The Role of Women Doctors in Nazi Eugenic Crimes: Gender, Professionalism and the Violent Paths of Social Mobility

by

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**Introduction**

In 1974, a young father brought his third-born daughter to the Allgemeines Krankenhaus Celle (Celle General Hospital). The infant girl had been born with physical deformities on her feet, hips, and lower jaw and was placed in the care of the head physician of the children’s ward, Dr. Helene Sonnemann. After briefly examining the girl, Dr. Sonnemann said to the young father: “Nothing will come of this child and there is nothing or not really much to be done.” The father of the infant girl was shocked, and decided to have her admitted to another hospital. There, the young girl underwent a number of operations that eradicated most of her physical impairments. She grew up to live a nearly independent life, and was bothered by her remaining physical impairments only to the extent that she could never wear high-heeled shoes. She died in 2001, of a circulatory failure that had nothing to do with her birth-defects.

Dr. Helene Sonnemann, the woman doctor who had told the girl’s father that nothing would ever come of her, had only moved to Celle in 1943. Before that, she worked at the Kinderkrankenhaus Rothenburgsort (Rothenburgsort Children’s Hospital), where she actively implemented Nazi eugenic ideals. What this means is that Dr. Helene Sonnemann, between the years of 1938 and 1942, murdered multiple disabled children and infants. The Celle Staatsanwaltschaft (Celle public prosecutor’s office), concluded in a postwar investigation that Sonnemann was single-handedly responsible for the death of seven children.
The investigation files prove her to have murdered these children while they were in her care at Rothenburgsort, where they had been admitted for treatment for their respective disabilities. Most of her victims barely lived to celebrate their first birthday.

In spite of the postwar investigation, during which she notably admitted to having participated in these murders, Sonnemann was never prosecuted nor did her post-war career suffer as a consequence to her violence. She retired as a respected physician in Celle, only two years after having told the young father in 1974 that his child was a hopeless case. In 1998 she died of old age, with her husband by her side.

Historians have long neglected the role of women as active participants in Nazi medical crimes. Notable is the relative preponderance of historical investigations on the role of men within the Nazi medical profession. Although scholars have advanced beyond the reductive categorization of women only as victims, there remains room for the reconciliation of women and violence in a way that does not sensationalize that synthesis. Prevailing gender roles have allowed female perpetrators to hide behind the socially imposed feminine ideal, and ultimately evade personal culpability. Our understanding of perpetratorship remains gendered, so that the few women perpetrators who have been acknowledged within historical discourse are sensationalized in the mainstream and presented as monstrous anomalies; and exceptions to the rule. This has led to a problematic generalization of women perpetrators, wherein they are
typified as anomalous caricatures and their acts of violence sensationalized as unfathomably inhuman. This generalization is dehumanizing in a way that actually benefits the women perpetrators: by caricaturing them, we are simply reinforcing gender as an exclusive, all-encompassing identification. It is this fetishization of gender that allowed the majority of female perpetrators to elude responsibility for their actions after World War II. Because of their subordinate position in the patriarchal Nazi regime, most women were denied the capacity for agency and thus presumed innocent.

The prevailing characterization of women, as victims or sensationalized anomalies, has obscured the fact that for the most part, female perpetrators in Nazi Germany were just ordinary women navigating the existing avenues for self-realization. This characterization is only amplified in the case of female doctors, as they embody two identities historically presumed to be in conflict with perpetratorship. In this way, the intersection of gender and medical practice marks a sphere historically dissociated with violence and murder. The over-reliance on female doctor’s discriminatory gender-structured reality denies them agency, and more importantly, incapacitates considerations of how presumed social categorizations might have actually enhanced female agency. Within the prevailing historical discourse, women continue not to be taken seriously as conscious actors with individual agency.

This prompts a new line of questioning: What is the scope of women doctors’ human agency within gender-defined structures and norms and the
male hierarchy of the German medical profession? How did gender, professionalism and the nature of German medical practice interact to enable women doctors’ participation in Nazi medical crimes? How was gender a hindrance or an advantage in some of these crimes? How was gender deployed to evade responsibility?

In the first two decades after World War II, there was very little historical research on the role of women in Nazi Germany. The historical discourse on women and gender in Nazi Germany first took hold with the *Historikerinnenstreit* between Gisela Bock and Claudia Koonz. In 1983, Bock published the article “Racism and Sexism in Nazi Germany: Motherhood, Compulsory Sterilization and the State,” which focuses on motherhood and compulsory sterilizations, and the complex interdependency between sexism and racism.¹ Ultimately, Bock believes that all women’s bodies belonged to the state, and therefore argues that all women were subjected to Nazi dichotomous oppression - ultimately rendering all women victims.² A fundamental problem with Bock’s argument is that it rests on the assumption that if women had had a choice, or any agency at all, they would not have participated in furthering Nazi ideals. In this way, Bock repudiates women’s capacity to have been Nazi perpetrators out of choice, thus actually feeding into the same reductive

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² Ibid., 420.
typification of women as the gentle, helpless victims that the Nazis institutionalized.

Claudia Koonz, in her 1987 book “Mothers in the Fatherland,” disputes Bock’s diminutive characterization of all women as mere “instrumentalized” victims of the Nazi patriarchal system. Koonz’s fundamental argument is that just because women were victim to a discriminatory gendered system, it did not mean that they were completely powerless. She describes women’s complicity in the Nazi system, in the form of maintaining “normality” within the private domestic sphere, as mothers and housewives, and in that way providing support through stability to Nazi men. Critical is Koonz’s proposition that women’s motives paralleled those of men, so that women who supported Hitler “did so from conviction, opportunism, and active choice.”

However, although Koonz’s work paved the way for subsequent historical research on gender and agency in Nazi Germany, her assumptions fail to extend women’s agency beyond the role of the mother and the housewife.

At this point in time, both Bock and Koonz’s arguments are outdated. Taken together, they present a reductive binary that generalizes women’s identification with either victimization or culpability. Adelheid von Saldern, in her article “Victims or Perpetrators? Controversies about the role of women in the Nazi State” moved away from the Koonz-Bock reductive binary in recognizing women to have had the capacity to be both perpetrators and victims

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at the same time: while women had less agency than men, they were “by no means powerless.” Almost all individuals in Nazi Germany were the product of “complex and contradictory” combinations of perpetrator and victim. It is ironic that von Saldern’s focus on women as mothers rests on two assumptions that in themselves are reductive typifications of women. The first is that von Saldern implies motherhood to be the ultimate means of female self-realization. From there, she presumes mothers intrinsically adhere to certain (indicated but not explicitly stated) standards, in this way serving as a blanket generalization of all women characterized by typically female qualities. These problematic assumptions explain why ultimately von Saldern fails to accredit women with having not just been “co-observers” and “co-listeners” of “guilty knowledge,” but also independent perpetrators themselves.

Atina Grossman’s 1993 article “German Women Doctors from Berlin to New York,” marked an important development in the literature on women’s participation in Nazi Germany, in arguing that women’s predominance within bureaucratized public health systems was the product, not only of them being marginalized to subsidiary positions within the medical profession, but also of women “claiming” the assigned female qualities to advocate their distinct gendered value as doctors. Grossman’s work was thus instrumental in being one of the first to not just point to, but actually demonstrate female agency in Nazi Germany, notably within the

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5 Ibid., 157.
professional sphere. Further, in examining the transformation of women’s professional presence as a part of the feminization of the medical profession, Grossman points to the continuities between the Weimar and Nazi Germany with regards to social policy, specifically racial-hygiene.\textsuperscript{6} She exposes how women doctors intrinsically furthered eugenic measures in deploying “maternalist and modernity” rhetoric as a means of expanding female professional presence.

Melissa Kravetz developed many of the ideas that Grossman introduced, but failed to effectively elaborate on them in her 2011 dissertation “Creating a Space in the Medical Profession: Female Physicians, Maternalism, and Eugenics work in Weimar and Nazi Germany.” In direct alignment with Grossman, Kravetz argues that female physicians in Weimar and Nazi Germany reconciled their careerism with their motherhood roles through deploying “maternalistic language” to find and create exclusively female spaces within the male-dominated medical profession. Kravetz illustrates how female physicians voluntarily “self-mobilized,” notably, “notwithstanding systematic discrimination or perhaps even because of it.”\textsuperscript{7} In this way, both Grossman and Kravetz critically demonstrate female physicians’ intentionality regarding their support of Nazi health policies but fail to extend their arguments to consider how this translated explicitly into women physicians’ involvement in Nazi medical crimes and the implications of their participation in eugenic practice.

In 2011, Wendy Adele-Marie Sarti published her book “Women and Nazis: Perpetrators of Genocide and other Crimes during Hitler’s Regime, 1933-1945.” Sarti uses various primary source documents to reconstruct the narrative of four women that committed crimes in Nazi Germany as concentration camp guards, and argues explicitly that these women “all made a choice to consciously act in the way they did.”

Unlike historians before her, Sarti attempts to understand the psychological motives of the female perpetrators, emphasizing that “one must understand that for the most part these women were normal, educated, intelligent women,” who became violent perpetrators simply because “their government allowed them to do and they wanted to.” Sarti relies too much on Nazi ideology as an explanatory factor for the crimes committed by these women, thus ignoring periodization continuities. Sarti’s work made a valuable contribution to the feminist scholarship, in proving that women attained positions of power within the Nazi hierarchy to a hitherto unestablished degree. With that, Sarti critically acknowledges women perpetrators’ gender to have innately enabled their evasion of culpability. However, her work is problematic in that she argues that perpetratorship cannot and should not be gendered, and that therefore gender roles must be ignored in this case. This emphasizes the need for further historical investigation that recognizes gender as a critical framework for positioning female perpetrators within their indisputably distinct socio-political reality, while avoiding its sensationalization.

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9 Ibid., 191.
Up until now, the particular intersection of gender, professionalism, medicine and perpetratorship has only been examined by Rebecca Schwoch, in her 2004 article “Female Doctors at the State Institute Görden. 1936 - 1947. Adaptation, Subordination or Careerism?” Schwoch examines the involvement in medical crimes of four women doctors at Görden, to discuss the intersection of gender, the “caring” profession, and perpetratorship.\(^\text{10}\) She suggests that the medical profession presented a unique avenue for female physicians’ self-realization, within which a “specifically female pattern of involvement in medical crimes” presented itself. She argues, “despite the distinct nature of their respective involvement, their subordinate positions, and the societal demands made on them as women within a male-dominated institution and policy, they nevertheless became perpetrators within Nazi medicine.” Schwoch goes so far as to propose that women doctors, as a result of their socially-imposed role as the caretaker as well as their distinctly female socialization, were predestined for medical practice. For Schwoch, this marked the intersection of Fürsorgeerziehung (social-caring-education), psychiatry, and ultimately “euthanasia.” In this way, Schwoch argues that although women had distinctly female avenues for self-realization, they cannot be separated from their male counterparts as perpetrators. Although Schwoch’s arguments are incredibly valuable, the limited evidence and analysis they are rooted in highlights the need for a much more elaborate and detailed examination of the specifics and backgrounds of women doctors’ involvement in Nazi medical crimes. Within that, Schwoch fails to

consider the ideological continuities with regards to the social policy approaches between the Weimar Republic and Nazi Germany: only in tracing their historical origins in as much detail as possible, can we hope to understand the multiplicity of factors and dynamics that interdependently shaped the motives of female perpetrators.

My work arises from the existing gap in the literature regarding an in-depth examination of the distinct way in which gender, professionalism, and the character of German medical practice intersect to open up violent paths of social mobility in Nazi Germany. The distinct intersection of gender, professionalism and German medical practice existed already in the Weimar Republic, but only under the Nazi regime did it assume violent implications. The continuities between Weimar Germany and Nazi Germany, especially with regard to social policy, will thus be at the center of this examination.

A primary issue with the existing literature is the absence of an analysis of women doctor’s individual histories placed in context of their collective social group’s gender-structured reality that ultimately focuses on female agency. To address this problem, this thesis will be taking a prosopographical approach to its women subjects. Prosopography collectively studies individual actors in history by investigating their common background characteristics, first introducing the institutional framework and then reconstructing a collective portrait of the individual actors using statistical information.\(^{11}\) The collective study of individual actors is

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\(^{11}\) Hoi-eun Kim, *Doctors of Empire: Medical and Cultural Encounters between Imperial Germany and Meiji Japan* (Buffalo, N.Y.: University of Toronto Press, 2014), 87.
shaped by critical features of socialization, such as economic circumstance, level of education, familial situation, and personal motives. In this way, a prosopographical analysis allows for both the conscious and collective nature of women doctors activity to be revealed. Through this approach, women doctor’s agency within their gender-defined structural reality is most effectively recovered.

I will be drawing on primary sources that I found doing archival research in Germany, primarily from the Berlin-Lichterfelde archive and the Schleswig-Holstein archive. Additionally I will be using a range of digitized primary sources in the form of articles, trial transcripts, government documents, and publications.

Chapter One will examine the origins of German eugenics, which emerged as a way of thinking at the very beginning of the 20th century. I argue that the First World War was critical in constructing the mainstream character of eugenic thinking and allowing it take hold at the institutional level in the Weimar Republic. I further argue that the pervasive Depression-era political discourse on women’s reproduction, centered around abortion and sterilization, established women’s role in society as limited to only that of the mother and wife—marking a continuity between Weimar and Nazi Germany.

Chapter Two concerns the role of female physicians in the Weimar medical profession. The First World War reinforced misogynistic stereotypes, which translated practically into women’s marginalization to gender-specific fields within
the medical profession. In alignment with Kravetz’s work, I argue that women
consciously exploited gender-specific norms to carve out their own space within the
male-dominated medical profession.

Chapter Three investigates the role of female physicians in Nazi Germany,
highlighting the continuities from the Weimar Republic. With a focus on female
physicians’ gender specific specialization, I argue that women doctors in Nazi
Germany continued to exploit the socially imposed feminine ideal to further expand
their professional presence. I go on to distinguish between Nazi ideology and the
pre-existing way of thinking that Nazi ideas were built upon.

Chapter Four reveals the nature and character of women doctors’ distinctive
involvement in Nazi eugenic practices, with particular focus on the child “euthanasia”
program. I argue that the women’s involvement was wholly voluntary.

Chapter Five examines the four women doctor’s post-war activity. I argue
gender to have operated as a means of minimizing women’s accountability for the
crimes they committed before 1945 and intrinsically enabled their evasion of
culpability.
Chapter I: The Origins of German Eugenics

Alfred Ploetz: Die Tüchtigkeit

The origin of the eugenics movement in Germany is marked by the 1895 publication “Die Tüchtigkeit unsrer Rasse und der Schutz der Schwachen” (The efficiency of our race and the protection of the weak) by the German physician Alfred Ploetz. The book, essentially a eugenics doctrine in which Ploetz formulates his thoughts addressing the soziale Frage (social question), fundamentally focuses on the health of the Rasse (race), his definition of which is difficult to directly translate from German. Ploetz’s general conception of a Rasse seems to be any human population that engages in interbreeding and thus displays homogenous intergenerational mental and physical features. However, Ploetz’s idea on the welfare of the human race is limited only to reflect the interests of the Western Aryan race: “The hygiene of the entire human race converges with that of the Aryan race, which apart from a few small races, like the Jewish race — itself quite probably overwhelmingly Aryan in composition — is the cultural race par excellence. To advance it is tantamount to the advancement of all humanity.”\(^{14}\) The Germanic lineage is emphasized later on in the book as the ideal part of the ‘Aryan race,’ yet generally speaking Ploetz seems to be concerned with whites as a whole. Notable is the accreditation of Jews to the same standing as Aryans, given their contribution to humanity’s intellectual history, and the explicit condemnation of anti-Semitism as a “pointless pursuit — a pursuit whose

support will slowly recede with the tide of scientific knowledge and humane democracy.”

Although the superiority of the Aryan race is thus central to the book, Ploetz’s argument is fundamentally concerned with the reconciliation of Darwinist thinking and socialist-humanitarian notions of eugenics. Ploetz points to the need for revolutionizing the conceptualization of ethics within the scientific realm, with a focus on the reconceptualization of hygiene so as to counteract the unconstrained individualism that pervaded social conceptions of ethics and health at the time. The new hygiene was to replace the existing movement of Individual-Hygiene (individualistic hygiene) which dictated the social and economic system according to the health of the individual, instead shifting the focus onto improving the hereditary health of the entire human race. In practice, according to Ploetz, this would take the form of controlled breeding as the solution to the existing social miseries, as grounded in what Ploetz calls Variations-Beherrschung: the understanding and manipulation of the laws of variation so as to improve the quality of offspring. The logic underlying the belief that “the more we can prevent the production of inferior variations, the less we need the struggle for existence to eliminate them,” is technocratic. Ploetz is concerned with the pay-off regarding the state’s investment in lessening the hardship of the biologically and financially unfit, at the expense of society’s collective biological health. War, free healthcare for the poor, alcohol, and venereal diseases are what Ploetz calls “counter-selective effects,” which threaten to

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15 Ibid., 142.
16 Ibid., 227
obstruct the proliferation of the number of individuals of a Rasse. The preservation of
the number of individuals is absolutely central to the lasting preservation of a Rasse.\textsuperscript{17}

Archiv für Rassen- und Gesellschaftsbiologie

By 1903, Ploetz decided to publish a monthly journal on racial hygiene, so to
further the movement as well as demarcate the field itself. The first issue of the
Archiv für Rassen- und Gesellschaftsbiologie (Journal of Racial and Social Biology)
was published on January 26, 1904, with Fritz Lenz as chief editor. By the end of its
first year in publication, the Archiv had more than 2,000 subscribers.\textsuperscript{18}

In a foreword of the journal, Ploetz discusses how the examination and
understanding of the optimal conditions for the maintenance and development of the
Rasse, as this pertains to the welfare of the family and the Volk, is possible only
through science. Inherent to this is how Rasse relates to society, whereby Rasse is
defined by Ploetz as the maintenance and development Einheit (unit) of continuous
life, with its specific action identified as replacement by reproduction and its element
as the sum of the individual beings belonging to a reproductive cycle. Society, as
defined by Ploetz, is a group of individuals whose functions are predominantly
mutually beneficial, with its specific action being the exchange of help and its
element an individual or related group of individuals who exchange help with other

\textsuperscript{17} Ibid., 54
\textsuperscript{18} Paul Weindling, \textit{Health, Race and German Politics Between National Unification and Nazism 1870-1945} (Cambridge University Press, 1993), 129.
individuals or groups. Their mutual relationship is thus such that society is a partial phenomenon within the *Rasse*, and the sociology of society is a part of racial biology.

The task of science, Ploetz writes, is to examine and establish the internal and external conditions of racial development, with the collective task of the humanities and the natural sciences being the acknowledgement of all psychic processes as having a physical parallel, and to investigate their fixed correlation. Thus, according to Ploetz, science is the only solution to counteracting the absence of natural selection in existing societies. The solution is conceivable in two ways: a provisional one whereby *schlecht beanlagte* (poor genetic aptitude) individuals are prevented from producing offspring and thus prevented from passing on their “weaknesses”; second, a final way whereby the ineffective germ cells whose inferiority has somehow been observed is eliminated. Yet in order to realize the protection and improvement of future generations, while meeting the humanitarian ideals of the altruistic religions and ethical systems, scientific observation and experimentation must go hand-in-hand with sociological-statistical research to control reproduction. Simply put, “if no weak ones are produced, then they do not need to be eradicated.”

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20 Ibid., 132.
21 Ibid., 136.
Die Gesellschaft für Rassenhygiene

In 1905, Ploetz founded the first eugenics society, the Gesellschaft für Rassenhygiene, as a derivative institutional development of the Archiv. The Gesellschaft’s purpose was to further the “study of the relationship of selection and elimination among individuals as well as the inheritance and variability of their physical and mental traits.” 22 In a letter to Max von Gruber, Ploetz states another central purpose of the Gesellschaft to be the establishment of the racial hygienists position between “Pan-German Aryan ideologues on the one side, and the social hygienists and socialist doctors on the other.” 23 The Gesellschaft’s first meeting was held in Berlin on June 22, 1905, and attended by its founding members: the psychologist Ernst Rüdin, anthropologist Richard Thurnwald, lawyer Anastasius Nordenholz, and later joined by biologist Ludwig Plate. By December 1905, the Gesellschaft had 28 members, which increased to 40 members in 1906 and reached 88 members by 1907. 24

For Ploetz, and the other founding members, the Gesellschaft was not just to be a means of propagating the racial hygiene movement, but also a model of racial elitism in itself, as reflected in its members. Membership was only offered to “ethically, intellectually, and physically fit” white individuals. 25 Accepted members were then encouraged to go through an anthropological examination, the results of

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23 Ploetz Papers, Ploetz to Max von Gruber, 19 November 1911, quoted in Weindling, Health, Race and German Politics, 141.
24 Weindling, Health, Race and German Politics, 142.
25 Alfred, Denkschrift über die Gründung, 5.
which were subsequently sent to the central office of the Gesellschaft. For unmarried members, the Gesellschaft encouraged marriage only after having reviewed the potential spouse. Those that complied to an anthropological examination were granted the title of Gründer (founder) members, whilst those that wished only to attend lectures and meetings were denoted as Förderer (patron).  

When Ploetz moved to Munich in 1907, the Gesellschaft split into local branches in Munich and Berlin, and changed its name to the Internationale Gesellschaft für Rassenhygiene (International Society of Race Hygiene). This signaled the intended expansion of the racial hygiene movement into the international realm, in accordance with Ploetz’s belief that *Rasse* exceeds national boundaries. Although the Internationale Gesellschaft did not have a defined program or set of policies, a list of practical objectives proposed by Ploetz at a meeting in 1910 evince the Gesellschaft’s intended international emplacement through national productivity:

(a) Opposition to the two-child system, fostering "fit" families with large numbers of children, combatting luxury, reestablishment of the motherhood ideal, strengthening the commitment to the family;
(b) Establishment of a counterbalance to the protection of the weak by means of isolation, marriage restrictions, etc., designed to prevent the reproduction of the inferior; support of the reproduction of the fit through economic measures designed to make early marriages and large families possible (especially in the higher classes);
(c) Opposition to all germ-plasm poisons, especially syphilis, tuberculosis, and alcohol;
(d) Protection against inferior immigrants and the settlement of fit population groups in those areas presently occupied by inferior elements-to be accomplished, if need be, through the expropriation laws;
(e) Preservation and increase of the peasant class;
(f) Introduction of favorable hygienic conditions for the industrial and urban population;
(g) Preservation of the military capabilities of the civilized nations;

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26 Weindling, *Health, Race and German Politics*, 143.
(h) Extension of the reigning ideal of brotherly love by an ideal of modern chivalry, which combines the protection of the weak with the elevation of the moral and physical strength and fitness (Tüchtigkeit) of the individual.\textsuperscript{27}

This set of practical objectives is evidence of the comprehensive scope of the Gesellschaft’s ideals, encompassing practical eugenic ideals from the family-level to the national-level. Notable is that these were published in 1911, years before eugenics was adopted into the mainstream. This proves the onset strength of the Gesellschaft’s ideological orientation, even during the earliest stages of the emergence of the German eugenics movement.

\textbf{Dr. Agnes Bluhm}

Agnes Bluhm was Germany’s principal female eugenicist, even considered to have been the “only influential female eugenics advocate” in Germany during the early twentieth century.\textsuperscript{28} Bluhm established herself early on within the field, in being one of the first three female physicians to set up her own office in Berlin as early as 1890.\textsuperscript{29} Edward Dickinson explains this by stating that other German women were simply not interested in racial hygiene. Dickinson points to an article by Gertrud Bäumer, published in the journal \textit{Die Frau} in 1910, as reflective of the general consensus among women at the time with regard to the main concern being “protecting women’s health from men’s immorality.”\textsuperscript{30} Bäumer focused on the

\textsuperscript{30} Ibid., 113.
physicality of racial hygiene as being the reason that it “can in and of itself never be the ultimate goal of culture — because human society is after all something different from a stud-farm or a chicken-ranch.”

Bluhm, however, was a dedicated eugenicist in principle and also one of the first members of the Gesellschaft. Her work was strongly influenced by Ploetz’s ideas, as evinced by Bluhm’s fundamental concern with the improvement or perfection of humanity as a whole, as opposed to the preservation of individuals. In direct alignment with Ploetz, she believed the solution to be racial hygiene, as demonstrated in an article published in 1913 in *Die Frau*, wherein she writes that “the natural sciences, genealogy, the history of civilization…are working hand in hand to create a secure foundation for race-hygiene, for ‘eugenics’.”

Although Bluhm’s later work centered around the degenerative effects of alcohol, the initial focus of her work in eugenics was very much limited to topics regarding women. Women within the early twentieth-century German medical profession naturally assumed and were pressured — by the members of the pre-existing male-dominated medical profession — to specialize in women’s issues. This was because at this point in time, the Bundesrat had only just allowed women to study medicine. 1901 was the year the first German woman graduated with a doctoral degree in medicine. Accordingly, it was assumed natural for a female eugenicist to

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focus on topics regarding women, grounded in the condescending idea that female professionals lacked the capacity to master anything beyond their female sexuality.

The focus of Bluhm’s early work on legal prohibitions to prevent the spread of venereal disease as well as her work on the impairing effects of obstetrics on natural selection, thus reflect the internalization of the stereotyped image of the professional woman as naturally limited to family-oriented disciplines. In 1912, Bluhm published an article in the *Archiv*, entitled “Zur Frage nach der generativen Tüchtigkeit der deutschen Frauen und der rassenhygienischen Bedeutung der ärztlichen Geburtshilfe,” in which she argued for the decisive power over generative processes to be handed to doctors, who then were to medically investigate the chance encounter between men and women that led to conjugal relations, and rationally influence their sexual relations: “not a cruel life selection, but mild, conscious germ selection, that is the best solution. Putting this into practice is a matter of social policy.”

This is to say, Bluhm believed social policy measures such as medical services and obstetrics would have to become compatible with the demands of racial improvement. Notable is that Bluhm, for racial reasons, rejected women having a principal occupation: “employment and motherhood are and remain opposites for the majority of women, and if united today under the protection of social policy, this means a compromise between racial hygiene and economic policy in which race is

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disadvantaged.” Bluhm’s work was thus critical in the development of the eugenics movement, in that she emphasized the relationship between hereditary factors and their milieu-related development as central in identifying racial hygiene as the common denominator. More importantly, the intersection of her gender-specific biological interests and her Social Darwinistic eugenic thinking marked the way in which her work would significantly shape female physicians gender-specific specialization, in giving medical sanction to the idea of gynecology as a “natural” field of specialization for women within the medical profession.

Eugenics and the First World War

In the build-up to World War I, German eugenicists became increasingly concerned with the growth of the population. At the center of their concern lay the liberal movement which encouraged the use of birth control, which they posed as the solution to the soziale Frage as well as a means of eliminating poverty. This movement was heavily criticized by racial hygienists, who, as originally explicated in Ploetz’s “Die Tüchtigkeit,” advocated a high birth rate so to ensure the proliferation of the number of individuals in, and the intrinsic development of, a Rasse. Within that lay the inherent criticism of the disregard for differentiation between valuable and weak genetic lineage, especially with regard to birth control at the time not being

36 Kater, Doctors under Hitler, 91.
widely accessible to the lower classes. Thus, the encouragement of birth control
cultivated the limiting of genetically “superior” middle and upper class families,
while the lower class, or “weak” portion of society, continued to reproduce at
considerably high rates. In a continuation of Ploetz’s original writings in “Die
Tüchtigkeit,” voluntary contraception was seen as a derivative of the culture of
individualism which racial hygienists opposed.

The outbreak of war brought the population question to the very center of
German eugenicists’ focus, with concern over the war expending the population’s
“racial capital,” as articulated by Fritz Lenz.39 In accordance with intensifying
corns regarding the population question, a set of ‘resolutions’ was issued by the
Deutsche Gesellschaft, outlining policy implications intended to prevent the
decreasing birth rate. These are the most notable of the resolutions:

“An inner colonization (back-to-the-farm) movement with privileges for large
families; economic assistance to large families and consideration of the size of
public and private employees' families in determining wages; abolition of
impediments to early marriage for army officers and government employees;
 obligatory exchange of health certificates before marriage; prizes to artists
who glorify the ideal of motherhood, family, and the simple life; and attempts
to awaken a sense of duty toward the coming generation-including education
of the youth in this direction.”

However, despite the issuing of these ‘resolutions,’ together with the collective
intention by additional German eugenicists to compose policy reform plans, there was
no actual adoption of eugenicist reform at the institutional level.

39 Fritz Lenz, “Zum Begriff der Rassenhygiene und seiner Benennung,” Archiv für Rassen-
und Gesellschaftsbiologie 11 (1915): 448.
Eugenics in the Weimar Republic

During the Weimar years, racial hygienists shifted their focus from the international to the domestic level, with the German Volk and state at the center of concerns about the biological degeneration of society. The Treaty of Versailles stimulated widespread resentment among the German peoples, regarding what were perceived to be fundamentally degrading and unfair terms: considerable loss of territory, an effaced military, immense financial reparations and most importantly, the forced imposition of the sole “war guilt”, through Article 231, onto the Germans. The enforcement of these terms by, what were considered by Germans to be historically ‘weaker’ or ‘lesser’ countries was central in shaping the development of racial hygienic ideas throughout the Weimar period. Especially during the early years, German eugenicists mobilized this collective German resentment to propagate the notion of a German Volk and state struggling to survive among critical geopolitical and financial conflict with demonized Western European and Russian adversaries.  

In 1920, the psychiatrist Alfred Hoche and jurist Karl Binding published “Die Freigabe der Vernichtung Lebensunwerten Lebens” (Allowing the Destruction of Life Unworthy of Life), which was concerned with the “burden” that the physically and mentally disabled, characterized as leere Menschenhüllen (empty human shells), inflicted on society through their mere existence. They argued for the necessary murder of all Ballastexistenzen (ballast existences), in the form of their systemic}

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41 Proctor, Racial Hygiene, 28.
euthanization, to extricate resources to be more “productively” re-allocated.\textsuperscript{43} Hoche and Binding’s work was the first to formally and legally give sanction, and most importantly medical sanction, to utilitarian eugenic ideas.\textsuperscript{44} In this way, the publication of “Die Freigabe” marked the beginning of the social-biologization of the German medical practice.

There was significant expansion of the eugenics movement at the institutional level so that by 1923 a university chair for race hygiene was founded in Munich, with Fritz Lenz as the first to hold that position. In the following years, more than forty eugenics lecture courses were introduced at multiple universities across Germany. The founding of the Kaiser Wilhelm Institute for Anthropology, Human Heredity, and Eugenics in Berlin by 1927, marked a crucial development in establishing the first Institute dedicated solely to the studies of eugenics. In 1926, the Deutscher Bund für Volksaufartung und Erbkunde was founded in Berlin, as an organization committed to the propagation of eugenic ideas in a form accessible to all German classes.\textsuperscript{45} The Bund was headed by chairman Karl von Behr-Pinnow, a German eugenicist and physician. Most important was von Behr-Pinnow’s position as a high-ranking government official, which enabled the Bund’s ties with, and funding from, the Association of German Registry Officials, the German Ministry of Welfare as well as the German Ministry of the Interior.\textsuperscript{46} The Bunds main journal, the

\begin{flushright}
\textsuperscript{43} Ibid. \\
\textsuperscript{45} Faith-Weiss, “The Race Hygiene Movement,” 219. \\
\textsuperscript{46} Ibid., 220.
\end{flushright}
Zeitschrift für Volksaufartung und Erbkunde (Journal for National Regeneration and Heredity), reflected many concerns found in the Archiv, specifically regarding the German birth rate decline and the problem concerning the ‘wrong’ lower classes having the highest birth rate. However, the absence of pro-Aryan and anti-semitic beliefs in the Bund’s publications indicated the divergence from racial hygiene as it had existed up to that point. With its emphasis on Volksaufartung (national regeneration) as its central non-racist ideal, the Bund exemplified the mainstream eugenics; the notion of Eugenik replaced Rassenhygiene in the prevailing discourse, establishing the mainstream character of the eugenics movement throughout the Weimar years to be “non-Aryan-supremacist.” 47

Although eugenics was thus adopted into the mainstream as a means to further national and cultural productivity, the racist dimension inherent to its original conception continued to be propagated by members of the Gesellschaft. The socio-political polarization in Germany that followed the founding of the Weimar Republic had translated into increasing polarization among German racial hygienists regarding the scientific value and legitimacy of Aryan eugenics. However, the Gesellschaft remained united even after the relocation of headquarters to Berlin in 1922, continuing as a “collection of relatively autonomous local chapters.” 48

In 1921, Fritz Lenz, Eugen Fischer and Erwin Bauer published the “Grundriß der menschlichen Erblichkeitslehre und Rassenhygiene” (Human Heredity Theory and Racial Hygiene). This publication was to become the standard work in

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47 Ibid., 219-222.
48 Ibid., 219.
contemporary racial-hygienic literature up until 1945, as well as a central influence in Adolf Hitler’s “Mein Kampf.” Its significance lay in being the first attempt to construct a scientific work by systematically synthesizing three sub-sciences — genetics, anthropology and pathological genetic engineering — from which racial hygiene ideas were recruited.\(^4\) Lenz, who was to have considerable influence over the shaping of Nazi racial policy after 1933, clearly formulated his pro-Aryan ideas in the publication. He believed western races, specifically European and German, to be ‘fitter’ and culturally superior, thus inherently more worthy of conservation than others. Jewish and Nordic races were at the top and ‘Negroid’ races were at the bottom of Lenz’s racial hierarchy, which linked racial ‘fitness’ to education and higher social standing.\(^5\) It is the dominant cultural dimension which differentiated Lenz’s divergence from the common racial-hygienic beliefs. More than anyone else, Lenz saw cultural productivity as an inherent aspect of eugenic aims, as evinced in an extract from “Grundriß”:

The German revolution had an overwhelmingly unfavorable selective effect. As a result of the one-sided promotion of the interest of the manual workers, those who work with their brains are forced into a terrible struggle for survival.... If one views German society as a whole, there can be little doubt that the results of the revolution will lead to the extinction of educated families- the primary standard bearers of German culture.\(^6\)

Lenz placed the ‘Nordic man’ at the top of his racial hierarchy that celebrated Nordic supremacy. Under this schema, women were implicitly denounced as “un-Aryan” for their traditionally female characteristics, emotionalism and incendiarism. Women were seen as “having an entirely different mission to fulfill in the life of the race.”

This is to say, within the racial-hygienic discourse that marks the continuation of ideas from Ploetz’s original publication of “Die Tüchtigkeit” to the implementation of Nazi racial program after 1933, women were seen as the means to an end, rather than the end itself.

The Economic Crisis and Women’s Reproductive Role

The economic crisis that occurred in Germany after 1929 changed the general consensus on welfare as necessarily structured around a standard of economic and eugenic principles. By 1930, the unemployment rate had gone from 1.8 million to 5.6 million, with tax revenue per person having decreased by over fifty percent, falling from 65.4 marks to 27.2 marks. In response, after years of inaction by the state, there was a “massive overreaction” with regards to cuts to all social services; the Brüning regime’s Catholic Center government imposed emergency decrees, which aggressively reduced the number of health and social workers, shutting down multiple clinics and downsizing benefit payments. Weindling characterizes the years

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52 Faith-Weiss, The Race Hygiene Movement in Germany, 216.
54 Weindling, Health, Race and German Politics, 445.
55 Ibid., 442.
1918 to 1923 as the *Aufbau* (construction), while the years following 1929 were the *Abbau* (reduction).

In response, focus was re-shifted onto population policy, pushing pre-existing concerns over the declining birthrate and “suspiciously high rate of miscarriages” to the forefront of German public discourse.\(^{57}\) The discourse centered around concerns regarding the “health, working ability, and regenerative capacities of the German Volk,” which, in light of the fact that women were regarded as the “biological capital of the Volk,” naturally translated into a focus on women’s sexuality, sexual freedom, and reproductive rights.\(^{58}\) It is in light of this that it became clear how the continuities between the Weimar Republic and Nazi Germany, as marked by a social policy informed by (negative) eugenics, shaped and manifested the role of the individual woman in society as limited only to that of the mother and the wife.

The economic crisis harmed women especially. The Brüning regime’s reduction of social services targeted women’s social insurance and right to work with an aggressive attack on “double-earning households” (married women profitably employed); women had a higher chance of being cut off from unemployment insurance, received “lower compensation due to an original wage differential, and in any case were more likely to be found as wage laborers in un-insured domestic industries or temporary jobs.”\(^{59}\) Consequentially women’s reproductive responsibilities, linked to their roles in the domestic sphere, intensified as the welfare


cuts stimulated a “general re-privatization of socialized reproduction.” As women, especially married women, were pushed out of the labor market, the Reich Education Council provided subsidiary childcare, health, and nursing classes for the unemployed women. Women doctors were even marginalized from the Nationalsozialistischer Deutscher Ärztebund (National Socialist German Doctor’s League), as Leonardo Conti — who was to become the Reichsgesundheitsführer (Reich Health Leader) under the Nazi regime — denounced women taking on “medical functions in the party” and subsequently set up the Nazi-Frauenschaft, a separate women’s organization which focused on training women in the duties of “mothers service,” thus attempting to confine women within the domestic realm.

The removal of the state’s role in the social welfare sector expanded women’s responsibilities within an informal social welfare regime. Women literally became intermediaries, compensating for social welfare cuts by taking on responsibilities previously undertaken by the state or employer, which reinforced the marginalization of the individual woman to the household, thus forcibly limiting her to the roles of mother and wife.

In response to the pervasive Depression-era political discourse on women’s reproduction as it pertained to the German Volk’s health and vitality, the Reichstag Criminal Justice Committee reformulated the criminal code in 1929, the central point of dispute being Paragraph 218. This law called for the incarceration of women, as well as any aides, who aborted their fetuses, with the exception of those deemed

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60 Ibid., 124.
61 Weindling, Health, Race and German Politics, 457.
62 Ibid., 480.
absolutely necessary for medical reasons. Additionally, any abortions performed for “commercial gain” or without consent of the woman, were considered a serious crime resulting in the perpetrator’s indefinite incarceration. Atina Grossman states that this was one of the two sections within the German penal code which directly regulated and restricted women’s everyday choices and control over their own lives. The other section of the German penal code which Grossman references is Paragraph 184/Section 3, which prohibited the promotion or exhibition of contraceptives, which were characterized as “objects intended for indecent use,” which had hitherto been linked to extra-marital sex and were thus objects emblematic of sex not for the sake of reproduction, but for pleasure.

However, by 1931 an approximated one million abortions (mostly illegal) had been carried out since the beginning of the Weimar Republic. Roughly ten to twelve thousand of these cases resulted in women’s deaths. In the context of mass unemployment that enhanced pre-existing class conflict, an alliance emerged between left-wing sexual and social reformers that called for the legalization of abortions to eradicate the classist discrimination that came with access to safe abortions; upper-middle class women could afford to pay doctors to perform safe abortions under the guise of being “medically necessary.” This alliance of left-wing sex reformers emerged against a background of the growing Sex Reform movement,

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64 Ibid.
65 Ibid.
whose origin lay in the 1905 founding of the Deutscher Bund für Mutterschutz und Sexualreform (German League for the Protection of Mothers and Sexual Reform) by Helene Stöcker. The 1922 Richtlinien of the Mutterschutz Bund (Guidelines for the League for the Protection of Mothers) effectively outlined the Bund’s fundamental goal: “to protect life at its source, to let it develop pure and strong: to protect mothers; to recognize human sexuality as a powerful instrument, not only for the propagation but also for the progressive development of a joy in living, i.e. sexual reform, which is the content and final goal of our aspirations.” 68

The Bund, however, propagated the same distinct type of feminism which characterized Helene Stöcker’s personal work on “Marriage as a Psychological Problem,” in which she called for the recognition of the traditional form of marriage as the ultimate realization of love, based on total equality between man and woman. 69 Atina Grossman explains this distinct type of feminism — reflective of the pervasive attitude of retrenchment at the end of the Weimar Republic — as characterized by a “motherhood-eugenics consensus which assumed that motherhood was a natural and desirable instinct in all women.” 70 Moreover, the fundamental assumption was that despite a call to recognize women’s rights over their own bodies and to sexual freedom, “female nature and sexuality could only be truly fulfilled in motherhood.” 71

The Sex Reform movement, in aiming to cultivate a modern conception of sexual mores as free of regulation and expectations while also preserving the traditional marriage ideal, inherently pushed women back into the role of mothers and wives.\textsuperscript{72} This brings to light the complex nature of the disputed boundaries of female sexuality, which marks the intersection of sexuality, politics, religions, medicine, the law, and the economy in the late Weimar Republic.

A 1932 article entitled “Geburtenregelung Männersache!” (Birth Control - A Man’s Business!) the writer and psychologist, Walter von Hollander, discusses the multi-dimensional nature of the question of progeny. Von Hollander focused on the dispute over Paragraph 218, which he describes as a movement characterized as both “for and against the freedom of the individual, for and against the interference of the state in the life of the family, for and against the interference of the individual in a process of nature.”\textsuperscript{73} This reflected prescient awareness of the multiple milieu of perspectives that characterized the discourse on the politicized female body, at the center of which stood the question of the individual woman’s role in society. Regardless of the recognition of the complexity of the issue, von Hollander ultimately called upon the man to recognize and accordingly take proprietorship of his paternal responsibilities: “[men] alone have the responsibility of whether children are to be conceived or not...because he [the man] has the possibility of mastery.”\textsuperscript{74} Von Hollander’s work is reflective of the consensus on abortion as driven by eugenic

\textsuperscript{72} Kaes et al., \textit{The Weimar Republic Sourcebook}, 694.
\textsuperscript{74} Ibid., 716.
principles, wherein the woman as an individual is recognized but ultimately regarded in utilitarian terms; von Hollander himself believed that non-regulated procreation “has no chance to improve the posterity of the race.”

Here it becomes clear how the issue of abortion operated as a social yardstick for the new approach to social policy. An article calling for the removal of the anti-abortion law, written by Berlin women doctors and published in 1931 in the journal _Die Frau_, demonstrates the central eugenic component to the abortion struggle, as part of the wider Sex Reform movement. The article argues for the legalization of abortion according to the logic of forced motherhood being in conflict with the “dignity of human rights and the position of the woman within the state,” but notably also promotes abortion as an effective mechanism for ensuring “high quality offspring and the preservation and encouragement of the ethical power of the family to preserve the state.” Abortion, in this context, was a component of the form of negative eugenics mainstreamed in light of the economic crisis after 1929, characterized by the paradoxical discourse on who controlled the body of the woman. To understand the nature of the social policy that developed under the Weimar Republic after 1929, as shaped by ‘scientific’ eugenics concerning the health and vitality of the Volk, is to understand that the role of the woman in society was limited only to that of the mother and the wife. This notion was merely appropriated, not constructed, by the Nazis.

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75 Ibid.
Economic Crisis: Political Developments

As the welfare state began to disintegrate in light of financial austerity, this gave way to the rise of a new “broad-based alliance.” This alliance was comprised of various middle-class professional and agrarian interest groups, and critically members of the lower-middle class, linked by their collective resentment toward Depression-era low prices and high interest rates.\textsuperscript{77} They sought to displace the democratic system that had failed them, and actively promoted a eugenic approach to welfare subsidies that limited benefits only to those individuals genetically valuable to society as a whole.\textsuperscript{78} Right-wing parties, especially the Nazi party, capitalized on the changing welfare consensus, and began enthusiastically promoting eugenic sterilization. In light of this, left-leaning parties and their supporters, such as Dr. Julius Moses — a Weimar (social democrat) politician and symbol of Weimar left-wing medicine — were forced to recognize that sterilization could no longer be considered “progressive.”\textsuperscript{79} Weindling explains how, beginning in 1929, the NSDAP “appropriated” ‘scientific’ racial hygiene and eugenics “as appealing to professional classes and as offering the basis for selective welfare policies.”\textsuperscript{80} The success of this is evinced by the establishment of the Nationalsozialistischer Deutscher Ärztebund (National Socialist German Doctors’ League) on August 3, 1929.\textsuperscript{81} The League aimed to promote and spread Nazi racial hygiene principles, thus effectively linking the medical profession with Nazism through ‘scientific’ racial hygiene. Originally headed

\textsuperscript{77} Weindling, Health, Race and German Politics, 469.
\textsuperscript{78} Ibid., 449.
\textsuperscript{79} Ibid., 454.
\textsuperscript{80} Ibid., 470.
\textsuperscript{81} Ibid., 479.
by the German surgeon and gynecologist Ludwig Lang, the League was taken over in 1931 by Gerhard Wagner, a general practitioner who was to become a pivotal figure in the *Gleichschaltung* (enforced conformity) of the German medical profession according to Nazi racial principles.82 Popularity, as measured by the League’s membership, rose dramatically from 300 attendees at the League’s first rally in 1930 to over 1,000 in September 1932, reaching 2,786 members by January 1933.83 The League’s popularity can be explained by the fact that traditionally negative eugenic principles, specifically sterilization, were gradually normalized as a positive measure; many in German society, overwhelmed by economic trouble, recognized the potential of reducing the financial burden imposed by the “unproductive” members of society, and thus inherently transferring resource allocation to benefit “productive” individuals.84

The April elections of 1932 resulted in strong support for the NSDAP, shortly after which Heinrich Brüning resigned as Reich Chancellor. By June, the conservative leader Franz von Papen had initiated political dealings with the NSDAP, attempting to pave the way for the establishment of a more authoritarian regime.85 Von Papen condoned welfare policies informed by negative eugenics, especially compulsory labor schemes and sterilization, thus reinforcing the fact that the “welfare

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82 Ibid., 480.
83 Ibid.
state was becoming part of an authoritarian political structure.” 86 It was not difficult for eugenicists to gain foothold in a government that administered Sozialpolitik (social policy) according to the genetic material of the population, wherein those responsible for the People’s Welfare Organisation took the largely speculative findings of Erblehre (Heredity and Racial Science) as scientific fact.87

Against this political background, Hermann Muckermann’s 1931 work on welfare and eugenics provided further empirical legitimacy to the utilitarian eugenic thinking pervading German society at the time. Muckermann pointed to the financial burden of supporting one institutionalized ‘mental defective’ with 3.45 marks a day, amassing to over 185 million marks a year. The problem, for Muckermann, lay in the burdening support of the “mentally defective” during a time when financial conditions failed even to prevent the healthy from starving. Muckermann emphasizes a clear differentiation “in the entire welfare system such that means available are first appropriated for preventative care, and only then given out to people who cannot be brought back to work and life.”88 This reflected the general concern with rationalization and maximization of economic efficiency that became pervasive in the Weimar Republic as a direct result of the Great Depression after 1929 and began to manifest itself at the institutional level in 1932.

The Prussian Upper House representative, Dr. Struve, put forth a resolution which was approved January 20, 1932. This resolution officially recognized eugenics

86 Weindling, Health, Race and German Politics, 449.
and strove to popularize it in every way possible, decreasing immediately the amount of money given out for the care of the “hereditarily defective” to a “level that can be supported by a completely impoverished people.” Subsequently, a Prussian Health Council meeting was held July 2, 1932 on the topic of ‘Sterilization in the Service of Welfare,’ wherein leading eugenicists, amongst them Muckermann, held talks with the Committee for Population Policy and Eugenics of the Prussian Health Council.

As a direct result of the meeting, the Prussian Upper House adopted eugenic proposals and most importantly, a sterilization law draft on July 30, 1932. The draft proposed the legalization of voluntary sterilization of persons with hereditary defects, requiring “proof be given that the defective traits were in fact genetic.” It is important to note here that the sterilization law, as proposed in the 1932 draft, remained bound to the consent of the affected. Weindling references Rüdin in explaining that eugenicists at the time accepted the lack of compulsion “for tactical reasons,” and not out of principle. Although this marks an important difference with the Nazi’s 1933 mandatory sterilization law, the 1932 draft (composed, yet never passed) under the Weimar Republic ultimately served as the preliminary version of what was to become the compulsory Nazi sterilization law.

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90 Ibid.
91 Ibid., 225.
93 Ibid., 225.
Chapter II: The Role of Female Physicians in the Weimar Republic

The Effect of World War I onto the German Medical Profession

The First World War encouraged notions of male superiority and dominance, reinforcing misogynistic stereotypes that translated into the professional realm. In the medical field, this phenomenon created an increased focus on the definition of masculinity, so that a “sensually determined hierarchy” established certain medical professions as more ‘masculine’ than others.\textsuperscript{94} At its essence, these developments were manifestations of pre-existing notions of male supremacy, so that men and their value system counted for everything, and women — female doctors included — were objects of condescension or contempt.\textsuperscript{95}

Even before the outbreak of the war, the German medical profession was marked by deep-rooted misogyny. This explains why Germany was the last major European country to allow women to study medicine. Only by 1899 had the Bundesrat voted in favor of allowing women to obtain the German license to practice medicine.\textsuperscript{96} It can be said, at least partially, that the eventual admittance of women to medical school was one of the first demonstrations of the exploitation of socially-imposed feminine ideals by women themselves, to further their own interests with regard to the medical profession. The women’s movement argued that the absence of women doctors was harmful to women’s health, because the reluctance

\textsuperscript{94} Kater, “Professionalization and Socialization of Physicians,” 685.
\textsuperscript{95} Ibid.
\textsuperscript{96} Ibid., 687.
and shame felt by many women when they underwent physical examination by a male doctor meant that many women were not going to the doctor at all.\(^\text{97}\)

Only with the scientific developments in the late 19th century did this claim gain legitimacy, as the introduction of the scientific paradigm and the associated new research methods and devices fundamentally changed the nature of interaction between patient and doctor. In the decades prior a consultation had required only observation and questioning of the patient. However, the normalization of new diagnostic instruments (such as the stethoscope or the vaginal speculum) in the 19th century required exposure of the body. This legitimized the call for the admittance of women to the medical profession, so to overcome the norms and taboos inherent in doctor-patient interactions at the time.\(^\text{98}\)

Although 1901 marked the year when the first German woman graduated with a doctoral degree in medicine, it was not until 1908 that women were permitted into medical faculties across the entirety of Germany.\(^\text{99}\) Before the beginning of the First World War, there were already 1000 female medical students in Germany so that by 1915, 233 female doctors had been approved, comprising approximately half of a percent of the entire German medical profession.\(^\text{100}\) Although the numbers appear small relative to the male presence within the medical profession, they prove an important fundamental; many women wanted to become doctors, and were thus


\(^{98}\) Ibid.


\(^{100}\) Wittern-Stetzel, “Frauenärzinnen,” 48.
actively establishing their presence within the medical profession. In the context of reinforced notions of male superiority encouraged by the war, a collective sense of male entitlement developed among male physicians. This meant that the end of the war prompted fear among male physicians regarding the potential competition posed by their newly admitted female colleagues.

The Position of Female Physicians in the Weimar Republic

As the number of German female physicians continued to grow, this collective sense of male superiority among male physicians manifested in relegating women to the marginal sectors of the medical discipline. Discrimination against women doctors meant that it was more difficult, relative to their male counterparts, for women to attain state positions in hospitals, prisons, law courts or as medical health officers. However, there was an extraordinary growth in the number of women that entered the medical profession, with an increase from approximately 500 female medical students in 1911 to 3,500 in the 1929-1930 winter semester. There were 82 women doctors in 1909, and this number rose to almost 4,000 right before Hitler came to power in 1933. Although this statistic made up only 6 percent of the 51,527 total number of German doctors, it still represented for double the number of female medical students in Britain in the mid-1920s, where they had been admitting women to the medical profession since 1880.

102 Ibid., 110-111.
It is important to note that by 1925, the *Reichsmedizinalkalender* (directory of doctors) stated there were 1,395 female physicians in Germany, while the *Statistisches Reichsamt* (Reich statistical office) stated there were almost twice as many, with 2,572 female physicians. The discrepancy in numbers is explained by Renate Wittern-Sterzel as the product of variations in computing methods used by the different institutions.\(^{103}\) However, this discrepancy also points to the difficulty of accurately mapping the demographic development of women doctors within the medical profession during the Weimar years.

Regardless of statistical inconsistencies, certain is that while the number of female doctors in Germany grew continuously throughout the Weimar years — reaching around 3,000 by the 1930s — the female to male medical student ratio remained notably imbalanced.\(^{104}\) This imbalance reflected the aforementioned collective sense of entitlement among male physicians, so that despite formal emancipation, women within the medical profession continued to be subjected to “rejection and condescension” and to other forms of discrimination by their male colleagues which forced them into subordinate positions.\(^{105}\) Regardless of the formal emancipations granted to women within the medical profession throughout the Weimar years, deep-rooted sexism against female professionals within medicine was the norm. Even by 1930, the well-respected physician Dr. Undeutsch wrote that “the current problems of a surplus of doctors could only be solved by closing the universities to women students,” reflecting the prevailing notion among male

\(^{103}\) Ibid.
\(^{105}\) Kater, “Professionalization and Socialization,” 687.
professionals to be that female medical professionals were subordinate and their inclusion in the field of medicine was inappropriate. By the end of the Weimar Republic, “the male-dominated professional organizations” introduced a quota limiting the number of female physicians so that “not more than five per cent of the newly-to-be-certified physicians were permitted to be women.”

Dr. Helene Sonnemann, born March 13, 1922 in Flensburg, graduated from the Auguste-Viktoria-Schule Flensburg in early 1930. In a 1961 commemorative volume of the Auguste-Viktoria-Schule Flensburg, a chapter entitled “Aus dem Leben einer Ärztin” (From the Life of a Female doctor) written by Dr. Helene Sonnemann provides anecdotal evidence regarding the active effort on behalf of the male-dominated medical profession to discourage women from studying medicine; Sonnemann describes how after her graduation her father was willing to finance her medical studies, even when “shortly after my graduation from high school a warning report was sent to the house not to let his daughter study medicine because the medical profession was overcrowded and hopeless.” Dr. Sonnemann was later to become heavily involved with the Nazi “euthanasia” program during her time at the Kinderkrankenhaus Rothenburgsort (Children’s Hospital Rothenburgsort, KKR), where she was appointed assistant director by 1942. By the end of her five years at the KKR, she held responsibility for the deaths of twelve disabled children and is

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106 Ibid., 688.
107 Ibid.
presumed to have killed even more, which however cannot be proven due to the destruction of many files following the Rothenburgsort bombing in 1943.\textsuperscript{110}

In the background narrative to Helene Sonnemann’s career path it is important to highlight that her father, Paul Sonnemann, had himself originally wanted to become a doctor but became a land-surveyor instead. Paul was known for adamantly refusing to trust doctors and instead doing all medical work himself. However, it was Paul who, given the absence of a son in the family, pushed his first-born child Helene to study medicine. This choice was not out of respect for the profession but rather a way to vicariously pursue his own career aspirations. Paul’s determination to have his child become a doctor went so far that the entire family’s allowance was used for Helene’s medical studies — requiring Helene’s younger sister to stay at home after graduating high school to replace the maid who the family could no longer afford.\textsuperscript{111}

Despite Paul’s determination to push his daughter into the medical profession, he otherwise exhibited behavior that revealed an internalization of the mainstream consensus about gender roles at the time. He was not the most attentive father, often retiring to his study even when his children were small and needed their father, because he believed the children were his wife’s responsibility. The decision then, to push his daughter into a male-dominated profession, demonstrates status anxiety and a prioritization of career aspiration over any belief in women’s emancipation.

Under these conditions, it can be argued that Helene Sonnemann entered the medical profession for reasons in no way correlated to a personal passion or respect

\textsuperscript{110} Ibid., 41-43.
\textsuperscript{111} Ibid., 56-57.
for the principles, morals, and prestige of the profession. Interesting to note here is that although she graduated from the Auguste-Viktoria Schule (Auguste-Viktoria School) in early 1930 with the assessment “good,” only her performance in Latin was marked with “satisfactory” — not exactly an unimportant subject for future physicians.\textsuperscript{112} As her decision to study medicine was the product of her father’s facile projections of his own personal failure to become a doctor, Sonnemann was driven to become a doctor not by a focus on the actual nature of the profession, but rather a focus on the career aspect. This is important to consider with regard to understanding how the reasons for Sonnemann’s initial decision to study medicine translate into understanding her later actions and motives as a doctor under the Nazi regime.

The early life of Dr. Herta Oberheuser, another German female physician who became deeply involved in Nazi negative eugenics, can be examined as a way to understand better the reasons why women studied medicine despite the rampant gender discrimination that characterized the medical profession during the Weimar years. Oberheuser was born on May 15, 1911 in Cologne, into what she described as a “middle class conservative Christian family.”\textsuperscript{113} Her father was an engineer who suffered huge financial losses after the First World War. The Oberheuser family as a whole was left, like many German families after the war, in a state of economic ruin,

\textsuperscript{112} Raimund Reiter, Helene Darges-Sonnemann: Erfolgreiche Kinderärztin und Verstrickung in NS-Verbrechen (Celle: Stadt Celle, 2010).

bitter and angry and collectively humiliated by the defeat. Herta Oberheuser herself stated how “after the inflation there were financial difficulties for my parents and I was forced to finance my studies in part myself.”

Driven by the bitterness and humiliation that accompanied the Oberheuser’s financial troubles, the parents voted for the Nazi party in the 1932 elections, convinced Hitler and the Party were Germany’s chance to restore the nation’s honor and greatness. As with Sonnemann, Oberheuser’s decision to study medicine was largely influenced by her family and their desire to escape the bitterness and humiliation that accompanied their post-war economic descent. Herta’s family saw her medical career as a way to escape destitution and low social status. Unlike Dr. Sonnemann, then, who clearly showed independent interest to pursue a medical career, Dr. Oberheuser’s choice to enter the medical profession was significantly influenced by her family’s vulnerable economic situation. It may be possible to extrapolate from these cases the motivations of many other women who entered medical studies in the Weimar Republic.

The end of the war thus marked the establishment of women physicians’ presence within the male-dominated medical profession, driven by a complex of motivations but with economic need and status anxiety rather than emancipatory idealism driving that process in a still deeply patriarchal and misogynistic culture and society. To leave it at that, however, would be to ignore the capacity of women doctors to navigate the oppressive gender-defined structures of the medical profession.

\[114 \text{ Ibid.}\]
The Bund Deutscher Ärztinnen

Despite the hurdles in their way, Weimar-era female physicians organized to represent and defend their interests. The Bund Deutscher Ärztinnen (League of German Female Doctors, BDÄ) was founded in Berlin in 1924 by more than 300 women and by the end of its first year included over 600 members, which represented nearly half of all women doctors in Germany at the time. Its membership grew in conjunction with the rapid growth of the number of female physicians in Germany during the Weimar years, so that by the early 1930s it boasted 900 members — almost a third of all women doctors.115

The BDÄ’s eugenic perceptions were shaped by the dysgenic effects of World War I.116 One of its primary objectives was to promote a female approach to the advancement of social hygiene legislation. This is clearly stated in the opening statement of the BDÄ’s first journal publication written by its first president, Hermine Heusler-Edenhuizen: “the grave need of the Volk calls the woman, whose natural instinct tends to caring for others, and who is better able — more than the theorizing man — to feel herself in the misery of the individual, and thus of the whole Volk.”117

This opening statement in the BDÄ’s first journal publication by Heusler-Edenhuizen, entitled “Was Wir Wollen!” (What We Want!) and published in July 1924, evinces a conscious understanding of the position of the woman within the

gender-defined structure of the medical profession at the time. Moreover, Heusler-Edenhuizen’s words demonstrate an awareness of the feminine stereotype and a conscious understanding of how to navigate those structures to establish women doctors’ distinctive place within it: “And in professions that are particularly paradigmatic to her [the woman] maternal attitude, like our medical profession, we want her [the woman] not to imitate the manners of the male, but rather consciously pursue her own style. With the same knowledge and ability, she then complements what is missing in the work of the man.”

Heusler-Edenhuizen’s statement, as first president of the BDÄ, is thus indicative of a pervasive consciousness among German women doctors regarding their capacity to exploit the otherwise repressive socially-imposed female gender role. This proves that already in the early Weimar years women doctors deployed the typically presumed feminine qualities as a way to argue for their distinctive value to the medical profession and further themselves professionally. This signifies the first demonstration of female physicians’ conscious exploitation of gender-defined structures and norms, to carve out their own space within the male-dominated medical profession.

Women Doctors: Abortion Law Reform and Eugenics

With an estimate of around 250,000 illegal abortions that took place during the 1920s, abortion law reform dominated the public discourse. The polarization

\[118\] Ibid.
among female professionals regarding the topic was striking, which is demonstrated by a synopsis report on the discussion of abortion law reform commissioned by the journal of the BDÄ in 1924. The synopsis report was written by the Berlin lawyer Margarete Berent, and subsequently published in the Vierteljahresschrift (quarterly publication) of the BDÄ. Berent concluded in her report that the discussion’s polarity was due to that the “fundamental attitude of the women doctor is primarily driven by her world view, rather than the fact that she is a doctor or a woman.”

Polarized opinion regarding abortion law reform continued to deepen, marked by the presentation of two conflicting petitions to the Reichstag in 1930. One petition, signed by 356 women doctors from Berlin, called for the complete revocation of Paragraph 218, the law that criminalized non-medical abortions. In this demand, it was radically feminist for its time as it was supported by the argument that abortion should not be seen as a benefit granted to women, but rather as a right intrinsic to women controlling their own bodies. The other petition, signed by 400 (predominantly Catholic) women doctors starkly countered the Berlin petition in calling for the continuation of the criminalization of abortion (health reasons excluded). While there was thus an evident divide on the issue of abortion law reform among women doctors, those women in favor of reform argued on the basis of

119 Usborne, Women Doctors and Gender Identity, 114.
122 Usborne, Women Doctors and Gender Identity, 116.
123 Ibid., 114.
gender solidarity in framing the abortion law issue as a microcosm for gender equality issues as a whole.\textsuperscript{124}

Cornelie Usborne, in her work on gender identity in the Weimar, points to how, in contrast to abortion reform, the principle of negative eugenics did not polarize the medical profession along religious lines and instead actually united female doctors.\textsuperscript{125} The principle of negative eugenics — the regulation of hereditary health through manipulation of reproduction to prevent genetically “inferior” offspring — was espoused by women doctors, and the subject of eugenics as a whole was seen as gender-nonspecific. In fact, Usborne states that she has “not found a single case of a woman doctor speaking out forcefully against the principle of state-regulated differential breeding.”\textsuperscript{126}

When considering that this means the same women doctors advocating for the repeal of medical adjudicators of women’s choices regarding their own bodies simultaneously accepted the central role of physicians in eugenic schemes — wherein physicians identified hereditary defects and subsequently advised on sterilization — the word that comes to mind is hypocrisy.

Important to note is that women doctors in the Weimar Republic readily accepted eugenics as part of the dominant belief in the superiority of science and the professionalization of medicine that developed during the early Weimar years as part of the shifting social focus onto financial pragmatism. In the context of post-war financial constraints and “social dislocation,” eugenics was adopted into the

\textsuperscript{124} Ibid., 117.
\textsuperscript{125} Ibid., 118.
\textsuperscript{126} Ibid., 117.
mainstream discourse as a medically-driven alternative to costly welfare programs.\textsuperscript{127} The general intellectual climate of the time thus provides a partial explanation for women doctors’ support of eugenics. Intrinsic to this is that women doctors (active and/or passive) support was an attempt to conform to the mainstream belief, so to avoid further problems within a profession that still discriminated heavily against their gender as a whole.

Usborne proposes an additional narrative, wherein women doctors “conflated the interests of their women patients and those of the community,” which enabled the rationalization of eugenic schemes in their minds. This is because women doctors mostly handled proletarian women exhausted by too many children they did not plan on having and existed within a society exhausted by welfare obligations “it could not fulfill.”\textsuperscript{128}

What Usborne fails to consider, however, is the possibility for women doctors’ support of eugenic principles to have been not only conscious, but also calculated. The previous discussion on the BDÄ demonstrated women doctors’ capacity for conscious and calculated exploitation of systemic elements, so to reshape the medical profession to benefit their own gender. Women doctors’ support of eugenics must thus be considered as part of their conscious advocacy and support of whichever policies allowed them to further consolidate their place within the male-dominated medical profession. Determining the degree of influence that the different explanatory narratives actually had on women doctors’ motivations behind

\textsuperscript{128} Usborne, \textit{Women Doctors and Gender Identity}, 119.
their support for eugenics then becomes a question of these women doctors’
priorities. Did they prioritize professional interests, personal interests, or gender
interests? To what extent do these interests overlap, and to what extent are they
mutually exclusive?

Gendered Specialization within the Medical Profession

The specialization pattern of female physicians during the Weimar Republic
provides an effective basis on which to consider the intentionality behind women
doctors’ place and position within the German medical profession at the time. Of the
recorded female physicians in the Weimar years, approximately 25 percent of them
were medical specialists, almost half of them in pediatrics and approximately 15
percent worked in gynecology and obstetrics. A nephew of Dr. Helene Sonnemann
tells of his aunt: “She wanted to become a surgeon and she was the best in her
training group, but a less gifted, less intelligent, male colleague was preferred for the
job, so there was no other choice but to become a pediatrician. In pediatrics, the male
competition was not so great.”

This retelling by Dr. Sonnemann’s nephew reveals that Dr. Sonnemann
herself was representative of the general specialization pattern of female physicians;
although most female doctors worked as general practitioners, they were marked with
the addition of "for women and children" to their professional title.

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130 Wittern-Sterzel, “Frauenärztinnen,” 49.
Michael Kater, in his discussion of the socialization of female physicians in the Weimar Republic, accredits the notably disproportionate specialization of female physicians in the fields of gynecology or pediatrics to two intrinsically tied phenomena. First, women doctors’ choice of specialization, according to Kater, was limited as a result of systemic discrimination by male colleagues fearing the competition posed by the growing presence of women in the field. Kater presents the case of Dr. Käte Frankenthal to demonstrate the sexualization and patronization that female physicians were subjected to within the professional realm. During the war, Dr. Frankenthal offered her services as a military doctor, in response to which she was told that to be a doctor she would have to be an officer, which was not possible given that a German male “cannot serve under a woman, this would endanger discipline.”

A few years later in 1924, Dr. Frankenthal was offered a research position in Berlin under the condition that she “becomes the mistress of the institute’s director.” In alignment with Kater’s narrative, Melissa Kravetz, in her work on female physicians in the Weimar Republic, states that male physicians were “resentful and emasculated by the growing presence of women in the professions and public life.” As a result, she argues, women doctors were “pushed to the margins the medical profession where they primarily treated women and children in counseling centers and schools.”

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132 Ibid.
134 Ibid.
Secondly, Kater explains that women doctors demonstrated an independent “preference” for only these two fields, as a result of their internalization of their socially determined role as “servant-like or sex-specific beings.”

To consider only these two explanations for the specialization pattern of women doctors in the Weimar would be to deny the capacity of female physicians to create their own space within the medical profession, expanding the professional opportunities available to them through appropriating the gendered characteristics imposed upon them. The two hitherto examined explanations are overly structural, which is not to say they are not true. However, it must be considered that within their discriminatory gender-structured reality, women doctors were not entirely rid of individual choice and agency. The following section therefore examines an alternative explanation for the female specialization pattern. It must be recognized that this stands not in opposition to the existing explanations, but rather complements and supplements them to construct a more comprehensive understanding of the ways in which structural forces and female agency interacted to confirm women’s place within the German medical profession.

**Female Physicians’ Agency in the Weimar Republic**

Returning to the effect of World War I on German eugenics discourse, the declining birthrate in Germany following the end of the war — the lowest of any nation in Europe apart from Austria — continued to drive the concern over the

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population question. These concerns were the product of nationalist Great power status anxiety and centered around the topic of marriage. Marriage, at the time, was seen as the “cornerstone” of family, society, and most importantly, offspring. The declining birth rate was thus inherently associated with the breakdown of the marriage tradition and female emancipation, prompting the establishment of marriage counseling centers by the Prussian Welfare Ministry in mid-February, 1926.

Although the term eugenics was nowhere used in association with these marriage counseling centers, the centers were clearly founded along the lines of the fundamental eugenic principle first formulated by Ploetz, wherein the aim to create a superior Rasse through manipulation of racial development by preventing the genetically “inferior” from reproducing. The counseling centers were led by physicians, providing advisory counseling by doctors regarding individuals’ genetic “health” status for marriage, especially with regard to implications for the genetic health of potential offspring. The counseling concerned sexual health, focusing primarily on the female body and the woman’s role within the relationship. Notable is that women at the time overtly supported these counseling centers. Moreover, the job of marriage counselor was not popular among male physicians, for it did not pay well and was seen as “nurturing” and “caring” in nature. Women doctors, thus “dominated” in numbers; the normalization of women doctors’ dominant presence

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137 Ibid.


139 Kravetz, “Promoting Eugenics and Maternalism,” 73.
within marriage counseling centers is evidenced by a 1931 article in *Die Neue Generation*, wherein the fact that the doctor in question is female is in no way emphasized, if not even barely mentioned.\(^\text{140}\)

Melissa Kravetz points to the lack of personal records of women doctors at the time, which makes it very difficult to determine the extent of their consciousness behind their career decisions.\(^\text{141}\) However, gendered discrimination meant that women doctors primarily treated only women and children. In the context of the socially designated role of mother and housewife, which women were assumed to adopt in the professional realm, the marriage counseling centers provided a situation in which women doctors could exploit the socially-imposed feminine ideal to establish their place within the male-dominated medical profession. This is to say — regardless of the extent of consciousness behind their actions — women doctors legitimized their suitability to working in marriage counseling centers and thus established a place for themselves within the otherwise male-dominated medical profession. Kravetz’s examination of the BDÄ serves as evidence of this, in which she presents Hermine Heusler-Edenhuizen (the first president of the Bund Deutscher Ärztinnen) and Dr. Ilse Szagunn (a female doctor at a major counseling center in Berlin) as models of women who effectively propagated the necessity of marriage counseling centers, by intrinsically tying the sexual health of the female public to the German *Volksgesundheit* (the health of the nation) as a whole. Implicit to the improvement of the female public’s sexual health, was the need for female doctors. In the context of


\(^{141}\) Kravetz, “Promoting Eugenics and Maternalism,” 70.
the “sensually determined hierarchy” which deemed marriage counseling one of the least “masculine” fields of the medical profession, the emphasis on their stereotypical feminine qualities enabled women doctors to prove their value within the field. The alignment of socially designated feminine qualities and the successful furthering of prevalent eugenic ideas in the German public’s eye allowed women doctors to establish and legitimize a space for themselves within the medical profession during the Weimar years.

The (conscious) exploitation of societally-enforced gender roles by female physicians, as a means to further their careers within the medical profession is already seen during the Weimar years. What changed after 1933 was thus not the motivations dictating the behavior of women doctors, but rather the incentives behind establishing their place within the male-dominated medical profession. The following chapter will examine the continuities between Weimar and Nazi Germany with regard to the role of female physicians and the nature of the German medical profession.
Chapter III: Gender and the Medical Profession in Nazi Germany

The Role of Female Physicians: Continuities between the Weimar Republic and Nazi Germany

The years under Nazi rule marked a continuation of the pre-1933 trends that characterized the role of women doctors in the German medical profession. First off, the number of women entering the medical profession continued to grow steadily, with the cumulative percentage of female physicians rising from 6.5 percent in 1932 to 7.9 percent by 1937. By 1939 9.8 percent of medical students were women, climbing to 12.4 percent by 1942. The proportion of women doctors, with respect to the number of German doctors as a whole, grew as well, with female doctor making up 17 percent of all doctors registered with the Reichsärztekammer (Reich Physicians’ Chamber) between 1936 and 1945. An article published November 21, 1937 in the Berlin-Börsen Zeitung provides a more detailed account of the proportional increase of German female physicians. According to the 1937 directory of the Deutsche Ärzte und Heilanstalten (German medical and Sanitorial institutions), the article claims that the number of female physicians increased from 52,342 in 1935 to 55,259 in 1937. According to the article, female physicians contributed in particular to the increase in the total number of doctors, with the number of female physicians climbing from 2,279 in 1932 to 4,339 by 1937. This continued growth

142 Kater, Doctors under Hitler, 89.
143 Ibid.
144 Ibid.
146 Ibid.
in the number of women entering the medical profession is striking in light of the prevailing targeted systemic discouragement of women practicing medicine, initiated by the 1930 quota discussed in the previous chapter, which limited the number of permitted women to the profession intending to prevent any more women medical students in the Weimar Republic.\textsuperscript{147} This policy was continued by the Nazi health administration.\textsuperscript{148}

The continuities between the character of the German medical profession under the Weimar Republic and the Nazi regime are marked primarily by the misogyny which drove continued gender discrimination, and relegated women to the margins of the profession. Dr. Herta Oberheuser, one of the female physicians discussed in the previous chapter, was to become the only woman to be tried at the Nuremberg Doctor Trials. She is quoted in the first Trial’s transcript saying that she desired to change places of work in 1942 and had challenges doing so, “because being a woman, the difficulties were increasingly great for me.”\textsuperscript{149} In a later section of the Trial transcript, Oberheuser implicates her gender as the reason why she faced disrespect and discrimination from her colleagues when she was merely looking for help “as a woman and as a doctor.”\textsuperscript{150} From this quote it becomes clear that for Oberheuser, her gender and her profession were intrinsically tied. Within the same section of the transcript Oberheuser gives examples of disdainful comments made by her (presumably male) colleagues that made her work environment “hostile” and

\textsuperscript{147} See Chapter II of this thesis, Section: The Position of Female Physicians in the Weimar Republic, 45; Kater, “Professionalization and Socialization,” 688.
\textsuperscript{148} Kater, “Professionalization and Socialization,” 688.
\textsuperscript{149} McHaney, \textit{Military Tribunal}, 4.
\textsuperscript{150} Ibid.
drove her to isolation within the workplace: “I withdrew to my own specialized field.”\textsuperscript{151} Regardless of there being “too much work” in her department, Oberheuser often worked unaided to prove her professional capabilities were not limited by her gender: “I had to rely on myself for all my great amount of work.”\textsuperscript{152}

Dr. Helene Sonnemann, another female physician examined in the first chapter, parallels the experience of Oberheuser. Sonnemann was deeply involved in the Nazi negative eugenics program as the second in command at the Kinderkrankenhaus Rothenburgsort (KKR). At the 100-year-anniversary celebration of her high school, the Auguste-Viktoria-Schule Flensburg, in 1961, Sonnemann held a commemorative speech in which she referred to her training at the KKR as an “exhausting and a silent battle for open positions.”\textsuperscript{153}

Both Oberheuser and Sonnemann’s experiences are reflective of the continuation of the wider trend, that began in the Weimar Republic, of women doctors facing gender discrimination within the medical profession. Under the Nazi regime, women doctors stood just about half the chance to establish themselves in panel practice relative to their male counterparts.\textsuperscript{154} Oberheuser states in her trial that she was “never independent during my activity [as a doctor].” This adhered to the broader pattern in which the 5,146 salaried women doctors, making up 54.6 percent of all women doctors by 1942, 3,453 were employed in clinics and hospitals and a further 700 placed by the KVD.\textsuperscript{155} Only a tiny percentage were independent

\textsuperscript{151} Ibid.  
\textsuperscript{152} Ibid.  
\textsuperscript{153} Babel, \textit{Kindermord im Krankenhaus}, 47.  
\textsuperscript{154} Kater, \textit{Doctors under Hitler}, 90.  
practitioners. In extension of the post-1929 Weimar Republic’s welfare austerity program which specifically targeted married women through an aggressive attack on *Doppelverdienertum* (double-earning households), the Nazis made it clear in their first year in power that male candidates would be prioritized for positions for young doctors, and that unmarried female candidates would be favored. Under the Nazi regime, this was justified along the lines of the fundamental Nazi principle that proclaimed the carrying and raising of children to be women’s ultimate purpose. Under this framework, working in professional employment was posed as inhibiting women’s ability to fulfill their ultimate purpose. A statement made in 1933 by Dr. Friedrich Bartels, who was to become the deputy Reichsgesundheitsführer (Reich Physicians’ Leader), is evocative of how the broad attack on working women affected the general consensus on women doctors. Bartels recognized the value of female physicians in social services yet believed that the reintegration of “the married woman, the working mother, into the family,” should be the ultimate priority.

Helene Sonnemann began her work placement at the Universitäts-Frauenklinik Hamburg (University Women’s Hospital Hamburg) to become a pediatrician in 1936, at the same time as writing her doctoral dissertation at the Universität Hamburg (Hamburg University) with Professor Heynemann. Her dissertation was concerned with the frequency and treatment of breech presentation, using statistical evaluations of birth certificates from Hamburg, and contained an

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156 Ibid.
157 *Kater, Doctors under Hitler*, 92.
158 Ibid., 93.
159 *Reiter, Dr. Helene Darges-Sonnemann*, 9.
extensive evaluation of malformations in newborns — notably absent of any eugenic or racist references. The focus in her doctoral dissertation as centered around gynecological and pediatric subject matters, indicates that Sonnemann adhered to the broad pattern of gender-specific specialization of female physicians. Her nephew, years after her death, remembers that Sonnemann “actually wanted to be a surgeon and was the best in her training group, but instead a less talented, less intelligent, yet male colleague of hers were preferred so she had no choice but to become a pediatrician.” Sonnemann’s nephew’s comments emphasize the male-dominated medical profession’s gendered discrimination pushing female physicians into gender-specific fields. This is made more explicit by Sonnemann’s nephew subsequent explanation: “in pediatrics, male competition was not very substantial.”

As women were pushed to the margins of the profession, the number of women specialists in private employment was incredibly low, at 5.5 percent by 1937, with a mere 0.1 percent increase the following year. The specialization pattern of female physicians, as it was first established during the Weimar Republic, was marked by the notable restriction of women to the fields of gynecology and pediatrics, the assumption being that this pattern was shaped by the discrimination of male colleagues pushing women into professional fields that were an extension of their socially designated roles of mother and housewife, limiting their treatment only to women and children. As discussed in the last chapter, however, this narrative is

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160 Ibid.
162 Ibid.
163 Kater, *Doctors under Hitler*, 91.
reductive in denying female physicians the capacity to create their own space within
the male-dominated medical profession through the appropriation of the gendered
characteristics imposed upon them. To develop an understanding of the intentionality
behind women doctors’ position within the German medical profession in the Third
Reich, the distinct specialization pattern after 1933, as it pertains to individual women
doctors, must be further examined.

Female Physicians’ Specialization in Nazi Germany

In slight divergence from the specialization pattern recorded during the
Weimar Republic, there was a decreasing frequency of women specializing in
pediatrics under the Nazi regime; the percentage of female pediatric specialists had
been 45.7 percent in 1930, dropping to 43.3 percent by 1935, and further declining to
42.4 percent by 1937.\footnote{164} Important to note here though, is that regardless of the
frequency index, by 1938 women still constituted 42.6 percent of all pediatricians.\footnote{165}

Gynecology remained the second main field of specialization for women doctors,
which Michael Kater accredits to Agnes Bluhm, whose work in the early 20th century
on obstetrics — examined in the first chapter — popularized gynecology among
women within the medical profession. Kater explains how Bluhm’s work, in that it
“tied gynecological and obstetrical issues to a vulgarized Social Darwinism” was
central in Nazi appropriation and propagation of the idea that gynecology was a
“natural” area for women to specialize in.\footnote{166}
While the general pattern of female physician’s gender-specific specialization continued from the Weimar Republic to the Third Reich, Herta Oberheuser was evidence of a new phenomenon that developed only after 1933. Oberheuser specialized in skin diseases and venereal diseases, attesting to the diversification of female physicians’ specialization to fields such as internism, otology, or dermatology under Nazi rule, which had not been seen before. While Oberheuser is evidence of a pattern marked by the diversification of female physicians’ specialization, her specialization choice diverges from the wider trend of female physicians’ sex-specific specialization. With regard to the implications of this specialization pattern for female physicians’ agency — as discussed in the first chapter apropos female physicians in Weimar marriage counseling centers — there must be a recognition of female physician’s exploitation of the socially imposed feminine ideal to establish a place for themselves within the medical profession, as a dimension of this gender-specific specialization pattern. Here, gender became the vital category for women doctors to recognize their relative position, and thus pertinent to their scope of social mobility, to find a space for themselves within the male-dominated medical profession. The continued pattern of this notably limited specialization of female physicians to the fields of gynecology or pediatrics after 1933 points to the need for an approach that recognizes women doctors’ capacity to identify and navigate the gendered structure of the German medical system in the Third Reich. Indeed, pediatrics and gynecology were deployed as somewhat autonomous spheres of professional advancement.

McHaney, Military Tribunal, 4.; Kater, Doctors under Hitler, 91.
Gender intrinsically shaped the character of women’s medical practice, however, not just in the way that the misogynistic disposition of the medical profession forcibly marginalized them but also in the conscious, individual choices women made for themselves. Women were victims to the male-dominated discriminatory medical profession, but at the same time champions for their distinct value and competence in the fields concerned with women and children. This becomes especially important in light of Nazi appropriation and amplification of the female social stereotype, as it had emerged in the Weimar Republic, which actually provided further legitimacy to the idea of female doctors as indispensable to fields within the medical profession that pertained to women and children, an idea introduced by the women’s movement as early as the 19th century. Under Nazi rule, the reinforcement of women’s socially designated role as the mother and caretaker amplified the value of female physicians — as marked by her distinctly female qualities — in the gender-specific fields of pediatrics and gynecology.

Oberheuser’s non-gender-specific specialization in the field of dermatology thus does not speak to an exploitation of the socially imposed feminine ideal. That said, her subsequent choice in early 1941 to work at the women’s concentration camp, Ravensbrück, does reflect a capitalization on the opportunity to conform to the Nazi axiom, and to legitimate her suitability to sex-specific work and thus establish a place for herself within the otherwise male-dominated medical profession. It thus

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169 Wittern-Sterzel, “Frauenärztinnen,” 47.
170 Sarti, Women and Nazis, 172.
adheres to the wider trend of women physicians’ capitalizing upon the gendered structure of the medical profession to establish a distinctively female space for themselves.

Oberheuser’s specialization choice also indicates a genuinely scientific motive. Female physicians that specialized gender-specifically posed less of a threat to their male colleagues, given that typically very few male physicians actually wanted to enter the fields of gynecology and pediatrics. In this way, those women doctors that specialized gender-specifically were not in competition for the same jobs as their male colleagues, which also made them less of a target for discrimination. Gender-specific specialization for female physicians thus meant lower barriers of entry into the male-dominated medical profession, as well as the potential for professional advancement to a degree otherwise unthinkable for women at the time.

In choosing to specialize in dermatology, Oberheuser indicated a disregard for the implications of gender-specific specialization that points to a genuine interest in her field. To understand how this translates into the motivations behind her later actions — as a physician conducting gruesome experiments as part of the Nazi eugenic agenda — Oberheuser’s personal conception of Nazi principles, in relation to her professional interests, must be examined.

Female Physicians’ Socialization in Nazi Germany

Central to understanding Herta Oberheuser’s internalization of Nazi ideology is her socialization under Nazi rule, significantly shaped by her time as a Blockleiterin (female block leader) of the Hitler Youth Girls Organisation, the Bund
Deutscher Mädel (League of German Girls) in 1935 at only 24 years old. At her trial at Nuremberg, Oberheuser gives a comprehensive explanation of how her involvement came about:

As a senior medical student, we were called upon to place ourselves at the disposal of the BDM; that is, we were ordered because there were so few female doctors in Duesseldorf. I found young girls there who had been forced into this organization; they had too much sports to do and too much service. The parents had already objected to this. I tried to do something to alleviate these conditions and we examined the girls medically. We were present at sport meetings in order to avoid leaving the young girls to their young leaders so that they would not over-exert themselves. This was a purely medical activity, and this was part of the reason why I later became a party member.\(^{171}\)

Oberheuser’s statement is evidence of the emphasis placed on health and physical fitness within the BDM, wherein the girls’ personal health and hygiene was placed in direct parallel to the health of the nation.\(^{172}\) The BDM medical exams that Oberheuser performed comprehensively assessed the girls’ physical conditions for eligibility requirements heavily weighed racial features.\(^{173}\) Membership disqualification resulted from diagnosed hereditary diseases.\(^{174}\) In this way, physicians participating in the BDM were implementing the racial-eugenic dogma of the Nazis. On the other hand, this served to further embed Nazi racial-hygiene into the minds of the physicians, wherein it can be assumed that this shaped Oberheuser’s thinking as well. Important to note here is that BDM racial-hygiene rhetoric was structured around identifying characteristics that qualify a “real,” healthy German (the in-group), as opposed to

\(^{172}\) Kravetz, “Creating a Space in the Medical Profession,” 257.
\(^{173}\) Ibid., 259.
\(^{174}\) Ibid.
being structured around the targeted identification of out-groups. Interestingly, at her trial discussing Oberheuser’s later work at Ravensbrück, where she infamously performed painful experiments on inmates and was also involved in sterilization experiments and “euthanasia” killings (which is to be discussed later in this chapter), there is no indication of a conscious targeted identification of distinctive out-groups. Instead of using distinctive racial-eugenic descriptions of her victims, such as “Jewish” or “disabled,” Oberheuser only ever really points to the fact that they were definitively not German. This way of thinking indicates the nature of Oberheuser’s racial-eugenic thinking to be directed less by an active contempt for particular out-groups, and more by a rudimentary mental distinction between Germans and non-Germans; real human beings and guinea pigs.

Also notable in light of the previous discussion, is Oberheuser’s emphasis on her work for the BDM as having been “purely medical.” Considering that her work for the BDM was the direct link to her joining the Nazi Party in 1937, it can be assumed that her approach to Nazi Party affiliation followed from the same motives. This is to say, Oberheuser’s Nazi socialization was driven by her professional medical interests, indicating she prioritized her career. Oberheuser was driven by careerism, but only to the extent that it pertained to her scientific interests: she seemed to have had career ambitions strongly rooted in her genuine passion for science and medicine.

For Oberheuser then, Nazi principles presented a framework within which she could further her medical career. Kater attests to this, in explaining how Nazi party membership for female physician was an instrument, “ideal for documenting political loyalty while at the same time allowing greater leverage in maneuvering against the medical establishment.”

Oberheuser’s involvement in the BDM reveals a broader current of it being the most popular form of women’s organization among women doctors under the Nazis. Beyond serving as an apparatus to signal political reliability as was required under Nazi rule, it was “useful as a springboard for attractive, remunerative careers in the future.” By 1939, an estimated 1,300 female physicians were part of the BDM, with membership peaking at 1,500 in 1941. Oberheuser’s testimony also documents the daily practices of BDM doctors, and especially female medical students, whose responsibilities lay in educating the young girls in “hygiene and general health care, to act as orderlies in youth camps, and to assist female physicians in physical checkups.” As clearly stated by Oberheuser, the BDM “was part of the reason why I later became a party member,” indicating the organization’s function as a crucial link to adult Nazi organizations, especially the gender-specific ones for women.

In contrast to Oberheuser, Helene Sonnemann’s participation in Nazi socialization did not appear to be predominantly driven by professional scientific

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177 Ibid., 108.
178 Ibid., 109.
179 Ibid., 102.
180 Ibid., 108.
interests. Rather, Sonnemann’s involvement in Nazi socialization indicates a genuine engagement with National Socialist principles and beliefs, that suggest an interest not purely motivated by career aspirations. Unlike Oberheuser, Sonnemann joined the NSDAP in 1939, without having been channeled into party membership through a subsidiary Nazi organization.\textsuperscript{181} In 1941, Sonnemann joined the NS-Ärztebund, and, more importantly, took on the role as deputy leader of the Gesundheitsabteilung im Nationalsozialistischen Deutschen Studentenbund Hamburg (NSDStB, Health Department of the National Socialist German Student Union Hamburg).\textsuperscript{182} Sonnemannn’s participation in the NSDStB is particularly notable given the heavy ideological focus of the organization, which distinguished her from the general trend of female physicians in the Third Reich preferring service-oriented organizations.\textsuperscript{183} This indicates a much stronger ideological commitment to Nazi principles than displayed by Oberheuser that goes beyond a “purely medical” interest.\textsuperscript{184}

War served as an important catalyst that broke down many remaining barriers. An article titled “The Increase in Women Doctors” in the \textit{Kölnische Zeitung}, dated May 5, 1943 provides an anecdotal account of the effect of wartime-preparation on the role of women doctors within the German medical profession. As men were called up to the front there was a shortage of doctors within a wartime-bound economy that was dependent on doctors more than ever. As a result, women doctors became increasingly desired and valuable, leading to a dramatic increase in the number of

\textsuperscript{181} Reiter, Dr. Helene Darges-Sonnemann, 10.
\textsuperscript{182} Ibid.
\textsuperscript{183} Kater, \textit{Doctors under Hitler}, 102.
\textsuperscript{184} McHaney, \textit{Military Tribunals}, 4.
women entering the medical profession — and notably, an almost twofold increase in
the number of salaried women doctors from 21.1 percent in 1935 to 41.4 percent by
1939, climbing to 54.6 percent by 1942.\textsuperscript{185} A translated extract of the 1943 \textit{Kölnische
Zeitung} article, narrating this development, reads as follows:

In a small hospital on the outskirts of the city, ten years ago, only male
doctors were employed. Later, under a new boss, a female doctor was
employed; she did not find it easy to gain recognition. However, she
developed great abilities, but above all tenacity, which gradually led her to
become a senior physician. When the war began, the chief male physician was
assigned to front service. The female doctor took over his patients and took
on, as the circumstances of war required, his responsibilities and function.
When the hospital had to surrender more male doctors, it was decided to
replace them with women, which came to be accepted gradually. The women
have the same responsibilities as their male colleagues — something that has
not always been a given.

This development is reflective of the general situation. The small hospital is
one of many institutions undergoing change. The conditions of war have
favored this process of change, but are hardly solely responsible for it, as the
steadily increasing number of studying physicians had to first obtain a larger
field of activity (Betätigungsfeld). On the other hand, however, one can again
object in arguing the increased career prospects to have driven the increase in
the number of women entering the medical profession.\textsuperscript{186}

This account alludes to the sudden reliance of the Reich health administration on
certified physicians, irrespective of their gender, as prompted by the outbreak of war.
The shortage of male doctors in a wartime economy, against the socio-political
background of increasing systemic rejection of certified Jewish candidates caused a
breakdown of the “gender-specific organizational politics.” Women doctors, even
married ones, were summoned back to fill positions (generally still subsidiary to men)
at medical offices and clinics as part of an aggressive campaign to incentivize and

\textsuperscript{185} Kater, \textit{Doctors under Hitler}, 90.
\textsuperscript{186} Article, “Die Zunahme der Ärztinnen,” \textit{Kölnische Zeitung}, May 5, 1943, NS/5/VI-7090,
Berlin-Lichtefelde Archiv, Berlin.
coerce women doctors to enter the medical network out of sheer necessity.\textsuperscript{187}

Significant is the article’s allusion to the natural consequences of increased “formal recognition, leading to greater nominal parity with men.”\textsuperscript{188}

**Women and Eugenic Sterilization and Abortion**

It is important to understand that social policy after 1933 did not see a break but continued with pre-existing ideas simply appropriated and amplified by the Nazis. This is effectively demonstrated when considering the development of the Gesellschaft für Rassenhygiene, discussed in Chapter One as the first established racial hygiene organization in Germany, founded in 1905 by Ploetz.\textsuperscript{189} Its membership had steadily grown throughout the Weimar years, boasting 1,100 members by 1931.\textsuperscript{190} By 1933, the Gesellschaft — thriving on the same ideological platform it had been founded on back in 1905 — was *gleichgeschaltet* (coordinated) as it was absorbed into the larger Reichsministerium des Innern (Reich Ministry of Interior) as part of a special Reich Commission for National Health Service with the mission to support the Nazi government in its racial hygienic goals.\textsuperscript{191} In the 1934 edition of the Gesellschaft’s journal *Archiv*, originally founded in 1904, Ernst Rüdin writes that: “The significance of *Rassenhygiene* (race hygiene) has become publicly manifest to all aware Germans only through the political work of Adolf Hitler, and it

\textsuperscript{187} Kater, *Doctors under Hitler*, 97
\textsuperscript{188} Ibid., 107.
\textsuperscript{189} Weindling, *Health, Race and German Politics*, 142.
\textsuperscript{190} Faith-Weiss, "The Race Hygiene Movement," 221.
\textsuperscript{191} Peter Weingart, "German Eugenics between Science and Politics," *Osiris* 5 (1989): 270.
is only through him that our thirty-year-old dream to put race hygiene into practice, has become reality.”

Rüdin clearly accredits Hitler with granting political legitimacy to the race hygiene movement as a science. While the absorption of the Gesellschaft into the Nazi regime as a government organ marks the first time that the Gesellschaft (and thus its racial hygiene principles) gained explicit, official government endorsement, this does not mark a massive break. 1933 marked the first time that the Gesellschaft’s ideas coincided with the officially stated interests of the ruling regime, but it had reflected those of a growing portion of the German public for years.

This continuity was first manifested clearly in the adoption of the sterilization law draft, which had been originally drawn up by the Weimar government in 1932. By July 14, 1933 the Nazis put into effect the Gesetz zur Verhütung Erbkranken Nachwuchses (Law for the Prevention of Hereditarily Diseased Progeny). A notable modification was changing the terms of the original draft into a compulsory enactment, accompanied by the establishment of Erbgesundheitsgerichte (hereditary health courts) which functioned as the legal structure administering and determining the sterilization process. The law reads:

(1) Anyone who has hereditary disease can be sterilized by surgical intervention if, in the experience of medical science, it is highly probable that his offspring will suffer serious bodily or mental hereditary damage.
(2) For the purposes of this Act, Erbkrank (hereditarily diseased) is anyone who suffers from one of the following diseases:
   1. Congenital nonsense,
   2. Schizophrenia,

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193 Weingart, German Eugenics, 270.
3. Circular (manic-depressive) insanity,
4. Hereditary epilepsy
5. Hereditary Veitstanz (Huntington's Chorea),
6. Hereditary blindness,
7. Hereditary deafness,
8. Severe physical deformity

(3) Furthermore, anyone can be made infertile who suffers from severe alcoholism.\(^{194}\)

The 1934 publication by Arthur Gütt, Ernst Rüdin and Falk Ruttke, titled “Zur Verhütung erbkranken Nachwuchses” (For the Prevention of Genetically Diseased Offspring) provided comprehensive explanations and justifications for the law. Most importantly, their work explicitly defined \textit{Erbrank}:

\textit{Erbrank} is one who, personally possesses or has possessed a disease (a disease, a defect, a disorder, a malformation) which has been proven

\begin{enumerate}[a)]
  \item To be inherited by some resounding or overlayed form of Mendelian rule \[\ldots\] or
  \item Has proven, according to other systematic prognostic tests performed on a large number of diseased families, to be undoubtedly hereditary, or
  \item Within a single particular family to have visibly developed into an abnormal condition among relatives \[\ldots\]
\end{enumerate}

One of these proofs is enough.\(^{195}\)

The introduction of the book stated that the sterilization law asserted the “primacy of the state over the sphere of life, marriage and family.”\(^{196}\) This reveals how compulsory sterilization was inherently gendered, for anything addressing the


\(^{196}\) Ibid., 5.
creation and preservation of life intrinsically implies women. The “departure from
the norm” as the psychiatric measure for “inferiority” introduced by the Nazis, was
held against the heteronormative standard of the respective genders. An important
distinction was that for women, the assessment of their work behavior expanded into
an examination of housework and parenting behavior. Women’s sexual behavior was
also heavily weighed. Men’s assessment remained limited only to the professional
sphere.

It is important here to discuss briefly the implications of the gendered
character of sterilization, to understand how it both shaped and reflected women’s
role in Nazi society. Among the intrinsic gendered aspects of sterilization was the
“separation of sexuality and procreation.” The implications of sterilization within
the sexual dimension were inherently different for men and women. Compulsory
sterilization was officially promoted as a way to prevent pregnancy as the
“consequence” of possible rape, and a government decree in 1936 ordered that “in the
case of the female hereditarily sick, the possibility of abuse against her must be taken
into account.” If nothing else, this proves how likely — and thus normalized —
rape against even “hereditarily inferior” women was regarded. Moreover,
 involuntarily sterilized women became targeted victims of sexual abuse, given that

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197 Gisela Bock, “Antinatalism, Maternity, and Paternity in National Socialist Racism,” in
Nazism and German Society 1933-1945, ed. David F. Crew (London and New York:
198 Ibid., 118.
199 Ibid., 116.
200 Ibid., 118.
the absence of the victim’s potential pregnancy eradicated men’s concerns over the
repercussions of their assault as it directly pertained to them.201

Within the same law as the Gesetz zur Verhütung, voluntary sterilizations
were made illegal under article 14; not a single sterilization that took place under the
Nazi regime was voluntary.202 Gisela Bock argues that the sterilization law was one of
the earliest expressions of Nazi racism, one that had been mischaracterized as
pro-natalist when in fact it was anti-natalist.203 However, the outlawing of voluntary
sterilizations intrinsic to the compulsory sterilization law, as well as the undeniable
effort on behalf of the Nazi regime to motivate Aryan women to reproduce, points to
‘selective pro-natalism’ as a more accurate term. A 1934 Nazi brochure stating
women’s responsibility to be not mere procreation, but rather “regeneration,” speaks
to the idea of selective pro-natalism as the most befitting term to describe the nature
of Nazi population policy.204

State-sanctioned negative eugenic policies continued to develop, with the
introduction of compulsory health examinations for anyone planning on getting
married: registrars were forbidden to authorize marriages unless the passing of the
health examination was proven with a Ehegesundheitszeugnis (official certificate of
marriage health). This served as an extension of the 1933 sterilization law, as it was

201 Ibid.
202 Ibid., 114.
203 Explaining Bock’s use of the term Nazi “racism” in a eugenic context: Bock states Nazi
eugenics to have been a form of racism: “racism means not only discrimination of “alien”
races or peoples, but also the “regeneration” of one’s own people, in so far as that was aimed
at through discrimination of the “biologically inferior” among one’s own people. See page 115
in Crew, Nazism and German Society.
204 Bock, Antinatalism, 119.
intended to prevent marriages of Erbkranké as defined by those afflicted with the particular “diseases” listed in Gesetz zur Verhütung.\textsuperscript{205}

Michael Burleigh explains how the success of Nazi sterilization practices amplified the focus on those deemed “incurable.”\textsuperscript{206} It is important here to once again emphasize that 1933 did not mark a break in social policy approach, only the formal institutionalization of notions that had pervaded German society since the late Weimar Republic. At the core of all of this stood “war utilitarianism,” a belief which fundamentally shaped Nazi eugenics (especially the developments within the field of psychiatry) but had underpinned public thinking since the very beginning of the Republic.

**War Utilitarianism**

“War utilitarianism” is defined here as a way of thinking that emerged from post-war austerity, implicitly referenced in the first chapter’s discussion of the effect of World War I on eugenics. The war pushed the population question to the forefront of public discourse.\textsuperscript{207} The economic crisis and the loss of thousands of the population’s most physically capable men at the front naturally shifted public thinking on social policy into utilitarian terms. That is, scarce resources following the war shifted focus to the financial burden posed by those members of society incapable of “productively” contributing to the social and economic reconstruction of


\textsuperscript{206} Michael Burleigh, *Ethics and Extermination: Reflections on Nazi Genocide* (Cambridge, New York: Cambridge University Press, 1997), 120.

\textsuperscript{207} Faith Weiss, “The Race Hygiene Movement,” 211.
Germany. Institutionalized patients, especially long-term ones, became the target of the war utilitarian conception of “unproductive” individuals. This was intensified with the introduction of occupational therapy, first implemented by the German psychiatric reformer Hermann Simon in 1919 and quickly adopted by psychiatric facilities all over Germany.\(^\text{208}\) Although occupational therapy proved incredibly successful in improving patient behavior, it also meant that patients began to be innately regarded in terms of their economic value.\(^\text{209}\) Occupational therapy innately established a distinction between the “able-bodied” and those “incurable/impervious to therapeutic improvement.” Long before the Nazis came to power an inferior category of individuals within a social group already marginalized had been established. The post-1929 Depression-era discourse once again reinforced war utilitarian thinking, until it was appropriated under the Nazis as part of state-sanctioned eugenic policies.

Here it must be emphasized that although war utilitarianism was an intrinsic component of Nazi social policy, it fundamentally distinguished itself in important ways. It can even be said that its development was not directed by the Nazis, but rather that Nazi social policy was a mere reflection of war utilitarianism as it had existed since the very beginning of the Weimar Republic. This is a harsh reality to face for many, especially contemporary Germans, for it is easier to accept the narrative in which all morally deformed thinking was created by and enforced solely


under the Nazi regime. In reality however, German society had been characterized by such moral deformation years before the Nazis came to power, as manifested by war utilitarianism.210

The racist, sexist and ableist dimension to war utilitarianism is undeniable, yet it must be recognized as a way of thinking that emerged from war and austerity and was shaped by considerations regarding the ethical distribution of scarce resources informed by rational utilitarianism; at its essence, it came down to economic pragmatism. The discriminatory dimension of this thinking was that it posited that certain people were more “worthy” or “deserving” of certain resources than others. War utilitarianism was thus marked by collectivism, informed by the functional belief that certain individuals, indeterminate of gender or race, are relatively less valuable as determined by their relative incapacity to contribute to the advancement of the collective. Following this line of thinking, those individuals with lower socio-economic utility are less valuable and thus undeserving of having national resources allocated to benefit them at the expense of “productive” individuals. In itself, this way of thinking had existed for decades and was propagated and adopted in a variety of different circumstances at different scales. However, the important distinction is that under the Nazi regime, the definition of “health” and the idea of what a “healthy” collective looked like was deeply discriminatory and racist. War utilitarianism, at its root, was concerned with effective and practical rationing; under

210 Gerd Krumeich, Die unbewältigte Niederlage: Das Trauma des Ersten Weltkriegs und die Weimarer Republik (Verlag Herder, 2018).
the Nazis, death became accepted as a means of rationing.\textsuperscript{211} It is this thinking that paved the way for the implementation of the child “euthanasia” program and enabled its rationalization as a necessary economic measure.

\textsuperscript{211}M A. Faria, "Utilitarianism and the Perversion of the Ethics of Hippocrates" \textit{Western Journal of Medicine} 172, no. 4 (2000).
Chapter IV: Women Doctors in Nazi Medical Crimes

Child “Euthanasia”

The child “euthanasia” program must be recognized as the cumulative product of a radicalized social policy approach, shaped by war utilitarianism. Important to note is that in part, as emphasized by Burleigh, the child “euthanasia” program was a response to public appeal for “mercy killings.” This began with the first “euthanization” of a severely disabled baby at the wish of its father, following an assessment of the boy by Werner Catel, the Leipzig Chief of Pediatrics, and Karl Brandt, Hitler’s personal physician, in the Summer 1939, in Leipzig. This first “euthanasia” killing prompted a general authorization from Hitler, post-dated to September 1, 1939, to proceed analogously in similar cases thus paving the way for the organized mass murder of the sick and disabled people. The official authorization written by Hitler reads:

Reichsleiter Bouhler and Dr. Brandt, M.D. are charged with the responsibility of enlarging the authority of certain physicians to be designated by name in such a manner that persons who, according to human judgement, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death.

(signed) A. Hitler

This authorization initiated the establishment of around 30 Kinderfachabteilungen

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212 Burleigh. Ethics and Extermination, 122.
(special pediatrics unit, KFA), such as the one at Hesterberg, in the summer of 1940.

These children’s wards functioned as special psychiatric institutions of hospitals or Heil- und Pflegeanstalten (psychiatric hospitals), where children were sent for ‘treatment’ (a euphemism for murder) after having been reported to the child “euthanasia” front organization Reichsausschuss zur Wissenschaftlichen Erfassung Erb- und Anlagebedingter schwerer Leiden (Reich Committee for the Scientific Registration of Severe Hereditary and Congenital Disorders) by doctors or midwives for ‘serious hereditary defects’ in the form of:

1. Idiocy as well as Mongolism
2. Microcephaly
3. Hydrocephalus
4. Malformation of any kind, especially missing limbs, severe clefts of the head and spine
5. Paralysis, including Littlesch's disease.  

The Gutachter (appointed experts) of the Reichsausschuss (RA) were Werner Catel from Leipzig, Ernst Wentzler from Berlin, and the director of the Brandenburg-Görden hospital, Dr. Hans Heinze. Notably, the director of the KFA at Görden was Dr. Friederike Pusch, a female physician from Straßfurt.

Dr. Pusch, as a female physician heading a KFA, does not represent an anomaly, but rather what can be logically traced as a systemic phenomenon. As

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discussed, the gendered structure of the German medical profession marginalized female physicians and led to the conscious decision by women to specialize in fields solely concerned with women and children. And so when the KFA were created, it appeared logical if not natural, to appoint a female physician as its head.

Dr. Erna Pauselius, a female physician born in 1908 and the first director of the KFA at the Schleswig-Hesterberg Hospital is a typical example. The formation of this KFA in December 1940 marked the culmination of eugenic activity in the form of sterilization of those afflicted with “hereditary diseases,” which had begun at Hesterberg in 1934. In 1938, prior to the formation of the Hesterberg KFA, the director of the clinic at the time, Dr. Wilhelm Mack, killed himself in what was presumed to have been a direct response to the escalating eugenic activity. We know that Pauselius was in a training program at the Görden institution in September 1941, which indicates that she was very much aware of the developments in the child “euthanasia” program, and more importantly, aware of her role in its development as the head of the KFA. These training programs at Görden were notably led by Dr. Pusch, and were part of her responsibilities as the head of the Görden KFA. This further allows us to assume (unless for some reason Dr. Pusch was absent at that point in time), that Pauselius and Pusch met and interacted during Pauselius’ training in 1941.

The intention of the training at Görden headed by Pusch was to introduce other physicians in charge of KFA’s, such as Pauselius, to the practices and killing

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methods of “euthanasia.”\textsuperscript{220} That is, the training at Görden largely comprised Pusch explaining and instructing other KFA directors on how to effectively kill admitted children without raising suspicion, beginning with how the child was not to be killed instantly after admittance to a KFA. Rather, the child was to be kept at the facility for a few weeks to give the impression that it was being treated medically through therapy among other treatments. Depending largely on the behavior of family members (including frequency of visits and extent of emotional investment and attachment to the child) the amount of time that the child would be kept alive varied. Once it was made sure that family members were not suspicious, the child’s murder was arranged usually by the KFA’s director. The order to kill was rarely explicit, as evinced at the Rothenburgsort hospital, where the physicians involved were often simply handed a handwritten note with the name of the child that was to be killed.\textsuperscript{221}

It is easy to read a descriptive narrative of a killing process when not faced with the important reminder that the victims of the described killing process were not just numbers but individual humans. The case of Edith Schulz, a young girl born with “cerebral palsy” on September 10, 1938 and transferred to Görden July 16, 1941 reflected the customary killing procedure of the child “euthanasia” program, as taught to other directors by Pusch. At the time she arrived at Görden, Edith’s patient record read: “Bread she can eat alone, otherwise she must be fed. She can entertain herself

\begin{footnotes}
\footnote{Marc Burlon, “Die ’Euthanasie’ an Kindern während des Nationalsozialismus in den zwei Hamburger Kinderfachabteilungen” (Medical Dissertation: University of Hamburg, 2010), 89.}
\end{footnotes}
with toys. Is a quiet child. Announces her needs.” At Görden she was treated by Pusch, who, following the consent from the father, undertook an X-ray of Edith’s skull and removed nerve fluid. Apart from underdeveloped gross motor skills, Pusch pointed to no further illnesses or impairments in the examination’s physical findings of July 17, 1941. According to Pusch’s notes, Edith showed no signs of progress. But Edith, as noted by Pusch, proved herself fully capable of recognizing her parents and understanding that she had been separated from them by her admittance to the hospital: “E. knows her parents. At the time of her admittance, she seemingly understood that she was being separated from them. Also, on the occasion of a visit, E. immediately recognized her father and showed a happy expression.” Edith, physically handicapped only by underdeveloped motor skills, was a quiet, “low-key” child that happily occupied herself but was communicative when she needed something. Although happy to keep to herself, she displayed “beaming” joy when adults did engage with her.222

By August 18, 1941, Pusch noted in Edith’s file that the child had developed acute gastroenteritis on July 30, which developed into bronchitis. This is evidence of the customary killing procedure, wherein massive quantities of sedatives and/or sleeping medication, primarily Luminal but also Veronal), were given to the child in the form of dissolved tablets. Given that many of the children, due to physical disabilities, struggled to drink, the sleeping medication was also often injected. The later testimony of an intern at Görden emphasizes this: “[Dr. Pusch] has explained to

me how she handles children’s euthanasia (in “putting them to sleep” [=killing them] with Luminal tablets and syringes)."

Regardless of how the Luminal was administered, the mass quantities would lead to the child suffering an overdose which meant a slowing of all bodily functions and taken together with the low caloric intake that the children were limited to, a reduction of consciousness. Critically, the sedative overdose would cause the child’s airway patency to dwindle which, given the absence of treatment, would rapidly develop into a lung infection, then pneumonia, and ultimately death. In this way, the customary killing procedure of the child “euthanasia” program was quite passive, which is to say that the injection in itself did not directly lead to the child’s death, but rather stimulated a biological process which had to necessarily be left untreated to ultimately be fatal. It can be assumed that many women doctors’ effectively evaded culpability after the war in part due to the technically passive role played by them within the “euthanasia” killing procedure, relative to the active role of the natural biological processes stimulated by injection.

By August 7, Edith’s bronchitis had “led to the exitus letalis.” The next day, Pusch dissected the “corpse of a three-year old child in good nutritional health,” noting the cause of death as “bilateral lower lobe pneumonia.” Edith’s official death certificate cites the cause of death to be “cerebral palsy, idiocy, febrile bronchitis.”

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225 Friedlander, The Origins of Nazi Genocide, 54.
226 Reuter, “Die Tötung eines Kleinkindes.”
Most medical files of the child “euthanasia” victims listed the cause of death as “pneumonia” or “bronchitis,” but failed to mention the initial injection of Luminal and subsequent absence of treatment once symptoms of pneumonia emerged. The fact that “technically,” the child ultimately did die from pneumonia (as induced through Luminal), enabled the effective concealment of the active role of physicians in killing the child. Edith’s patient file reveals particularly perfidious evidence of the KFA’s concealment tactics, wherein the first Schlechtmeldung (negative message) to Edith’s father informed him on August 8, 1941 that “your daughter Edith Schulz is suffering from a febrile bronchitis. The condition gives cause for serious concern.” On August 16, less than a week later, Pusch writes to Edith’s father: “I regret to inform you that your daughter Edith Schulz’s general condition has worsened since her last visit. One must be prepared for her demise.” Only two days later, Edith was dead.

It is thus important to note that the listing of “pneumonia” as a child’s cause of death, especially in the KFA’s records, definitely indicates that the child was a victim of a “euthanasia” killing. “Pneumonia” was a euphemism for death as the result of intentionally induced sleep medication overdose at the hands of a physician.

Through the introductory training in killing methods at Görden, the facility became the Reichsschulstation (Reich Training Center) for the child “euthanasia” program. Dr. Erna Pauselius’ participation in the training at Görden indicates her

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228 Reuter, “Die Tötung eines Kleinkindes.”
awareness of the child “euthanasia” program, further suggested by the fact that she also attended a 1941 conference at the home of Schleswig-Holstein’s Landeshauptmann (provincial governor) Dr. Wilhelm Schow in Kiel, during which all attendees were fully informed of the implementation and procedures of Aktion-T4 (code name for adult “euthanasia”) which included including murder by gassing. It is the latter detail which informed the post-1945 prosecutorial investigations that determined it was impossible for Pauselius not to have known about the child “euthanasia” program, thus making her — at the very least — complicit in the murders.230

It is at this point important to highlight that none of the women doctors examined were forced to take the murderous actions they did. Marc Burlon, in his examination of the child “euthanasia” killings at Rothenburgsort, points to the fact that all but one female physician participated in the killings. The exception was a Catholic doctor who for religious reasons did not want to participate and, notably, was not forced to.231 Nowhere else is there an account of forced participation in the killings, which emphasizes that the women doctors discussed here acted willingly and of their own volition.

An account from November 1940, wherein the father of a child under Pauselius’ care at Hesterberg took to writing Pauselius to ask how his daughter was doing, indicates that Pauselius’ attitude was furthermore informed by war utilitarianism. Pauselius responded to the father by saying that he should not get his

231 Burlon, “Die ‘Euthanasie’,” 89.
hopes up, as “any financial sacrifices would be money thrown out the window.” Pauselius’ remark, thus encapsulates the rudimentary principle that shaped war utilitarianism: the thinking that emerged from post-war austerity and was shaped by considerations regarding the rational distribution of scarce resources informed by collectivism.

Michael Burleigh in his work on Nazi eugenics, without actually using the exact term, argues that war utilitarianism informed the Nazi approach to psychiatry. Burleigh emphasizes that Nazi psychiatry was a continuation of the type of thinking that first emerged in the Weimar Republic, characterized by a war-bound economy that shifted focus onto cost-effectiveness, the need to free bed space in hospitals and to increase the number of available doctors. Nazi psychiatry, as discussed by Burleigh, must thus be understood as rooted in war utilitarianism.

Going back to November 1940 case, it is important to mention that the child in question died in April 1941 from pneumonia (=Luminal-induced death), without any indication of attempted treatment. Given the loss of records after the war, it is not possible to say definitively in which form of “euthanasia” was primarily carried out at Hesterberg. Considering the account of the child dying from untreated pneumonia, it is possible that no lethal injections were given, and that children died simply from lack of treatment. Thomas Beddies discusses how it was this non-treatment of

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233 Burleigh, Ethics and Extermination, 175.
234 Ibid., 113-116.
diseases, together with a systemic shortage of medication, that accounted for the incredibly high mortality rate among Görden’s RA children under Dr. Pusch.  

This stands in contrast to what can be classified as a more active form of murder of RA children, as carried out by Dr. Sonnemann at the KKR, wherein children were injected with overdosages of sleeping medication (Luminal or Veronal). The indictment of the State Attorney’s office indicates that Sonnemann carried out the killings using the KKR’s one central Luminal bottle (50 ccm3) from which the deadly syringe was filled when necessary, using 6-10cc of Luminal 20% for lethal injections. This aligns with Sonnemann’s personal retelling: at “the Rothenburgsort, I made Luminal injections of 5 to 7 cubic centimeters, depending on the age of the child.” Sonnemann’s statement is drawn from the Amtsgericht Celle (local court Celle) investigation files, in which she further states, “I believe that I myself had about five ‘euthanasia’ cases.” This stands in conflict with the indictment that proclaimed Sonnemann carried out most of the killings at the KKR.

Although it is believed that Sonnemann was responsible for the deaths of 12 children if not more, the loss and destruction of various pertinent files after the war meant that the prosecution lacked sufficient proof. Thus, the Staatsanwaltschaft (public prosecutor’s office) ultimately assigned Sonnemann responsibility only for the death of seven children.

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236 Burlon, “Die ‘Euthanasie’,” 89; Babel, Kindermord im Krankenhaus, 43.
237 Babel, Kindermord im Krankenhaus, 42.
238 Ibid.
To illustrate the general pattern characterizing the diagnosis and subsequent murder of targeted children — and more importantly to give names to the victims, so at the very least to grant them dignity as individuals and not statistics — the medical files of the known victims murdered by Dr. Sonnemann will be reviewed here.

Andreas Ahlemann, an infant boy born in Munich, described early-on by his mother as “not quite normal,” was moved from the Berlin Charité hospital, after having been diagnosed with “small head with increased accumulation of cerebral fluid in the interiors” and “whooping cough,” to the KKR. Sonnemann added “idiocy” to his diagnosis, before giving him the fatal injection. Andreas died on December 17, 1941, having barely lived eleven months.239

Hermann Beekhuis was born in 1941 in Weener, Ostfriesland, with several physical deformities, but regardless of being noted as “severely underweight” exhibited perfect heart and breathing conditions. At only six months old, on September 4, 1941, Sonnemann gave him the fatal injection.240

Harro Noll was born in Hamburg at the KKR, with a bladder exstrophy, a serious physical disability wherein his bladder lay outside his body. Harro occupied a bed at the KKR children’s ward under Sonnemann for six months, before she fatally injected him on March 21, 1942. He had just turned one year old in January.241

Ute Konrad, born 1940 in Hamburg-Wandsbek, was brought to the KKR at 14 months old in December 1941. A nurse later told the investigative judge that she saw the mother of Ute collapse onto the floor during a conversation with Dr. Sonnemann.

239 Ibid.
240 Ibid.
241 Ibid.
Ute’s mother clarified that her collapse was a response to Sonnemann saying to her that her child was “geistig minderwertig (mentally inferior/degenerate).” Ute died in August 1942, supposedly from congenital cerebral underdevelopment and bronchopneumonia, as stated in Ute’s KKR medical file. In actuality, Sonnemann injected her with Luminal while the ward-nurse Gertrud Menke held Ute down.\textsuperscript{242}

Renate Müller was born with hydrocephalus, a split medulla and was partially paralyzed. On February 14, 1942, Renate was killed at only nine months old by fatal injection carried out by Sonnemann.\textsuperscript{243}

Werner Nohr was born in June 1941, in Hamburg, with Down syndrome. At 14 months old, he was transferred to the KKR, where he spent two months before Sonnemann gave him the fatal injection on October 28, 1942.\textsuperscript{244}

Renate Wilken, born with Down syndrome, was killed on January 19, 1942 by Sonnemann with the assistance of Dr. Ingeborg Wetzel through fatal injection after having lived barely eight months. Apparently, Wetzel also intervened so that Gertrud Menke, the daughter of a pastor, could be “spared” that day. Menke later admitted to having participated in at least six cases of “euthanasia” killings. The anecdotal remark regarding the “sparing” of the pastor’s daughter only serves to reiterate that the female physicians examined here were not coerced into participating in the “euthanasia” killings; they did so consciously and willingly.\textsuperscript{245}

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\item\textsuperscript{242} Ibid.
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In reading Sonnemann’s investigation files, it is difficult to detect any signs of remorse. In thinking about her professional development — especially her commitment to propagating Nazi ideology through her work for the NSDStB — it seems that Sonnemann genuinely believed in and internalized the values of war utilitarianism. This assumption is further verified by an account recorded in 2009, by her nephew, attempting to explain how Sonnemann’s worldview drove her professional development:

At that time it must have been the case that people generally thought that there was unworthy life, and then it was so exaggerated in a frighteningly National Socialist way ... she was one of those who probably did not even realize the guilt at first because they thought they were doing something good for humanity, not for the individual being, but for the whole...she would have said to herself "if you do something, then you do it right."  

It must be noted here that, although Sonnemann’s nephew does not appear to be making excuses for his aunt, we must remain critical of him and his statements. Ultimately, he is simply a family member stating his subjective interpretations. Therefore, his remarks on Sonnemann have been regarded not as certainties but as personal judgements from which valuable extrapolations can be made. Having acknowledged this caveat, the nephew’s recollection of Sonnemann’s childhood provides valuable insights regarding the roots of her personal war utilitarianism. It must be kept in mind that with this information in particular, the nephew’s recollections are the interpretation of what Sonnemann herself once told him of her childhood. In this case, however, the fact that Sonnemann’s nephew was not even

\[\text{Ibid.}, 57-58.\]
alive during her childhood means that the information rests on Sonnemann’s personal reflections more than it does on the nephew’s which lends his statements credibility.

Sonnemann’s father’s financial incompetence forced her to take on the role as the administrative head of the family at only twelve years old. Especially during the years of inflation, Sonnemann was the family’s financial administrator, forced from a very young age to efficiently allocate the money her father collected, before it depreciated any more in value.\textsuperscript{247}

From this we can assume that the early internalization of economic practicality shaped Sonnemann’s war utilitarian thinking, so that by the time she was a university student she thought of “frugality as the most important educator,” and believed in “education instead of dowry.”\textsuperscript{248} Sonnemann’s personal war utilitarian principles, informed strongly by collectivism, blended easily with the Nazi worldview.

In existing discussions regarding the involvement of doctors in Nazi crimes, the central focus has often been on the fact that it was the members of society whose chosen profession intrinsically warrants to “either help, or do no harm to the patient,” that so deeply betrayed their pledge to society.\textsuperscript{249} With regard to Sonneman, it is clear from her own reflections in the 1961 commemorative volume of her school, that her choice to study medicine was not inspired nor even informed by a personal appreciation for medical ethics: “My career aspiration since the earliest moments of

\textsuperscript{247} Ibid., 57.
\textsuperscript{248} Ibid., 47.
my childhood, was to become a doctor, although I had no closer relationship to this profession.” She continues by explaining that she never really suffered from any disease that required medical attention, and neither did her family members, thus she “knew no doctor from the point of view of the patient.” The lack of personal ties to medicine, and more importantly, the lack of personal experience with doctors translates into Sonnemann never having been personally exposed to medical ethics in practice prior to beginning university. When describing the joy she felt upon first beginning her job at the KKR in 1938, she emphasized only the joy that came from finally making money. This indicates the absence of medical ethics. To put it simply, Sonnemann’s own words indicate that the moral aspect of practicing medicine was never something she was concerned with nor did it mark part of the profession’s appeal for her. Sonnemann’s morally detached approach to the practice of medicine, together with a worldview strongly informed war utilitarianism, framed a set of personal principles that placed career ambitions at the center of her motivations.

Sonnemann’s nephew corroborates the need to recognize her careerism as central in explaining her choices: “In the situation of the Nazi era, she was unaware of the full legal implications of her actions. She was ambitious and wanted to make a career.” The role of careerism as a central driving factor of Sonnemann’s decisions becomes clear in light of her actions following the Rothenburgsort bombing in 1943, after which Sonnemann brought 200 evacuated patients and around 60 nurses to Celle. She was subsequently offered the position of senior physician at the children’s

251 Ibid.
252 Babel, Kindermord im Krankenhaus, 49.
clinic there, which she took in light of more promising career opportunities. This can
be tied back to Sonnemann’s discussion of beginning her work at the KKR in 1938,
and the joy she found in the money that came with her employment at the hospital.253

In the 1961 commemorative volume of the Auguste-Viktoria-Schule Flensburg,
Sonnemann stated that from a professional standpoint that if she were given the same
career choices as she had been as a young graduate, she would have done it all
exactly the same way.254

Adelheid von Saldern, in her work on the role of women in the Nazi state,
aims to define the nature of “specifically female guilt.”255 Pertinent here is von
Saldern’s concluding discussion on women perpetrators’ motivations, in which she
calls for the reconstruction of the elements which “were self-determined and those
which were determined by exterior forces, as well as a mixture of both.”256 However,
in light of the examination of Sonnemann’s motives, von Saldern’s analysis is
reductive; establishing motive is by no means as simple as constructing a three-part
whole. The self-determined and the external are intrinsically tied, reinforcing and
inhibiting one another in complex ways.

In the case of Sonnemann, war utilitarianism informed her actions by shaping
her worldview in a way that blended easily with Nazi social policy. War
utilitarianism, for Sonnemann, functioned as the foundational framework through

253 Ibid., 45.
254 Ibid., 46.
255 Adelheid Von Saldern, “Victims or Perpetrators? Controversies about the Role of Women in
the Nazi State,” in Nazism and German Society, 1933-1945, ed. David F. Crew (New York:
Routledge, 1994), 155.
256 Ibid., 156.
which the implementation of Nazi eugenic policies was justified and rationalized. Careerism, however, operated as the motor which drove the active implementation of said war utilitarian principles, in the form of Sonnemann’s conscious participation in the child “euthanasia” program through the murder of patients. To put it clearly, war utilitarianism shaped the thinking of many medical professionals at the time but did not directly translate into those individuals becoming active murderers under the Nazis. What distinguished Sonnemann was the force of careerism in executing war utilitarian principles.

Another quote from Sonnemann’s nephew calls for the consideration of an additional motivation of element behind Sonnemann’s actions. The nephew says that “ultimately, my aunt was always more concerned with what the ‘others,’ the ‘high society,’ the peer-groups as one would put it nowadays, thought of her, than whether the things she was required to do were ‘right.’”257 This indicates that Sonnemann’s desire to raise her social standing translated into a willingness to do whatever it took to gain the approval of the elites. On the one hand, this speaks to an entrenched need to prove herself in seeking social validation. In this way, her desire for social advancement fed into her careerism, the two elements working in conjunction.

On the other hand, Sonnemann’s fixation with social advancement indicates a sense of entitlement regarding a higher social standing; on a more personal level, this reveals an entrenched belief that she deserved to belong to the “high society.” This would introduce an additional dimension to the narrative of Sonnemann’s motives,

wherein to an extent her choices reflected the belief that she was simply doing what was necessary to obtain what she was entitled to. Naturally, it must be acknowledged that these reflections comprise extrapolations that, although not unsubstantiated, are speculative. This is the inevitable result of the limited available source material. Though speculative, these extrapolations are neither unfounded nor untenable and thus should be taken into serious consideration. Suppositions founded in the admittedly limited available material expand a narrative of these physicians, representative of a group of women historically misrepresented.

Herta Oberheuser, unlike the other examined female physicians, did not directly participate in child “euthanasia” because she was employed at the Ravensbrück concentration camp as opposed to a children’s hospital. Although Oberheuser is thus excluded from the discussion on the female trend of participation as it pertained to child “euthanasia,” she is evidence of the broader pattern of female physicians making individual choices that defined and expanded their role within the discriminatory medical profession. It is important to note here that an additional reason for why Oberheuser is being examined here despite not having been directly involved in child “euthanasia” is because she has been historically utilized as the fetishized example of an exception: the anomalous doctor who became a “monstrous” Nazi perpetrator despite also being a woman. Herta Oberheuser performed experiments and medical surgeries that were truly inhumane. However, simply labeling her as a “monster” is to allow the scale of her actions to obscure the reasonings behind them. It is time to recognize that while Oberheuser inflicted
exceptional pain and violence, she herself was not an exception. As such, her capacity for rational intention must at the very least be considered.

The need for such consideration becomes critical in light of the fact that Oberheuser, as the only female defendant at the Nuremburg doctor trials, displayed strategic deployment of gender-specific arguments throughout her trial that in part indicate a conscious exploitation of what might be called a maternalistic strategy. When asked during her cross-examination whether following medical operations, she had seen it as her duty to care for patients at Ravensbrück, Oberheuser replies that she did understand it as her duty and, most importantly, “hoped to be able to help here as a woman too, because I saw a chance that the women would be pardoned, and I thought I could help here as a woman.”

Oberheuser’s words stand in parallel to the previously discussed narrative employed by woman physicians to establish their distinctively female value within the medical profession, wherein the maternalist strategy is employed through the amplification of their “nurturing” and “caring” qualities. Oberheuser’s final defence statement evinces an even more evident employment of gender-specific rhetoric: “In administering therapeutical care, following established medical principles, as a woman in a difficult position, I did the best I could.”

Although deployed with the intent of evading culpability through minimizing accountability by emphasizing her gender, Oberheuser’s conscious employment of gender-specific rhetoric attests to the complex ways in which gender influenced intent.

259 Ibid.
Although she might not have been involved in child “euthanasia” specifically, Oberheuser was heavily involved in the implementation of Nazi eugenic policy. Oberheuser performed “mercy killings,” mostly on adult camp prisoners but some children too, using chemicals in the form of gasoline, injections of oil, and Evipan. Notable in Oberheuser’s description of her eugenic practices during her trial, is her insistent adherence to the narrative of “mercy killings,” through the emphasis on the “unbearable” pain she saw prisoners suffer and stressing the number of patients begging for “release”:

The patients lay there without any possibility of aid and waited for their painful death. They were a picture of heartbreaking misery. I can still hear their pleas for help. In my distress, I remembered what was done in a big clinic in such cases, I remembered that in seen cases, the wish of the hopelessly sick person was complied with. I decided on my own responsibility, as a doctor, to act and then I asked my medical superior, the post physician, and when I had his approval, I went back to the sick room, I stopped all the drugs and then increased the drugs alleviating pain...I gave them an intravenous injection so that they would go go to sleep. I used morphium and a mixture I received from the post physician.

Oberheuser clearly deployed a narrative adhering to that of “mercy killing,” assumedly to evoke sympathy. However, Oberheuser then goes on to clarify that it was “a case of euthanasia which was necessary from a medical point of view.” This aligns with the section of her cross-examination that touches her eugenic practices, wherein Oberheuser was asked how many people she “helped” with the “mercy-killings,” to which Oberheuser replied that what she did “was not mercy

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261 McHaney, Military Tribunals, 4
262 ibid.
killing. It was medical help for suffering patients in their death throes.\textsuperscript{263} Taken together with Oberheuser’s own characterization of her Nazi socialization as “purely medical” in nature, from this we can assume that her motivations were primarily scientific. Unlike Sonnnemann’s careerism then, which was shaped by war utilitarianism and the desire for social advancement, Oberheuser’s careerism was shaped by a scientific drive. Although we can assume that Oberheuser also wanted to establish her professional scientific standing, her actions and choices were primarily driven by a desire to move the frontiers of science.

Dr. Pusch’s motivations are comparable, to those of both Oberheuser and Sonneman. Joining the NSDAP as early as May 1933 while still only just a medical student indicates an early conviction of Nazi principles, also displayed by Sonnemann. However, like Oberheuser, Pusch’s scientific career aspirations were the driving force behind her actions, which is evident in light of her steep career path. Pusch was a senior physician and director of central departments —

\textit{Fürsorgeabteilung} (welfare department) as well as the \textit{Säuglingsstation} (child ward) — at the Brandenburg-Görden Hospital from 1938 until 1947, cultivating and maintaining an intense professional relationship with hospital director Dr. Hans Heinze.\textsuperscript{264} She preserved close professional relations with renowned neuropathologist Professor Julius Hallervorden, under whom she practiced in 1943 at the prestigious Kaiser-Wilhelm-Institute for Brain Research. Unlike any other female doctors

\textsuperscript{263} Ibid.
working at the institute, Pusch countersigned numerous important medical files. In 1941 she was recruited as an employee of the Reichsausschuss, receiving 200 marks paid by the RA to her private account that same year as a Sonderzuweisung (special payment). She continued to receive Reichsbeihilfen (financial aid/assistance from the Reich) for her work until the end of 1944.

The intensely scientific dimension of her motivations is revealed in her repeated habit of carrying out the preparatory work and subsequent medical evaluations for case histories through the dissection of those children examined and “treated” by her. Rebecca Schwoch explains that this scientific exploitation of murdered or fatally-neglected patients was, for Pusch, simply a conversion of “life unworthy of life” into “valuable organ material.” This is evidence of the elementally scientific framework within which Pusch approached her eugenic practice. In this way, Pusch’s motivations align with Oberheuser’s, in that both women aimed to advance the frontiers of science. However, Pusch’s career choices, marked by close professional relationships kept with a number of renowned scientists, evidence that the desire to establish her scientific professional standing exceeded her scientific drive as the primary driving force of her actions.

Ibid., 196.
Ibid.
Ibid.
Ibid., 197.
Ibid.
Erna Pauselius’ murderous actions within Nazi child “euthanasia” were thus a display of entrenched war utilitarian thinking. Helene Sonnemann was driven by amoral careerism and entrenched war utilitarianism, and a strong desire for social advancement. Herta Oberheuser was primarily motivated by the desire to move the frontiers of science and, secondarily, establish her scientific professional standing. Friederike Pusch was driven also by the desire to move the frontiers of science, but only insofar as this furthered her scientific career and advanced her professional standing. It is in light of the explicit nuances within and among these women’s displays of careerism, that we must recognize the multifarious character of women doctors’ motivations driving their participation in Nazi eugenic practices.
Chapter V: Women Doctors’ Post-War Activity

Feminism and Nazism

The last four chapters examined the capacity of gender to be deployed within a socio-political system structured around misogyny to expand the scope of women’s agency and broaden their opportunities. In this way, the arguments here have relied on the notion of gender differences as first introduced by feminist theorist Simone de Beauvoir, who regarded women as a distinct social category.\(^\text{270}\) The elemental problem with the notion of differences among social categories is its reductive essentialism, which fosters overgeneralization and leads to the homogenization of the entire social category in question. The problem with the notion of gender differences, more specifically, lies in that it has historically reflected the male perception of women: men have utilized the phenomenon as an instrument of oppression and exclusion. Carrie Menkel-Meadow explains this in arguing that differences only become a problem when assumed to be essential and fixed as part of a biological, rather than social construct. According to Menkel-Meadow, differences become destructive when “those who have the political power” utilize them to establish the implications of the assumed differences.\(^\text{271}\) Menkel-Meadow points to the most important condition which determines gender differences as problematic; namely who utilizes them. The association of women with “typically female” qualities takes the form of a classic discriminatory perspective from the point of view of men. To put it


another way, gender differences were and have been historically utilized by men primarily to benefit their social category, thus intrinsically oppressing and marginalizing women.

With respect to the topics examined in this thesis, the utilization of gender differences by men resulted in an oppressive set of structural interactions and institutional patterns that marginalized women within the medical sphere. Yet women deployed gender differences to expand their scope of agency and broaden the opportunities available to them within the German male-dominated medical profession.272 It must be acknowledged that the typically female caring qualities were, in fact, “artifacts” of oppression, out of which female physicians created an oppositional culture through which they expanded their role within the medical profession.273 I argue that this is evidence of feminist practice, which is to say, I argue that the female physicians who operationalized gender within a gender-structured reality were feminists. I recognize this to be a provocative claim. However, I believe, in alignment with Karen Offen’s argument put forth in her article “Defining Feminism: A Comparative Historical Approach,” it necessary to position feminism within diverse traditions and contexts, to expand our investigative horizons and recognize its “historical range and possibilities.”274 Most importantly, I make this claim because personally, I truly believe these women doctors to have been feminists.

The term “feminist” as it is used here must be explicitly defined. Karen Offen defines feminism as a “system of ideas,” that claims the necessary equalization of social, economic, and political power between the sexes, “in the name of their common humanity, but with respect for their differences,” within given Western societies.\textsuperscript{275} Within this, Offen proposes a triad criterion delineating the standard by which actions and ideas may be considered feminist: in assessing women’s social status relative to men they must recognize and acknowledge women’s interpretation of their own history and claimed values; they must display “consciousness of, discomfort at, or even anger over institutionalized injustice” against women; most importantly, to be a feminist, one must challenge the prevailing ideas, institutions, and practices that uphold male privilege and power within one’s particular culture to champion for the elimination of the institutionalized injustice. Essentially, to be a feminist, is “necessarily to be at odds with male-dominated culture and society.”\textsuperscript{276} In this way, “feminist practice” is defined here as the practical application of these three rudimentary feminist principles.

In arguing that these female physicians were feminists and displayed feminist practices, the reductive character of the conventional categorical analysis rendering women’s activity the product of \textit{either} individual choice \textit{or} discrimination becomes clear. Rather, occupational gender-segmentation within the German medical profession as first observed during the Weimar Republic and continued into the Nazi regime was the product of women’s choices and structural discrimination operating

\textsuperscript{275} Ibid., 150-151.
\textsuperscript{276} Ibid., 152.
interdependently. In this way, once cannot disentangle the relative force of choice and
discrimination as explanatory variables. More important is their sequence:
intra-occupational gendered segregation within the German medical profession was
first assigned but then chosen by women to establish mobility within the conventional hierarchy.

The transition from the Weimar Republic to the Nazi regime shifted the
implications of women doctors’ feminist practice. Women doctors under the Nazi regime continued their feminist practices, by claiming typically feminine caring qualities to affirm their role within the medical profession. After 1933, however, the distinctly female sphere within the German medical profession was characterized by new discriminatory practices. By adhering to gender-specific fields of medicine to establish and further their roles within the male-dominated medical profession, thus deploying gender expectations to defy the prevailing male dominance in that sphere, Helene Sonnemann, Herta Oberheuser, Erna Pauselius and Friederike Pusch were feminists. I recognize that in light of their participation in Nazi eugenic practices, calling them feminists may appear problematic. It is important to clarify that I delineate their feminist practice as the actions they took, mobilizing the oppressive female ideal imposed on them to effectively challenge the male prerogative within the medical profession, as women doctors had done since the beginning of the Weimar Republic. These actions placed women in extraordinarily high positions of power within the German medical profession. However, the subsequent choice made by Sonnemann, Oberheuser, Pauselius and Pusch, once in their positions of power, to
partake in medicalized murder has nothing to do with feminism. Rather, their feminist practice positioned them to exploit a range of new professional opportunities. Their voluntary choice to partake in violent eugenic practice, as one of the opportunities presented to them, has nothing to do with feminist practice. It was simply murder.

Their participation in institutionalized violence and murder does not, however, invalidate their characterization as feminists. Because their exploitation of gender roles actually facilitated their involvement in Nazi eugenic practices, it cannot even be argued that their dual identity as murderers and feminists were mutually exclusive. These women doctors displayed feminist practices — as had female physicians since the very beginning of the Weimar Republic — that established and furthered their medical careers. What changed after 1933 was the implication of their feminist practice as it translated into their medical practice.

In this final chapter, female physician’s post-war activity will be examined to recognize that gender also operated as a means of minimizing female accountability for the crimes committed under the Nazi regime after 1945. Gender thus appears as a double-edged sword for these female physicians; their gender rendered them victim to systemic discrimination that extended from the private sphere deep into their professional life. At the same time, it not only permitted but actually facilitated, their evasion of culpability. This chapter intends to demonstrate how gendered the understanding of perpetratorship was, in that it granted murderers exoneration from responsibility for the crimes they committed solely because they were women. Herta Oberheuser was the only one of the four women doctors examined that was actually
tried in court, and even there, her conscious deployment of gender-specific arguments allowed her to effectively minimize her culpability. As a result, her punishment was perturbingly light.

**Friederike Pusch and Erna Pauselius**

Pusch and Pauselius’ will be examined here in tandem because their post-war lives were unremarkable. That fact in itself reveals the intrinsic way that gender operated as a way of evading accountability for these women. To put it clearly, neither Pusch nor Pauselius ever faced consequences for their involvement in the Nazi child “euthanasia” program bears witness to how simply being a woman sufficed to avoid becoming a target of serious suspicion. This was the product of the persistent stereotype of women as gentle and nurturing that stood in stark contrast to the conventional idea of a violent, cold-hearted murderer, which meant that society as a whole (including the judicial system) failed to recognize women as active perpetrators. The same misogynistic assumptions that pushed women to the margins of the medical profession enabled their evasion of culpability regarding the choices they made.

Friederike Pusch worked at Görden until 1947, before transferring to Neuruppin which she eventually left with an impeccable report regarding her work there written by the medical director at the time, Dr. Franz Polik. Afterwards, Pusch briefly worked at the district hospital Blankenburg until October 1950, when she took on the job as scientific assistant at the University of Halle-Wittenberg’s Department...
of Neurology in the German Democratic Republic. She returned to Blankenburg in 1953, where she continued to work until her retirement. In 1965 the district court of Frankfurt am Main opened an investigation into her pre-war activities yet ultimately found nothing definitive and concluded that even her political attitude could not be assessed. It appears that the main concern that arose from the investigation was the indication that she kept connections with her brother who lived in West Germany. To highlight: the post-war investigation was more concerned with the potential communication Pusch kept with her brother across the inner German border than with her suspicious wartime activity as the head of the Görden KFA. It is safe to say that Pusch continued her career that suffered no break as consequence of her pre-war involvement in child “euthanasia.” Pusch’s experience speaks to the innate way that her gender operated (even without conscious deployment), as cover for evading of responsibility.  

Similarly, Erna Pauselius’ postwar activity was markedly unremarkable. Although her husband had written a letter on her behalf in 1946 requesting a denazification certificate, Pauselius was never actually granted denazification, as the regional Medizinalrat (medical offer) had replied to her husband that "perhaps it will be enough if I certify that a dismissal or suspension for political reasons did not take place." The Medizinalrat further referenced Pauselius’ denazification Questionnaire from June 1945, in which she had declared very little engagement in Nazi Party affiliations. Never needing denazification, Pauselius went on to take over her late

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278 Personalakte Dr. Erna Pauselius Provinzial-Oberärztin, Abt. 611, Nr. 2361, Schleswig-Holsteinisches Landesarchiv, Schleswig.
father-in-law’s medical practice together with her husband in 1946. Her father-in-law had passed away during the final months of fighting in Saxony. Right before relocating, Pauselius took time off from her position at Neustadt, during which she wrote in a letter to the Medizinalrat on August 14, 1946 in which she described her family’s post-war situation: "Apart from the current difficulties that come with the struggle for the practice and life with colleagues, it is quite bearable here. With regard to access to food we are much better off here, especially in the countryside! The occupying powers have been hardly noticeable to us." Following her relocation to Saxony, financial records and random correspondences show nothing remarkable until her application for her pension insurance in 1970, which leads to the conclusion that she lived an ordinary life running her father-in-law’s practice until the day she died. Pauselius and Pusch evaded responsibility for their pre-war actions effortlessly, simply by being women.

Helene Sonnemann after 1943

After the evacuation of the KKR to Celle, Dr. Sonnemann took on the position of senior physician in the autumn of 1943, heading the children’s ward of the Allgemeines Krankenhaus Celle (AKH) and the newly established school for infant nurses. In 1944 she began offering private medical consultation at the hospital, and

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279 Letter from Dr. Erna Pauselius to Medical Officer of Health, August 14, 1946, Personalakte Dr. Erna Pauselius Provinzial-Oberärztin, Abt. 611, Nr. 2361, Schleswig-Holsteinisches Landesarchiv, Schleswig.
280 Personalakte Dr. Erna Pauselius Provinzial-Oberärztin, Abt. 611, Nr. 2361, Schleswig-Holsteinisches Landesarchiv, Schleswig; Erna Pauselius, Abt. 64.1, Nr. 48, Schleswig-Holsteinisches Landesarchiv, Schleswig.
additionally gave lessons at the Kaiserin-Auguste-Viktoria Schule. That same year she was granted provisional specialist recognition, which was finally approved after the end of the war, on June 28, 1946.\textsuperscript{281} It seems important to note here, that years after her retirement in 1976, the Celler Garnison Museum displayed the War Merit Cross she was awarded for her role in evacuating over 200 patients in 1943. That museum exhibition mentioned nothing about her work at the KKR. Even when Raimond Reiter published his investigation in which he explicitly uncovered Sonnemann’s participation in the child “euthanasia” program in 2009, the museum failed to incorporate this alongside the display of Sonnemann’s medal. Dr. Friedrich Bartels, the medical director of the AKH at the time, justified this by arguing that Reiter’s investigation did not reveal Sonnemann applied her discriminatory thinking practically at Celle. For Bartels, the exhibition was about “writing history from the point of view of the AKH, toward a future that can go into a new direction.”\textsuperscript{282} This displays the entrenched incapacity to reconcile the idea of a successful woman doctor who saved the lives of over 200 patients, with the fact that her medical practice was determined in part by systematized, intentional murder of disabled children in the Nazi years.

Sonnemann was granted denazification status by the Allies, the Denazification Committee in 1948 on the grounds that:

She [Sonnemann] joined the Nazi party in November 1939, according to herself, only with the purpose of avoiding being professionally disadvantaged. From the submitted statements, it is implausible to presume the person concerned was politically engaged; however, she has successfully proven herself very reliable in her job as a doctor following the destruction of the

\textsuperscript{281} Reiter, Helene Darges-Sonnemann, 26-27.
\textsuperscript{282} Babel, Kindermord im Krankenhaus, 52.
Children’s Hospital in Rothenburg and has made an outstanding contribution to the accommodation of children. She is to be relieved.283

The Committee’s evaluation of Sonnemann is not wrong about the nature of her Nazi association. As discussed in the previous chapter, Sonnemann’s politics were not characterized by internalized Nazism, but fundamentally shaped by an entrenched war utilitarianism that had existed since the very inception of the Weimar Republic and was merely appropriated and amplified to form the foundation of Nazi eugenics.

This becomes clear in light of Sonnemann’s marriage to Fritz Darges in 1952. Darges was once Hitler’s personal adjutant, and although by the end of his life recognized as the last living adjutant, he was never convicted of any crimes. Before Sonnemann’s death, her husband often found himself in heated discussions, adamantly defending his involvement in Nazism as merely having been a seduction of power. Sonnemann’s nephew says that after her death, however, it was clear that his uncle never actually abandoned his entrenched Nazi principles.284 Shortly before his own death in 2009, at which point he was the last living member of Hitler’s inner circle, Darges began to actively publicize a manuscript he wrote recording the years he spent working alongside Hitler, whom he still considered to have been “the greatest who ever lived.”285 Darges believed Hitler to have been a “genius,” and said “that is why I served him and would do it all again now.”286 Sonnemann’s nephew

283 Reiter, Helene Darges-Sonnemann, 28.
284 Babel, Kindermord im Krankenhaus, 49.
286 Ibid.
said that in light of these statements, he believes his aunt was responsible for holding her husband back from advocating Nazism. This suggests that it may be a mischaracterization to describe Sonnemann as a Nazi. It follows that her war-utilitarian thinking allowed her to naturally tolerate her husband’s entrenched Nazism, but also that she actively prevented him from publicizing his beliefs in the post-Nazi era.

Incidentally Darges was actually the first official manager of the Celle Deutsche Rotes Kreuz (German Red Cross) after the war, regardless of the widely known fact that he had served as Hitler’s personal adjutant only a few years prior. Moreover, Darges was “highly revered” in his position as the Celle Red Cross manager, indicating the continuities between Nazi Germany and the Federal Republic of Germany (FRG) with regard to people in positions of power.287

The same year that Sonnemann was granted denazification, an investigation was opened by the Hamburg public prosecutor’s office examining Sonnemann, along with eight nurses, on the grounds of suspected infanticide. The investigation files dated 1948 conclude by first clarifying that the accused’s participation in unlawful murder was indisputable. But they rule that the actions were not convictable on the grounds that the accused themselves did not think of their actions as unlawful at the time, and in fact believed themselves that they were enforcing the law through their actions:

...The consciousness of the illegality becomes the intent heard, that is, represents a Schuldelement (an element of guilt). Thus, if, according to this view, the accused cannot be shown to be aware of the illegality, there is no

287 Babel, Kindermord im Krankenhaus, 49.
proof of their guilt and therefore they cannot be condemned. The Criminal Division is of the opinion that this proof would not be available in a possible trial.\textsuperscript{288}

Although this judicial rationale applied to hundreds of Nazi crime cases is a legal perversion which allowed many guilty individuals to live the rest of their lives having never to answer for their cruel, inhumane actions, it alludes to an important point. Namely, the murderous crimes committed under the Nazi regime were not the result of an extraordinarily high number of innately cruel and vicious Germans between the years 1933 and 1945. Rather, it points to the fact that a collective moral deformation occurred and was mobilized at the institutional level to produce an entire nation tolerant of targeted violence and murder. Of course, this idea is grossly structuralist and does not exonerate individuals. The Nazi “euthanasia” program was a structural phenomenon, that, however, was mobilized by individuals with agency. What this means in reference to Sonneman is that simply because her participation in child “euthanasia” can be traced as the product of structural circumstances, the fact is that she was an individual with a degree of agency who ultimately chose the nature and the extent of her participation.

During her time at Celle, Sonnemann was said to have run a “strict regiment.” Her stringent leadership is further evinced by the published accolade written by Dr. Hans Jacobi in 1981 for her 70th birthday: "In the interest of the children entrusted to her, Dr. Darges-Sonnemann placed high demands on her employees as well as on

\textsuperscript{288} Reiter, Dr. Helene Darges-Sonnemann, 15.
herself. She was an experienced clinician with a steadfast eye for important findings.**289

Naturally the question arises of whether Sonnemann continued to be actively involved in child “euthanasia” during her time at Celle before the end of the war. Raimond Reiter argues that given Sonnemann’s internalization of the child “euthanasia” program’s purpose, it can be assumed that she continued to be convinced of its validity during her time at Celle and even continued to actively implement it until May 1945.290 Postwar testimony given by Sonnemann to the Hamburg prosecutor’s office corroborates Reiter’s argument: "I also had cases of idiocy in Celle, I referred all the patients to the responsible Gesundheitsamt (health department). There were no cases of euthanasia within my department."291 Sonnemann’s reference to having referred all cases of “idiocy” to the responsible Gesundheitsamt indicates that while she may not have directly performed “euthanasia” on patients herself during her time at Celle, she did participate in reporting disabled children to the front organization for child “euthanasia,” the Reichsausschuss, which resulted in their transport to the nearest Kinderfachabteilung (the closest to Celle being the Lüneburg Kinderfachabteilung) where the children would have been murdered. In this sense, Reiter argues, although there is no way to prove it, it is highly likely that Sonnemann did continue to actively aid the murder of disabled children at Celle during the war.

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289 Ibid., 39.
290 Ibid., 25.
291 Ibid.
In claiming that Sonnemann internalized the purpose of the child “euthanasia” program, Reiter is referring to what has been demarcated as entrenched war utilitarian thinking. Multiple witness accounts reveal that Sonnemann continued to subscribe to war utilitarian thinking, validating Reiter’s assumption about her wartime activity in Celle. The first case concerns a witness’ second son (A.), who was born April 24, 1956 in the Landesfrauenklinik in Celle with a severe heart defect. The mother of A. remembers how after initially taking her son home, his health deteriorated rapidly (blue skin, suffocation, foaming in the mouth) which led to his admission to the children's ward of the General Hospital four weeks after birth. In reference to the medical care her son subsequently received, the mother says that she remembers no medical interventions: “in retrospect, I have the impression that they just waited.” The mother then asked if it would not be better to take her son home. The nurse replied, "there is no substitute for maternal love, but such a decision can only be made by the boss." When she turned to Sonnemann with the same question, Sonnemann replied that "she understands my [the witness] request, but that does not make much sense, and his [the son] prospects for survival are extremely small.” Sonnemann explicitly discouraged the mother from taking her son home, saying A.’s condition to be “hopeless,” and the “burden too great” for her if he were to die at home. The mother decided to take him home anyway, for “if he was to die anyways, then that might as well happen at home in my arms.” The mother remembers A. being handed to her by an acquainted nurse who smiled at her warmly and said “well done!” After undergoing two very difficult heart operations at the Göttinger clinic, the son lived to
develop normally for the most part. He mastered a profession, lived independently, had a vibrant social life and was very involved in youth and community work. He died of leukemia at age 41. Had A.’s mother followed Sonnemann’s advice, her son might not have lived to celebrate his first birthday.292

Ilse H., born in 1950, was admitted to the Celle children’s hospital for four to six weeks once a year beginning in 1956 after having developed diabetes at age six. By the age of ten, Ilse had developed double-sided pneumonia and bronchitis. She remembers hearing Sonnemann say “It’s not certain that we’ll get the child through” and “it’s [Ilse, the child] not going to make it to 30 anyways…”. That same year, her younger brother was born in the same hospital with a heart defect and brought into the care of Sonnemann. Ilse remembers that only a few days later, "we received the news that the boy had died, and that his corpse was to be picked up.” Her parents were handed the infant boy’s body bundled in corrugated cardboard, wrapped with parcel cord. More than half a century later, Ilse says: “Today I’m 66 years old and doing very well, in spite of my diabetes.”293

Ursula Raab was treated in 1957 as a seriously ill newborn baby for almost three months at the Celle Children's Clinic, under the direction of Sonnemann. Eight years later her brother was born, also with a serious illness, and Ursula often accompanied her parent’s hospital visits, where she would wait opposite Sonnemann’s office. Apart from the fact that Sonnemann did not make a particularly warm-hearted impression, Ursula remembers the cold way in which Sonnemann dealt

292 Ibid., 33-34.
293 Babel, Kindermord im Krankenhaus, 55-56.
with concerned parents of deathly-ill infants, never inviting anyone into her office but merely giving the worried parents short measure standing outside in the hallway.

After some time, Ursula’s infant brother fell into such mortal danger that he was given an emergency baptism. During that time, Dr. Sonnemann was on vacation and a substitute physician had taken over the management of the clinic. The boy’s mother remembers that as the doctor was examining the child, the doctor called out: "But he's shouting, so he wants life!" Apparently, the substitute physician subsequently initiated the treatments that saved her brother's life. In 2016, Ursula said that both she and her mother “now suspect that Dr. Darges-Sonnemann might have given the order to let my brother die during the transfer.”

One of the most tragic cases revealing Sonnemann’s war utilitarian thinking, occurred in 1969, when Sonnnemann told the mother of a sick child: “Let me give you this advice, if the child gets sick, do not go to the doctor. Put it [the child] in a passageway, then the child gets pneumonia and then do not go to the doctor, for then it dies.” Only years later did the mother confess to her second-born daughter that she did actually kill the sick infant by suffocating it with a pillow. The surviving daughter said that she is “convinced that without the advice of the doctor Sonnemann it would never have come to this tragedy.”

As late as 1974, two years before her retirement, Sonnemann continued to dispense such advice. That year she said to a young father, in reference to his third child Luna (name changed), born with physical disabilities (deformities on feet, hips

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294 Ibid., 55.
295 Ibid., 51.
and lower jaw) that “nothing will come of this child and there is nothing or not really much to be done.” After this conversation with Sonnemann, the father says he was “horrified” and immediately took care of having his child admitted elsewhere. The physical impairments were largely eliminated by several operations: Luna learned to walk and ride a bicycle a bit later than is customary, but she attended elementary school and passed her high school diploma with the mark "good." Later, she completed a commercial apprenticeship and led a nearly independent life. Although she suffered from the fact that she could not wear high-heeled shoes, a family member recalls that Luna “mastered her life with flying colors." Luna’s father said later in 2011 in reference to Sonnemann: “This Nazi doctor had clearly still internalized that you have to breed Aryan people.”

These witness accounts all speak to Sonnemann’s enduring internalization of war utilitarianism, which substantiates its pivotal role in understanding the motives behind her murderous actions at the KKR. Sonnemann’s nephew commented years later that “one must remember the public customary tolerance of euthanasia, as it existed up until the 1950s.” In reality Sonnemann’s war utilitarian tendencies continued until the very end of her medical career.

Intrinsic to the depth of Sonnemann’s commitment to war utilitarian thinking is that she most likely never recognized her own culpability. One of Sonnemann’s nieces remembers Sonnemann saying at some point in the 1960s "I did not do anything bad, it was so common then." In another discussion years later, Sonnemann

\[296\text{ Ibid.}, 55.\]
\[297\text{ Ibid.}, 49.\]
said that "passive euthanasia cannot be bad" in incurable cases where the dying are
tormented. It is important to remember here that under no circumstances was
Sonnemann ever forced or coerced during the Nazi years to give the lethal injections
to sick children. It seems that Sonnemann really believed her actions were
reconcilable with the Hippocratic Oath until the very end.

https://andreasbabel.wixsite.com/kindermord/helene-sonnemann.”

298 Ibid., 50.
The argument regarding the need to stop conceptualizing Nazi crimes as the product of phenomenal, monstrous individuals’ activity may appear obvious — if not repetitive — at this point. It is evermore important to emphasize again in this case, to remember that these women were driven not by blind-monstrous-bloodlust, but by established and identifiable motives.

By the end of her life, Helene Sonnemann suffered from dementia and was in a wheelchair. She died on September 10, 1998, twelve years after retiring from the medical profession.\(^{299}\) In her retirement address, Sonnemann compared her career path to a hike, wherein “the goal has been achieved without any troubles/mishaps/casualties.”\(^{300}\) When considering these words in light of her involvement in child “euthanasia” one cannot help but read it as an almost perverse mockery of the murdered children that were victims of her fatal injections.

Herta Oberheuser

Oberheuser was the only one of the women examined here to have actually been tried in court for medical crimes as a defendant at the Nuremburg Doctors Trials which lasted from December 1946 to August 1947. As discussed in the previous chapter, Oberheuser’s trial transcript shows the explicit deployment of gender-specific arguments intended to minimize her culpability, encapsulated by her final defense statement: “In administering therapeutical care, following established medical principles, as a woman in a difficult position, I did the best I could.”\(^{301}\)

\(^{299}\) Ibid., 59.
\(^{300}\) Ibid., 47.
Oberheuser furthermore capitalized on her gender by claiming that she operated only as an assistant to the male doctors. She did so by downplaying her knowledge of details pertinent to the experimental operations performed at Ravensbrück, and insisted on having only “helped and assisted,” rather than having personally performed the experiments. Beyond that, Oberheuser portrayed the extent of her involvement as only in monitoring the patients following experimental operations. However, the testimonies of multiple former Ravensbrück inmates and survivors of Oberheuser’s violent medical experimentations decidedly discredited Oberheuser’s attempts at downplaying her own involvement in the medical crimes. Their witness accounts explicitly outlined Oberheuser’s pseudo-medical barbarities, and most importantly, effectively proved Oberheuser’s actions were conscious and intentional.

It should be highlighted here that of the examined perpetrator women doctors, Oberheuser’s case is the only one in which survivors of her violence existed. This partially explains why neither Pusch, Pauselius nor Sonnemann were ever tried in court: none of the sedative-injected children survived to testify against their murderers.

Accredited largely to the testimonies of her former victims, Oberheuser was found guilty on two counts, war crimes and crimes against humanity, and was subsequently sentenced to 20 years in prison. Dr. Alfred Seidl, Oberheuser’s defence council, petitioned for the reduction of her sentence. The denial of this petition was justified by the fact that:

302 Ibid.
303 Sarti, Women and Nazis, 178.
Evidence relating to this defendant shows that she is a cruel, merciless woman. She became a concentration camp doctor of her own free will...The evidence is convincing that she badly neglected the experimental subjects and was many times needlessly cruel. She admitted killing a number of sick inmates by injections. The argument that the defendant could not have prevented the experiments is not significant. The basis of her guilt is her voluntary and active participation in the atrocities.\footnote{OFFICIAL TRANSCRIPT OF THE MILITARY TRIBUNAL IN THE MATTER OF THE UNITED STATES OF AMERICA AGAINST KARL BRANDT ET AL, DEFENDANTS, SITTING AT NURNBERG, GERMANY, ON 21 NOVEMBER 1946, 1000--1110, JUSTICE BEALS PRESIDING. Medical Case Transcript (Nurnberg, Germany: Nov. 21 1946), 5. Part of the Nuremberg Trials Project (Harvard University), accessed January 20, 2019. http://nuremberg.law.harvard.edu/transcripts/1-transcript-for-nmt-1-medical-case.}

Subsequently, Oberheuser was sent to War Crimes Prison No. 1 in Landsberg, Bavaria, where her sentence was reduced from 20 to 10 years following a number of appeals. However, after having sat barely five years of her sentence, Oberheuser was released in 1952 under authorization of the American general in Germany John McCloy.\footnote{Sarti, Women and Nazis, 180.}

In light of the tough sentences that other Nuremburg Doctor Trial defendants received, most of whom were sentenced to life imprisonment or even death, it is hard to deny that Oberheuser’s gender, and more importantly her effective deployment of gender-specific arguments during her trial, played a primary role in minimizing her culpability.

The most perturbing part of Oberheuser’s post-war activity is that after being released Oberheuser went back to practicing medicine. She opened a private practice in Stocksee (near Kiel, in Schleswig-Holstein), and practiced pediatric and family medicine. Important to highlight is that her post-prison return to practicing medicine
was enabled by the provision of interest-free financial subsidies from the West German government for the first six years. The West German government additionally afforded Oberheuser prisoner of war status, and accorded her insurance. At the same time, not a single one of her victims received financial compensation from the state for the disabilities inflicted upon them by Oberheuser’s inhumane medical experiments. In this light, the state-sanctioned aid provided to Oberheuser reveals the dark hypocrisy that characterized the West German government’s dealings with Nazi criminals, even regarding proven murderers, and underscores the continuities between Nazi Germany and the Federal Republic.

It was only after one of Oberheuser’s former victims recognized her in 1956 that a story uncovering Oberheuser’s return to medical practice was subsequently published on March 4, 1958 in the Daily Express. The story was met with widespread anger, especially from the British Medical Association, which was expressed in numerous articles published the months following the Daily Express publication. The public protests culminated in Helmut Lemke, the Minister of the Interior of Schleswig-Holstein, revoking Oberheuser’s license to practice in August 1958. However, Oberheuser responded with adamant efforts to appeal the Lemke’s verdict, so that it wasn’t until July 1961 that Oberheuser officially “relinquished the designation of doctor.” It is believed however, that she nonetheless found work at a

306 Ibid.
pharmaceutical laboratory in 1967. There is no known record of her activity between then and January 24, 1978, which is the day that Oberheuser died at age 66 in a nursing home in Linz am Rhein.\textsuperscript{310}

\textsuperscript{310} Ibid., 184.
Conclusion

In light of the growth in the number of female physicians despite continued misogynistic efforts to expel women from medicine, it must be recognized that there was an independent desire, among women under the Nazi regime, to become doctors and practice medicine. The character of women’s professional track was not solely the byproduct of misogynistic and discriminatory forces, but also directed by the independent choices made by individual women. This can be traced back to the Weimar Republic, when women identified and exploited their socially-imposed gender role to establish a space for themselves within the male-dominated medical profession. This exploitation of the imposed female stereotype was characterized by a maternalist strategy, that is, the conscious emphasis on innate feminine qualities that made women naturally equipped for the requirements and responsibilities of medical practice. In this way, women weaponized their reduction to typically feminine qualities by embracing and amplifying those qualities to demonstrate their distinct ability to serve women and children within the professional dimension. The maternalist strategy essentially extended the distinctive value of typically feminine qualities from the domestic to the professional sphere. This was particularly successful within the medical profession given its implicitly gendered biological focus. To put it simply, given that the study and practice of medicine is fundamentally concerned with human biology and the human body, as rudimentarily separated into two categories (female and male), this granted distinctive legitimacy to the gender-specific argument advocating women’s exclusive expertise in children and
women’s health; on the grounds of biology, women were innately more qualified to serve women and children than men were.

The interplay between state-sanctioned gender-discrimination and women’s choices in light of this discrimination explains the specialization pattern of female physicians in the Weimar Republic. The continuation of this specialization pattern post 1933 indicates the prevalence of its underlying dynamics. Rebecca Schwoch discusses the idea of a “specifically female pattern of involvement” in medical crimes, which she explains as rooted in the nature of female socialization, even going so far as to consider the involvement in medical crimes as a “predestination” for women doctors. However, I argue that the particular female pattern of specialization translated into a systemic phenomenon wherein specialization patterns facilitated easy entry into racial-hygienic areas of medicine from which developed the “euthanasia” program.

In the Nazi-era field of medicine, Volkskörper-politics (the politicization of the healthy collective body of the German people) were combined with distinctly female qualities. This translated into an assumption of women’s natural capacity to cultivate Nazi racial health and population policy goals. In this way, 1933 did mark a break regarding the implications of women establishing their own sphere within the male-dominated medical profession, characterized by a maternalist approach rooted in biological arguments. Under the Nazi regime, racial-hygienic ideas were institutionalized within a biological framework. However, these racial-hygienic ideas,

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in their most essential form, had pervaded German society since even since before the
Weimar Republic. Resource scarcity in the wake of World War I shifted public
thinking on social policy into utilitarian terms, wherein individuals were categorized
by their capacity to “productively” contribute to society. This type of thinking has
here been defined as “war utilitarianism,” and was essentially characterized by
maximizing national economic practicality, as framed by collectivist principles.

Alfred Hoche and Karl Binding’s 1920 publication, discussed in the first
chapter, was the first to formally and legally give sanction, and most importantly
medical sanction to war utilitarianism. This marked the beginning of the
social-biologization of the German medical practice, that was later entrenched under
the Nazi regime through the institutionalization of racial-hygiene. The
institutionalization of these ideas changed the formal definition of “health.” This new
definition, due to reasons outlined above, assigned women the responsibility to
actively further the nation’s health goals. In this way, the reorientation of medicine
towards social biology, as first manifested in the early Weimar years, was what led to
the total subordination of medical ethics.

What it all essentially came down to, was a transformation of the meaning of
Fürsorge, which cannot be translated directly into English, but encompasses the
notions of care, welfare, benevolence, and aid. Thus, Fürsorge describes how
feminine qualities were applied in the medical sphere. Fürsorge marks the
conjunction of the character of women’s private domestic role and that of their

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312 Binding and Hoche, Die Freigabe der Vernichtung Lebensunwerten Lebens.
professional function. The institutionalization of racial-hygienic ideas under the Nazi regime innately changed the definition of “health,” and thus also the meaning of Fürsorge. After 1933, “relieving” pain, as constitutive of Fürsorge, meant performing “euthanasia” on the “unproductive” members of society so to relieve the national collective financial burden. The nature of female physicians’ activity after 1933 did not mark a decisive break, for they simply continued to carve out spaces for themselves in a male-dominated profession through a maternalistic strategy. What changed, however, were the implications of their activity, as consequence of the Nazi regime’s new definition of Fürsorge.

It is critical to recognize that war utilitarianism and the social-biologization of medicine were first legitimated years before the Nazi rise to power. Nazi social policy simply manifested the bureaucratic appropriation of war utilitarianism as it had existed since even before its legal and medical sanctioning through Hoche and Binding’s work in 1920. Herein lies my central argument: war utilitarianism marked a fundamental ideological continuity between the Weimar Republic and Nazi Germany that proves German society to have been characterized by moral deformity for years before 1933. I have attempted to demonstrate and emphasize this continuity, as I argue it critical in explaining and justifying the fundamental, overarching point of this thesis: perpetrators under the Nazi regime were individual human beings that were, for the most part, driven by rational considerations and unnervingly human motives. By the term “unnervingly human,” I point to what I believe is a fundamental issue in the discourse about the Nazi regime. When trying to understand how the entire
German nation became complicit in Nazism, there has been a tendency for reductive typification as a way to understand an otherwise overwhelming phenomenon. In reality, however, the “Nazi phenomenon” was the product of Germans navigating distinctive avenues of self-realization within an innately discriminatory socio-political system that primarily distinguished itself from prior systems through its institutionalization of violence. To recognize this basic reality is to accept that the brutality and violence that took place under the Nazi regime was carried out not by demonic monsters, but by human beings. It follows that these human beings, for the most part, were driven by unnervingly human motives — unnerving in that they are discernible and relatable.

I emphasize the ideological continuities between the Weimar Republic and Nazi Germany as a way to move beyond a narrative that blames solely the Nazis for the pervasive moral deformity that underpinned their inhumane crimes. Not only is this narrative reductive, but it is also dangerous, for it constructs a perverse collective perpetrator identity in which the ‘Nazi’ becomes a faceless caricature of monstrous Germans. By focusing on the ubiquitous ‘Nazi,’ there is an effacement of individual perpetrators’ identity that innately eludes personal responsibility. We must recognize ‘Nazis’ to have been individual human beings, for their collective classification rids the individual perpetrators of agency, accountability, and personal culpability. Only then can we understand Nazi perpetrators to have been human individuals that, for the most part, were driven by rational human considerations.
The intersection of perpetratorship and gender makes explicit the way in which simplification through reductive typification has been historically deployed to make approachable an otherwise overwhelming reality. In the same way that it is less unnerving to accredit brutality to the extent and scale that it occurred in Nazi Germany, to the work of inhuman, bloodthirsty monsters, there has been a reluctance to acknowledge women — as innate victims of Nazi misogynistic reality — as capable of the same violence as men. Those few women perpetrators that have been examined, Herta Oberheuser being one of those, have been presented as anomalies in some way or another, if not fetishized as extraordinary female monsters. To clarify, this is not to say that women and men under the Nazi regime should be considered in the exact way. Women existed within a fundamentally different structural reality than men, which limited their relative scope of agency but, notably, did not eliminate it. The fact that they were victim to a discriminatory gender-structured reality does not mean their actions can be solely accredited to ‘the patriarchy.’ Instead, what it means is that their avenues for self-realization took on a different shape than those of men. Their gender positioned them in distinctive margins, within which however, it was ultimately their individual choices that led to them becoming perpetrators.

In this way, the four women doctors examined served as a microcosm of German society as a whole, whose actions speak not for their womanhood but for a society that had been characterized by moral deformity for over a decade before the Nazi regime. The point is to underscore their humanity, so that the actions they took and choices they made were horrifying, not because they were women but simply
because they were people. Within this, we must ask: what does it mean that they were women?

I argued in the last chapter that I believe these women to have been feminists, which I also believe to intrinsically define the significance of their gender. The fact that they were women meant that they were victim to a discriminatory gender-structured reality that pushed them to the margins of the medical profession and rendered them to be characterized only in terms of their typically female qualities. At the same time, these women mobilized the typically female ideal, as it attested to gendered-oppression, through the deployment of gender differences as a means of delineating and expanding their distinctive space within the medical profession. The reciprocal forces of these two processes gave women more agency (relative to that of women in other professions/spheres) but served no further to determine their actions. Their distinctive motives for professional advancement are reflected in the individual choices they made and emphasizes that ultimately it was their individual choices that caused them to become perpetrators. To put it simply, the narrative behind women doctors becoming child murderers under the Nazi regime reflects, at its essence, individuals navigating the existing avenues of self-realization. It is by the same token that I argue for these women to have been feminists: if nothing else, characterizing them as feminists should underscore their humanity and point to the fact that the actions they took as professional women were in themselves not wrong. The actions they took as professional women only positioned them so that various opportunities, with the potential to be harmful, emerged. No one forced them
to take those opportunities, nor is there record of coercion to do so. It is their actions as individuals, by which I mean the voluntary choice they made to murder young children within the framework of Nazi eugenic practice, that ultimately made them into murderers.

The latitudes for professionals were significant, underscoring the fact that we have been far too obsessed with Nazi ideology as something written in stone and imposed from the top down in a pyramidal figure. Going forward, there is a clear need for further historical investigation into the role of professional women in Nazi Germany, especially with consideration of the violent paths of social mobility. In thinking about intentions and ethics, we must stop relying on professional and gender norms to further our understanding of the multiplicity of motives that drove individuals’ actions. There must also be more work done in the future on the continuities between the Weimar Republic and Nazi Germany, to move beyond the periodization problem and break down reductive divisions.
Bibliography

Archival
Schleswig-Holstein State Archive
611/2361. Personalakte Dr. Erna Pauselius Provinzial-Oberärztin.

64.1/48. Bezüge von Erna Pauselius

Berlin-Lichtefelde Federal Archive


Published Primary Sources


Stöcker, Helene. “Sexual Reform Congress” (London, September 8-14, 1929), edited


Secondary Published Sources


Weindling, Paul. *Health, Race and German Politics Between National Unification*

# Glossary

## Glossary of German Terms

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<tr>
<td>Heil- und Pflegeanstalten</td>
<td>Psychiatric Hospitals</td>
</tr>
<tr>
<td>Rasse</td>
<td>Race</td>
</tr>
<tr>
<td>Rassenhygiene</td>
<td>Race hygiene</td>
</tr>
<tr>
<td>Soziale Frage</td>
<td>Social question</td>
</tr>
<tr>
<td>Sozialpolitik</td>
<td>Social policy</td>
</tr>
<tr>
<td>Volk</td>
<td>The Nation/People</td>
</tr>
<tr>
<td>Volksaufartung</td>
<td>National regeneration</td>
</tr>
<tr>
<td>Volksgesundheit</td>
<td>Health of the Nation</td>
</tr>
</tbody>
</table>

## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKH</td>
<td>Allgemeines Krankenhaus Celle (General Hospital Celle)</td>
</tr>
<tr>
<td>BDÄ</td>
<td>Bund Deutscher Ärztinnen (League of German Female Doctors)</td>
</tr>
<tr>
<td>BDM</td>
<td>Bund Deutscher Mädel (League of German Girls)</td>
</tr>
<tr>
<td>FRG</td>
<td>Federal Republic of Germany</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td><strong>KFA</strong></td>
<td>Kinderfachabteilung (Special Pediatrics Unit)</td>
</tr>
<tr>
<td><strong>KKR</strong></td>
<td>Kinderkrankenhaus Rothenburgsort (Rothenburgsort Children’s Hospital)</td>
</tr>
<tr>
<td><strong>NSDAP</strong></td>
<td>Nationalsozialistische Arbeitspartei (Nazi Party)</td>
</tr>
<tr>
<td><strong>NSDSbB</strong></td>
<td>Gesundheitsabteilung im Nationalsozialistischen Deutschen Studentenbund (Nazi German Students’ League)</td>
</tr>
<tr>
<td><strong>RA</strong></td>
<td>Reichsausschuss (Reich Committee)</td>
</tr>
</tbody>
</table>