concurred with their American and British colleagues regarding a scale of human worth, dividing the German population into those who were superior (*hochwertig*) and inferior (*minderwertig*). Thus, eugenics asserted that the "feebleminded" (a generic, inaccurate term covering everything from mental retardation to alcoholism) were almost always so because of inherited inferior characteristics. From these assumptions, they "saw the cause of the social problems of their times, such as alcoholism and prostitution, as inherited feeblemindedness, and viewed the manifestations of poverty, such as intermittent employment and chronic illness, as a hereditary degeneracy" (Friedlander, 1995, p. 6).

However, without the political heterogeneity that encouraged diverse views within the genetics movement in the United

States and, to a lesser extent, in England. German eugenicists' views were much more radically homogeneous. Until Germany's defeat in World War I, the German eugenicists concentrated on "positive Eugenics," through the encouragement of higher birth rates among superior populations, which reflected the German eugenic concentration on class rather than race. However, a precursor of future troubles appeared in a eugenic faction that favored the concept of the Nordic racial ideal and despised its inferior counterpart, the anti-Nordic (Friedlander, 1995). It was this concept that eventually dominated German eugenic discourse and became enshrined in the Nazi idea of Aryan supremacy.

The two genocidal markers of Social Darwinism and eugenics were firmly in place in the professional and lay psyche when the National Socialists, under the leadership of Adolf Hitler, were elected in January 1933. Thereafter, German acceptance of humanitarian inequality mixed with Hitler's racist convictions to produce the political ideology of the "Thousand Year Reich," a major component of which was the elimination of those deemed inferior (Friedlander, 1995). Furthermore, these two markers became the bedrock of increasingly coercive official policy, eventually killing thousands of people with disabilities. These two genocidal markers were then enacted in the real world, first by involuntary sterilization.

### **Marker 3: Forced Prevention of Disability**

Discussions of eugenic sterilization in Germany became more prominent in the early 1920s and were bolstered by contemporaneous debates about the worth of human life, although sterilization was illegal in Germany until Hitler became chancellor. One of the first official acts undertaken by the Nazis was the enactment of a sterilization law in 1933, less than 6 months after their election. Grandly titled the Law for the Prevention of Genetically Diseased Offspring, it decreed compulsory sterilization for persons characterized by a wide variety of disabilities. The law also established a mechanism for deciding who should be sterilized, which consisted of 220 regional Hereditary Health Courts, each made up of a judge and two physicians. People in or recently discharged from institutions were particularly vulnerable to this law for obvious reasons. Approximately 30% to 40% of those sterilized between 1934 and 1936 were patients in asylums across Germany (Burleigh, 1994). The sterilization law reached many categories of the "hereditarily sick," including persons with mental retardation (200,000), schizophrenia (80,000), Huntington's chorea (600), epilepsy (60,000), blindness (4,000), hereditary deafness (16,000), grave bodily malformation (20,000), hereditary alcoholism (10,000), and other specified groups (Lifton, 1986).

The law was repeatedly amended to close loopholes that might allow some persons with disabilities to escape sterilization. For example, an amendment was added to cover women with a "hereditary disease" who became pregnant prior to sterilization, or women who were impregnated by men with such "diseases." In such cases the law officially sanctioned abortion

and simultaneous sterilization (Friedlander, 1995). The law also stipulated heavy penalties for physicians carrying out such actions on persons or unborn children legally judged to be healthy.

Also in 1933, the Nazis enacted the Law Against Dangerous Habitual Criminals, a law that further blurred the distinction between bona fide criminal behavior and inappropriate social behavior that characterized many people with disabilities. The law stipulated that these criminal *asozialen* (asocials) could be committed to state asylums, held in indeterminate protective custody, and, in the case of sex offenders, officially castrated (Friedlander, 1995).

These and other laws were the precursors of the Nuremberg Laws of 1935, which, while directed primarily at Jews, also regulated marriage among people with disabilities. For example, the Marriage Health Law prohibited marriage between two people if either party suffered from some form of mental disability, had a "hereditary disease" as previously defined by law, or suffered from a contagious disease, particularly tuberculosis or venereal disease.

To this point, while Nazi law had become increasingly segregationist and isolationist for people with disabilities, it had not yet sanctioned murder, even though it is clear that as early as 1935 Hitler voiced thoughts that he would use the cover of war to murder psychiatric patients in fulfillment of a long-held belief that he had articulated in *Mein Kampf* (Yahil, 1987). However, Hitler understood that state-sanctioned homicide would depend on other factors to severely curb public outrage until war became reality. The war, Hitler reasoned, would provide both a distraction and an excuse for officially killing those deemed undesirable. One such factor was the use of propaganda to convince the public of the desirability of some lives over others.

### **Marker 4: Disability Propagandized as Life Unworthy of Living**

By 1938 the tide of public and official benevolence toward people with disabilities had begun to turn. The public mind now characterized people with disabilities as a separate, different, often criminalized group of less economic value than their counterparts without disabilities. German literature and art soon depicted lives unworthy of living in a host of propagandistic projects (Lifton, 1986; Michalczyk, 1994). For example, two 1935 silent documentaries produced largely for distribution among Nazi Party functionaries and sympathizers depicted persons with severe physical and intellectual disabilities in staged scenes to show them to their greatest disadvantage (Burleigh, 1994; Lifton, 1986). Other films were produced for wider audiences. A 1935 propaganda sound film, *Das Erbe* (*The Inheritance*), depicted, in a pseudoscientific format, the medical, social, and economic consequences of hereditary disabilities. Other films soon followed. The 1937 film *Opfer der Vergangenheit* (*The Victim of the Past*) went much further, comparing healthy, ideal German citizens with institutional-

ized people with severe disabilities and adding that Jewish mental patients were creations in violation of natural law. The film proposed the solution of compulsory sterilization.

Propaganda was not limited to film, however, but also appeared in German literature. An exemplar of this work is the novel *Sendung und Gewissen (Mission and Conscience)*, which was turned into a very popular film, *Ich Klage an! (I Accuse!)*. In the story, a beautiful young woman suffering from multiple sclerosis decides that her life is no longer worth living and requests a "merciful death" at the hand of her husband, a physician. In the film's death scene climax, he administers the fatal injection to his wife, who dies peacefully to the strains of soothing piano music played by a friend in the next room. At his trial, the doctor heroically refuses to allow his colleagues to invent an alibi for the murder and challenges the court by asking, "Would you, if you were a cripple, want to vegetate forever?" Predictably, the court acquits the physician because his actions were merciful, not murderous, a notion reinforced in the closing scenes, where the words of the Renaissance physician Paracelsus are recalled, that "medicine is love" (Proctor, 1988).

This type of propaganda, fueled by then current perceptions of disability and euthanasia, profoundly affected the German public. By the late 1930s, requests for mercy killing were being received by Nazi officials. For example, requests were received from a woman ill with terminal cancer and from a man who had been severely injured and blinded in a construction accident (Burleigh, 1997). The state was also receiving similar requests from parents of newborns and young infants with severe physical and intellectual disabilities (Lifton, 1986).

To this point, Nazi involvement with mercy killing, while implicit, appears to have been muted and uninitiated by the state. However, social perceptions of disability had been radically modified, and requests for mercy deaths were increasing and were generally viewed as more acceptable, whether conducted by individual citizens or the state. Essentially, disability was widely acknowledged to be a legitimate justification for murder.

### **Marker 5: Disability as Justification for Individual and State-Sanctioned Murder**

The threshold for beginning official killing of people with disabilities was reached in 1937 and 1938, when publicly reported cases of "mercy" killing galvanized the population. Two cases are most often cited. The first, an act of individual commission, involved the murder of a German male with emotional and behavioral disorders by his father. The second, the case of the Knauer child, signified a critical shift from individual citizens' responsibility for and commission of "mercy killing" to that of the state. These two cases heralded a significant shift from voluntary requests by the suffering individual for "merciful" death to decisions to kill made by others based only on the disability of the victim.

In 1937, the *Frankfurter Zeitung* reported the case of a farmer who shot his adolescent son to death as the boy slept.

Charged with murder and facing the death penalty if convicted, the father justified his actions by suggesting that his son's emotional disabilities made the boy "mentally ill in a manner that threatened society" (Proctor, 1988, p. 12). At trial, in addition to the harm-to-others defense, the father's attorneys and Nazi Party officials argued forcefully that the son had been an unnecessarily heavy financial burden on the family. The father was sentenced to only 3 years in prison, of which he served 1.

The Knauer child was a frail child with several severe disabilities. While the case has become quite mythologized, it seems that she was blind, without one leg and part of an arm, severely mentally retarded, and suffered from chronic convulsions (Friedlander, 1995; Lifton, 1986; Proctor, 1988). Her father petitioned the Nazi authorities to grant her a "merciful death" but received no official response. Subsequent to this request, in the winter of 1938–1939, the Knauer child was admitted to the University of Leipzig's pediatric clinic after attending physicians discussed her plight with her persistent father. Aside from the child's obvious physical and intellectual disabilities, the father asserted that the child, by remaining at home, was causing his wife significant psychological and emotional stress. He requested that the physicians proceed by "putting it to sleep." Initially, the doctors refused, reminding the father that such action was against the law. Undaunted, the father, encouraged by the child's grandmother, petitioned Hitler directly to sanction the child's death (Gallagher, 1990). Arguably, the persistence of this one man became the catalyst for official genocide.

Hitler's personal attending physician, Karl Brandt, was dispatched to Leipzig to examine the child and to evaluate the extent of her disability. Brandt testified at his Nuremberg trial that he discovered in Leipzig a "creature . . . born blind, an idiot—at least it seemed to be an idiot—and it lacked one leg and part of an arm" (Burleigh, 1994, pp. 94–95). Brandt had prior instructions to meet with the Leipzig consulting physicians to confirm the father's view of the child. He had further been directed that should the child indeed be severely disabled, he should instruct the attending physicians, in the name of the state, to "carry out euthanasia."

In his trial testimony after the war, Brandt emphasized that part of the rationale in this approach was to absolve the parents and doctors of any guilt or incrimination if they were responsible for the child's death. Hitler, on behalf of the state, assumed responsibility for the death of the Knauer child, directing Brandt to assure the physicians that any legal repercussions resulting from their actions would be quashed. Hitler's personal assurance was also relayed, via Hitler's deputy, Martin Bormann, to Franz Guertner, the minister of justice (Burleigh, 1994). Clearly, the state now both sanctioned murder and offered absolution from guilt for the perpetrators.

The attending Leipzig physicians appeared to have offered little resistance, assuring Brandt that the Knauer child should die. Citing their professional experience on the maternity wards, they informed him that it was "quite natural for doctors themselves to perform euthanasia in such a case without

anything further being said about it" (Burleigh, 1994, p. 96). Shortly thereafter, a junior physician administered a lethal injection to the child while the nurses were taking a coffee break.

Subsequent to the death of the Knauer child, Hitler authorized high-level officials to formally establish a state-sanctioned program to kill children with physical and intellectual disabilities (Burleigh, 1994, 1997; Burleigh & Wipperman, 1991; Friedlander, 1995).

### *Marker 6: Disability as State-Sanctioned Homicidal Health Policy*

The Knauer child's death demonstrated that social and official precursors to widespread, organized homicide of people with disabilities were firmly in place. In May 1939, Hitler ordered the creation of an advisory committee that would pave the way for the widespread killing of children with disabilities. Ironically, 1939 was the year designated by the Nazis as the year of "the duty to be healthy" (Proctor, 1988, p. 177). The children's killing program was to report directly to Hitler's Chancellery through a front organization under the pseudoscientific moniker of the Committee for the Scientific Treatment of Severe, Genetically Determined Illnesses. However, this impressive title belied its function, as it was headed by Hans Hefelmann, an agricultural economist (Lifton, 1986). On August 18, 1939, prior to the German invasion of Poland, which began World War II, this committee produced a secret report, disseminated to all state governments, requiring all midwives and physicians who delivered infants with obvious congenital disabilities to register these children and the nature of the disability, ostensibly

to clarify certain scientific questions in areas of congenital deformity and mental retardation [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. (Proctor, 1988, p. 186)

The directive applied to children up to the age of 3. Across Germany, these new requirements were officially added to other information routinely required by the state at the birth of any child, such as evidence of venereal or other contagious diseases. As added incentives, midwives were paid for every infant with disabilities so referred. Failure to report these cases resulted in substantial fines. This directive would also later require teachers to report these disabilities among their students in schools.

Information on the registered children was returned to the Reich Health Ministry in Berlin, where a panel of three professionals—physicians, psychiatrists, or a disparate array of related professionals (such as ophthalmologists)—sorted the

children's records into three groups. Children included in the first group, their records marked with a minus sign, were permitted to survive. Inclusion in the second group, designated by the phrase "temporary assignment" or "observation," meant that a decision on the child's fate was to be postponed until a later date. Children in the third group, designated by a plus sign on their records, were identified for "treatment" (Lifton, 1986), "disinfection," "cleaning," "therapy" (Glass, 1997), or "selection" (Proctor, 1988), all Nazi euphemisms for extermination. Unanimous votes were required for each child. This process was facilitated by each panelist's being aware of what previous panelists had decided. Decisions were made exclusively on the basis of the information on the registration form, thereby transforming life-and-death decisions by the state into a macabre administrative exercise.

The fate of the "plus" children was swiftly realized. In most instances, parents, weary with the significant care issues their child with disabilities generated, or perhaps being aware of the current national stigma assigned to disability, were often eager to acquiesce to official urgings that their child be remanded to a state-run facility for "expert care." Parents who appeared reluctant to do so, especially single mothers, were coerced to do so by the state's welfare agencies (Friedlander, 1995).

Those designated for extermination were transferred to one of 28 facilities, among them several of Germany's oldest and most respected hospitals, where they were housed in specially designated killing wards. The Nazi authorities took great care to inform parents that their children would be safe in special wards at the clinics, which would "provide all available therapeutic interventions made possible by recent scientific discoveries" (Friedlander, 1995, p. 47). These assurances were always given with the caveat that such endeavors were also fraught with mortal risks.

There is little doubt that hospital staff were complicit in these endeavors. A particularly gruesome account of these circumstances survives in eyewitness testimony to the actions of Hermann Pfanmuller, the physician in charge of the hospital at Egfling-Haar:

I took a conducted tour of the madhouse. . . . Pfanmuller led us into a children's ward. The ward made a clean and cared-for impression. In about fifteen beds there were as many children, all aged between about one and five years old. . . . Pfanmuller explained his intentions at some length. . . . "As a National Socialist, these creatures (he meant the aforementioned children) naturally only present to me a burden upon the healthy body of our nation. We don't kill with poison, injection etc., since that would only give the foreign press and certain gentlemen in Switzerland [the Red Cross] new hate-propaganda material. No: as you see, our method is much simpler and more natural." With these words, and assisted by a nurse who worked in this ward,

he pulled one of the children out of bed. He displayed the child around like a dead hare, he pointed out, with a knowing look and a cynical grin, "This one will last another two or three days." The image of this fat, grinning man, with the whimpering skeleton in his fleshy hand, surrounded by other starving children, is still clear before my eyes. (Burleigh, 1994, pp. 45-46)

The methods of killing at the institutions varied. In some instances, children were simply starved to death, which was not considered ideal because it took too long (Friedlander, 1995). However, starvation did allow these murders less chance of detection. Other methods included allowing children to die of exposure in the cold German winters by turning off all heat in the institution (Proctor, 1988). At several asylums, children perished after being administered chemical warfare agents. A more grisly approach involved a method reserved for children who were resistant to other poisons or, because of their disability, were unable to swallow the poison in pill form: fatal injections directly into the heart (Glass, 1997). The most popular lethal drug was Luminal, a barbiturate, closely followed by morphine for children resistant to the Luminal. These were usually administered in pill or liquid form. The genius of this form of homicide was the normally expected availability of these medications in hospitals. Also, some poisons killed indirectly over short periods of time by precipitating fatal medical complications that were then reported as natural causes of death. There is evidence that physicians exchanged information about the efficacy of various medications when they visited each other's institutions or met at the Reich Ministry of Health in Berlin (Friedlander, 1995).

The murder of the children also followed a particular administrative and logistical course. As the condition of the child deteriorated following the fatal dose, the parents would be informed that their child was seriously ill, with a quick follow-up via a standardized letter announcing the child's death before parents could arrange to visit their sick child (Burleigh, 1994). This letter always noted that the child had died suddenly and unexpectedly of one of a number of diseases. Popular choices included brain edema and appendicitis. The favorite cause of death, however, proved to be communicable disease, which necessitated immediate cremation to avoid the danger of an institutional epidemic (Proctor, 1988). However, despite this assurance already having been relayed to their families, not all children were immediately cremated. Instead, they were autopsied in the interests of "science" by Nazi scientists attempting to find obtuse causes for the child's disability.

Two examples of these circumstances are provided by Burleigh (1994). In the first case, 4-year-old Klara H.'s 25-year-old mother, pregnant with her sixth child, was unable to cope. Klara, an "idiot" toddler, was nonambulatory, mute, and not toilet trained. Klara's mother, already coping with four other healthy children, was also attempting to tend the family farm while her husband was on active military duty. Klara was

admitted to the pediatric clinic at Kaufbeuren, where 2 months later she died of "pneumonia."

In the second example, Anna Maria R., fondly called Annemarie by her parents, spent most of her life, beginning at age 2, in institutions. She was diagnosed as having "feeble-mindedness of the highest degree" (Burleigh, 1994, p. 108). Her parents appear to have been very concerned about her welfare, often sending her clothing and candy. They also requested that her hair be cut more attractively than was the usual institutional style. The parents' letters to the staff inquiring after her health always received courteous responses, indicating, for example, that "your child Annemarie is in good health and order" (Burleigh, 1994, p. 109). Indeed, upon admission, Annemarie had been frail and so weak that she could neither walk nor talk. For a while she appeared to improve; at least that was what her caretakers conveyed to her parents:

Your dear Annemarie has adjusted to life here very well. She is always breezy and happy and shows no traces of homesickness. She is eating so well that she has gained 1kg [kilogram]. I hope that your dear child will yet learn to speak. (Burleigh, 1994, p. 109)

After a sudden, unexpected transfer to another institution for extermination in 1938, the director there issued a more sober case report unfettered by the usual niceties found in letters to families:

Unchanged over the duration of this report. Dirty. Cannot stand. Very strong arms. Very good appetite, cries a great deal, particularly at night. Lies still in bed, moves her eyes when one approaches the bed, but shows no mimetic change, laughs a lot, but only says "ah," otherwise nothing. Has not developed in any respect whatsoever. Unchanged, lies still in bed. Can only sit up. (Burleigh, 1994, p. 109)

Soon after, a letter to her parents sympathetically informed them that Annemarie had died of "bronchial asthma and heart failure, a case of idiocy" (Burleigh, 1994, p. 107).

By December 1940, it was officially permissible to include children older than 3 for killing, and by late 1941, children and adolescents up to 17 years of age were also ensnared. Initially, Jewish children were excluded from this program because they did not deserve this "easy death." By 1943, however, just before the program was discontinued, it was extended to include healthy children of "unwanted races" (Proctor, 1988). By that time, approximately 6,000 children had perished.

Disability as a genocidal marker was not reserved only for children. As a logical extension of the children's killing program, adults with disabilities were the next group targeted for disposal. The children's program had established the necessary prototypical bureaucratic processes and boasted a host of officials willing to be complicit in mass murder. In the summer of 1939, Hitler directed top-level officials to implement

an adult euthanasia program, issuing a formal directive on his personal stationery that certain officials were "charged with responsibility to extend the powers of specific doctors in such a way that, after the most careful assessment of the condition, those suffering from illnesses deemed to be incurable may be granted a mercy death" (Burleigh, 1994, p. 112).

The letter, dated September 1, 1939, the day of the outbreak of World War II, was actually written a month later and backdated to imply that it was part of the war effort instead of the culmination of years of prejudice against people with disabilities. Furthermore, the use of Hitler's official stationery carried the imprimatur of an official decree while simultaneously circumventing formal legal processes that would have made this plan public. An entire bureaucracy of sham organizations was then created to execute this new project. Surreptitiously headquartered in an unmarked, nondescript villa in Berlin, the program was named Aktion T-4, after the villa's address at Tiergartenstrasse 4. Initial efforts to establish the adult killing program included augmenting the three-man panels that had decided the fate of so many children. Swiftly, high-level officials who had directed the children's program asked several asylum directors and prominent academics to initiate the program, ostensibly to free up hospital beds and nursing staff for war casualties. Almost all of them agreed.

At about the same time, German soldiers were engaged in the mass murder of institutionalized patients across occupied eastern Europe; the first of such killings occurred in north-eastern Germany and in occupied Poland in early January 1940 (Proctor, 1988). Field officers informed Himmler, for example, of "the elimination of approximately 4,400 incurably mentally ill from Polish insane asylums" (Proctor, 1988, p. 189). In this action, patients from several asylums were rounded up, taken to nearby woods, and individually shot in the back of the head. Between 1939 and 1944, almost 13,000 Polish psychiatric patients were killed in this way (Burleigh, 1994). However, in such instances, it quickly became evident that the perpetrators' close proximity to the resulting gore exacted a heavy psychological toll that could be reduced only by using less grisly methods.

The logistical necessities involved in killing large numbers of asylum inmates were also problematic within Germany itself. After rejecting several improbable solutions (such as mass train wrecks), it was decided that carbon monoxide gas would be the most effective. The choice of gas was reinforced after attempts to destroy groups of Polish asylum inmates by tying several of them together and blowing them up with dynamite proved too unsavory (Friedlander, 1995). A human experiment on the effectiveness of the gas was conducted in January 1940. A number of senior officials responsible for Aktion T-4, including many asylum directors and several others who would later make their names infamous at Auschwitz, gathered at a defunct prison near Berlin. Approximately 20 naked asylum inmates were herded into a prototypical gas chamber by psychiatric nurses. The enthusiastic onlookers watched closely as the inmates died from carbon

monoxide poisoning. Eight further inmates were administered lethal injections, but when the poison had little immediate effect, these inmates were gassed as well (Friedlander, 1995). Buoyed by the dreadful success he had just witnessed, Viktor Brack, one of the top Aktion T-4 officials, victoriously declared the importance of using physicians to administer the gas through his oft-repeated motto: "The needle belongs in the hand of the doctor" (Proctor, 1988, p. 190).

This gassing process was then repeated several times to refine its efficacy. Soon after, gas cylinders were delivered to six regional killing centers across Germany. The first center to engage in experimental gassing, which quickly got the adult program under way, was housed in an isolated castle at Grafeneck, which for many years after its purchase by a religious order had served as an asylum for persons with mental retardation. Grafeneck boasted workshops, livestock farming, and a small local trade in eggs and honey. Confiscating Grafeneck from the owners, the Nazis quickly transferred the inmates to other institutions. Arriving in plainclothes, men of the SS Death's Head division converted the castle into an extermination center. A few hundred yards from the castle, a gas chamber and crematorium appeared. Based on the logistical experiences of killing children with disabilities, similar administrative networks for registering the adult victims and the sham system of notification of next of kin were put in place. The euphemistically named Community Foundation for the Care of Asylums was the official unit responsible for hiring the killers and building staff, acquiring the gas, and later recycling gold teeth and selling jewelry from the dead. Another sham organization, the Community Patients' Transport Service, Ltd., transported asylum inmates from other institutions to the killing centers.

In contrast to the bureaucratic patina exuded by upper-level officials, the personnel actually carrying out the killings were chosen for their brutality and uncompromising Nazi dedication. It was at Grafeneck and other killing centers that many of these personnel honed their murderous skills for the death camps in which they eventually became guards, camp commanders, and generic sadists. As always, physicians were recruited as the persons responsible for actually turning on the gas that flooded the death chambers.

Elaborate administrative procedures similar to those in the children's program established who the adult murder victims would be. Asylum directors were required to register specific groups under their care, including those suffering from schizophrenia, epilepsy, senile dementia, and feeble-mindedness; those who had been institutionalized longer than 5 years; the criminally insane; foreign nationals; and "racial aliens." In the rare instance that an asylum director refused, perhaps fearing some egregious purpose behind the registrations, roving groups of registrars were dispatched to obtain the information (Burleigh, 1994). All data were returned to Berlin, where the fate of the victims was quickly decided in the same manner as in the children's program. Notice was then given to the asylum directors to prepare the victims for transport to the killing centers,

which functioned between January 1940 and August 1941. The Community Patients' Transport Service's buses, painted gray with white windows, would arrive at asylums across Germany. Inmates identified for execution were made ready for the journey by asylum personnel, usually under the pretense of some kind of pleasant outing. They were then led to the buses and boarded with the help of nurses and orderlies, who were assigned to every bus. Those who refused were forcibly placed aboard. No provisions were made for food or much comfort for the journey.

In spite of everyone's best efforts, many inmates sensed their fate. Some attempted to escape, while others appeared more resigned to their deaths. For example, Helen M., an inmate committed for epilepsy, managed to smuggle two letters out of the asylum at Tretten. In the second she wrote:

Dearest Beloved Father: . . . Today I must write these words of farewell as I leave this earthly life for an eternal home. . . . Father, good father, I do not want to part from you without asking you and all my dear brothers and sisters once more for forgiveness, for all that I have failed you in throughout my whole life. . . . always think that I am going to heaven where we will all be united together with God and our deceased dear ones. . . . I won't lament, but shall be happy. I send you this little picture by way of a memento, your child will be meeting the saints in this way too. . . . Please pray a lot for the peace of my soul. See you again, good father, in heaven. (Burleigh, 1994, pp. 142-143)

Helen M.'s father's efforts to save his daughter were too late to prevent an official letter of condolence from the asylum informing him that she had died of "breathing problems."

When patients arrived at one of the six killing centers, they were unloaded via a covered wooden corridor. Wheelchairs or stretchers were provided for the infirm. The inmates were escorted to a large room, where they were completely undressed and supplied with military overcoats. Most groups were either male or female. If the group was mixed, however, separate changing facilities were used. In a separate examining room, patients were relieved of their coats and examined naked. Their identities were checked and they were closely observed by a physician, who attempted to match the size and appearance of the patient with a sham cause of death that was shortly to follow (Friedlander, 1995). Patients were then weighed, photographed, stamped with a number, and given a piece of cardboard with a corresponding number for retrieving their clothes later. Those who possessed gold dental work were further marked with an X on their backs. Others were also carefully marked if they were deemed appropriate for "scientific" autopsy after death. Most patients' fears were allayed by these seemingly routine medical procedures, which they had all undergone many times before.

The gas chambers were approximately 10 feet by 17 feet wide and 10 feet high, paneled with ceramic tile. Benches lined

the walls, hiding a 1-inch perforated pipe that encircled the chamber. A sturdy metal door included a rectangular viewing window. Victims were told they were to enter this "inhalation room" for therapeutic reasons (Friedlander, 1995). Subsequently, at other killing centers and in the death camps, gas was delivered via shower heads, thus further allaying victims' fears and eliminating the rather puzzling "inhalation" premise (Friedlander, 1995).

Sixty at a time, the inmates were locked in the chambers to await their deaths. Troublesome or resistant patients were quieted with an injected sedative or manhandled into the chamber by brute force. A physician then opened a valve, which allowed the gas into the chamber. The reinforced glass opening in the door proved a popular vantage point for many employees, who regularly came to view the executions. Some perpetrators, in postwar testimony, insisted that this "easy death" meant that victims simply "went to sleep." However, to at least one eyewitness, death seemed much more difficult:

I looked through the window. . . . In the chamber there were patients, naked people, some semi-collapsed, others with their mouths terribly wide open, their chests heaving. I have never seen anything more gruesome. I turned away, went up the steps [where] I vomited everything I had eaten. . . . A few were lying on the ground. The spines of all the naked people protruded. Some sat on the bench with their mouth wide open, their eyes wide open, and breathing with difficulty. (Friedlander, 1995, p. 96)

Within 5 minutes, the victims were unconscious, and within 10 to 15 minutes, all were dead. After a wait of approximately 1 hour, the chamber was ventilated and the marked bodies were transferred either to the autopsy room or to the crematorium for incineration. Prior to cremation, however, the bodies were plundered. Gold-filled teeth and dental bridges were broken from the corpses' mouths and were delivered to the business office. Secretaries stored the foul-smelling teeth in cartons until enough had been accumulated to be forwarded by special courier to Berlin for the Nazi war coffers (Friedlander, 1995). Organs, especially fresh brains, and sometimes skeletons, were harvested at autopsy. They were carefully packed and shipped to the research laboratories of Germany's most distinguished universities. Autopsy activities also provided experience for novice surgeons, who often received academic credit for their efforts (Friedlander, 1995).

The Nazi fascination with difference clearly provided a vast research reservoir of human material. In one instance, in order to study hereditary retardation, 56 inmates with mental retardation, epilepsy, or evidence of significant brain injury were delivered to a research institute, where they were observed, examined, and then killed. Their brains were quickly removed and studied by making comparisons between the autopsied brains and the data collected prior to the patients' demise.

At the killing centers, the logistical problems of burning the bodies far outweighed the relatively simple killing method. Between two and eight bodies were cremated at a time. This protracted process resulted in a backlog of bodies that were often putrefying by the time they were cremated. After cremation, residual bone was crushed in mills or by mallet on specially constructed worktables. Ashes dug from an ever-growing pile were collected in urns, and the nonspecific remains were returned to those next of kin who requested them—at the kin's expense. In these cases, each killing center maintained a tracking map so that not too many urns arrived simultaneously in the same geographical area. This system also ensured that causes of death reported to families in close proximity were markedly different, thereby allaying suspicion. In addition, orderlies were careful not to overfill urns that were supposed to contain the ashes of a child. Concocted causes of death included the now familiar list: communicable diseases such as meningitis, which was possible in people of all ages; pneumonia, a common cause of death secondary to other serious diseases; and cases of stroke, a favored sham diagnosis among the elderly.

There is little doubt that the caretakers at the killing centers knew what they were doing and had become expert at their tasks and that many relished their tasks. At the killing center at Hadamar, for instance, a festive party was held in the crematorium, complete with beer, food, and a polka band. The highlight of the evening was a blasphemous mock burial ceremony over the swastika-festooned corpse of the 10,000th victim gassed at the center (Gallagher, 1990). Unsurprisingly, murderous graduates of Aktion T-4 were the first camp commandants in Sobibor, Belzec, and Treblinka (Aly et al., 1994).

During the life of Aktion T-4, the official body count was 70,273, although postwar German prosecutors put the number at well over 80,000 adults with disabilities. These atrocities had been carried out at more than 100 hospitals, asylums, and medical facilities across Germany (Proctor, 1988). This sad number was not a random achievement, however, but was the precisely calculated goal of the killing program. In the planning stages of the program, Nazi statisticians generated a formula for these deaths. They estimated that for every 1,000 Germans, 10 would need some form of help for their disability. Five of the 10 would require intensive care, and 1 of the 5, the worst of the worst, would need to be killed. Using the 1,000:10:5:1 formula for the German population of 65 million to 70 million citizens, they had, a priori, calculated that between 65,000 and 70,000 persons with disabilities needed to die, very close to the number actually killed (Proctor, 1988). Aktion T-4 statisticians had also recorded the economic triumph of murdering those with disabilities: the 70,273 official "disinfections" had saved the country 885,439,980 Reich Marks (RMs), including 13,490,440 RMs saved on meat and sausage (Friedlander, 1995), 708,350 RMs on jam, 1,054,080 RMs on cheese, and 20,857,026 RMs on bread (Burleigh, 1994).

## Resistance to Disability as Genocidal Marker

There is little evidence that asylum directors openly opposed the killing of their patients. However, some questioned the legality of the program, and others deliberately avoided meetings that would have given them no choice but to become personally involved. Some quibbled with the accuracy and utility of the identification process. Scattered instances of delay, deliberate incompetence, and other forms of resistance also occurred. In spite of these efforts, reluctant asylum personnel were often reduced to making difficult choices of who would be taken to the killing centers and who would not.

Soon after the killing program began, there were signs that its secrecy was beginning to fail. Workers from the killing centers talked of their efforts while they relaxed in local taverns. The smoke from the killing centers' crematoria always followed shortly after a gray bus delivered patients to the facility. This intense crematorium activity meant that townspeople had to keep their windows tightly shut, and workers in the fields were often nauseated by the stench of burning flesh (Burleigh, 2000).

Furthermore, while the bureaucratic meticulousness of sham causes of death often held, there were also glaring mistakes that aroused suspicion. In many villages across Germany, for instance, citizens became suspicious when several inmates from the same village or town appeared to have died at approximately the same time, sometimes seemingly from similar ailments. There were other troubling signs. For example, some patients' deaths were officially given as being caused by appendicitis, but families knew that the patient's appendix had been removed several years earlier (Proctor, 1988); other kin received ashes containing hairpins although their relative had been a male asylum inmate (Burleigh, 1994).

By the summer of 1941, there was enough public knowledge to exert pressure on the authorities to discontinue the killing programs. The general outcry was started by parents and families of the deceased, although families were by no means unanimous in protesting the deaths of their relatives with disabilities. Several concerned families approached German legal authorities or, ironically, the Nazis themselves. As the groundswell of protest gained significant momentum, the Nazis did their best to quell rumors and to placate the louder voices of protest. It is generally accepted that the catalyst for the official end to these programs was a fiery sermon delivered by the German Roman Catholic bishop of Munster, Clemens von Galen, on August 3, 1941, which was subsequently circulated around the country. Von Galen openly accused the Nazis of organized homicide of people with disabilities (Friedlander, 1995). The authorities, alarmed that further public exposure would result in a backlash against the regime, quickly shut the programs down.

When the official programs at the six killing centers ceased, the task of euthanasia reverted to hospitals and other institutions across Germany that housed people with disabili-

ities. The preferred methods of killing once again became lethal injection, starvation, and intentional exposure (Proctor, 1988). Such routine killing occurred throughout the rest of the war and even for several months thereafter (Lifton, 1986; Proctor, 1988).

### Some Implications for the Present

In retrospect, the Nazi example makes plain that macropolitical and social forces can have a negative impact on people with disabilities. Special education professionals would be well served to use treatment of people with disabilities in a bygone era as an historical touchstone to inform some perceptions of disabilities at the dawn of the new century, including the role of science, the power of ideas, the convergence of macrosocietal conditions, the complicity of the medical profession, and the role of propaganda.

#### *The Role of Science*

A major impetus for Nazi ideology was its claim of legitimacy based on the pseudoscience of Social Darwinism, which drove perceptions of difference from benign recognition to active genocide. Not only was the pseudoscientific claimed as science (i.e., as established fact, data based, and replicated over time), but it was used as an instrument of deceit to perpetrate murder. On one hand, the appeal to "science" allowed the willing German intelligentsia to be more easily convinced to support and participate in brutality masquerading as research. On the other hand, the claims of Social Darwinism fed the public's long-held distrust of those who were different, whether racially or in terms of disability (Friedlander, 1995; Lifton, 1986).

The enchantment of the intelligentsia with pseudoscience and the willingness of the public to seize pseudoscientific "facts" as legitimate knowledge remain problems in special education today, albeit in more benign forms (e.g., Kauffman, 1999; Mostert & Kavale, 2002). For example, the unfortunate history of facilitated communication (FC) eloquently demonstrates that fairly nonsensical ideas can be widely and enthusiastically embraced by people who should know better. Many university professors, university teacher-training programs, and school districts across the United States promulgated FC as a cutting-edge intervention for persons with severe communication problems. Furthermore, FC's proponents have attempted to legitimize their claims with "research," which on closer examination is shot through with serious problems of validity and logic (see Mostert, 2001). The results of these actions were extremely damaging, both practically and ethically, to many of the people FC was supposed to assist. The reactions of many members of the public and media, who embraced FC based on the flimsiest of evidence, were hardly less astonishing.

These events emphasize that it is only by careful attention to canons of converging and replicable experimental

evidence over time that we have any hope of rooting out pseudoscience, thereby improving the lives of persons with disabilities by the most effective and efficient means. Special educators have a distinct responsibility for understanding the principles and ramifications of experiential and quasi-experimental research, for becoming more informed consumers of educational research, and by becoming more willing to challenge every fad foisted upon them by less-than-neutral parties.

#### *The Power of Ideas*

The events described in this article demonstrate the power of ideas and their consequences in the real world. In Nazi Germany, harshly prejudicial ideas toward people with disabilities replaced other, less extreme ideas. Eugenics, for example, did not appear in and of itself sinister, but it was quickly co-opted for nefarious ends. The idea of eugenics was dangerous to people with disabilities because it propelled action with scant regard for decency and compassion. In the marketplace of ideas, eugenics was embraced largely because it served a wider prejudicial purpose, namely, to control and then rid Germany of people deemed different, inferior, and asocial. The minority who resisted were soon silenced in the tidal wave of a demand for conformity to a master race superior to all others. Other, less lethal ideas could have been adopted. For example, energy could have been directed to renewed efforts at understanding deviant behavior, especially behavior resulting from and characteristic of physical, emotional, and intellectual disabilities.

There is ample evidence of special educators co-opting ideas that in and of themselves may have some value for academic debate but that raise serious concerns about significant, negative real-world implications. For example, the application of postmodern ideas to special education research and practice may well prove unnecessarily divisive and counterproductive in treatment of and interventions with persons with disabilities. As Sasso (2001) noted, these ideas may well have some worth at the level of philosophical jousting, but in real terms they may prove damaging to children with disabilities in schools if they negate effective interventions and service delivery.

#### *Convergence of Conditions*

Political, intellectual, and social conditions were ripe in Germany in the late 1930s to translate theoretical ideas into action. Forced sterilization would have been less likely had it not had the support of the government, medical and other science professionals, and at least by their silence, the German public. The official act of sterilization, therefore, melded perception of difference, frenzied optimism over the possibilities of genetics, a pressing need to curtail inappropriate social behavior, and the willingness to destroy people with physical, emotional, and intellectual disabilities.

There can be little doubt that at the dawn of this new century, societal forces and other macrosocial conditions are arranged in ways that may have profound implications for persons with disabilities. On one hand, the level and quality of services provided to people with disabilities is perhaps higher than at any other time in history, as is society's acceptance of physical, emotional, and intellectual difference. However, it is equally apparent that perceptions of people with disabilities, especially those with severe and profound disabilities, are increasingly being framed by their societal and economic worth. For example, the worth of people with disabilities is becoming part of profound and difficult debates around abortion, stem cell research, and euthanasia. Special educators must confront the reality that rapid advances in genetic and other medical research have ascribed new and different notions of worth, not always positive, to children with disabilities. For example, it is possible to identify certain disabilities in utero (e.g., Down syndrome), which may change the parents' perceptions of the viability of the fetus.

Abortion of children with disabilities relates to other, even broader biomedical issues, such as stem cell research and organ harvesting (Hershey, 1999a, 1999b). Stem cell research undoubtedly provides enormous potential for new and significant scientific discovery. However, using stem cells that are abortion by-products is ethically problematic for many people. Coupling the undesirability of some in utero conditions with the potential medical and societal worth of these same fetuses postabortion may well meld into increased abortion of fetuses deemed imperfect yet usable for other purposes.

In terms of euthanasia, notions of the economic worth of children with disabilities such as those espoused by Singer (1993) are already well established. In sum, Singer calls for a radical reassessment of what to do with children born with severe and profound disabilities. Through quality-of-life arguments, Singer suggests that the value and fate of newly born children with severe disabilities should be decided according to the child's potential communal worth, including the child's economic worth (Kuhse & Singer, 1985). That is, whether the child is allowed to live or not is completely dependent on the parents' and community's judgment of the child's potential to serve the community, not on the child's inherent right to exist. As with Binding and Hoche, the justification for being allowed to live is based not on the act of involuntarily existing but on societal usefulness.

Concerning the opposite end of the life span, recent developments in the United States and Europe are changing the voluntary nature of a "gentle death" still further, also based, in part, on economic worth. In the United States, Oregon voters have not only designated the power of the state to support physician-assisted suicide, but also established economic criteria for who should and who should not receive expensive health care via Medicaid health-care rationing. Oregon law, for example, specifies denial of treatment for some late-stage terminal illnesses and very low birthweight babies (Smith, 2000). Irrespective of personal preferences on either side of

this debate, the Oregon example clearly shows a shift from strict compassion and ethical obligation for treatment of individuals to a more practical medical euthanasia based on collective economic viability. Various U.S. disability groups have strongly opposed such legislation (e.g., Not Dead Yet, 2000). Nor are these issues confined to the United States. The Netherlands, for example, has legislated euthanasia as a citizen's right, legally absolving physicians from criminality in these procedures—an unobvious reincarnation of Viktor Brack's ghoulish notion that "the needle belongs in the hand of the doctor." In both Oregon and the Netherlands, the state has become an arbiter of decisions about life and death for its citizens, including persons with disabilities. These issues are in urgent need of discussion among special education researchers and practitioners alike.

### *Complicity of the Medical Professions*

It is important to note that the enactment of prejudice against people with disabilities in Nazi Germany could not have succeeded without the complicity of the medical and adjunct professions. Power over life and death was placed firmly in the hands of physicians who became white-coated executioners, having long abandoned the "do no harm" clause of the Hippocratic Oath. Currently, there is evidence of the medical community's again being willing agents in hastening the deaths of people deemed not viable, including people with disabilities, through familiar methods for ending the lives of terminally ill people, such as starvation and death by thirst. Furthermore, there is evidence that "do no harm" is now viewed as a somewhat quaint throwback to a distant, less sophisticated era. For example, many physicians no longer take the Hippocratic Oath before beginning their careers, and many standard hospital treatment protocols now stipulate that staff physicians may override next-of-kin requests for patient treatment if the physician decides that treatment will likely be ineffective (Smith, 2000). Once again, patients, including those with disabilities who are terminally ill, now bear the responsibility of justifying their existence and their need for treatment. This being the case, and with the clear understanding that not all physicians put the greater good ahead of their individual patients, there should at least be some debate about what this means for people with disabilities, many of whom rely extensively on the assumption that their physicians have their best individual treatment interests at heart and will treat them regardless of utilitarian arguments to the contrary.

### *Propaganda*

The Nazis needed a means of influencing public opinion for more active perpetration of actions already planned. Propaganda became a useful tool. Nazi propaganda was created by many leading German artists, authors, and other creative persons impressed by the Third Reich, who lent their credibility and prestige to film, literature, and other public projects. In-

expert in matters of science, but eager to be on the cutting edge of issues of the day, many high-profile celebrities willingly embraced National Socialist dogma.

In a media-savvy age, celebrities and socially prominent persons can have a profound effect on perceptions of disabilities in the wider culture. For example, the American Olympian Bruce Jenner has increased public awareness of learning disabilities by his public acknowledgment that he himself has a learning disability. Others in the public eye have not fared so well: The actor and comedian Jerry Lewis's annual telethon for muscular dystrophy has raised significant amounts of money for research, but he has also been criticized by disability activists for his lack of sensitivity to disability issues (e.g., Hershey, 1999b; New York City Consortium for Independent Living, 2001). It is incumbent upon such public figures to be sure of what they are supporting and espousing before going public to do so, given the persuasive station of their social status.

## Conclusions

People with disabilities in Nazi Germany were assumed to be useless, subhuman, of no economic value, and certainly incapable of anything resembling a decent quality of life. These aspects won out over the few protests and documented evidence that, indeed, many people with disabilities, all things considered, lived quite fulfilling lives. Learning these lessons and being aware of similar, if more subtle, problems and conditions facing people with disabilities in this new century should be carefully considered by special education professionals, parents and families, and society at large.

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