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Medical Authority in East Central Europe

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Special Editors of the Thematic Issue

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BOOK REVIEWS

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Social Class in the Czech Physicians' Quest for Professional Authority and Social Acknowledgement, 1830s–1930s

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In the mid-nineteenth century, physicians in the Czech lands could claim neither elite status as a professional group nor unquestioned authority in the medical field. Despite the legal protection granted by the Habsburg Monarchy, they did not have an efficient monopoly on medical authority and practice and had to face fierce competition from lay healers, male and female, and other medical professionals. This article examines how Czech-speaking physicians navigated social dynamics in nineteenth-century society in urban and rural areas and how they strove to strengthen their authority in the medical field both through appeals to their professional credentials and through class and gender discourses. We identify individual strategies of social ascension and collective efforts to boost the standing and authority of the whole professional group. Practices such as socializing in patriotic circles and authoring medical guidebooks for laymen proved as important as publications in the professional press and the work of professional associations in this complex effort, which was eventually crowned with success in interwar Czechoslovakia.

Keywords: social class, Czech physicians, professional authority, social mobility, individual strategies

In the mid-nineteenth century, physicians in the Czech lands could claim neither elite status as a professional group nor unquestioned authority in the medical field.[1] Despite the legal protection granted by the Habsburg Monarchy,[2] they did

1 Hanulík, "Professional dominance."

2 As early as in 1770, the health ordinance for the Habsburg domains established that "regional physicians" had the obligation to punish uneducated or incompetent persons who engaged in so-called *fušerství*, or "intrusion" into an expert field in which they were not considered qualified to work. Lenderová et al., *Tělo mezi medicínou*, 76–80; Tinková, *Zákeřná Mefitis*; Svobodný and Hlaváčková, *Dějiny lékařství*. See also Lang, *Medicinische policey in den habsburgischen Ländern der Sattelzeit*.

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not have a monopoly on medical authority and practice and had to face fierce competition from lay healers, male and female, and other medical professionals.[3] In this article, we analyze how Czech-speaking physicians navigated social dynamics in nineteenth-century society in urban and rural areas and how they strove to strengthen their authority in the medical field both through appeals to their professional credentials and through class and gender discourses. We identify individual strategies of social ascension and collective efforts to boost the standing and authority of the whole professional group. Practices such as socializing in patriotic circles, employing fashionable architects to have their houses built, and publishing memoirs proved as important in this complex but eventually successful effort as publications in the professional press and the work of the various professional associations.

Our analysis is based on one main type of primary source: physicians' memoirs, unpublished and published (mostly during the physicians' lifetime). We complement these sources with analyses of one physician's edited notes, another physician's private correspondence, and public lectures delivered by a physician's child. They all share one feature: they were written in Czech. The use of Czech by authors in this multilingual and multiethnic region is a significant detail that should not be taken for granted or passed over. Further research also needs to be done on German-speaking physicians from this region, and it would be useful to compare the social backgrounds and careers of these physicians with the social backgrounds and careers of the physicians who left written narratives of their work in Czech. This would enable us to assess whether ethnic origins and the languages used in professional practice and social interaction were, in any way, relevant factors in a given doctor's social status. Moreover, future research should also examine the careers of physicians who came from the Czech lands but pursued practice in the imperial capital, as those who "made it" in Vienna probably did not write or publish memoirs in Czech, even if they were born into Czech-speaking families.

The edited notes and memoirs written by several male Czech physicians from the years between 1836 and 1936 constitute a rich corpus of sources that allows us to examine the long-term development of the profession as perceived by the physicians throughout a period in which several major political and administrative changes took place that had an impact on the physicians' professional practice.[4]

3 See Rambousková, "The Doctor and his Patients"; Hanulík, *Historie*.

4 Lenderová et al., *Tělo mezi medicínou,* 76–80; Tinková, *Zákeřná Mefitis*; Svobodný and Hlaváčková, *Dějiny lékařství v českých zemích*; Svobodný, "Lékaři v českých zemích"; Tinková, "Uč se vážit svého zdraví."

These notes and memoirs are sources of a personal nature from which we get hints concerning the physicians' understanding of themselves as physicians, as Czechs, and as respectable men of a certain social standing. In the case of two nineteenth-century physicians, we learn about their origins, professional practice, sociability, and attitudes through extensive laudatory lectures given by their children in the early years of the twentieth century and then published in print. The very fact that physicians' children engaged in such a practice and a growing number of physicians published their memoirs may point to the rise in the importance attributed to physicians by their close family members and by the physicians themselves and also to their increasing social standing. In these earlier memoirs and edited notes, family pride and Czech patriotism seem to have been among the motivations for publication. The memoirs from the later period offer proof of a perceived interest in the medical profession in Czechoslovakia, and they also tend to dwell on details concerning politicians, actors, other celebrities, and the changing political circumstances. The authors who had had bright professional careers under communism also seem to have sought to distance themselves in their writings from the regime and to stress their allegiance to the First Czechoslovak Republic (1918–1938), but this will be dealt with in future research.

Despite the differences among the sources, we observe a striking similarity in their structure and in the information they provide. The physicians tended to give details concerning their family backgrounds. They mention their parents and siblings, and sometimes they comment on their wider families. They explicitly address the financial means of their families, particularly linked to their own education. If they needed extra support and funding and their parents were unable to provide it, they tended to acknowledge this openly and even dwell on it. This indicates that, rather than trying to mask their social origins, they actually took pride in overcoming these initial financial obstacles. They describe their secondary studies, showcasing the key importance of the dense network of high schools created in Bohemia and Moravia in the first half of the nineteenth century.[5] They also tend to explain their motivations for choosing to study medicine. Concerning the years spent at medical school, the physicians discuss their teachers and their lectures. Some critically assess their teachers, their attitudes, and their talents as teachers (or lack thereof). Their narratives

5 The costs of education including, high school, five years at the faculty of medicine, and at least one year of free practice at a clinic, came to approximately 12,000 zlatých/guldens. See Sinkulová, *Stát,* 96.

dwell on the issue of practical training and on the choice of and preparation for future medical practice, including choosing a specialization and deciding whether to work at a hospital, start a private practice, or accept a public post in the provinces. Financial aspects of this decision-making process are often explicitly addressed.

The sections of the various narratives which touch on actual medical practice comment on everyday experiences with healing and its financial aspects. Medical doctors who worked in small towns tend to showcase their devotion to scientific innovation by commenting on the purchase and use of medical instruments, while physicians in urban settings linked to hospitals tend to make references to their professional publications and distinguished patients. Probably due to the notion of professional discretion, the edited memoirs do not include information on the diseases suffered by their patients or the treatments provided, but rather comment on how these distinguished patients came to require the services of a particular physician and on their social interactions with them. The physicians also comment on leisure activities, including occasional trips abroad, which were not always linked to their profession, including international conferences, patriotic events, theater excursions, and social occasions.

In the discussion below, we focus on the following questions: What was the social background of Czech-speaking physicians who practiced in the Czech lands in the second half of the nineteenth and first third of the twentieth century? Which motives did they cite for their choice of profession and the choice of a specific professional path? Which aspects of their education and training did they emphasize? How did they present their professional practice to their readers? How were they perceived by the communities in which they lived? In what kinds of social events and pastimes did they engage, both professional and casual? How did they spend their free time? We then offer conjectures, based on the answers provided by the sources to these questions, concerning the relationships between the physicians' social status and shifts in their social standing on the one hand and new legislation and social and political changes on the other.

Our historical analysis is enriched by sociological approaches and methodologies. Pierre Bourdieu's analytical concepts, including economic, social, and cultural capital, as well as his notion of distinction.[6] Erving Goffman's emphasis on self-fashioning and the ritual elements in social interactions has

6 Bourdieu, "The Forms of Capital"; Bourdieu, *La Distinction*.

made us sensitive to the different ways in which the physicians strove to embody what they considered their role and how they were transformed in the process. In line with the analysis by Kaat Wils, we understand that their attitudes, their ways of presenting themselves in their narratives, and their behavior can only be interpreted in relation to the specific and changing settings of their education and practice (including the state regulation of both) and to the internal dynamics of their professional community.[7]

The period under study allows for an analysis of long-term dynamics in a changing context, a methodological choice that makes it possible for us to de-naturalize the middle- and upper-middle class status the physicians achieved by the mid-twentieth century and explain it as a result of a culturally specific historical process. For the same purpose, we make occasional comparisons with other European countries in the same period. In the period under study, the Czech lands were part of the Habsburg Monarchy that morphed into Austria-Hungary in 1867, an imperial arrangement thought to be an efficient answer to the rising nationalist and constitutionalist movements in Hungary but left many other nationalist leaders less than satisfied. The Great War (1914–1918) opened the gate to the creation of Czechoslovakia in 1918, a nation state in which the Czech lands played the leading role.

Major changes also took place in the institutional and legal framework of the medical practice. Austria was early in granting the exclusive practice of the medical profession to physicians with specific credentials by law (see footnote 2). The implementation of this legal measure was patchy, at best, and physicians still felt the pressure of competitors in the medical field in the 1860s and 1870s. There were several milestones in the institutionalization of healthcare: the creation in 1817 of the post of a municipal physician paid by the municipalities, the abolition of the nobility physicians *(vrchnostenský lékař)*, which was a consequence of the drastic reduction in the role of nobility in the regional administration due to the revolutionary movements of 1848 and the imperial law on healthcare from 1870, which created a dense network of municipal and provincial physicians.[8] In addition to state initiatives, the professional cohesion and social status of physicians were also boosted by medical associationism.

7 Goffman, *Všichni hrajeme divadlo*; Wils, *Scientists' Expertise*.

8 The young Czechoslovakia did not approve any general law on healthcare that would be valid in all its territory. Thus, healthcare continued to be regulated by legal measures that had been introduced in Austria-Hungary. See Sinkulová, *Stát*. For a systematic treatment of the regulation of the medical field in the Czech lands during the period in question, see Svobodný and Hlaváčková, *Dějiny lékařství v Českých zemích*.

The first professional associations were founded in the Czech lands in the early 1860s, and they showcased ethnolinguistic divisions. In 1861, German-speaking physicians founded an association in Prague and a journal titled *Prager medizinische Wochenschrift*. As was often the case in an environment marked by ethno-nationalist strife and competition, Czech-speaking physicians followed suit in 1862, founding the Spolek českých lékařů (Society of Czech Physicians) and its journal, *Časopis lékařů českých* (Journal of Czech Physicians). In Moravia, an association of German-speaking physicians, Centralverein deutscher Ärzte, was active between 1875 and 1894.[9]

Social Origins of the Physicians and Funding for Their Studies

The fact that many university-educated Czech-speaking physicians who practiced in the second half of the nineteenth century in the Czech lands were of lower-middle class and working class (craftsmen/artisan) origins may come as a surprise. Both the documents examined in this article and the university registers analyzed by Barbora Rambousková show that many of them were sons of craftsmen. Josef Salmon,[10] for example, was one of the five children of a stonemason, and Josef Pavlík[11] was the son of a miller, a craft that tended to come with a certain material wellbeing but still implied manual labor. A glance at the origins of the Czech cultural nationalists of the mid-nineteenth century confirms the presence of craftsmen's children among liberal professionals in the Czech lands. The physician Norbert Mrštík[12] offers a paradigmatic example of this: his father was a shoemaker, and he became a physician. His brothers, Alois and Vilém, who became famous writers and playwrights, went on to be part of the Czech cultural elite. One of the reasons behind this social mobility might be the fact that, in the Austrian Empire and particularly in the wealthy kingdom of Bohemia, a dense network of high schools had been established in the first half of the nineteenth century. It therefore became rather easy for a well-off artisan family to support its sons, and the study of medicine was seen as a means of social ascension for the whole family. The public high school system granted

9 Černý, "Lékařství," 277.

10 Josef Salmon (1844–1931). See Muzeum Českého ráje v Turnově. A – P-JS. Documents of physician Josef Salmon.

11 Josef Pavlík (1863–1926). Státní okresní archiv Tábor (State District Archive in Tábor), Rodinný archiv Petříčkův [Archive of Petříček's family] Documents of physician Josef Pavlík.

12 Norbert Mrštík (1867–1905). See Havel, *Nedosněné sny*.

these lower-middle and working-class young men important cultural capital, the wider family network and other patrons provided funding, and the expected outcome was for the future doctor to achieve social capital that could be passed on to future generations.

For lower-class students, the funding of their studies was clearly a matter of concern, though the physicians never attribute the decision to study medicine to financial motivations. Instead, they stress their desire to help others or illness/death in their family, following the centuries-long tradition of physicians' self-fashioning as selfless benefactors of the sick. However, they do acknowledge the problems they faced because the lack of money often became obvious already when they were in high school. One option to solve this problem was to call on wealthier relatives, or the budding physicians could turn to others, such as wealthy patrons, the Church, and, later, patriotic societies. Josef Salmon, for example, did his first four years of high school at the German Piarist High School in the town of Mladá Boleslav in central Bohemia. His uncle, royal and imperial civil servant Josef Dolanský, worked at this institution and supported Josef during his studies. Due to Josef's excellent academic performance, he was given the opportunity to continue his studies at the College of Clementinum in Prague. From 1862 on, he received 124 zlatých/guldens a year from the Johann Anton Střepský Foundation, which depended on the Royal and Imperial Governor's Office. In exchange, he had to assist at all Catholic festivities in the Saint Vitus Cathedral and the Basilica of Saint George. Still, to earn more, he had to complement his scholarship with private lessons. After he finished his secondary education, he enrolled at the Faculty of Medicine at Charles University in 1864 and successfully concluded his studies in 1870 as doctor of medicine. Salmon's story was not exceptional. Many students worked, mostly teaching younger primary and high school students, and some of them saved up to invest in their professional practice.[13]

The first half of the twentieth century brought about an important shift. The authors of the edited memoirs now tended to be of middle class-origin, often sons or relatives of a physician (Vladimír Vondráček, for instance).[14] Jan Bělehrádek[15] was the son of a clerk with a degree in law. Zdeněk Mařatka's father

13 Muzeum Českého ráje v Turnově.

14 Vladimír Vondráček (1895–1978). See Vondráček, *Fantastické*; Vondráček, *Lékař vzpomíná*; Vondráček, *Lékař dále vzpomíná*; Vondráček, *Konec vzpomínání.*

15 Jan Bělehrádek (1896–1980). See Linhartová, *Jan Bělehrádek a jeho cesta k svobodě ducha.*

was a renowned artist, and his uncle and cousin were physicians.[16] Jiří Syllaba's father belonged to the medical elite of the time. He was personal physician to the first president of the Republic of Czechoslovakia, Tomáš Garrigue Masaryk.[17] Josef Charvát[18] stands out among these sons of middle-class professionals as a "remnant of the past," when many physicians had been of artisan-working class origins. But he was also the child of his time, consciously commenting on his social background and proud of his rise through hard work and merit. As noted above, it was common for high school and medical students not only in the Czech lands, but also in Germany, Spain, and France to support themselves through private lessons. European fiction and memoirs are full of references to the financial difficulties students faced when pursuing their studies. However, Charvát's willingness to support himself by accepting a working-class job as a night watchman speaks of the porousness of Czech society in terms of social class. Charvát, whose father was a locksmith and whose mother worked as a concierge and did laundry for people in the neighborhood, felt that he faced no mental barriers to this kind of job, nor did he feel any need to hide it when he became a respectable doctor. On the contrary, he seems to have been proud of this, considering it another sign of his individual merit, one that further distinguished him from his more privileged colleagues.

Choosing a Path within the Medical Profession

Social origins continued to shape the physicians' careers after they finished their studies. Diplomas did not serve as equalizers. Once they had a diploma in their hands, the young men faced a key decision: choose between a practice that combined healing with medical research or take a well-paid post in the provinces which would grant them a stable income and the respect of local society but which would also place them on the lower echelons of the professional community. Hospital practice, scientific pursuits, and life in the capital were important considerations in the hierarchy of both social and professional prestige. From our sample, it seems that the young physicians' social origins were a key factor in the early-career choice of professional path. The physicians who opted for a career in research knew that they would have to work at a clinic free of charge for several years before they received a salaried post. Vladimír

16 Zdeněk Mařatka (1914–2010). See Mařatka, *Medicína*.

17 Jiří Syllaba (1902–1997). See Syllaba, *Vzpomínky*.

18 Josef Charvát (1897–1984). See Charvát, *Můj labyrint*.

Vondráček (1895–1978) stated he had served the state free of charge for 15 years. During this time, they could, of course, work for private clients, which Vondráček did, but whether they were actually willing or able to take such a risk and attract paying clients more often than not depended on the social status of the given physician's family.[19]

In the 1830s and 1840s, these career patterns were not yet clearly distinguishable and the situation was hard to read for the young graduates, as the memoir by Frantisek Bouček, who studied in Vienna, indicates: "Right after graduating, I wanted to stay in the hospital, but due to the lack of money and unstable health I could not."[20] He therefore chose to practice in his hometown of Hradec Králové, but this also proved difficult, partly for personal reasons. Bouček complained that his local friends expected him to provide care for them for free. He also complained about structural problems, namely the lack of a clear career path for young physicians: "What misery there is among the physicians! Many had to leave the hospital without getting any post. Nobody takes care of the physicians."[21] After a few years of practicing in Hradec, in 1838, Bouček applied for the post of *praktikant* at the General Hospital in Vienna. He brought with him his meagre savings, 212 zlatých/guldens, to establish himself in the city. Once again, as a young physician with no connections in the Habsburg capital, he wrestled with various challenges. Bouček ultimately accepted the post of manor physician-surgeon in the manor of Poděbrady in Bohemia, an administrative unit that represented the continuing administrative functions exercised by noble families in Austria, a remnant of feudal structures that did not exist, for example, in France or Spain at the time. Poděbrady manor covered an extensive area, and Bouček had to provide care for people in 63 villages which were often hard to access. He received a fixed salary of approx. 30 guldens a year, a flat in the Poděbrady chateau, wood for heating, and cereals. His tasks consisted of providing healthcare for the manor officials, servants, and retirees, for the sick in the manor hospital, and for poor subjects. He also had to supervise the recruits and carry out cadaver examinations and autopsies. When he could get private patients (he was allowed to provide care for them after he had fulfilled his manor duties), they would often pay him *in specie*, and Bouček stated that it would have been almost impossible for a physician to practice in the rural parts of the country without a fixed salary. In 1848, bondage was abolished and so

19 Vondráček, *Fantastické*, 403, 652.

20 František Bouček (1810–1882). See Bouček, *Zápisky*, 9.

21 Ibid., 27.

was the nobility's administrative role. Bouček lost his post and a "cruel struggle for existence"[22] began. He moved to the town of Chlumec in Eastern Bohemia, where he worked as a physician to the poor and as a coroner. He was paid for each service rendered, with no fixed salary, and this was a source of anguish for him. He later returned to Poděbrady, where he accumulated several posts. It took him decades to establish a relatively comfortable living for himself.[23]

Josef Pavlík, who was the son of a miller and thus also not a child of privilege, showed clear determination. He decided to study medicine after his mother died of illness. To fund his studies, he gave private lessons during his high school years. After graduating from the University of Prague, he worked at the university hospital with the obstetrician Karel Pawlik. He admitted to his daughter later in his life that his decision to leave his promising hospital career and settle in the provincial town of Tábor was motivated by financial reasons, in addition to his wish to "work among the people." In 1900, he combined his long-term post in Tábor as municipal physician with work for the Workers' Illness Fund, which provided medical care for insured workers and employees. He clearly made the right choice leaving Prague, as he established a prosperous practice that allowed him to buy a house in the city center and travel abroad. He traveled to Spain, Morocco, and Algiers. He did not give up on the ambition to keep up with progress in the medical sciences either. With his own money, he bought an x-ray machine for his practice in 1910, and he also attended the World Hygiene Exhibition in Dresden. He had a lively and remarkable social life, both in local and national circles. While in Spain, for instance, he was invited to attend the celebration of the fiftieth birthday of Oskar Nedbal, a famous Czechoslovak opera singer, engaged in the Bratislava Opera, who was on a widely advertised tour on the Iberian Peninsula. In his town of residence, he was active in the patriotic circles, taking part in the campaign to build a monument to Jan Hus, a medieval Bohemian preacher and reformer who became one of the main symbols of Czech nationalism.[24]

Josef Salmon, who practiced from 1870 to 1921, also sought financial stability after graduating. He applied for a post in the imperial army but was rejected on the grounds of "physical weakness." He found employment at the Emperor Franz Joseph Children's Hospital in Prague. He started as an assistant physician but rose to serve as deputy head of a hospital department *(zástupce*

22 Ibid., 40.

23 Bouček, *Zápisky*.

24 See Státní okresní archiv Tábor.

primáře). He also provided care for poor patients, which seems to have been expected of hospital physicians with a charitable spirit or social consciousness in many places in Europe and beyond at the time. In 1876, he opened a private practice in Prague. In addition to receiving paying patients, he also provided care for those insured by the Vltava Insurance Bank, which guaranteed him a steady income of 200 guldens per year. He built a respectable clientele. As he noted, his last patient in 1921 was the daughter of the president of the Czechoslovak Supreme Court. He had provided care for four generations of this prominent family.[25]

Vladimír Vondráček was the son of a middle-class family who started his career in the interwar period. Vondráček was even more explicit about the financial considerations involved in the choice of career path. He complained that most of the hospital posts available for recent graduates (such as junior doctor or *secundarius*) meant working with no salary. The graduates were supposed to be grateful to get practical training and prestige linked to a job in hospital, while they lived off money earned by providing care for private patients and/or family money. Vondráček, who clearly positioned himself against this system, nevertheless admitted that he worked "for the republic" for free for 15 years, abandoning ambitions to work as a psychiatrist, which was the most interesting field of medicine to him: "During that period, I understood I needed to deepen my knowledge of internal medicine. I found it interesting, and it also seemed to me that it would ensure me better financial conditions than I could have had at the time in psychiatry, it was not even clear if I would not have to leave Prague."[26] His precarious financial situation finally made him accept a post as spa physician in the Slovak spa of Ľubochňa (or Fenyőháza, by its Hungarian name). Slovakia was not considered a particularly desirable destination among the Czech physicians, and the pay and extra income were good. It was thanks to his practice as spa physician in Slovakia that Vondráček was able to save enough money to move back to Prague and establish himself as psychiatrist, the branch of medicine he had always dreamt of pursuing. [27]

The sources suggest that the situation for physicians improved in the interwar period, and more salaried posts were available in the hospitals. Several factors contributed to this change. First and foremost, more hospitals were opened in many cities and towns in Czechoslovakia, providing a growing number of

25 Muzeum Českého ráje v Turnově.

26 Vondráček, *Fantastické*, 211.

27 Ibid., 255.

salaried posts for qualified physicians. As the concept of hospital was rapidly becoming less and less associated with poverty and charity and the hospitals were becoming truly interclass[28] establishments, the notion that physicians should work in them for free was gradually abandoned, too. Moreover, training at a clinic became mandatory if one sought to open a specialized private practice, and thus many graduates were, in fact, given a chance to catch the eye of a senior hospital physician who would support their careers if they were inclined towards combining care for hospital patients with medical research. As in the past, patronage thus continued to be important even as medical institutions were expanding and consolidating. However, the powerful men who wished to provide support for young, talented people now had more opportunities to help them find a paid post that would truly enable them to follow the path their patrons had envisaged for them, as there were more such posts available in the system.

The career of Josef Charvát is a good case study of these changing patterns. As a young medical student from a working-class background, he worked with Professor Lhoták at the Pharmacology Institute as a medical student. As he notes in his memoirs, he did the work of an assistant physician (with a corresponding salary of 900 Czechoslovak crowns), but as he had not yet graduated, he could only be officially employed as assistant scientific staff (200 crowns), though he was paid an extra 300 crowns. After he graduated, Charvát obtained a post at the II. Clinic of Internal Medicine. As he was paid 200 crowns there, it was probably a post of assistant scientific staff.[29] Nonetheless, this proved a gateway to a stellar career for Charvát, the son of a locksmith and a concierge. His boss, Professor Josef Pelnář, was a well-respected, fatherly figure in the Prague medical community. He was also very authoritarian when convinced of someone's professional value. Charvát, who had married as a student, was constantly concerned about his income. His original plan was to work in a hospital only for the time required to obtain a license for a private practice. But Pelnář stepped in, told him he should strive for habilitation, and arranged several training trips abroad (to Paris, London, and Belgrade) for his talented young colleague. Years later, when Charvát wanted to apply for the post of Director of the Internal Medicine Section in a provincial hospital in the town of Hradec Králové, Pelnář used his symbolic authority and told him: "You are

28 Several researchers have examined how hospitals in different European countries morphed into interclass establishments at the turn of the century. See, for example: Horrent, *La population*; Barry and Jones, *Medicine.*

29 Charvát, *Můj labyrint,* 13–15.

not going anywhere, you are staying at the clinic."[30] Pelnář's authoritarian care for his talented colleague eventually proved beneficial for Charvát. Thanks to Pelnář's support, Charvát ended up reaching the highest echelons of the medical hierarchy in the Czechoslovak capital. Following Pelnář's advice, he applied for and got the prestigious post of Head of the Department of Internal Medicine at the Polyclinic. During these years, he socialized with members of the highest echelons of Prague society. As a man of working-class origins, Charvát originally lacked the social and cultural capital a physician would need to get private patients, but Pelnář was there for him in this sense, too. When Charvát opened a private practice, Pelnář recommended him to wealthy people, who became his patients. Charvát stressed that he used the income thus obtained to purchase medical equipment in order better to provide care for his patients, who came both from the capital and from rural areas. During the last days of World War II, he participated in the occupation by Czech medical staff of the First German Clinic of Internal Medicine in the General Hospital, where he remained until his retirement in 1970, successfully continuing his career under the communist regime.

Pelnář appears as a key actor in the career of two other physicians who wrote memoirs but came from far more privileged families than Charvát. One of them was Jiří Syllaba and the other was Zdenek Mařatka. As noted earlier, Syllaba was born into the Czech social elite. He was the son of the president's personal physician. After finishing his studies in 1926, he embarked on several journeys abroad to further his education (he went to Great Britain, France, and the United States). After returning to Czechoslovakia, he worked at the II. Clinic of Internal Medicine of the General Hospital in Prague, headed (and lorded over) by Professor Pelnář. His post was that of an unpaid *docent*: a senior physician who "after his habilitation worked as scientist-researcher and as teacher at the clinic for free every morning (for 6 hours). He then had to earn his living through private practice, generally two or three times a week."[31] According to Syllaba, robust scientific activities at the clinic were possible because the staff ran parallel private practices: "At Pelnář's clinic, up to 50 scientists worked in the period between 1922 and 1938, including three extraordinary professors (Cmunt, Prusík and, later, Charvát), about 10 to 14 docents, several paid medical assistants, and more unpaid assistants, demonstrators, scientific staff, and *fiškuses*

30 Ibid., 17.

31 Syllaba, *Vzpomínky a úvahy lékaře*, 63.

(medical students who practiced at a clinic even before the mandatory practice during their studies)."[32] Pelnář's ambitions reached beyond "his" clinic and encompassed Czech medicine as a whole. He strove to further the quality and status of the medical profession and also had nationalist goals. According to Syllaba, he came up with a plan to send his protégés to work as spa physicians. These were lucrative posts in pleasant locations. Pelnář's intention was to boost the standing and improve the scientific infrastructure of Czech spas, but, as Syllaba explicitly stated, he also wanted to "Czechify" them (that is, to reduce their German character): "For that purpose, he selected Pirchan to work in Jáchymov, he sent Vančura to Mariánské Lázně (Marienbad), Šimek to Františkovy Lázně (Franziskenbad), […] Hejda to Bohdaneč."[33] Syllaba himself was chosen for a position at the most prestigious Czech spa resort, Karlovy Vary (Karlsbad), and he worked there every year for four months over the summer months between 1932 and 1938. Clearly, the fact that his father has served as President Masaryk's personal physician may have played a role in him having been chosen for the most prestigious spa in the country.

Like Jiří Syllaba, Zdeněk Mařatka was also born into privilege, as he was the son of a famous Czech sculpturer. In his memoirs, Mařatka presented himself as having been very strategic in his career choices and having made the right decisions in terms of finance, professional prestige, and personal inclinations. His early and constant awareness of the possible pitfalls and opportunities in a career in medicine can be interpreted as a sign of his social and cultural capital. His uncle Ladislav and his cousin were also physicians. In a way, his uncle Ladislav served for Zdeněk as a negative example. Ladislav had worked with the prestigious surgeon Eduard Albert in Vienna, but, as his nephew put it, he had not had an entrepreneurial spirit and he had provided care for patients free of charge. He had ended up in dire straits and had had to leave Vienna and accept the post of municipal hygienist in Prague.[34] Zdeněk was not going to allow this to be his career path. As a student, he started working voluntarily as an assistant medical student at a clinic even before he reached the stage of his studies when such practice was mandatory (which was called *fiškusovat*). Mařatka assisted Dr. Prusík, but he did not care for his approach, particularly the way Prusík treated his patients: "I felt [Prusík treated them like] experimental objects rather than

32 Ibid.

33 Ibid.

34 Mařatka, *Paměti*, 10–13, 20, 22.

as suffering individuals who need help."[35] In the fourth year of his studies, he went to assist the famous Professor Pelnář, following the advice of Dr. Syllaba. He worked there as medical assistant from 1936 to 1938 and, after 1939, as physician.

Mařatka's memoirs offer very outspoken descriptions of the tensions at the clinic, informing us about the lasting importance of status, class, and patronage in the institutional settings of a modern hospital. The main cause of tension was the unclear decision-making hierarchies due to the hospital institutes being at both hospital departments and university clinics at the same time.[36] As Mařatka put it,

> The clinics were under the command of the Ministry of Education, and they were headed by a university professor. The same person was, at the same time, the director of the department and in this sense was under the command of the hospital's director. (Medical) assistants were employees of the clinic, that is, of the Ministry of Education, but the junior doctors [Czech *sekundář*, lat. *secundarius*] were employees of the general hospital. This double-rail system was a source of constant conflicts between the assistants, who enjoyed higher social status, had longer vacations, and enjoyed several other advantages and the junior doctors, who were simple subordinate physicians as in other hospitals. To be employed at the clinic was nonetheless disadvantageous financially and meant economic hardship, as everyone had to start as a physician with no pay and show through his work whether he was capable of progressing in his qualification.[37]

Mařatka's description clearly reveals that the career path associated with prestige and professional merit was, at the same time, a path accessible mostly to the well-off. Only those who, like Syllaba and Mařatka, could rely on their families' support (or were lucky enough to find an extra source of income) could, in fact, prove their talent at the clinic. The expectation to work for free were a social barrier and a typical mechanism with which the elites managed to maintain their place in an ostensibly meritocratic system: only those who had extra financial means could afford to work for free, prove themselves professionally, and secure paid posts within the career line associated with higher prestige and, once the initial "filtering" period was over, with higher income.

35 Mařatka, *Paměti*, 44.

36 There were problems caused by the fact that teaching hospitals depended on the university hierarchies in the twentieth century in other countries, too. See Núñez-García, "Los hospitales docentes."

37 Mařatka, *Paměti*, 76.

There were other aspects to this system of informal filtering. Mařatka was well aware of the fact that the "capacity for autonomous scientific work" was understood not only a question of knowledge and skills but also of "character" and social class. As the head of the clinic, Pelnář expected the young men to participate in and speak at weekly public meetings of the Society of Czech Physicians. He also fostered self-confidence and a sense of *esprit de corps* and entitlement among the selected group of young men at his clinic, granting them the right to discuss and approve the selection of new colleagues, so they felt that they were an essential part of the process to which they had had to submit and thus became emotionally involved in its perpetuation and defense.[38] Syllaba shows no hint of criticism when describing Pelnář's authoritarian attitude toward his protégés. Even Mařatka's more ambiguous description of the whole situation is a proof of the ways in which meritocratic discourse was used and how those who "succeeded" learn to perceive the system as a guarantee of quality, even if, like Mařatka, they acknowledged that it also worked as a social filter.

Mařatka called the clinic a "strainer" through which "only those passed who had skills and a will to renounce financial advantages temporarily and risk an unsure future," but he also presented this filtering system as a desirable means of ensuring high standards and scientific progress at the clinic. While most of his colleagues ended up leaving to take better-paid posts as municipal physicians or physicians in other hospitals or devoted themselves fully to private practice, Mařatka climbed the ladder with the financial support of his middle-class family, including his wife, who worked as an employee in a bank, while her mother helped in the household. After working for free for two years, Mařatka obtained a fellowship of 200 and later 400 crowns a month. Several years later, he was earning 2,000 crowns a month as an assistant physician. He still complained about his salary after he earned his habilitation degree and worked as senior physician at a clinic *(docent)*, and he maintained that he and his colleagues in the same position used their free afternoons to provide care for paying patients in their private surgeries.[39] In such a system, middle-class men like Syllaba and Mařatka, particularly those who had family in Prague, could succeed if motivated. Working-class *docents* like Charvát were an exception. He "made it" due to the continuous and multifaceted support of the boss, Professor Pelnář. Had Pelnář not constantly guided Charvát in his career choices, scolded him for

38 For a thorough analysis of these dynamics in an allegedly meritocratic selection system, see Charle, *Les hauts fonctionnaires*; Bourdieu, *La noblesse d'État*.

39 Mařatka, *Paměti*, 76–77.

wanting to leave, recommended him for paid posts, and sent paying patients to his protégé's private practice, Charvát (the talented son of a locksmith and a concierge) would probably have ended up working in a provincial hospital, like many of his, Mařatka's, and Syllaba's peers did.

Not all the patrons were as domineering as Pelnář. When invited by Professor Babák to join the faculty of medicine at Masaryk University in the Moravian city of Brno, the talented young scientist Jan Bělehrádek accepted the post under the condition that he could first pursue further studies abroad in the Belgian city of Leuven. After returning in 1923, he worked with Babák as junior physician, and he became a private docent in 1925. After Babák's death, Bělehrádek took over a great part of his mentor's work and was appointed extraordinary professor. It was now his turn to serve as a patron. He took pride in telling his son that he refused to favor the sons of his colleagues at the exams, and when some of them failed several times to pass, he advised them to pursue another career. Bělehrádek, who had been interested in science since as a child, also prided himself on his research. He must have been quite successful in his pursuits, as in 1934 he was made Chair of General Biology and dean of the faculty of medicine at Charles University in Prague, the oldest university in Central Europe. Again, timely intervention by a research-oriented patron, Professor Babák, had been decisive in setting the young Bělehrádek on track towards remarkable success in his desired academic career.[40]

"Slaves to Their Patients": Class and the Rise of the Physicians' Professional Authority

The clinic was clearly a privileged space of medical training, research, and practice and an important center where professional identities and self-confidence were forged. The existence of clinics enabled the physicians to present themselves as men of science and highly qualified professionals who had total control over their patients' health and recovery.[41] However, the physicians had to negotiate their collective status in everyday contact with patients, both in their homes and in private practices.[42] Hospital care was becoming more important, and the emergence of an interclass hospital was underway, but in the second half of the nineteenth century, healthcare in Europe, including the Czech lands, was still

40 Linhartová, *Jan Bělehrádek*, 62–93.

41 See Foucault, *Zrození kliniky*; Hanulík, *Historie*; Ackerknecht, *La médecine*.

42 See a long-term perspective on a patient-physician relationship in Nicoud, *Souffrir*.

far from being a hospital-centric system.[43] When a physician provided care for his patients at their homes or at his private surgery, he could present himself as an important senior physician at a university hospital and as a renowned man of science,[44] but he needed to use different tactics and tools to win his patients' respect and earn a fee for his services. Vladan Hanulík, Daniela Tinková, Milena Lenderová, and Barbora Rambousková have done research on the relationship between patients and physicians in the Czech lands. In his recent article on several Czech physicians who worked in hospitals in the late eighteenth and early nineteenth centuries, Hanulík shows that these physicians had precarious incomes and ambiguous social status. He quotes a physician who complained about the many physicians who, motivated by their "poverty," bent over backwards to please their patients, including flirting and even sleeping with their upper class female patients.[45] Still, at the same time, Hanulík shows that marriage to a wealthy patient of higher social status was also an option, from which we may interpret that these young physicians, if they played their cards well, could indeed be "read" by their patients as respectable bourgeois men.

The physicians who practiced in the Czech lands understood themselves as part of the good society, and they constantly worried about maintaining this status,[46] not unlike physicians in France, Germany, Spain, and Great Britain. The sense of entitlement to live as a gentleman and the anguish caused by not being able to finance this lifestyle characterized the careers of most physicians until the late nineteenth century.[47] Moreover, as Rambousková shows, Czech physicians, like their German and British colleagues, seemed very aware of the constant need to negotiate and assert their authority as experts with their patients. They had to engage in a twofold struggle: to assert their status as experts and to affirm their image as respectable men who were entitled to respectable incomes. Josef Salmon dwelt extensively on these issues when narrating his career to

43 This term has been widely used in France for decades and has been used in the official documents of the WHO, too, but it became popular recently in the history of medicine, as well. For an early criticism, see Sanquer, "Hospitalocentrisme," 61–63. For a recent application in historiography, see Comelles et al., "Del hospital."

44 On the professional elite within the medical profession in the mid-nineteenth century, before the physicians achieved a monopoly on authority in the medical field, see, for example, Núñez-García, "A Physician."

45 Hanulík, "Professional dominance."

46 Rambousková, "The Doctor and his Patients."

47 See, for example, Maehle, *Doctors*; Malatesta, *Professionisti e gentiluomini*; Martykánová and Núñez-García, "Sacerdotes en el mercado."

his son Jaroslav. He built his narrative on the highly topical notion of medical profession as a call *(poslání)*, a mission, and a passion. This topos was common in the discourse of medical professionals in Europe and beyond. To support this image, he impressed his public with the sheer quantity of "visits": 200,000 bedside visits plus patients for whom he provided care in his private practice. His "record" was 42 visits in one day during the influenza epidemic. He claimed that he provided care for patients from all social classes, stressing that patients of all social backgrounds liked him, but he also noted that he provided care for very prominent people, such as the world-famous composer Antonín Dvořák, Czech politician and journalist Julius Grégr, and the aristocrat Jiří (Georg) Lobkowicz. Overall, his practice was sustained by a stable clientele of paying patients, including several generations of some families. Like many physicians in Europe and America at the time, he maintained that he became a family friend of these long-term patients.[48]

However, he also addressed the issue of fees. As he put it, he charged his patients "according to their coat." While he charged the most prominent patients 200 guldens, he insisted that he provided care for patients who "lived in the sous-terrain lodgings of the Prague houses" (in other words, poor patients) for free. While he adapted his fees to his patients' financial circumstances, he claimed that he treated them all the same. He presents himself as friendly but strict, paying short visits. He took pride in memorizing his patients' addresses and ailments. He maintains that he resisted pressure to prescribe unnecessary medicine and that he refused to continue treating patients who did not follow his recommendations. He presents himself as firm and assertive but also fair and caring authority figure. This image was on the rise as the new ideal of professional practice in the second half of the nineteenth century. As a physician of his time, though, Salmon did not hesitate to acknowledge the need to dress to impress. He emphasized that he changed his shirt and shoes twice a day to ensure that he would always be presentable.[49]

Bouček and Mrštík practiced in rural areas, where sources of income were limited and competition was high, particularly from healers whose presence in the medical field was well established, though the physicians came to consider it illegitimate by the mid-nineteenth century.[50] According to Bouček, in the rural

48 Muzeum Českého ráje v Turnově.

49 Muzeum Českého ráje v Turnově.

50 On the continued presence of other figures in the medical field, in addition to physicians, see Jütte, *Medical Pluralism*.

areas of Poděbrady, broken limbs were healed by the miller until 1870, the sick went to the charmer until the 1890s, and the local skinner (who was in charge of killing or getting rid of stray animals) provided the ill with ointments and pomades. The rural physicians' patients were self-confident in terms of trying to control their healing and choosing expert advice and help only if they regarded it as necessary. They did not acknowledge the physicians claim of expertise or authority in the medical field. Rather, they saw the physician as one of many actors in the field from among whom they could choose. The physicians, of course, interpreted this attitude as a sign of ignorance and an inability to draw a distinction between medical science and quackery. Bouček made an observation in his narrative that captured his sense of resignation: "Once I found real human excrement placed onto phlegmon manus! Animal excrement is often placed on fresh wounds. Recently, an injured man was brought to me, the wound went through the skull up to the brain, and in order to stop the bleeding, they had put a horseshit on the wound!"[51]

Norbert Mrštík was particularly blunt in his correspondence about his view of the patients and competitors, which is perhaps not surprising, since his opinions were, initially, private and intended only for his family, which was not part of the community in which he practiced (the municipality of Olešnice). He took pride in his communication skills and in his capacity to convince and manipulate the patients: "I never would have guessed how good an actor I am [...]. People show trust in me, even an affinity, and all this not thanks to my scientific qualifications, but due to my able mouth and this so-called psychological exploitation of people's stupidity, credulity, spoiledness, inclination to suggestion, etc."[52] To keep up appearances, Mrštík avoided places where people from different background socialized, such as the pub: "I don't want to go to the pub and I will not go. I do not wish to give those leeches so much as a finger. Cool politeness—this is what these sparrow heads are impressed with."[53] In addition to expressing his disdain in terms of social class, cultural capital, and the urban-rural symbolic hierarchy, Mrštík depicted his patients as a bothersome drain on his energy and resolution. He dealt with them by combining distance with calculated moments of congeniality and benevolence.

Private practice in the city, including the capital, did not necessarily guarantee the physicians less competition (although at least in the urban environment

51 Bouček, *Zápisky*, 39.

52 Havel, *Nedosněné sny*, 142.

53 Ibid.

competition came mostly from other physicians, not alternative healers) or more respect for their authority as experts. Vladimír Vondráček complains that, up until the 1930s, he had to provide care for patients in their homes, a complaint about a practice which had been common in earlier centuries, clearly made a posteriori, when this had become almost unimaginable. Vondráček complains about how patients would doctor-hop and about how hard it often was to make the patients describe their symptoms. But his primary complaint was that many sick and injured people still preferred to control their healing process and give advice to other people on their health instead of accepting the supreme authority of the physician and following his orders. Vondráček complains of this traditional attitude, presenting it as illegitimate and stupid due to the laymen's lack of knowledge: "Few would dare to repair a watch, though more do try it with their car. […] Since the dawn of time, though, people have dared to repair their own organism, i.e., heal themselves or give advice on healing to others. However, they do not possess even the most basic knowledge of anatomy, physiology, or pathology."[54]

The aforementioned Jirí Syllaba, who was also an urban practitioner, also insisted on the active role patients continued to play in private medical practice:

> The sick naturally [...] choose physicians according to their nature, taste, and character: some prefer an outgoing, merry, and noisy physician, others a solemn, serious one. Some like them younger, some prefer older ones. Some prefer an energetic treatment, even a painful one, while others demand a painless one. Some patients always insist on operating immediately, others avoid even the mention of surgery. It is not rare to see the sick choosing the physician who is ready to tell them what they wish to hear. Often to the detriment of the patient himself.[55]

The physicians who worked at clinics commented less on their interactions with patients. This could be seen as an indication of their more robust position as experts whose authority was beyond question. However, many of them still wished to present themselves as benefactors of the patients and as people for whom patients mattered. One could think of Mařatka's disapproving remark (mentioned earlier) concerning on Prusík's tendency to treat his patients as experimental objects and his contention that this was the main reason why he switched to work with Pelnář, though Pelnář was clearly the more powerful

54 Vondráček, *Fantastické*, 593.

55 Syllaba, *Vzpomínky*, 108.

patron of the two. Pelnář's good reputation in this sense is confirmed by other sources, such as the memoirs of his other protégé, Jirí Charvát. Charvát admired Pelnář's friendly attitude towards his patients. He affirms that Pelnář remembered his patients' names and took time to chat with them. Pelnář is thus depicted as a powerful clinician who, however, still had some of the habits of the ideal physician from the times of bedside medicine,[56] when physicians had provided care for paying patients in their homes, such as a caring and friendly attitude towards the patients and a willingness to take time to gain their trust through conversation, albeit in a setting marked by a clear hierarchy of authority and control over the process of healing, with the physician on top. The role of hospitals in enhancing physicians' authority was by no means limited to Prague and Brno. The aforementioned Vladimír Vondráček, who served as head of a provincial hospital, offers a description which clearly reveals the prestige enjoyed by physicians in the clinic setting:

> The head of a department at a provincial hospital performs all kinds of surgery, gut, limbs, sometimes also the throat, nose, ears, eyes […] The chief surgeon of a hospital was the lord and sovereign of the region, the good god, the savior, the healer. He was honored and appreciated, and his income was high, as there were classes in the hospital. However, his work was exhausting.[57]

However exhausting the work may have been in rural hospitals and however time-consuming it might have been for the urban clinicians to chase private patients, the framework of the interclass hospital guaranteed those who were employed there authority and the respect of their patients.

Among Colleagues: Vertical and Horizontal Ties

Relationships with colleagues were key in the late nineteenth and early twentieth centuries in the physicians' quest for supreme authority and middle-class social status not only for themselves as individuals but for the whole profession. They needed to acknowledge existing professional hierarchies and make good use of them, but at the same time, they had to develop a strong collective identity that would reduce competition among them and allow them to present a common front *vis à vis* patients. In this sense, instead of insisting on specific individual

56 See Shorter, *Doctors*; Bynum, *The Western*; Stolberg, *Experiencing*.

57 Vondráček, *Fantastické*, 172.

privileges as university professors or royal physicians, even the most privileged physicians became involved in the mission to strengthen the social standing of all physicians and their status as expert authorities. The white coat would become the symbol of this professional unity.

We have already discussed the continuing importance of patronage and the role of senior clinicians in shaping the careers of their younger colleagues. The quest for the consolidation of authority and status required horizontal solidarity, too. Notions of professional honor and collegiality were therefore mobilized to regulate competition among physicians and police their behavior, since questionable conduct on the part of one physician could cast a shadow on his colleagues. Medical journals and societies became useful spaces for internal discussion, where disputes and conflicts could be addressed so that physicians could face patients with coherent and consistent attitudes and discourse. Physicians in the Czech lands, whether Czech-speaking or German-speaking (or both), did not fall for the tribunals of honor and dueling like the physicians in the German Empire analyzed by Andreas-Holger Maehle. They stuck to their *petit-bourgeois* ways and showed respect for state institutions and administrative procedures, peppering their discourse with nationalist attitudes and meritocratic topoi.[58] Moreover, while physicians were expected to ridicule alternative healers and undermine their patients faith in these "charlatans," they were also expected to refuse to listen to patients' complaints about other doctors and discourage doctor-hopping by refusing to provide care for patients who were seeing other physicians. Salmon claims to have "hated" being invited to see a patient who was seeing another doctor, and if he discovered that one of his patients was seeing another doctor, he "took his hat and left, never to come back" (at least according to his account). He only provided care for another physician's patients if asked to do so by the physician himself and only if he had a suggestion concerning a new treatment for the patient, and he insisted that his colleague be the one to communicate this suggestion to the patient. This behavior was far from the norm in a period when physicians still needed to compete for paying patients, but it was becoming an ideal. This is clear from the fact that Salmon's colleagues liked and appreciated Salmon's behavior and reinforced his reputation as a selfless and capable practitioner, capable of earning the trust of his patients who, in fact, included some of his colleagues.

58 Maehle, "Doctors in Court."

In articulating a common ideal of the physician that would unite them all in terms of expert authority and social class physicians had to negotiate complex and often contradictory considerations and principles.[59] Like their German, French, and Spanish counterparts, Czech physicians had to reconcile the notions of selflessness and sacrifice, which were the basis of their claim to honor (a concept that experienced a revival at the end of the nineteenth and the early twentieth centuries in Central Europe)[60], with the need to get and satisfy paying patients, whose fees they needed so that they and their families could maintain a middle-class lifestyle. Although pressure decreased with the growing number of well-paid posts and the spread of the medical insurance system (and in the 1920s and 1930s, physicians' wives could also contribute to the family income as women's work in white-collar jobs became respectable and even fashionable among the upper-middle classes in Prague), this tension still existed and influenced physicians' relationships with their peers.

Syllaba, the son of an elite, well-off physician, proposed a typology of physicians according to their attitudes towards the medical profession. In his assessment, there were businesslike doctors who only saw their patients as a potential source of profits, but they were rare exceptions. Most physicians, he contended, were the "lovers of humankind" and fanatics of their profession, and they were in danger of being totally absorbed with and exhausted by the task of providing care for their patients. Syllaba's criticism of this model is interesting, because it also stresses the importance of providing the best possible care for patients. He argues that, if they did not die prematurely of exhaustion, these selfless doctors who sacrificed themselves for their patients were unable to keep their medical knowledge up to date, which ended up affecting their skills as physicians. The ideal physician, according to Syllaba, sees the patient as an interesting "case" without forgetting that he or she is also a human being. As for himself, Syllaba emphasized his selflessness but also his interest in the progress of medicine:

> I always tried to help the sick. I empathized with their feelings, tried to understand their inner state, to sympathize with their worries and anxieties, and to calm them down at least by word, if expert help was not possible anymore. I never understood medical profession as a

59 For a case study of these dynamics in the context of the nineteenth-century state-building process, see Núñez-García and Martykánová, "Charlatanes."

60 Maehle, "Doctors in Court."

> business. To me, money was always only a means to buy medical books and cover the expenses of the travels of learning and study.[61]

Syllaba's colleagues—and not only those from poorer families—did not hesitate to note that they had experienced financial problems in their professional careers and worried more about covering everyday expenses than about traveling to conferences abroad. They too, however, took pride in attending international conferences and buying medical instruments and literature to keep up with medical science. Urban or rural, GPs or clinicians, most physicians wished to be seen as caring healers and men of science, not mere businessmen.

Trust and camaraderie among physicians were also encouraged at the clinics. Mařatka writes about spending hours playing chess with his colleagues after they had quickly checked up on their patients. Pelnář's habit of inviting his subordinates to participate in the decisions concerning the junior medical staff was another means of strengthening group identity. It was no coincidence that Pelnář emphatically encouraged his protégés to be active in the Society of Czech Physicians, which had the double aim of promoting the interests of the medical profession and those of ethnic Czechs among the country's physicians.[62] They were also expected to travel abroad to further their studies and to attend international events, such as conferences on medicine and hygiene, working towards the improvement of medicine and the medical profession and, at the same time, promoting Czech interests through scientific internationalism. This, of course, implied knowledge of foreign languages, a form of cultural capital that served as another social filter.

Keeping Up Appearances

The importance of informal sociability, appearance, and manners in the nineteenth-century physicians' quest for social recognition has been acknowledged and analyzed, for instance, in the work of Robert Nye on France, Andreas-Holger Maehle's work on Germany, and Martykánová and Núñez-García's research on Spain.[63] The sources we discuss in this article show that, like their French and Spanish peers, Czech physicians were similarly aware of the need to create and maintain an image that combined bourgeois respectability with the aura of professional authority. The physicians, for example, comment on their clothes

61 Syllaba, *Vzpomínky*, 108.

62 Mařatka, *Paměti*, 44.

63 Nye, "Medicine"; Nye, "Honor Codes"; Maehle, *Doctors*; Martykánová and Núñez-García, "Ciencia."

as a means of creating a certain impression. Salmon takes pride in changing his shirt and shoes twice a day to be always presentable in front of his patients. The period under study was a time of transition from dressing as a gentleman during practice to the professional uniform of the whitecoat, a very visible sign of the triumph of a strong collective professional identity over the socio-economic divides and hierarchies of prestige that had existed in the medical profession for centuries. There were still important differences, but by the end of the period under discussion, all physicians, both rich and poorer, whether clinicians or rural practitioners, saw an advantage in endorsing this common informal uniform.

While they opted for a white coat uniform when they practiced, physicians found other status symbols to put their social capital on display. An apartment or a house at a prestigious address was a sign of success in big cities and small towns alike.[64] Some physicians had their villas built by prestigious architects. They attended social events and parties and dressed properly for the occasion: the gentlemen wore smoking jackets and their wives donned long dresses. They took pride in socializing with famous people.[65] They also stressed their travels abroad, whether for professional reasons or leisure, thus projecting an image of cosmopolitanism.

It was not all about showing off. There were other ways of expressing one's middle-class status, such as charity. As his son argues, Dr. Pavlík was frustrated by his patients' poverty, and we have no reason to doubt his honest indignation, but the fact that he instructed his wife to send his patients food and clothes for their children can also be read as a means of reaffirming his family's position among the middle classes, since charity was one of the mechanisms of social distinction, one that began to become particularly associated with femininity in the mid-nineteenth century. The role of the wife was, overall, quite important and in a process of change: some physicians acknowledged their wives' key contributions to running the medical practice as nurses and accountants (Vondráček), while others presented them as companions at elite social gatherings (Charvát) and during their various travels. The case of Mařatka, whose wife helped him support the family's middle class lifestyle with her salary as a bank clerk while her mother took care of the household, is a clear sign of new times in a Czechoslovakia led by the openly feminist president Tomáš Garrigue Masaryk, who added his wife's surname to his own, and where an active women's movement existed

64 Linhartová, *Jan Bělehrádek*, 93–99.

65 Charvát, *Vzpomínky*, 101–2.

which successfully promoted political and civil rights for women.[66] A working, professional wife could now be an asset, not only in economic terms, but also as a clear sign of the modern Czech man's progressive attitude.

Patriotism was another way of asserting and affirming social status and presenting oneself as a respectable Czech gentleman. Physicians who practiced in towns were often active in patriotic societies, contributed to the local press, and actively participated in local middle-class social life by attending the theater, for instance. Physicians in big cities often had important Czech politicians and intellectuals among their patients, and as they note in their memoirs, they took pride in this. Several of them stress their resistance to the German occupation and the persecution they suffered during World War II, a very rewarding strategy of self-presentation in a society in which the "fight against fascism" remained a key part of the national narrative across different political regimes and political cultures during the second half of the twentieth century.[67]

Concluding Remarks: Future Comparisons and a Trans-Imperial Analysis

As in this article we focus on a specific group of physicians who wrote about their practice in Czech, we need to acknowledge that we cannot make generalizations about the physicians born and bred in the Czech lands, in part because we excluded physicians who practiced in the Czech lands but did not write in Czech but also because we left out doctors from Czech-speaking families whose professional careers developed mostly in other parts of the empire, particularly in Vienna. We nonetheless observe, even within this narrower group, several dynamics that had parallels in other European countries. First and foremost, there were two forces that led to the creation of a stronger collective identity of physicians as members of a profession. One was the quest for indisputable authority in the medical field, expelling or subordinating other actors, a quest that united physicians by giving them a common purpose and common enemies, despite differences in individual wealth and prestige among them. The other one was the redefinition of social status after the crisis of the Ancien Régime. The hierarchical society began to give way to equality before the law and new ways of legitimizing social differences. In the emerging class society, physicians struggled to position themselves firmly among the middle classes not only

66 See Jusová and Huebner, "Czechoslovak."

67 Kindl, "En Madrid."

as individuals, but also as a professional group. We have observed how they mobilized economic, social, and cultural capital in this collective pursuit. We have also shown how social differences shaped professional careers and how exceptions were integrated, interpreted, and used to legitimize the system and its hierarchies. In particular, we have identified a pattern: when a man knew he could rely on his middle-class family's material support, he could dream of pursuing a career in research. For less well-off physicians, however, obtaining a diploma was a costly achievement, and they felt compelled to start earning money as soon as they finished their studies. They sought posts that offered stable salaries and opportunities to earn extra income from private patients. The latter was not always easy in poorer regions, and even if physicians had private patients, they were often paid in specie rather than in cash. Patronage was a way of overcoming these material obstacles, and this practice did not disappear at the end of the period. Rather, it was strengthened due to the patrons' growing capacity to get paid posts for their protégés. In addition to individual patronage, the growing institutionalization of healthcare ended up giving most physicians some degree of financial stability, reducing the tension between the image of a selfless, lifesaving doctor and the need to secure an income that would permit a physician to live a middle-class life even when faced with competition from his peers. By the early twentieth century, a commitment to scientific progress and patriotism emerged as two other important pillars of the social representation of Czech physicians.

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"Separation is Required in Our Special Situation": Minority Public Health Programs in Interwar Transylvania

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This paper presents the distinctive manner in which the Hungarian public health system in Transylvania was built up, parallel to the state structures in the interwar period. In several policies and public health projects, the young medical generation of the 1930s formed the basis of the biologically based ethnic community of Hungarians in Transylvania. This process was presented by them as part of ethnic survival and made the presence of the doctor necessary. The paper discusses the foundation of minority health institutes and also the discourses around the formation of these.

Keywords: public health, interwar, Transylvania, Hungarian doctors, minority health protection, maternal and infant protection

Having found itself in the position of a minority after World War I and the collapse of the Habsburg Monarchy, the Hungarian minority in Transylvania developed numerous survival strategies[1] aimed mostly at its survival as a cultural and linguistic community. Public health, which in turn-of-the-century Hungary had already had a solid institutional foundation and a large number of specialists,[2] underwent major changes in interwar Transylvania. The health problems of the community were only sporadically part of minority policy, and these issues were left, in general, to civilian philanthropic organizations.[3] In the 1930s, however, this took an interesting turn when the number of Hungarian doctors increased, and the previously civilian-initiated public health programs were professionalized and gained new momentum and a new function as part of a specific minority community-building project. The main issues of European

1 See Bárdi, "Románia magyarságpolitikája 1918–1989."

2 See Kiss, "Egészség és politika"; Turda, *Eugenics and Nation in Early 20th Century Hungary*.

3 Among them, it was mainly women's religious organizations and their umbrella organization, the Central Secretariat of Hungarian Minority Women in Romania (Romániai Magyar Kisebbségi Nők Központi Titkársága). See Bokor, "A székely nagyasszony testőrei"; Bokor, "A mi kis világunk"; Bokor, "Minority femininity at intersections."

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public health discourses came to the fore: saving the nation, the race, the health of the peasants, the dangers of venereal diseases, alcoholism, and the protection of infants and mothers. The alleged biological element of community building, which built on a strong turn-of-the-century tradition, became more prominent in the various discourses.

The short period which forms the chronological framework for my discussion here begins with the search for a strategy by a new generation of the group of so-called erdélyi fiatalok (Transylvanian youths) and the process in which they were involved in 1930 of constructing a new minority identity. The period under discussion came to a close with the outbreak of World War II, the Second Vienna Award (1940), the dismantling of minority institutions, and their integration into the Hungarian national institutional network.

In this article, I examine the manner in which the Hungarian public health system in Transylvania was built up parallel to rather than as part of the state structures in interwar Romania. This public health movement was not particularly ambitious, which is not surprising given the lack of financial resources. In addition to studying minority health policy, in this article, I also examine how an alleged biological basis of Transylvanian Hungarianness was formulated and how this notion of biological racial kinship or ethnicity figures in these discourses and the ways in which the scientific paradigm of eugenics, which was extremely popular at the time, especially in the Eastern and Central European medical sphere, became part of the construction of minority identity.

The Hungarian Medical Profession in Transylvania in the Interwar Decades: The Labor Market and Problems of Recruitment

In 1919, when Transylvania was made part of Romania, the newly formed political-administrative authorities began taking over the most important and biggest university of the region, the university in Kolozsvár (today Cluj-Napoca, Romania). The Kolozsvári Magyar Királyi Ferencz József Tudományegyetem (Franz Joseph Hungarian Royal University of Kolozsvár) and its Faculty of Medicine moved to Budapest and then to Szeged in 1921. Very few of the leading figures remained in Transylvania, as the new Romanian state obliged intellectuals, including doctors, to take an oath of loyalty to the Romanian state and nation, which contributed to the mass emigration of Hungarian intellectuals. The change was also reflected in the decline of the number of medical students,

as the number of Hungarian students who enrolled in the Romanian university was negligible, mainly due to a lack of language skills.[4] As Victor Karady and Lucian Nastasă have emphasized in their monograph, for the authorities, the university meant a "symbolic process of nationalization of the region in the framework of the "Great Romanian" nation state.[5]

The Transylvanian medical profession dwindled after 1919, and its labor market opportunities became more limited. Hungarian doctors were less often employed in state institutions, and most of them pursued their work in private practice. There were only a few "Hungarian hospitals"[6] in the country, all of them in large cities. However, these institutions could provide a living for a very limited number of doctors, and it is also clear from the sources that the recruitment of the urban medical elite was mainly favored by private hospitals. In 1937, 80 percent of the 7,669 doctors in Romania lived in cities, while the vast majority of the population lived in villages. According to contemporary statistics, a significant number of doctors working in Hungarian-majority villages were also of Romanian nationality, making communication difficult between patients and doctors.[7]

The Hungarian doctors of the period who lived and worked for the most part in one of the major cities, were scientific specialists in at least one field of medicine. They reported mostly on diagnoses, data, and research in medical journals, without interpreting them in any ethnic context. They did not play any particular role in minority organizations, and they did not explicitly embrace, as a group, any specific political credo. They were not particularly involved in any kind of health policy or minority policy. Most of the Hungarian-language medical forums, such as *Egészség* (Health), *Erdélyi Orvosi Lap* (Transylvanian Medical Journal) (1920–1925), *Praxis medici* (1924–1940), *Clinica et laboratorium* (1932–1949), and *Orvosi Szemle* (Medical Review) (1928–1938) were professional journals that did not discuss health policy issues pertaining in any specific way to the Hungarian communities. It is also noteworthy that, unlike their Romanian counterparts, they did not talk in public about the so-called "social diseases," such as syphilis and other venereal diseases, which were considered among the biggest problems in

4 Gidó, *Oktatási intézményrendszer és diákpopuláció Erdélyben 1918–1948 között*.

5 Karady and Nastasă, *The University of Kolozsvár/Cluj*, 68.

6 Hungarian-run, mostly church-owned institutions.

7 Jancsó Béla. Az orvosi pályaválasztás akadályai, 45–52. Az Erdélyi Múzeum-Egyesület Gyűjteményei, Jancsó Béla papers.

Romania in the postwar period. The Hungarian-language press also tended to interpret the press statements made by Romanian doctors and health officials.[8] Although they occasionally gave lectures to wider audiences, this was not the main orientation of this elite group. In the Medical Section of the Transylvanian Museum Association (Erdélyi Múzeum Egyesület Orvostudományi Szakosztálya, hereinafter referred to as EME), departmental meetings were exclusively meetings among experts, and although lectures held to the wider public on health care and health issues were among the subjects addressed at these meetings, these experts also held talks that were intended for members of the more educated middle classes, who lived for the most part in the cities. In the decade after World War I, Hungarian doctors rarely addressed public health problems in their publications in medical journals or other forums. There were no organizations, no clearly articulated concepts of public health policy, and certainly no notions of minority health policy[9] behind the few publications on the subject, which were usually related to the highlighted diseases of the time, such as tuberculosis, syphilis, infant mortality, etc. (which were referred to as "social diseases," or *bolile sociale* in Romanian).[10]

During the first decade of the interwar period, the medical elite was undergoing a process of disintegration, though at the same time, the members of this elite were searching for new opportunities for institutionalization and for the security provided by the old institutions.[11] The medical elite was looking inwards, and largely ignoring the questions faced by contemporary society.

8 See Bokor, *Testtörténetek*.

9 See for example Goldberger, *Mit kell tudni*; Szelle, *A vérbaj*; Sándor, *A tüdővész*. Ede Goldberger's work on syphilis was published in six editions and also in Romanian translation.

10 Shortly after the collapse of the Habsburg Monarhy and the establishment of Romanian power in Transylvania and much of Partium and Banat, in February 1919, the Social Work Department of the Transylvanian Governing Directorate (Resortul de Ocrotiri Sociale al Consiliului Dirigent al Transilvaniei) published the organizational plan of the Outpatient Clinics, which set out the principles of their operation. This document identified the most pressing health concerns as venereal diseases, tuberculosis, and infant mortality in urban and rural areas. See Stanca, "Ambulatorul policlinic."

11 In April 1933, the Welfare Association of Hungarian Minority Doctors in Romania (Romániai Magyar Kisebbségi Orvosok Jóléti Szövetsége) was founded, an advocacy organization for doctors which tried to restore the internal security provided by prewar medical institutions and to make up for financial losses and uncertainties after the war. (Péter H., "A romániai kisebbségi orvosok.")

Hungarian Patients Should Be Treated by Hungarian Doctors:[12] *The Ethnicization of Medical Interests*

In the 1930s, there was a pronounced outward shift, with the medical elite becoming more sensitive to and engaged with the problems faced by the surrounding ethnic community. This was a period during which doctors, marginalized on ethnic grounds by the new state apparatus, also sought to organize themselves on ethnic grounds.

The Romanian state was neglecting the Hungarian communities, and this neglect had become a major talking point among the Hungarians, with experts criticizing the state's failure to participate in the modernization of health care in settlements populated by Hungarian-majorities. It is almost impossible to compare the situations in different regions under the jurisdiction of the Romanian public health system, which was underdeveloped from the outset. In 1938, the Ministry of Health did an extensive survey of the health situation in Romania.[13] Some of the reports submitted by the health inspectors provide useful information regarding the circumstances in the localities with Hungarian majorities, pointing out that the health conditions in these regions were a cause for concern. The health campaign, organized and conducted by the Ministry of Health and Social Works (and given the title "Sanitary Offensive"), resulted in the publication of monographs containing data about geography, topography, vegetation, climate, demography, household hygienic and sanitary conditions, sanitation infrastructure, and sanitation organizations in the Romanian regions. Nearly 74 percent of households were visited during the two-month campaign, 7,700,000 individuals were examined, over 42,000 radiological examinations were done, over 77,000 blood tests were taken, and over 360,000 injections were given. Although all the administrative regions, counties, and cities are included in these numbers, the case studies that suggest a more active medical presence are from localities with a Romanian majority. The Report of the General Inspectorate of Health of Sibiu/Szeben County points out that public health conditions in some of the cities of the Székely Land (Gyergyószentmiklós/Gheorgheni, Székelyudvarhely/Odorheiu Secuiesc, Csíkszereda/Miercurea Ciuc) were not satisfactory, as was also the case in the rural region of Csík/Ciuc and Udvarhely/Odorheiu. The report also notes that the situation in Csík

12 Györke and Gspann, "A fiatal erdélyi magyar orvosi nemzedék," 84–85.

13 Ministerul Sănătăţii şi Asistenţei Sociale, *Probleme şi realizări*, vol. 1–3.

County was the worst in terms of hospital beds, with a total of 100 beds and one hospital bed for every 1,571 inhabitants.[14] These data underline the concerns voiced by Hungarian doctors at the time and offer a rough impression of the ways in which the health policy of the period had clear disadvantageous consequences for Hungarian-speaking communities.[15] The data also shows, however, that most of the Romanian regions were also underdeveloped from the perspective of health care. The survey results were not satisfactory anywhere, at least not by European standards. In the rural area of Csík County, there were 15 doctors per 100,000 inhabitants (a detail mentioned several times by Hungarian doctors). The same was true in Udvarhely County, and there were only 21 doctors total in Háromszék County. But this sum was not below the national average. In fact, in the villages in Romania, the ratio was even worse, since according to calculations, there were 9.6 doctors for every 100,000 people.[16]

In Hungary, this ratio increased after World War I (some historians have contended to say this was due to the migration of doctors from the territories annexed by the surrounding states), as there were suddenly 56 doctors per 100,000 inhabitants. This brought Hungary up to the level of Western European countries. In 1921–1922, France had 62 doctors per 100,000 inhabitants, Germany had 73, Denmark 60, and Norway 40.[17]

The living conditions of Hungarian doctors were explained in the various sources by their ethnic belonging, and their employment barriers were associated with the region's underdevelopment. However, for some of the physicians of the time, the idea of having Hungarian doctors treat Hungarian patients seemed like a promising project. Transylvanian Hungarian physician Béla Schmidt, who organized a Hungarian-language midwife-training course in Târgu Mures/ Marosvásárhely after the war, made the following proposal:

> Thus, there remains nothing left but to build and awaken racial consciousness on a stronger and broader basis. An awakened and lively racial consciousness can bring with it the hope that the young Hungarian doctor can also hope to find a job. Because the idea of a "Hungarian patient being treated by a Hungarian doctor" will only become a reality if Hungarian national consciousness is strengthened and revived.[18]

14 Stoichiţia and Comşa, "Evidenţa sanitară a inspectoratului general sanitar Sibiu," 159.

15 Comes, "Judeţul Ciuc"; Pop, "Jud. Odorhei"; Creţu, "Jud. Trei Scaune"; Macavei, "Jud. Mureș."

16 *Praxis medici,* no. 6 (1937): 260.

17 Szabó, *A magyar egészségügyi ellátórendszer a két világháború között*, 41.

18 Schmidt, "Hozzászólás," 112.

As Schmidt's suggestion clearly illustrates, one of the issues at hand was that Hungarian doctors needed Hungarian patients in order to earn a livelihood. For Schmidt, the development of Hungarian national consciousness (and thus of a system of relations between patients and doctors that was founded on a notion of ethnic or national belonging) was a prerequisite for the ideal positioning of Hungarian doctors.

The feeling of professional deprivation among doctors was therefore closely linked to a series of social and administrative factors. However, the main cause for concern, beyond the feelings of neglect and professional marginalization, was the fact that the institutionalization of public health in Romania was part of a larger ethnicizing discourse used by the leading Romanian medical elite: the notion of Romanian identity as a fundamentally racial, biological identity lay at the core of these health politics. According to this discourse, the nation was defined by biological factors, and thus ethnic minorities were considered dysgenic elements and not part of the biological body of the nation.[19] This biological definition of the nation provided a pretext and justification for eugenics, which was closely linked to biopolitical interventionism and radical health regulation measures. It is also noteworthy that the board of these public health institutes was represented by a medical elite that was engaged in this discourse.

By the 1930s, a new generation had emerged in the elite layer of the Transylvanian Hungarian medical community which took an active role in communicating scientific knowledge to the lower classes and did not perceive its work merely as a scientific task, but rather undertook the project of saving "the people" as a kind of missionary endeavor. Most of the doctors involved in the public health movement had graduated from Romanian universities after World War I, but most of them were socialized in religious communities, and almost all of them were members of a Church. Although they were also members of the EME's medical section, they usually distanced themselves from the EME's medical elite.

Before analyzing the work of this group, I will discuss some elements of the context: first, the idea of népszolgálat, or "work in the social service of the people," which was the alleged moral basis of their work, and second, the research and service projects undertaken in rural areas in which the doctors were involved.

19 On this issue see Turda, *Eugenism şi antropologie rasială în România, 1874–1944*.

The Christian Socialist Idea of Népszolgálat *(Work in the Social Service of the People)*[20] *and* Népközösség *(Community of the People)*

Young Hungarian intellectuals, dissatisfied with the minority politics of the elites in the 1920s, developed a new model of social organization in the 1930s, and the subject of Hungarian minority policy in Transylvania has generated a body of secondary literature too vast to summarize here.[21] I would like instead briefly to touch on the idea of work in the social service of the people (népszolgálat) promoted by young intellectuals as an essential part of the ideological context in which the new generation of physicians worked. Népszolgálat was more than a political idea, as it sought to unite a highly stratified society, the whole minority community, or the so-called népközösség or "community of the people." According to Nándor Bárdi,[22] the Transylvanian Hungarian Christian socialist national and social attitude had two parallel theological foundations. For Catholics, the encyclical Quadragesimo Anno of Pius XI and its social teachings were decisive, and they formed the foundation of the social spirituality advocated by Áron Márton (1896–1980), an ethnic Hungarian Roman Catholic prelate and bishop of Gyulafehérvár/Alba Iulia. Márton distanced himself from any extremist nationalist ideas. He formulated his ideological standpoint as follows: "We demand freedom, but we are in a hurry to bury liberalism. We are calling for social care, and a radical reform of society, but we cannot go with Marxism. We undertake the sacred duty of loving the race, but the worship of blood is heresy."[23] Protestant authors promoted a critical view of the nation, based on a moral foundation: this moralized view of community was laid down by the Reformed Bishop Sándor Makkai in his work, *Magunk revíziója* (The Revision of Ourselves).

Creating new foundations for a society by reevaluating existing infrastructure, traditions, and human resources was evidently an enormous plan for a community.[24] As Dezső Albrecht, one of the young elite leaders of the community, stated in 1937, "[b]efore the war, Transylvanian Hungarian society was not receptive to social or deeper national issues, its spirit was also fragmented in many directions,

20 Work in the Social Service of the People (Volksdienst).

21 See Bárdi, "A romániai magyarság"; Bárdi, "Románia magyarságpolitikája"; Bárdi, *Otthon és haza*; Egry, *Etnicitás, identitás, politika*; Bottoni, "National Projects"; Bárdi et al., *Népszolgálat*.

22 Bárdi, "A népszolgálat genézise," 11.

23 Márton, "A mi utunk," 265.

24 Zsuzsa Török introduces an interesting perspective while analyzing this new generation of the Hungarian elite, especially the journal *Hitel*. She asks how "national minority," a political term, is filled with meaning in the context of antagonistic nation states. (Török, "Planning the National Minority.")

the conservative-nationalist conception of the aristocracy and the nobility, the radicalism of the urban bourgeoisie and intelligentsia were equally insensitive to social work, social organization, and social forces in general."[25]

The idea of working in the social service of the people was incorporated into a holistic view of the nation, in which the collective care of body and soul were prioritized. Albrecht captured the essence of the Hungarian community as follows:

> The protection of body and soul through the cultivation of body and soul. [...] An abandoned ethnic organization, deprived of the beneficent assistance of the state, whose natural development of its national existence has been blocked, is forced to rely on these fourfold activities: 1. Protection of the soul, i.e., the protection of morals, 2. Protection of the body, or health, 3. Ensuring prosperity, i.e., economic protection, 4. the cultivation of culture, i.e., the protection of literacy. These four activities are preserved and encouraged by political activity.[26]

Rural Healthcare Programs in the 1930s

Several rural programs were created in Romania after the war, and the discourse of the populist "national ontology"[27] also gained an important place in public discussions. Rural culture and rural lifestyle were given more and more attention in the life of the Hungarian minority as well. The figure of the peasant became the seed of national revival. Similarly to Dimitrie Gusti's sociological research school,[28] the Sarló-mozgalom, or Sickle Movement, of the Hungarian minority community in Czechoslovakia, and the Szegedi Fiatalok Művészeti Kollégiuma, or Art College of the Szeged Youth, various monographic research projects[29] were launched by the intellectuals gathered around the journal Erdélyi Fiatalok (Transylvanian Youth). Thus, turn towards village and peasant culture and life was not a passing interest among a small group of intellectuals. It was a pillar of minority policy and the foundation of a unified social vision for the minority. The intellectuals who represented the renewal of Hungarian culture, identity, and wellbeing among Romanian Hungarians, like their Czechoslovakian

25 Albrecht, "Társadalmunk átalakulása," 181.

26 Ibid.

27 Trencsényi, *A nép lelke*, 372.

28 Dimitrie Gusti (1880–1955) was a Romanian sociologist who invented the sociological monographic method. Gusti favored and theorized first-hand intensive observation of social units and phenomena, as well as interdisciplinarity. Their research work was carried out through intensive collaboration within the field of social sciences, but also with doctors, agronomists, and schoolteachers.

29 See Szabó T., "Az első munkatábor."

counterparts, "wanted to address, orientate, and integrate the village masses into their minority society organized on a national basis."[30] The self-help cooperatives were excellent examples of this social organization. The Mészkő cooperative, initiated by Ferenc Balázs,[31] enjoyed varying degrees of success,[32] and the Ágisz cooperatives launched by Sándor Kacsó[33] were able to employ intellectuals, such as doctors, lawyers, economists, whose salaries were paid by the community itself through monthly contributions.

The Hungarian initiatives in Transylvania differed both from the village research movements in neighboring countries and the Romanian Gusti movement in that the entire activity of social organization had to be planned and implemented without any state support, and village education projects and research became integral parts of the efforts to strengthen the ethnic minority community. Since these initiatives had no state support, the ecclesiastical world, which had contributed to the upbringing of this generation and in which this movement could operate, was even more powerful.

The doctors of the new generation also proclaimed the need for a new approach, emphasizing their responsibility for the wellbeing of the community. The critique of the elitism of the previous medical generations played an important role in the self-definition of the new generation of doctors: "We need a selfless (and not a materialistic) soul, a new generation of Hungarian doctors who are less demanding, who see the human and Hungarian depths of the issue, and who are self-aware in their willingness to address this issue. And Hungarian society must make every effort to help them so that they can be properly organized to provide the most elementary initial opportunities for settling in the village."[34]

The doctors involved in the endeavor—András Nagy, Béla Jancsó, Ernő Manyák, Kálmán Parádi, Elek Bakk, Béla Schmidt, and Lajos Küttel—were the best-known medical figures of the movement. They did not create independent medical organizations, but they were linked to the basic idea of social service. They worked in church organizations and cooperatives, and they were involved in the scientific research done by the new intellectuals.

30 Bárdi, "A népszolgálat genezise," 18.

31 Ferenc Balázs (1901–1937) was a Hungarian writer and Unitarian priest from Transylvania.

32 Kárpáti, "Az Aranyosszéki tervek," 92.

33 Sándor Kacsó (1901–1984) was a Transylvanian Hungarian writer, editor, publicist, and politician.

34 Jancsó Béla, Az orvosi pályaválasztás akadályai, 48. Az Erdélyi Múzeum-Egyesület Gyűjteményei, Jancsó Béla papers.

Since the idea of work in the social service of the people was part of a Christian-based social stance, the doctors who joined for the most part had strong ties to the Church. They were mostly young doctors from the medical department of the Katolikus Népszövetség Orvosi Szakosztálya[35] (Roman Catholic League of People): András Nagy, Ernő Manyák, Kálmán Parádi, Lajos Küttel, Béla Schmidt, and teachers from denominational schools, like Béla Jancsó. However, it was not unusual for them to be involved in programs organized by other denominations.

How can improvements be made to public health without a supportive public health policy? The medical elite of the 1930s claimed that there had to be a separate public health system for the Hungarian minority, because this community was very different from the majority ethnic group. The idea of institutionalized minority public health, integrated into state health policy but also somewhat separate from it, was conceived in the mid-1930s. Experts usually cited the shortcomings of the post-war Romanian health system as an argument for the establishment of a minority health policy, but they also noted the state's alleged lack of concern for minorities. The ethnocentric nature of state public health measures meant that Hungarian settlements were left out of the development process and were given less attention by the Romanian authorities.

In the initial phases, cooperation with the state was still a priority, as Béla Schmidt noted in a later issue of *Magyar Népegészségügyi Szemle* (Hungarian Public Health Review) in 1937.[36] Schmidt still thought that results could be achieved in minority health policy through the Hungarian political party Országos Magyar Párt, or OMP (National Hungarian Party),[37] and he felt that a public health protection department should be established as part of this policy. The primary task of this department would have been the biopolitical mapping of the Hungarian population. The other ethnic health policy program, which was formulated by András Nagy,[38] drew up a specific minority health

35 The Medical Section of the Roman Catholic League of People was founded in the autumn of 1935, with András Nagy as its president. In his memoirs, Nagy summarized the goals of the Section as follows: "the aim being to take stock of those doctors who belong to the Church not only because they were baptized into it but also because of their behavior, to make them aware of their activities and conduct, especially in the matter of abortion, and to give moral support to their work." Nagy, *Lót visszanéz*, vol. 1, 173.

36 Schmidt, "A magyar népegészségügyi védelem megszervezése."

37 The Magyar Party was a political party in interwar Romania. It was founded in 1922 by the Hungarian aristocracy and was intended to represent the rights and interests of the Hungarian ethnic community.

38 András György Nagy (1905–1982) was a Hungarian medical writer and public writer.

policy.[39] This program, however, considered the work of the OMP useless and, in contrast to Schmidt, it called for the establishment of a new health governing body, independent of politics, based on the Church, and building on the younger generation of the 1930s: "This health policy is the work of younger generations."[40] It was not organized against the state, but rather envisioned a public health program that would run parallel to the state institutions. An alternative to state care would have been the creation of a controlling public health body, a "silent association of doctors doing Christian social work," "a body entrusted with the health care of the minority churches."[41]

In his health policy program, András Nagy devised a plan for the creation of institutions, and he offered an explanation for the alleged necessity of a parallel minority health policy:

> We have different problems which are in many ways different from those of the predominant people, and the same problems manifest themselves in a different way in a Hungarian ethnic context. […] However, the birth and death rates differ from one ethnic group to another, the causes of mortality are different, and each suffer from different diseases.[42]

The minority health system was envisaged to be as complete as the state health system. It had to be based on research and censuses, and its operation had to be ensured by a public health management center which placed emphasis on the training of health personnel and medical students, the creation of health institutions with Church support and private funding, and conveying medical knowledge to the public with the help of village doctors, trained doctors and teachers, the press, and by prevention and treatment.

The Main Problems of Hungarian Minority Health Policy

Demographic indicators: birth rates, emigration

The increased concern of the Hungarian elite in Transylvania about demographic indicators can be observed after the publication of the results of the 1930

39 Nagy, "Egészségpolitikai vázlat"; Nagy, "Adatok az erdélyi magyarság népegészségügyéhez"; Nagy, "A népegészségvédelem megszervezése."

40 Nagy, "Egészségpolitikai vázlat," 58.

41 Nagy, "Egészségpolitikai vázlat."

42 Nagy, "Egészségpolitikai vázlat," 59.

census.[43] According to the 1930 census, Hungarians constituted 7.9 percent of the total population of Romania (18,057,028). Most of them (94 percent) lived in Transylvania.[44] According to the new data, there was a decrease of nearly 200,000 compared to 20 years earlier.[45]

The other demographic phenomenon that was a cause for concern was the large scale of emigration. According to some data, 197,000 Hungarians left Transylvania between 1918 and 1922.[46] The emerging concern surrounding the demographic data was also significantly influenced by the Romanian interpretation of the census data. In Romanian public opinion, the reception of the data was dominated by anti-revisionist views and the fears voiced by Sabin Manuilă, the head of the Romanian Demographic Institute, who was in charge of the Romanian census in 1930. Manuilă did not hide his joy at the fact that the Hungarian population in Transylvania was decreasing, and he also regularly influenced public opinion concerning the Romanianization of the region. "Time," he said to Romanian newspapers, "quickly brings the definitive consolidation of the Romanian ethnic mass and at the same time grinds down the country's ethnic minority groups."[47] He also added that "[e]thnic minorities are becoming fewer and fewer in our country, in a country whose population is growing vertiginously."[48]

Many of the medical activists wondered how birth rates in the minority community could be increased. An array of public health education materials illustrates clearly the areas of life in which doctors wanted to make a difference. The series launched by Ágisz Hasznos Könyvtár (Ágisz Useful Library) from Brassó/Braşov[49] undertook the publication of a number of health protection

43 Venczel, "Öt oltmenti székely község"; R. Szeben, "Transsylvania népmozgalma"; Nagy, "Az egyke Kalotaszegen"; Daróczi, "Egy kalotaszegi falu"; Kós, "Egy falu mezőgazdaságának rajza"; [N. n.], "Ciucmegye egészségügyi helyzetképe"; Nagy, "Szórvány és beolvadás."

44 The former was a census based on mother tongue, the latter on nationality. On the problems of data and data collections see the work of Attila Seres and Gábor Egry. They provide a good summary of the census' mismanagement of data and the use of census data for political purposes. See Seres and Egry, *Magyar levéltári források*.

45 Varga E., "Az erdélyi magyarság főbb statisztikai adatai."

46 See Varga E., "Az erdélyi magyarság főbb statisztikai adatai"; Horváth, "A migráció hatása."

47 Doctorul Ygrec, "Acţiunea revizionistă în lumina demografiei. Conferinţa de la Fundaţia Carol."

48 Vrânceanu, "Ştiinţă şi revizionism," 1.

49 Parádi, *A balesetek megelőzése*; Bakk, *Rajtad is múlik*; Herskovits, *Ismerd meg a fertőző betegségeket*; Schmidt, *A vérbaj*, vols. 1–2.

brochures, and the Reformed Church's journal *Kiáltó Szó* (Word of Outcry) also published a special edition of articles by Béla Jancsó.[50]

The main concern of this health policy was the perceived need to control demographic trends, and infant health, maternal health, and the one-child issue were given priority. It is perhaps no coincidence that the tangible results of this health policy were most visible in the discussion of birth rates, which may have been due to doctors' active cooperation with the Hungarian women's associations and women's religious organizations in Transylvania.

Maternal and infant protection

A broader social interest among Hungarian doctors in preventive care for infants emerged during World War I. In the public mind, the fate of the nation was inextricably linked to the health of the next generation and, of course, to the birth rates. The preoccupation with the health of future generations and the protection of mothers and infants was most powerfully expressed in the activities of the Országos Stefánia Szövetség az Anyák és Csecsemők Védelmére (National Stefánia Association for the Protection of Mothers and Infants).

After World War I, doctors had an even more important role in defending the supposed biological integrity of the community.[51] As was the case in Hungary, the new medical authorities in Romania made proposals concerning efforts to resolve the chaos in the wake of the war and to remove remnants of the previous political system. After World War I, a newly formed biopower provided for the security of the nation's health in Greater Romania. During this period, a range of reforms were introduced directly attaching the body and human sexuality to fertility in an attempt to control women's sexuality, to put women's bodies in the service of a eugenic ideal, and "to increase the rate of healthy births."[52]

Transylvanian Hungarian doctors also took on these tasks. They were the only ones qualified to give precise instructions to the community regarding its alleged biological integrity. And since childbirth and nursing were the mothers' domain, they provided a broad amount of information, including subjects such

50 Béla Jancsó (1903–1967) was Hungarian doctor, publicist, critic, and medical writer.

51 See Bucur, *Eugenie și modernizare*. See also my articles on Romanian eugenics and venereal diseases in interwar Romania: Bokor, *Testtörténetek*; Bokor, "Women and eugenics in interwar Transylvania"; Bokor, "Enemy of the World in City and Village."

52 Bucur, *Eugenie și modernizare*, 338.

as childbirth, childrearing, and issue ranging from children's shoes to bacteria, children's psychology, and the role of fresh air in children's growth.

In the following, I discuss some concepts included in the public health programs conceived by Hungarian medical doctors in Transylvania. I examine the initiatives of Lajos Küttel, the infant protection activism of András Nagy, and some brochures edited for mothers in the interwar period.

Lajos Küttel's name appeared in the Transylvanian Hungarian public discourse in the mid-1930s, as he regularly gave lectures to large audiences in Kolozsvár on inheritance, racial biology, and eugenics.[53] In 1935, as a doctor in Torockó/Trascău, he started a model campaign in his own village. The idea of the demonstration district[54] or "public health demonstration district" came from the United States. Essentially, a public health demonstration district was an experimental colony the aim of which was to establish and test "model health institutions."[55] While the campaigns in Eastern Europe (including Romania and Hungary) were supported by the Rockefeller Foundation,[56] the Torockó project was carried out on a voluntary basis by the local intellectuals and the district doctor.[57] In the infant clinic, 42 babies were examined regularly and vaccinated, and mothers were given advice on infant care. The doctor organized training courses on infant protection for nurses among local volunteers.[58] These nurses spent one day a week in the clinic and visited families with babies. The infant unit kept family registers and monitored the health situation of families.

Küttel planned to extend the model campaign to the whole of Transylvania, and he intended the Torockó infant protection action to serve as a model. In his policy paper, regarding the organization of child protection actions among the

53 In the series of educational lectures held by the EME in 1934 and in the lecture series held by the Ferenc Dávid Society in 1935, the authorities did not allow his lecture on race theory.

54 On public health demonstration districts in Hungary see Kiss, "Egészség és politika."

55 Pfeiffer, "A mintajárás," 72.

56 Romania, like most European countries, collaborated with the Rockefeller Foundation. The collaboration with Rockefeller also resulted in the establishment of the Institute of Hygiene and Public Health (Institutul de Igienă şi Sănătatea Publică) in Bucharest (1927), as well as in Cluj and Iasi (1930), and it also provided some finances for the Institute of Statistics (Institutul Central de Statistică). Several Romanian doctors and statisticians received Rockefeller fellowships in America (such as Sabin Manuilă, Iuliu Moldovan, and Gheorghe Racoviţă). This financial support also was directed toward Romanian national institutions (very few of Hungarian ethnic specialists were employed in these institutions, and none of them received fellowships).

57 Some data on this work was published in *Magyar Népegészségügyi Szemle:* N. N., "Figyelmet érdemlő kezdeményezés"

58 N. N., "A D.F.U.N.Sz. Csecsemővédő tanfolyama."

Roman Catholic, Reformed, and Unitarian and Evangelical Churches in Romania (hereinafter referred to as Draft[59]), he reports on the infant protection activities in Torockó and develops the operational plan for a Transylvanian Hungarian Church-based infant protection association. The infant protection association was never actually created, but the women's associations all made the problem of infant protection a priority, and in the autumn of 1936, the Unitarian Women's Association organized a course on infant protection with Küttel. The course included lectures on the physical and psychological development of children, healthy ways of feeding, alternative infant feeding, formula feeding, general hygiene, and illnesses. Five of the 16 lectures were on heredity and eugenics, which were Küttel's main areas of interest.

The Draft was one of the most remarkable initiatives of the Hungarian medical organization in the interwar period, as it modeled all the possibilities and perspectives that these two decades offered for the development of the public health movement: infant protection as a privileged field of minority biopolitics; the necessity of public health organization; the exclusive role of the Churches in the organization; and the extreme importance of the defense of the minority community understood as a biological community.

The Draft offers an unusual biological anthropological point of view: the reason for making mothers aware of the maternal instinct to provide care was to reverse the selection mechanism of nature. In this process of awareness-raising, Küttel considered morally and religiously sound infant protection important, but he claimed that in the circumstances faced by the minority community, Hungarians in Transylvania must prioritize the national objective, which was to "increase the strength of the nation." This is noteworthy because he expected Church support to implement the plan, but he wanted to involve the Church not as a moral authority but as a management unit, since it was the most organized body for the ethnic community.

The Draft proposes a eugenically-oriented project that goes beyond turn-of-the-century charity infant care and focuses on a new paradigm, the improvement of the national community's demographic indicators. In his 1936 treatise on eugenics Átörökléstan és eugénia kérdések (Heredity Theory and the Questions of Eugenics),[60] Küttel argues in favor of negative eugenics in the sense of Mendelian eugenics, supporting his arguments with Scandinavian, German,

59 Küttel Lajos. Vázlat a romániai római katolikus, református, unitárius, evangélikus egyház gyermekvédelmi akciójának megszervezéséről. Magyar Unitárius Egyház Kolozsvári Gyűjtőlevéltára.

60 Küttel, *Átörökléstan és eugénia*, also published in the EME's journal, "Eugéniai kérdések és az örökléstan."

and American examples, while positive eugenics is discussed in just one short chapter. He writes in first person plural, emphasizing not only his own position but also making the reader feel coopted. He is explicit in his contention that the large rural populations in Central Europe with high birth rates represent a "lower social stratum" than the populations of the modern, secularized Western states, and he claims that "the higher social strata is, on average, composed of more intelligent, healthier, and more industrious people than the lower social strata, on average."[61] The Catholic doctor András Nagy criticized Küttel for not taking Catholic views into account and for having composed a treatise the purpose of which was to promote and pass the German sterilization law for the Hungarian public.[62] Küttel replied with the phrase attributed to Galileo Galilei: "eppur si muove," or "and yet it moves."[63]

Despite Nagy's objections, there are common grounds in his work and Küttel's career. Both were members of the Medical Section of the Catholic League of People, and Nagy was well acquainted with Küttel's professional activities, both the Torockó demonstration district and his interest in eugenics. Küttel's work inspired Nagy to devise a plan for a public health center that was even more complex than the one in Torockó, which would become the nursing home (or health home or midwives' house) in Csíksomlyó/Şumuleu Ciuc. This home started out as a network of midwives but later grew into a complex maternity hospital which helped women from the rural area of Csík County provide care for their newborn babies. The nursing home as an institution for infant protection was also promoted by the Romanian Sanitation Law in 1930. Iuliu Moldovan,[64] who signed the law, stressed that rural medical dispensers should be more than just places to cure illness. He suggested that small institutions employing a doctor and a midwife should also do preventive work, and he proposed the name "nursing home" (casă de ocrotire) instead of "dispensary,"[65] placing emphasis on prevention instead of treatment.

61 Küttel, "Eugéniai kérdések és az örökléstan," 56.

62 Nagy, "Új könyv az ütközőponton."

63 "As for the objection that the view advocated by my book does not coincide with the view of certain ecclesiastical circles, my only reply is that it does not follow that I am wrong. 'Eppur si muove'." Küttel, "Új könyv az ütközőponton," 120.

64 Iuliu Moldovan (1882–1966) was a Romanian doctor who organized the Health and Welfare Service in Transylvania at the end of World War I and also served as the president of ASTRA (see footnote 83). He was the Undersecretary of State at the Ministry of Labor, Health, and Social Welfare and founder of the Transylvanian Romanian eugenic school.

65 Moldovan, "Casă de ocrotire sau dispensar rural?" 3–6.

In 1937, due to the joint efforts of the Roman Catholic Church, the Society of the Sisters of Social Service (Szociális Testvérek Társasága),[66] the President of the Catholic Women's Association, Mrs. Paula Bethlen (née Jósika, the wife of György Bethlen), and the physician András Nagy, the Salvator Egészségház (Salvator Nursing Home) was established. Initially, it employed a team of midwives who carried out family visits, provided prenatal and postnatal care, and offered assistance with home births in villages around Csíkszereda/Miercurea Ciuc. In 1938, it became a maternity hospital and employed a full-time doctor. In the beginning, it provided social support only for women for whom it would have been risky to give birth at home, mainly because of their health or hygienic conditions.[67] Between September 1938 and August 1940, 100 births were registered at the nursing home. Women usually stayed in the maternity ward for 10 days, during which time they received thorough "training" in childcare. This was a very specific, direct form of infant protection, education for the mother, the rewriting of former popular customs (which according to doctors were difficult to change), healing practices, and hygiene rules.

These two projects offer a good insight into how different ideologies can underlie similar types of initiatives. While Küttel was interested in improving the supposed biological quality of the ethnic community, and he emphasized that his work was not a form of charitable activity. András Nagy, in contrast, embraced Áron Márton's idea of work in the social service of the people and regarded his own policy as a philanthropic social program. It is also interesting to observe the different roles assigned by policymakers to the Church.

Handbooks for Mothers: "Childcare Has to Be Done without Sentimentality, Almost Mechanically"[68]

The press (e.g., *Magyar Nép*, or Hungarian Nation, *Harangszó*, or Toll of the Bell) and health magazines (*Magyar Népegészségügyi Szemle* or Hungarian Public Health Observer) regularly published articles aimed at mothers. The most complex materials were the medical booklets and brochures regarding healthy mothering and infant care.[69] Most of these booklets were written for general use, but some

66 A Roman Catholic religious institute of women, a society of apostolic life, founded in Hungary in 1923 by Margit Slachta (1884–1974).

67 Nagy, *Lót visszanéz*, vol. 2, 234.

68 Kacsó and Jancsó, *A szoptató anya és gyermeke,* 54.

69 Kacsó and Jancsó, *A szoptató anya és gyermeke;* Nagy, *A csecsemő gondozása.*

contained the curriculum for a specific course, usually a denominational course, and therefore provided mother and baby care wrapped in the dogmatic teachings of the respective Church. For example, the course Anyák iskolája (School for Mothers),[70] which was organized by the Roman Catholic Women's Association, discusses the principles of Christian marriage, stresses the importance of having children, and condemns birth control. In addition to marriage, parenting, and social issues, the most important chapter on health issues was written by András Nagy.

The doctor monitored the development of individuals from the beginning of their lives, through several types of supervised activities:

1. Prenatal care. The full medicalization of pregnancy is justified by the dangers of pregnancy. Nagy described pregnancy as follows: "the maternal condition [...] imposes a great burden on the mother, may be harmful to her health, and is almost as dangerous to her life as pneumonia, as is proved by the great number of diseases and deaths associated with pregnancy and childbirth."[71] On the level of discourse, a new register of feeling was introduced: that of deterrence, which was not an encouraging but rather a terrifying discursive practice intended, presumably, to instill doubt or fear of the possible consequences.
2. Giving birth following medical instructions. In the 1930s, doctors were rarely present for births. Midwives trained in medical institutions were expected to assist at birth. In anticipation of the eventuality that women might have to give birth without assistance, infant care booklets covered all the details of labor and delivery and gave precise instructions to the woman giving birth. Giving birth was not seen as a normal, natural human action anymore, but rather was considered a scheduled medical act.
3. Postpartum control. The aim was to protect the mother's health during the puerperium by emphasizing basic hygienic principles and delegitimizing old folk practices and popular traditional knowledge.
4. Requirements/rules for the care and feeding of the infant. These subjects were addressed in the most extensive chapters in the information booklets. These chapters dealt with every aspect of the newborn infant's care: cleaning, swaddling, dressing, breastfeeding, alternative feeding methods,

70 Anyák iskolája. A Szociális Testvérek Társaságának Levéltára, Kolozsvár.

71 Kacsó and Jancsó, *A szoptató anya és gyermeke*, 8.

etc. They emphasized the importance of strictness in breastfeeding and specified the duration of feeding and the length of time between two feedings: "strictly, precisely, at the same time."[72]

5. The outsourcing of infant care to the medical sector, the complete elimination of local "superstitious" healing practices and popular traditional healers (the doctors called them charlatans), and the acceptance of the doctor as the only legitimate healer. On the one hand, this is a responsibility, but on the other hand, the doctor–parent relationship also implies the social judgements of the mother: "The physical and mental development and health of the child is proof of how caring, good, and clever the parents are, and especially the mother. Such parents and mothers always seek in good time the advice and help of the one who has learned it and whose sacred duty is to give such advice and help: the doctor."[73]
6. Rules for childrearing. The authors of the booklets encouraged as little physical contact as possible between mother and baby, and care for babies was to be done without any sentimentality to avoid illness. They condemned kissing and rocking infants, as well as unscheduled feedings and comfort feeding of the newborn,[74] mentioning that healthy infants do not cry but stay in their beds all day long. "If it is necessary to care for the infant, it has to be done without sentimentality, almost mechanically, because the satisfaction of the baby's wishes will give it a few minutes of pleasure but will be harmful later in life. If he sees that his wish is not fulfilled when he cries, he stops crying and stops trying to achieve something by crying."[75]
7. Infant protection was regarded as important not simply for the health of newborns or because of demographic indicators, but also because it offered the promise, from a longer-term perspective, of a healthy youth with a strong character and a sense of action. "If he can do the small tasks himself, he will become independent and self-confident, and he will be able to take on big tasks when he grows up," the specialists contended in an effort to impress upon their readers the necessity of

72 Ibid., 35.

73 Kacsó and Jancsó, *A szoptató anya és gyermeke*, 25.

74 Nagy, *A csecsemő gondozása*.

75 Kacsó and Jancsó, *A szoptató anya és gyermeke*, 54.

> maintaining distance when rearing a child.[76] Youth in this discourse was a demographic and public health issue, especially in terms of employment policy: due to migration, it is precisely the lack of a viable, leading intellectual class that needs to be filled by youth education. Youth becomes one of the main and complex symbols of this social agenda. It is also a primary thread in the idea of the common people, the new man. As would be made concrete later in the program of the României Magyar Népközösség (Community of the Romanian Hungarian People), there was an expectation regarding the intellectual and emotional education development of young individuals whose main qualities were initiative, good organizational skills, obedience, responsibility, solidarity, constant perseverance, and a good understanding of the broad interrelationships among issues.[77]

The idea of consistent, meticulous childrearing and the minimization of physical contact between mother and child was based on the vision of a new generation growing up under strict, almost military conditions, raised by a health-conscious mother, under constant medical supervision, and thus able to function in the world as biologically fully developed individuals. The biologically perfect youth represented a social stratum on which the future of a minority could be based.

Examining ASTRA's[78] medical propaganda in Romania and comparing it with publications of the infant protection associations in Hungary[79] and the Transylvanian Hungarian medical information booklets, we see similar trends in infant care and childrearing in interwar Hungary and interwar Romania. Each was operating according to the same principles: the need for hygiene, fresh air, attention, adherence to the baby's schedule, putting the baby to bed, and strict programming of the infant's sleep and eating.[80] Drops in birth rates and cases

76 Ibid., 55.

77 A României Magyar Népközösség munkaterve. Az Erdélyi Múzeum-Egyesület Gyűjteményei, Jancsó Béla papers.

78 Asociaţiunea Transilvană pentru Literatura Română şi Cultura Poporului Român (The Transylvanian Association for Romanian Literature and Culture of the Romanian People or ASTRA) was the first central cultural institution of the Romanians in Transylvania, founded in 1861. After World War I, it continued its activity, with particular focus on the cultural and social progress of rural communities in Romania.

79 Bókay, *Töredékek a csecsemő-hygiene köréből*; Fekete, *Anyák iskolája*.

80 See Bókay, *Töredékek a csecsemő-hygiene köréből*.

of infant mortality were attributed to mothers' alleged ignorance and the use of birth control,[81] and a healthy baby was considered the future of a healthy nation.

In the Transylvanian Hungarian texts, there is a much closer association between the infant and the youth. In these texts, the infant is associated with the powerful young individual of a new ethnic community. This was a prospective gaze, and it therefore promoted a much more militaristic, more severe attitude and made a more strenuous call for distance between parent and child than the Romanian literature or the Hungarian literature written and published in Hungary. It is notable that the distancing attitudes and the condemnation of pampering are much stronger in the Transylvanian materials. The fear of attachment was built, as a new layer, on the medical culture of caution and excessive concern for health protection. The environment constructed in this way seems to be rather a minority bubble or "greenhouse." Growing up in a "greenhouse" was a distant goal, a means of survival, and a way of coping with harsh conditions. This vision was used as a justification for the alleged need for strict, transparent, and predictable care, the nurturing of both mother and newborn, and intensive medical control. This may have been why this type of infant care followed the turn-of-the-century tendency that Reinhard Spree notes in German infant care books so strictly. This paradigm "promoted purposefully organized, cleanliness-oriented, punctual, orderly, disciplined education. They warned against the imminent danger of indulgence and prescribed unrelenting strictness *(unerbittliche Strenge).*"[82]

The Question of Racial Qualities

Between 1900 and 1940, an impressive emphasis was placed in Hungary and Romania on defining race and its alleged connection to biological mechanisms of identification and classification. Physical anthropology, as Marius Turda has noted, became associated with all other processes intrinsic to the discussions of national identity, such as national particularity, historical destiny, and ethnic assimilation.[83]

Though the question of race was not at the forefront of the Transylvanian Hungarian youth community work or at least not in the way it was emphasized

81 Stoichiţia, *Îngrijirea mamei şi a copilului*; Astra, *Îngrijirea copilului mic*.

82 Spree, *Sozialisationsnormen in ärztlichen Ratgebern*, cited in Pukánszky, *A gyermek a 19. századi magyar neveléstani kézikönyvekben,* 117.

83 Turda, "Entangled traditions of race."

for Romanians or Transylvanian Saxons,[84] supposed racial qualities or racial belonging were questions to be answered in the community's self-positioning and in constructions of ethnic minority identity.[85] These discussions were also responses to the majority's eugenic discourses. Race, despite its eugenic connotations and uses among Hungarian doctors from Transylvania, was most often seen as synonymous with ethnicity and nationality, and as such, it was a regarded as an essential, even elemental component of the community.

The biologization of national identity in Romania became most pronounced after World War I. From the perspective of this understanding of national identity, the nation is described as a biological entity the birth and death rates of which must be kept under constant medical control. The Romanian eugenicists, like their Central European counterparts, were concerned about the fates of the newly emerging nation states. They worked to further the creation of a "homogeneous national community," and almost all of them shared the conviction that "the state should be a nation state in which the ethnic majority constituted the nation."[86]

In 2015, historian Marius Turda introduced the concept of eugenic subcultures.[87] He pointed out that, in parallel to the dominant eugenic discourse popular in the majority cultures in Central and Eastern Europe in the interwar period, minorities also created eugenically oriented programs, despite the exclusionary nature, in general, of eugenics programs, which regarded ethnic minorities as dysgenic elements and not as part of the supposed biological body of the nation.

The Romanian Saxons also created a bureau for so-called racial protection, the Rassenamnt der Selbsthilfe (Self-Help Race Office), which was founded by Alfred Csallner and the Landesamt für Statistic und Sippenwesen (National Office for Statistics and Genealogy),[88] as well as the Schwäbisch-Deutscher Kulturbund and the Kulturbund (Swabian-German Cultural Association) of the German minority in Vojvodina, Yugoslavia, and the Sudetendeutsche

84 For Romanian examples see Turda, "Minorities and eugenic subcultures in East-Central Europe"; Turda, "Gheorghe Banu's Theory of Rural Biology in the 1920s Romania"; Turda, "From craniology to serology"; Turda, "Entangled traditions of race: Physical anthropology in Hungary and Romania, 1900–1940." On Saxon eugenics, see Georgescu, *The Eugenics Fortress*; Georgescu, "Ethnic minorities and the eugenic promise."

85 Balázs, "Nép, Nemzet, faj"; Vita, "Faj vagy nemzet."

86 Turda and Weindling, "Eugenics, Race and Nation in Central and Southeast Europe," 7.

87 Turda, *Minorities and eugenic subcultures in East-Central Europe*, 8–17.

88 Georgescu, *The Eugenics Fortress*; Georgescu, "Ethnic minorities and the eugenic promise."

Jugendgemeinschaft (The Sudeten Germans' State Association for German Youth Welfare).[89] There are many common elements in the discourses of these institutes, which were focused on demographics but from the perspective of a racial and thus eugenic understanding of national identity. The alleged biological factors of the ethnic community were the most important elements in the identity project. The most important problems discussed by minority eugenicists were the issues of reproduction and the protection of marriage, children, and youths. The eugenicists prioritized birth rates and condemned abortion and the one-child system. Like their Hungarian contemporaries, the Saxon eugenicists, especially Alfred Csallner (but also members of the German Kulturbund in Vojvodina), placed great emphasis on birth rate trends and condemned the so-called Ein- und Zweikindersystem (one- and two-child system).[90]

Neither the Romanian nor the Saxon eugenicists' initiatives were echoed among Hungarian youth activists, at least not explicitly. These activists distanced themselves from the eugenic agenda of the majority society, other minority associations, and the eugenic agendas in Hungary. No eugenic center was established, and the Transylvanian eugenics school, so famous at the turn of the century, disappeared after the Treaty of Trianon. One of the factors that certainly slowed down the spread of eugenics among the Hungarian elite was the fact that one of the important backers of the Transylvanian youth movement, the Roman Catholic Church (through the youth sections of the Roman Catholic League of People), strongly influenced the ideology of this society. The papal Casti Connubii[91] condemned eugenics and all forms of social engineering. The other problem was the national policy of Nazi Germany, which was based on racial biology and was condemned by the members of the Transylvanian intelligentsia with religious backgrounds.

Although race biology was not embraced by young members of the Hungarian minority communities, the terminology used in the discourses of racial hygiene and eugenics was also part of the vocabulary of the Transylvanian Hungarian medical community. This was not coincidental, as this discourse was part of the postwar regeneration of nation states across Europe, and it was

89 See Kasper, *The Sudetendeutsche Jugendgemeinschaft*.

90 Georgescu, *The Eugenics Fortress*; Georgescu, "Ethnic minorities and the eugenic promise."

91 Pope Pius XI's encyclical of December 1930: Casti Connubii https://www.vatican.va/content/pius-xi/en/encyclicals/documents/hf_p-xi_enc_19301231_casti-connubii.html (last accessed: October 13, 2023)

most often doctors and medical societies who took on the task of guarding the supposed biological body of the nation.

Eugenics had different connotations in these Transylvanian narratives.

1. It was used to explain public health problems and processes. The solutions proposed were taken from the toolbox of positive eugenics. The public health problems to be solved were usually linked to the supposed decline in the biological strength of Hungarians. In this context, therefore, eugenics is best understood as the purported science behind public health, and thus the most important keywords of positive eugenics were used in the discourses behind efforts to explain and improve public health. These terms included mixed marriage, falling birth rates, population decline, one-child system, and sexually transmitted diseases. In 1935, the *Magyar Népegészségügyi Szemle* opened with an article by a famous Hungarian eugenicist, Gábor Doros,[92] on the front page with the title "Who should marry?" The article gives a eugenic reading of marriage, emphasizing the obligation to produce healthy offspring.

   The maintenance of the body, abstinence, and careful family planning were all part of a eugenic model through which parents could produce biological individuals of full (social) value. One of the main issues in reproduction was the one-child system. András Nagy gives a eugenic reading of this, saying that having only one child usually leads to the extinction of a species: "According to the eugenicists, having one offspring is also a selection process. Species that have lost their viability disappear from the world through the slow suicide of the one-armed man. The one-armed man occurs in parallel with the qualitative decline of species. The viable species are not one-legged." He highlighted the Székely's biological behavior, who anthropologically were though to belong to the more viable ancestral component of the Hungarian people, the East Baltic race, and thus were more reproductive than other groups of Transylvanian Hungarians.

   Eugenics also provided an explanation of how mixed marriages reduced the biological strength of the Hungarians,[93] the other obstacle to healthy

92 Gábor Doros (1892–1980) was a Hungarian eugenicist and a specialist in dermatology and venerology in Budapest who published several articles on the topics of healthy marriage, eugenics, and venereal diseases.

93 Nagy, "Szórvány és beolvadás"; Csűrös, "Vegyes házasságok Erdély városaiban."

reproduction. Another physician, Elek Bakk, saw venereal diseases as one of the main causes of social degeneration and considered pre-marital medical visits as the main means of prevention: "When it comes to our animals, we strive for a pure and faultless breed, so that we can obtain healthy and plentiful products from them. With marriages, it's a different story. People marry for money. Let us not wonder, then, if mankind is becoming more and more degenerate."[94]

2. The allegedly scientific findings of eugenics were part of education and research: "Of course, we hardly need to emphasize that the aspects of eugenic education must be included in the health education at all levels of education,"[95] András Nagy declared. Racial health as a subject was part of the curriculum of professional training in some institutions, at the Department of Pastoral Medicine at the Faculty of Theology of Gyulafehérvár/Alba Iulia, for instance, but also for other participants in the courses on infant protection and midwife training. Although eugenics was part of the curriculum, there was a lack of eugenic specialists. Béla Jancsó complained about the lack of such specialists in his 1934 career guidance course for young people, in which he emphasized the need for specialists in eugenics: "Our people are threatened by diseases in their physiological nature, and there is no one who can fight for a healthier Hungarianness with eugenics, the science of creating healthier generations, which is so advanced worldwide."[96] Race biology was also an extremely important aspect of village surveys. "Public Health Issues," the fourth chapter of Béla Demeter's handbook for rural surveys, included more than 100 questions regarding the health situation of the village studied. The last 10 questions referred to allegedly racial/biological characteristics and inherited diseases.[97]
3. Eugenics served to strengthen national consciousness by buttressing the notion that the nation was a biological entity with allegedly scientific principles. In one of his studies, András Nagy describes the racial structure of the Hungarians in Transylvania in a very graphic way. According to him, Hungarian people are largely descended from two indigenous components, the Turanian and the Eastern Baltic racial component. In

94 Bakk, "A syphilis társadalmi vonatkozásairól."

95 Nagy, *Lót visszanéz*, vol. 2, 175.

96 Jancsó, "Az orvosi pálya," 338.

97 Demeter, *Hogyan tanulmányozzam a falu életét*.

> his assessment, the latter had never had the element of warrior glory. They were hardworking people with good birth rates.[98] In the same study, he identified the collective goal of the Hungarians in Transylvania as follows: "Let's reproduce! […] Not for the purpose of expansion, but solely for the purpose of giving laborers to the lands that need to be cultivated, in order to create new families in the greatest possible number and with the largest possible population, and as such, maintaining an internal tension capable of withstanding external pressures."[99]

In 1939, the term "community of the people" *(népközösség)* became politicized. The political representation of the Hungarian minority in Transylvania was taken over by the institution called the Romániai Magyar Népközösség (Community of the Romanian Hungarian People), the objectives of which seemed to include the idea of work in the service of the people of the 1930s. In the Community of the Romanian Hungarian People, founded in 1939, we find the intellectuals who were already well known from the columns of *Hitel* (Credit) and Erdélyi Fiatalok and who thought about social and cultural issues. The idea of work in the social service of the people began to exert some influence at the political level in the social construction of the community. The idea of the community of the people and of work in the service of the people found explicit expression in the program of the Community of the Romanian Hungarian People:[100]

> The world crisis of today, which will sweep across the breadth of all humanity, the depth of all human questions, can only be solved by a new man and a new humanity. The new man is the whole man. […] The community of the Hungarians in Romania is the community of the people: a racial (blood) community, spiritual community (language, culture), and the community of destiny. Racial community, because descent is a common biological endowment, which is the bearer of all the specific spiritual and physical characteristics.[101]

98 Nagy, *Lót visszanéz,* vol. 2, 143.

99 Ibid., 142.

100 With the imposition of the royal dictatorship of Carol al II-lea (Charles II), political parties were dissolved in December 1938, and a single party, the Frontul Renaşterii Naţionale (National Revival Front), was allowed to function. On February 11, 1939, the Romanian Hungarian Popular Community was founded as a subdivision of the National Revival Front.

101 A Romániai Magyar Népközösség munkaterve. Az Erdélyi Múzeum-Egyesület Gyűjteményei, Jancsó Béla papers.

The biological strength of the Hungarian people, often mentioned in the public health movements of the 1930s, was given a major role in this socio-political program:

> The aim of the health program is to preserve and develop the biological stock of the Hungarian people, and for this reason: a) to nurture the awareness of shared origins as a blood community and to warn people of their biological duties, which make possible the survival and healthy development of the race (and its distinctive soul) and b) to build up the appropriate institutions of demography, medical treatment, prevention, and the health of the race and to clarify their tasks by means of preliminary health surveys and anthropological, race-biological, and race-characterological research.[102]

Conclusions

The construction of an understanding of ethnic identity based on a notion of biological belonging was in part a response by minority communities in interwar Central Europe to precarious citizenship situations, the disintegration of the health system, and neglect (or even the adoption of a hostile stance) by the state. In the case of the Hungarian minority in Transylvania, difficult access to resources and the underdevelopment of health infrastructure in minority communities, which were both evidence of state neglect, mobilized the young medical generation of the 1930s and formed one pillar of an understanding of the ethnic community of Hungarians in Transylvania as a biological community. This understanding made the presence of the doctor a necessary part of a commitment to the health and prosperity of this community. A kind of local (regional) bio-control was emerging, which was not state-based but functioned in a similar way: it created a powerful organization and governing body. The individual was no longer important as an individual, but rather as part of a community, understood as a biological unity. This local biopower, through disciplinary technologies, controlled individual bodies in the same way, treated the community as a social and biological body, and was interested in its biological processes, such as birth and death rates, health maintenance habits, etc.

In this program, eugenics appears to have been understood as a kind of regeneration program, but instead of being the guiding paradigm, it remained a tool with which to achieve the goal. The initiatives of Hungarian doctors in

102 Ibid.

the 1930s cannot be considered eugenic initiatives. While most of the eugenic movements across Europe worked to emphasize the primacy of the biological paradigm, for the Hungarian elite in Transylvania, biological, spiritual, and cultural aspects together became the defining factors of the ethnic community. What was new, however, compared to previous elite discourses, was that the supposed biological factor had come to be understood as an essential component of the life of the minority community and indeed was equated with the very survival of this community. Eugenic discourse became part of the identity-building processes.

This discourse, which put emphasis on the defense of the biological nation, was unique. It put the defense of the race on a quasi-eugenic basis by eliminating the state, the central element essential to eugenic modernization. All this was organized from below, while Romanian public health (and its eugenics engine) not only received state support, but also implemented state centralization to maintain the supposed nation's health. The Transylvanian Hungarian public health movements were opposed neither to power nor to the majority society. Rather, they were parallel projects working on a regional level and mobilizing members of the Transylvanian Hungarian community.

The discourse of positive eugenics became part of a socio-political program, incorporated into the concept of the népközösség, a notion which had been refined over the years, and then politicized in 1939 and validated in the identity-building process of an ethnic minority.

The Community of the Romanian Hungarian People ended its activity in 1940 in Northern Transylvania, and medical public health activism was redefined. Medical institutions and medical higher education became part of a complex, national Hungarian health system, and the terms ethnicity, *népközösség*, and race were given new meanings.

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Between Public Health and Propaganda: Tuberculosis in Czechoslovakia in the First Decades of the Communist Regime

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In early postwar Czechoslovakia, medical doctors identified the fight against tuberculosis as one of their fundamental tasks, since mortality and morbidity rates from this dreaded and hardly curable disease were still high. However, the country initially struggled with a lack of special institutions and trained staff. The situation became even more complicated in 1948, when the Communist Party seized power in Czechoslovakia and transformed the organization and practice of healthcare. Focusing on the first two decades of the postwar period, this article presents the strategies used by the socialist country against tuberculosis, stressing especially the importance placed, in the development of these strategies, on having a mass impact. The most significant shifts, which concerned not only tuberculosis but healthcare in general, involved changes to the legislation. The responsibility for the health of the population was transferred to the state, which declared that it would provide free treatment and care for all citizens, regardless of their social background. During this period, the first law to prevent and control the disease was passed, and mandatory vaccination and tuberculosis treatment were introduced. As was often the case, advances in medicine were used for political propaganda, and so, in the period after 1948, tuberculosis was labelled a "capitalist disease." This label implied that the fault for the continued presence of the disease lay at the feet of the prewar capital system. Yet as I show in the discussion below, many of these basic pillars of the fight against tuberculosis had already been established in the interwar period, and it was first and foremost the growing availability of antibiotics that helped bring this disease under control in the 1960s.

Keywords: tuberculosis, vaccination, antibiotics, communist regime, Czechoslovakia, public healthcare

Introduction

Tuberculosis and the strategies used in the fight against it were important issues almost everywhere in Europe and the United States of America in the nineteenth and twentieth centuries, yet Czech historians have paid little attention to this topic. The same is true of the history of medicine during state socialism,

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although this political regime brought about fundamental changes in the organization and practice of healthcare.[1] In international secondary literature, in contrast, tuberculosis has been widely discussed. A wide group of scholars has focused on the cultural aspects of tuberculosis, especially the ways in which it was presented in literature. These authors reflected on the romantic idealization of nineteenth-century literature and also showed that, in the twentieth century, in the context of the World Wars and civil wars, tuberculosis was masculinized and associated with soldiers.[2]

Other historians have identified the most important milestones in the history of the disease, such as the discovery of the tuberculosis bacillus and the development of the BCG vaccine in 1921, as well as its social aspect and its connection to the working classes. Various diagnostic and therapeutic procedures did not escape their attention. However, this body of secondary literature focuses mainly on the nineteenth century and the first half of the twentieth century, when the principles of tuberculosis control were similar in almost all the countries of Europe and the United States of America.[3]

Works dealing with the history of tuberculosis after 1945 are limited to the issue of antituberculotic drugs, their development, and their introduction into practice.[4] However, these authors stressed that success lay not simply in fighting the bacillary disease itself. Larger changes were also needed, such as social reform, affordable, sanitary housing, nutrition, good working conditions, etc. Thus, it was not only doctors who were responsible for the fight against tuberculosis, but the entire state and society.

1 On socialist healthcare in Czechoslovakia, see Svobodný, "Zdraví lidu – základ budování"; Svobodný, "Propagace socialistického zdravotnictví"; Hlaváčková and Svobodný, *Dějiny lékařství*, 217–30. On socialist healthcare and medicine in general, see e.g., Bernstein et al., *Soviet medicine*; Cooter and Pickstone, *Medicine in the Twentieth Century*.

2 Byrne, *Tuberculosis and the Victorian Literary*; Lawlor, *Consumption and Literature;* Day, *Consumptive chic*; Kot'átková, "Sanatoriums in Contemporary Narratives"; Casacuberta, "De Cauterets a Davos."

3 See Arnold, *Disease, Class and Social Change*; Ellison, *Healing Tuberculosis*; Bryder, *Below the Magic Mountain*; McCuaig, *The Weariness, the Fever, and the Fret*; Barnes, *The Making of a Social Disease*; Bates, *Bargaining for Life*; Dubos, *The White Plague*; Bynum, *Spitting Blood*; Báguena Cervellera, *La tuberculosis y su historia*; Sauret Valet, *La tuberculosis*; Armus, *La ciudad impura*; Pereira Poza, *La paciencia al sol*; Molero-Mesa, "¡Dinero para la cruz"; Hähner-Rombach, *Sozialgeschichte der Tuberkulose*; Condrau, *Lungenheilanstalt*.

4 Lerner, *Contagion*, 56–77; Bynum, *Spitting Blood*, 189–229.

Until the end of World War II, the fight against tuberculosis in Czechoslovakia was conducted mainly by volunteer organizations,[5] which launched campaigns emphasizing the personal responsibility of each individual. The state participated in this fight only by providing subsidies.[6] This setup was transformed after 1948, when healthcare was nationalized and the state assumed responsibility for the availability of healthcare and the strategy to be used in the fight against tuberculosis. The aim of this article is to map the development of the fight against tuberculosis in Czechoslovakia after 1948, to present its main pillars, and to evaluate its success. The discussion is based on medical literature and professional journals with which experts shared their experiences, opinions, and problems from their daily practice. Promotional materials and women's magazines offer insights into the methods used by medical doctors to appeal to the emotions of parents (and mothers in particular) and persuade them of the need for certain preventive measures, especially vaccination. Drawing on the data found in statistical manuals, the paper shows how the institutional foundation changed in the context of the socialist health system and its new strategy in the fight against tuberculosis. It also shows how successful the state was in this fight. The analysis will further a more nuanced understanding of how socialist experts approached the task of curing and preventing tuberculosis.

Historical Context

Tuberculosis became a major health problem in the nineteenth century, in part as a result of industrialization and the migration of people from rural to urban areas. Crowded housing, poor sanitation, and overwork caused increased morbidity and mortality almost everywhere in Europe and the United States of America. In order to prevent the spread of the disease, the first specialized organizations began to emerge at the end of the nineteenth century. In 1899, the Association for the Establishment and Maintenance of Lung Disease Sanatoriums in the Kingdom of Bohemia, the Margraviate of Moravia, and the Duchy of Silesia was founded in the Czech lands. Its main goal was to establish sanatoriums accessible to patients from all social strata. In 1901, Hamza's Children's Hospital

5 On the history of health campaigns, see Fitzgerald, *Kissing*; Teller, *The Tuberculosis Movement*. On poster health campaigns, see Castejón Bolea et al., *Las imágenes de la salud*; Serlin, *Imagining Illness*; Alves and Herrero, "Carteles en la comunicación."

6 On state intervention in the fight against contagious diseases, see e.g., Baldwin, *Contagion and the State*; Aisenberg, *Contagion: Disease*; Broch, *Médecins et politique*.

was opened, which was the first institution of this type not only in the Czech lands but in the whole of Central Europe. Following the French example, in 1905 Czech physician Emerich Maixner opened the first dispensary in Prague, which focused primarily on the prevention and search for new cases of the disease. In the same year, the Albertinum Children's Sanatorium was established in Žamberk, and the first sanatorium for adult patients was opened in Pleš in 1916.[7]

After the founding of the Czechoslovak Republic in 1918, the Association was closed and the main organization became the Masaryk League Against Tuberculosis, which was established in 1919. The league built on Emerich Maixner's initiative and promoted the creation of a wide network of dispensaries, which became an integral part of the fight against tuberculosis under the First Republic (1918–1938). Sanatoriums formed second main pillar. They focused only on treatment and combined all available resources, such as hydrotherapy, heliotherapy, treatment by rest, chemicals, and surgical procedures. However, the results of the treatments were uncertain, and so the experts focused on the issue of prevention. After 13 years of research, Frenchmen Albert Calmette and Jean-Marie Camille Guérin developed the BCG vaccine in 1921. The vaccine arrived in Czechoslovakia in 1926, but at that time only children from families with tuberculosis or areas heavily affected by the disease were vaccinated. The question soon arose of whether a law should be passed regarding the mandatory vaccination of children at risk. However, this step was perceived as too radical by politicians and physicians alike. They feared significant interference with citizens' freedom, while others doubted the stability of the vaccine's avirulence. With the outbreak of World War II, the issue of mandatory vaccination was not resolved, and indeed the whole issue of widespread vaccination campaigns was abandoned.[8]

From 1939 to 1945, the war diverted the attention of society and the state away from tuberculosis, and the fight against the disease, which had been successfully launched under the First Republic, was suspended. World War II contributed to the spread of the disease, which continued to be one of the main causes of morbidity and mortality among the population in both Nazi-occupied Czech lands and the fascist state of Slovakia. Many sanatoriums ceased to fulfil their primary function and served as war infirmaries or barracks. It was therefore necessary in the postwar period to restore the original institutional structure, which in principle would continue to be expanded throughout the territory of

7 See Rábová, *Tuberkulóza a společnost,* 112–18.

8 See ibid., 158–63.

the liberated Czechoslovakia.[9] However, the situation changed in February 1948, when the Communist Party, whose ideology put strong emphasis on healthcare and related issues, took over the country. The First Republic had presented tuberculosis as a common enemy of the Czechoslovak nation, and the citizens were encouraged to stand together in the struggle against it. This discourse included references to President Masaryk, the founder of the Republic, whose legacy was to be honored by fighting against the disease. When the Communists took over, this nationalist discourse was reformulated in a far more aggressive style. The new regime used tuberculosis as a propaganda vehicle for communist ideas, stressing its link to poverty and exploitation and promising to defeat it by providing healthcare for all.

From 1948 on, medical, professional, and popular literature from the USSR and literature which reflected or endorsed the communist ideology became widely available in Czechoslovakia. This was also reflected in publications discussing tuberculosis, which presented the illness as a social and proletarian disease and, above all, as an unavoidable consequence of the capitalist economy. The following statement offers a clear illustration of this: "A leading example are capitalist countries, where tuberculosis is a widespread disease among the working class. Exploitation, strenuous work, poor living conditions, malnutrition, and lack of basic medical care make tuberculosis the scourge of the exploited class."[10] The contemporary texts tended to explain the spread of the disease among the poor as a consequence of the unavailability of treatment to all members of society, as there was no state-funded medical care in capitalist countries, and hospital and sanatorium treatment was, given its high cost, a privilege for the wealthier social strata.[11]

The decline in standards of living during World War II resulted in an increase in tuberculosis cases in other countries as well, such as France and Germany. Nevertheless, the communist regime viewed this situation through its own lens, stressing that the USSR had successfully solved this issue: "In the Soviet Union, the situation is completely different. The exploitation of man by man has been eliminated here, and the social root of tuberculosis, as a disease of broad

9 For example, the sanatorium in Prosečnice (founded in 1922) was devastated in World War II and was dangerous for both patients and staff because of explosives in its vicinity. See NA Úřad předsednictva vlády – běžná spisovna 1945–1959, inv. no. 2207, sign. 257/1, Plicní sanatorium v Prosečnici nad Sázavou 1945–1946, box no. 147.

10 Ojfebach, *Prevence tuberkulosy ve škole,* 3.

11 Cf. ibid.

sections of the population, has been completely eradicated in Soviet socialist society. All the necessary preconditions for the disappearance of tuberculosis are here."[12] These assessments thus offered a negative characterization not only of the situation in capitalist countries but also of the First Republic's approach and its leading representatives, who according to the communist interpretation had focused only on patients from the higher social strata and had failed to eliminate the social inequalities which, in the opinion of the communist ideologues, were the main cause of high morbidity and mortality rates among the working class.[13]

A New Way of Fighting Tuberculosis: Mass Preventive Campaigns

After World War II, the isolation and treatment of infected individuals in sanatoriums continued to be one of the main ways of fighting tuberculosis. However, Czechoslovakia initially struggled with a lack of professional staff, including both doctors and nurses. Another pitfall was the low number of beds for tuberculosis patients, which was to be solved by constructing new premises, but this required time, while the need for new beds was urgent. For this reason, existing buildings were modified, and unused spaces and resources were sought that could be used to provide more beds for patients.[14] Moreover, views concerning the ideal site for a sanatorium also changed. In the past, places with a suitable climate were carefully selected. These sites, which were often far from big cities, provided patients with the peace and fresh air necessary for their treatment. Gradually, however, thanks to medical findings, the original passive therapy became more active, and so the experts concluded that tuberculosis could be treated almost anywhere, under the assumption that the patients would follow the recommendations of their physicians and adhere to the lifestyle prescribed.[15]

Since the average waiting time for a place in a sanatorium in the mid-twentieth century was three to six months and in some cases even a year, it was crucial to prevent new cases. While in previous periods, prevention campaigns had emphasized the personal responsibility of each individual, after 1948, the fight against tuberculosis was characterized by mass campaign: mass BCG

12 Ibid., 4.

13 See for example Šula, *Co máme vědět,* 1–3; Šrámková, *Zvítězíme*, 9; Křivinka and Raška, *Tuberkulosa,* 16–17; Červonskij, *Tuberkulosa a jak proti ní bojujeme,* 6; Briestenský, "Boj proti tuberkulóze," 25.

14 On the institutionalization of healthcare in socialist Czechoslovakia, see Hlaváčková and Svobodný, *Pražské špitály,* 132–45.

15 Doubek, "Boj proti tuberkulose," 14–17.

vaccination and an X-ray technique called abreography.[16] Mass X-raying was done in consulting centers or special stations which made it possible to examine a large number of individuals in a relatively short period of time (more than 300 people in one day). If the physician detected any problems during the X-ray, the patient was invited for a closer examination in a specialized hospital ward.[17] Socialist healthcare aimed to examine all citizens using individual invitations in most cases. The inhabitants of individual districts were gradually X-rayed using portable X-ray machines, with priority given to people in industrial areas, particularly those working in heavy engineering. If conditions allowed, employees in industrial plants with more than 1,000 people were examined directly in the plant. Mass X-ray examination had an enormous significance for the detection of new cases of tuberculosis, as the statistical data showed that, on average, three people per 1,000 of those examined were sick.[18]

According to the available data, roughly 85 percent of the population took part in the mass X-raying campaign. However, the experts had to face the fact that some people avoided the examination for various reasons. Most often, these individuals argued that it did not make sense to undergo the examination when the state was unable to provide institutional care for all those who were sick. They also feared that such an examination could harm them, or they were simply afraid of the possible detection of the disease and the subsequent treatment. However, X-ray examinations allowed doctors to detect processes in the lungs that were consequences of illness in their early stages, and thus some of the individuals who were diagnosed as sick did not actually have to be sent to a sanatorium. The patient could take antituberculotic medications and, if he or she kept a strict home regimen, could manage to improve his or her health.[19]

As noted above, the BCG vaccination campaigns were suspended during the war and recommenced after 1945.[20] Alongside the Soviet Union, the

16 Abreography is the term used for a mass X-ray examination during which small images were done. It was used for the initial detection of potential tuberculosis infection, which was subsequently confirmed by a more thorough examination. A similar practice was applied also abroad, see for example McCuaig, *The Weariness, the Fever, and the Fret,* 186–223. The idea of mass abreography had already been discussed in the 1920s, but at the time it could not be put into practice. Cf. Rábová, *Kulturní reflexe tuberkulózy,* 111.

17 Šrámková, *Zvítězíme*, 57.

18 See Doubek, "Boj proti tuberkulose," 20–22.

19 Křivinka, "Kotázce boje proti tuberkulose," 31; Šembera, Dymer and Šrámková, *Dnešní stav a program,* 68.

20 Cf. Rábová, "Matky, chraňte své děti!," 17–19. On the history of vaccination in general, see Holmberg et al., *The politics of vaccination*, 343.

Scandinavian countries, which had continued to study vaccinations even during the war and had begun to administer BCG vaccinations to adults with negative tuberculosis tests, also became an example worth following.[21] Moreover, these countries were some of the first to introduce mandatory vaccination. In 1946, therefore, several Czech experts set off for Denmark and Sweden, where they familiarized themselves with the production of the vaccine, the vaccination process, and its results.[22] Czechoslovakia subsequently participated in the so-called Joint Action, the aim of which was to test and, if necessary, vaccinate the highest possible number of children and adolescents. The campaign was intended primarily for countries in Central and Southeastern Europe that had been devastated by World War II. One of the most prominent organizers was UNICEF, which was also the main supplier of all the necessary equipment and materials. The Danish Red Cross, the Swedish Red Cross, and Norwegian Aid for Europe, which provided medical supplies and specially trained doctors and nurses, also took part in the campaign. The financing of the entire campaign was on an international scale, i.e., the individual organizations and ministries of the countries which participated in the campaign released funds according to their abilities. As soon as a country signed an agreement with the Joint Action, a Scandinavian vaccination group traveled there and trained the local doctors to test for tuberculosis and administer vaccinations.[23]

On May 21, 1948, Minister of Health Josef Plojhar signed a mass vaccination agreement with UNICEF.[24] The campaign commenced on July 1, 1948 under the patronage of the Danish Red Cross, to which Czechoslovak doctors and nurses were gradually assigned. A total of 3,328,810 persons were examined, of whom 2,118,562 were vaccinated. The campaign ended on August 31, 1949 and moved to the districts, where so-called calmetization[25] teams composed of workers trained by Scandinavian experts were established. These teams were tasked with testing individuals who had already been vaccinated, and if the test result was negative, the individual was revaccinated. Individuals who had not

21 The lowest death rates were in Denmark, where 40,000 individuals were vaccinated in 1945, and the following year the number of vaccinated rose to 100,000. Cf. Šula, "Ochranné očkování," 114.

22 Vojtek, "Zkušenosti s BCG vakcinací," 110.

23 *Mezinárodní protituberkulosní kampaň*, 3–4, 11–12.

24 A copy of the agreement is stored in NA, Ministerstvo zdravotnictví a tělesné výchovy, inv. no. 5108, sign. 1407/60, Dohoda mezi Mezinárodním dětským fondem, Dánským Červeným křížem a československou vládou o hromadné akci ochranného očkování proti tuberkulóze, 1948, box no. 1119.

25 Calmetization is the term used for tuberculosis vaccination.

been vaccinated during the mass vaccination campaign also fell under their jurisdiction.[26]

After the end of the mass vaccination campaign, newborns in inpatient facilities and centers began to be vaccinated on the basis of Ministry of Health Circular no. 948/1950. The newborn had to be in good health and weigh at least 2,500 grams. Vaccination in maternity hospitals took place without tuberculosis tests. If contact with tuberculosis could not be ruled out for the newborn, then it had to be isolated for six weeks. A tuberculosis test was performed after this period, and if it was negative, the child was vaccinated. Every immunized individual remained under medical supervision, and every death that had taken place soon after vaccination was properly investigated, including an autopsy. Vaccinations were postponed or were not given to children who were already infected with tuberculosis, suffered from some other acute disease, were recovering from severe acute or infectious diseases, or suffered from a chronic form of the disease and had a poor prognosis. Although the vaccine was originally administered orally, following the example of France, after 1945, under the influence of the Scandinavian countries, this changed to subcutaneous application, which proved much more effective and successful.[27] The revaccination of selected age groups was also introduced.[28]

The following table (Table 1) shows the numbers of vaccinated individuals between 1947 and 1953. For the initial years of 1947 and 1948, data is missing for Slovakia. However, Slovakia participated in the mass vaccination campaign under the patronage of the Scandinavian countries, and the number of individuals immunized there during the campaign formed roughly 25 percent of the total number. Although the numbers clearly show an increasing trend in the number of vaccinated children, this number did not double in the four years since the launch of the Joint Action. In the case of Slovakia, vaccinated individuals continued to constitute only 25 percent of the population, and in 1953 this number decreased slightly. This data attests to the relatively low interest in vaccination among parents, who were very cautious about this comparatively new practice and often even looked for ways to avoid it.

26 Vojtek, "Zkušenosti s BCG vakcinací," 111.

27 Subcutaneous vaccination began in Gothenburg, Sweden as early as 1928. Tests showed that this method of vaccination had a much higher success rate of up to 97 percent. In the case of peroral application, which Calmette introduced primarily to eliminate local injection site reactions, a negative tuberculin test occurred much later and in some cases not at all. Šula, "Ochranné očkování," 110–11.

28 See Doubek, "Boj proti tuberkulose," 13–15; Vojtek, "Zkušenosti s BCG vakcinací," 112.

Table 1. Vaccination rates among children between 1947 and 1953

Vaccination rates among children between 1947 and 1953[29]			
Phase or year	**Vaccinated in the Czech lands**	**In Slovakia**	**Total in CSR**
Preparatory phase 1947–1948	27,239	No data	27,239
Mass action to 1949	1,667,538	561,990	2,229,528
Up to the end of 1950	1,792,799	608,038	2,400,837
Up to the end of 1951	1,907,181	653,004	2,560,185
Up to the end of 1952	2,049,317	684,266	2,733,583
Up to the end of 1953	2,273,531	745,937	3,019,468

At the end of the 1940s and throughout the 1950s, doctors had to wrestle with hesitancy among the general population when it came to vaccinations, which at times meant simply a cold attitude and at times meant outright disapproval. The reasons for the negative attitudes varied. Many people argued that their physician did not recommend vaccination. Some parents did not want their children to undergo a tuberculosis test. Even in the mid-twentieth century, people still believed that tuberculosis was a hereditary disease and that if it had not occurred in the family, the child could not be infected and vaccination is unnecessary. The other extreme was families suffering from tuberculosis, who believed that their children would be infected with tuberculosis by those close to them and thus would develop immunity on their own.[30] Experts attributed these attitudes primarily to ignorance, and they therefore endeavored better to inform the general population through lectures and informative publications with statistical data which clearly demonstrated a decrease in cases of the disease among those who had been vaccinated. Efforts to raise awareness started in maternity hospitals, children's clinics, and nurseries. Schools, of course, played a key part in these undertakings. Mass programs were held to test children's immunity to the disease, and those with negative results were vaccinated. A school doctor working in collaboration with a phthisiologist[31] or pediatrician was supposed to talk to parents in school. Talks were also organized during which

29 Šula, *Očkování,* 112.

30 On other reasons for distrust concerning the BCG vaccine among the general public see Zahálková, "Kolektivní metody boje," 40–41.

31 Specialist in the prevention and treatment of tuberculosis.

the doctor tried to explain the importance of vaccination and responded to any questions or concerns.[32]

Women's magazines,[33] such as the Czechoslovak periodical *Vlasta*, provided an important communication channel.[34] There were special sections in which women shared their own experiences with the BCG vaccine, though their stories were almost identical. One could therefore cast some doubt on their truthfulness or the extent to which they should be trusted as honest accounts of real experiences, as they may well have been the work of an editor or expert who was trying to instill trust in people and encourage families to immunize their children. The articles can be divided into two categories, the first of which consisted of accounts by women describing the course of vaccination in their children and their physical reactions. For example, in an issue published in 1949, a story appeared of a woman who did not listen to her doctors' advice and out of fear did not let her son get vaccinated. He then contracted tuberculosis in 1947. In the same year, the woman gave birth to a daughter who was given the vaccine. The daughter received the vaccine without any complications, continued to thrive, and did not develop the disease.[35]

The accounts in the second most common type of article were purportedly written by women with two children, one of whom had been vaccinated, the other of whom had not. Both children contracted tuberculosis, but in the immunized child, the disease was less serious and passed more quickly. There were also cases (or accounts of cases) in which the vaccinated child did not become infected at all, despite having been in direct contact with a person with tuberculosis.[36] Regardless of whether these articles were genuine accounts or merely propaganda tools, their essential function was to combat enduring myths and fears and thereby increase the number of vaccinated children. The BCG vaccine not only protected children against the risk of infection (followed, in the vast majority of cases, by premature death), it also gradually reduced morbidity among adults. In practice, it was shown that most adults who contracted tuberculosis had already

32 Šrámková, *Očkování*, 1–3, 5–6.

33 On the impact of mass media and advertising on health promotion see Lupton, *The Imperative of Health*, 106–30.

34 In addition to a section dedicated to specific women and their stories, articles intended to inform the general readership by summarizing the history and principle of vaccination, including results proving its success, also appeared in the magazine.

35 See *Vlasta,* August 8, 1949, 5; see also *Vlasta,* March 28, 1957, 15.

36 See Šrámková, "Co jste chtěly vědět," 10. *Vlasta,* March 7, 1957, 15. On this topic, see also "Úspěchy hromadného očkování," 40.

originally been infected as children, and their disease was a mere reactivation of a many-years-old infection that flared up again as a result of poor living, housing, and working conditions. Children who were vaccinated immediately after birth were therefore also protected in the future, which after years of widespread use of the vaccination also helped reduce mortality and morbidity among people belonging to older generations. Experts therefore perceived the BCG vaccine as one of the essential resources in the fight against tuberculosis, and thus, not surprisingly, mandatory vaccination was introduced based on Act no. 61/48 Coll., on Certain Protective Measures Against Tuberculosis, whereby only children and adolescents ages 0 to 20 were vaccinated. Subsequently, in January 1953, mandatory across-the-board vaccination was introduced for all newborns and people between the ages of 20 and 30 with a negative tuberculosis test.[37]

The State Assumes Responsibility: Tuberculosis and Legislative Changes

The legislation concerning protective measures was drafted during the First Republic, but it was only approved and implemented after 1948, becoming the basis of the communist fight against tuberculosis. The directive, which ordered the implementation of several measures, attests to the importance attached to the campaign by the experts at the time. At the same time, however, the very need to take these steps offers clear proof that society in general consistently disregarded these initiatives. It was therefore necessary to address certain points in the fight against tuberculosis legally and to set clear sanctions for non-compliance or violation. Moreover, specific laws made it easier for the government to exert control over society as a whole and people's attitudes towards tuberculosis. The communist ideology thus no longer placed responsibility for this social problem on the shoulders of the individuals themselves, nor did it rely on the "natural" responsibility of the specific person or society as a whole. On the contrary, responsibility for the way in which the fight against tuberculosis was conducted and the regime's success in this fight was assumed by the state itself.

This was not an outright novelty. Legal regulations and measures had been adopted in the nineteenth century, when ministerial and gubernatorial sub-regulations were passed, but their effects differed greatly in the Czech lands, Slovakia, and Carpathian Ruthenia. Moreover, many of these regulations were applicable only to specific companies or institutions and were not universally

37 Šrámková, *Očkování*, 13.

effective. They concerned issues such as spitting in open public (which was banned), the placement of spittoons, and the isolation of people with tuberculosis in hospitals. In time, a regulation was also issued requiring a report to be filed in every case of death from tuberculosis and also when an infected individual changed his or her place of residence, as it was necessary to disinfect the dwelling.[38] A huge problem, however, was that the regulations that were issued often remained on paper, as there were no clear stipulations concerning who would supervise their implementation and who would monitor compliance. In addition, these regulations did not specify any penalties or sanctions for non-compliance, as a result of which many people tended to view them as mere recommendations.

After the foundation of the Czechoslovak Republic, the experts faced the question of whether some protective measures should be legally enshrined. The initiative to create a Czechoslovak law was launched by the Masaryk League Against Tuberculosis, which established a special commission for this purpose. In 1925, it presented the Ministry of Health and Physical Education with the final draft of the law, which had three basic sections. The first was related to the reporting of cases of tuberculosis, the registration of people who were infected, the disinfection of homes. The second section was devoted to dispensaries. It clearly defined the areas in which they should be established, how they should be financed and administered, and their basic tasks. The third section contained common provisions, such as sanctions for non-compliance with the regulations.[39] There was no consensus, however, concerning the virtues of the law, and it was still a subject of discussion and debate in the 1930s and had not been passed when the First Republic fell in 1938.

The communist coup of 1948 and the related ideological reorientation of the Czechoslovak Republic played the main role in the stimulus and shape given to healthcare legislation. The National Assembly passed Act no. 99/1948 Coll., on National Insurance, which repealed all previous laws in this area. On the basis of this act, national insurance was to become general for all citizens, for the widest possible range of social events, and with the most suitable security method. However, Act no. 185/1948 Coll., on the Nationalization of Medical and Nursing Institutions and on the Organization of State Institutional Medical

38 Cf. e.g., Bébr and Chaloupka, *Československé zdravotnické zákony,* 1045–46; Hůlka, *Sociální přehled tuberkulosy*, 98–99.

39 See NA, Ministerstvo veřejného zdravotnictví a tělesné výchovy, inv. no. 2435, sign. III/7/54, Návrh osnovy zákona o některých ochranných opatřeních proti TBC, 1932, box no. 516.

Care constituted a fundamental turning point in healthcare organization and administration. This act transferred all medical facilities to the hands of the state on the January 1, 1949. The issue of tuberculosis thus moved from the hands of private and voluntary organizations to the state, which was now responsible for the prevention and treatment of the disease.[40]

Despite the previous efforts of leading figures of the First Republic, the first tuberculosis law was only established under the communist regime, as Act no. 61/1948 Coll., on Certain Protective Measures Against Tuberculosis.[41] It immediately became one of the tools of socialist propaganda, which gave an unambiguously negative assessment of the efforts made in the fight against tuberculosis during the preceding periods and declared itself the final solver of the tuberculosis issue. The purpose of this law was primarily to provide a basis for the implementation of all protective measures aimed at reducing the rates of morbidity and mortality to a minimum. The main task was therefore to reduce the chances of tuberculosis infection as much as possible, to identify the pathological processes in their early stages, to cure patients using systematic therapy, and to isolate incurable cases so that they would not represent a risk to those around them and would not spread the disease further. Mandatory reporting of all those sick with tuberculosis and every tuberculosis patient's death was intended to contribute to achieving these goals, as was the systematic examination of selected groups of the population. As part of the protective measures, the state now had the right to order mandatory tuberculosis tests, mandatory X-ray examinations (both in mass and individual exams), and mandatory vaccination. The regulation also addressed isolation. Each infected person had to be isolated at home or in a specialized institution. If the patient could not self-isolate at home or did not heed the counselling center's recommendations, then the District National Committee could order this person to isolate in a hospital's pulmonary department. As for employees with tuberculosis, the District National Committee had the right to order the employer to ensure that the sick individual worked in a separate room and could prohibit selected dangerous individuals from practicing their profession. Persons suffering from an active form of tuberculosis, meaning that

40 *80 let sociálního pojištění*, 22–23; Act no. 185/1948 Coll., on the Nationalization of Medical and Nursing Institutions and on the Organization of State Institutional Medical Care. https://www.zakonyprolidi.cz/cs/1948-185. Last accessed on June 10, 2023.

41 This law introduced the aforementioned mandatory vaccination of persons aged 0 to 20.

they constituted a threat of contagion to those around them, were obliged to undergo treatment in a medical institution.[42]

During treatment, the patient received support based on his or her health insurance or nursing expenses during forced or voluntary isolation. Henceforth, the cost of treatment was borne not by the patients but by the state health administration, which allowed patients to spend a sufficiently long time in a specialized institution without having to pay the costs connected with the treatment and thus also without endangering the family's economic wellbeing and social standing. The law also specified criminal sanctions in the form of a financial fine of up to 10,000 Czech crowns or up to one month imprisonment. These sanctions applied primarily to a failure to fulfil reporting obligations or the breach of or non-compliance with protective and isolation measures.[43] Sanctions were also prescribed by § 80. of the Criminal Code no. 88/1950 Coll.: "Anyone who hinders, endangers or interferes with protective or therapeutic health care, including care for hygiene and the fight against diseases, particularly against social and transmissible diseases, shall be punished by a fine of up to 50,000 Czech crowns or up to two months' imprisonment."[44] Similarly, Criminal Code no. 86/1950 Coll. addressed the issue of the spread of infectious diseases: "Anyone who intentionally causes or increases the risk of the introduction or spread of a human infectious disease shall be punished by up to three years' imprisonment."[45] If this action caused a fatality or serious harm to the health of multiple individuals, then the perpetrator faced one to five years' imprisonment.

The issue of tuberculosis was subsequently addressed by the Resolution of the Government of the Czechoslovak Republic of December 21, 1955, no. 3593, on Measures in the Fight Against Tuberculosis, which had two parts. The first part contained the Ministry of Health's plan of measures in the fight against tuberculosis. The second part included the measures that the government imposed on other departments. The main focus was on prevention, which was to be ensured, for instance, by preventive examinations of selected groups: children and youth, university and vocational school students, pregnant women, employees of children's and educational facilities, and staff at schools and

42 See Doubek, "Boj proti tuberkulose," 8–9. The full version of the law is available at: https://www.zakonyprolidi.cz/cs/1948-61. Last accessed on June 10, 2023.

43 Ibid.

44 Administrative Criminal Code no. 88/1950 Coll. https://www.zakonyprolidi.cz/cs/1950-88. Last accessed on June 10, 2023.

45 Criminal Code no. 86/1950 Coll. https://www.zakonyprolidi.cz/cs/1950-86#hlava4. Last accessed on June 10, 2023.

extracurricular educational facilities. The inspections also applied to individuals who came into direct contact with food, as well as employees in healthcare, transport, barber shops, hair salons, etc. People in agricultural businesses where tuberculosis was discovered in cattle were also to be subjected to regular medical examinations. People who were in permanent contact, in a home or work environment, with a person who suffered from active tuberculosis were examined at least twice a year.[46]

The regulation also imposed the obligation to increase the number of beds in newly built pulmonary departments in hospitals so that medical care could be provided for as many infected individuals as possible. People with tuberculosis were not allowed to work nights or overtime. Persons suffering from or at risk of tuberculosis were to be given other work where they were not exposed to harmful influences and could not spread tuberculosis. A retraining center intended for patients whose ability to work had been affected by the disease was also to be established so that they would be able to remain involved in the work process, thus helping the state reduce economic losses caused by the high morbidity of people of work age. The Ministry of Local Economy and other members of the government who carried out housing construction were ordered to ensure that tuberculosis morbidity was taken into account when apartments in a given locality were assigned. This meant that people with an active form of tuberculosis were to be assigned the necessary living space to ensure their isolation, and infected individuals living in hostels were to be placed in special rooms.[47] Initiatives to raise awareness remained an integral part of the fight against tuberculosis. These efforts focused primarily on spreading information concerning mandatory vaccination programs and the need to participate in mass X-ray campaigns.

Once the Communist Party had assumed power in Czechoslovakia, laws were passed and regulations issued which legislatively enshrined the basic protective and curative measures. Although many of the various approaches had already been used under the First Republic, it was only after 1948 that free medical care was provided for all citizens of the Czechoslovak Republic, since before then, despite many forms of financial support and insurance, it had only been available to a comparatively small segment of society.

46 Křivinka and Raška, *Tuberkulosa*, 10.

47 Ibid., 6, 8, 12; Šembera, Dymer, and Šrámková, *Dnešní stav a program*, 15.

A Miracle Drug? Antituberculotics in Practice

Medical progress and the development of preventive measures led to a gradual decline in tuberculosis mortality all over Europe, but morbidity decreased only very slowly. There were several reasons for this. As a result of screenings,[48] which were conducted as part of mass campaigns and which were obligatory for selected social groups, new, as yet unrecorded cases of the disease were still being found. Modern and effective treatment prolonged the lives of patients, who therefore spent more time in medical institutions, and despite being cured, many of them were not deleted from the patient register as would have been done in the case of other chronic diseases, and so they were included in the morbidity statistics for many years, often until they died.[49]

Only the antibiotics used against tuberculosis, called antituberculotics, helped solve the problem of high morbidity. The first effective tuberculosis drug was streptomycin, isolated in 1943 by Albert Schatz, who worked under the direction of Selman Waksman. As early as 1932, Waksman, with the support of the National Research Council, began to study the survival of tuberculosis bacilli in soil. With the outbreak of World War II, it became clear to him that new drugs would have to be brought to the market. Therefore, from 1939, his laboratory worked on the isolation of substances which he collectively referred to as antibiotics. In 1942, a report appeared according to which a new substance called streptothricin had been isolated. Experiments on animals showed that streptothricin was able to destroy highly resistant types of microbes. Unfortunately, they also showed that the substance was highly toxic, as the animals on which it was tested gradually died, which meant that the drug would not be used in humans. After further experiments involving cultivation in special soils, a substance called streptomycin was produced which was effective in the fight against diseases, including tuberculosis, that were resistant to other drugs that had been used. At the beginning of 1945, a small amount of the substance was released for further testing to private doctors and the Army Medical Corps. Experts presented their results with the treatment of tuberculosis patients at an antibiotic research conference held in 1947 in Washington.[50]

48 Screening is the targeted search for sick individuals or sources of disease, either in the entire population or in selected groups.

49 Šembera et al., *Dnešní stav a program*, 4–5.

50 Epstein and Williams, *Streptomycin*, 104–9, 114, 120, 122.

It soon became clear, however, that streptomycin was not effective against all types of the disease, nor would it save the life of a patient in the terminal stages of the disease, when tuberculosis bacilli had spread throughout the patient's body. The biggest problem, however, turned out to be the organism's gradual buildup of resistance and the resulting decreased therapeutic effect of the medication in patients.[51] It was thus necessary to look for other substances that would help overcome resistance.

Interest thus grew in isoniazid as another potential antituberculotic. Isoniazid had first been produced at the start of the twentieth century, but the first report about its therapeutic effect on tuberculosis only appeared in 1952. Shortly afterwards, the substance was included in treatments for the disease, and it soon emerged as the most effective drug, with a minimal occurrence of side effects.[52] The third basic and also most frequently used drug was so-called PAS (para-aminosalicylic acid). It is a synthetically produced substance with which experiments were first carried out around 1940, but its effect on tuberculosis bacilli was only discovered in 1946.[53]

Treatment with antituberculotics therefore consisted of the long-term use of a combination of several drugs which helped counter the tuberculosis bacillus' aforementioned capacity for resistance. The most frequently used and most effective treatment regimen consisted of streptomycin, isoniazid, and PAS, although other drugs also appeared on the market over the years. Antituberculotics arrived in Czechoslovakia shortly after their development, and their introduction in practice was once again used as a sign of the impressive achievements of healthcare under the socialist regime, as shown by a statement made by lung specialist Rudolf Křivinka: "Even in the past, there were people in our country who saw the issue of tuberculosis correctly. But it was only the socialist social establishment and unified health system that made it possible to make the most of advances in phthisiology, especially newly discovered drugs."[54]

State-provided care applied not only to treatment in a specialized institution or surgical procedures, but also to antibiotics, which were able to treat even severe cases for which other forms of treatment were not sufficient. Moreover, patients treated with antituberculotics did not represent such a great threat to those around them, as the disease in them gradually lost its virulence and was no

51 Cf. ibid., 5–6.

52 Šimáně et al., *Antituberkulotika*, 15, 25.

53 See regarding this drug ibid., 50–59.

54 "Rozhovor s tradíciou," 280.

longer highly contagious. A persistent problem, especially in the eyes of those infected, was the length of treatment, which lasted at least one and a half years and more often two to three years. In rare cases, it lasted even longer.[55]

Patients were impatient and did not like the long-term use of multiple drugs, which is why treatment was initially conducted in a sanatorium or a hospital's pulmonary department. In addition, institutional treatment allowed for the regular monitoring of the given patient and, if he or she were initially highly contagious, helped prevent the spread of the disease. Subsequently, treatment was conducted on an outpatient basis, and the nurse supervised the medication regiments by making random inspections in the patient's home and making sure he or she was taking the drugs as advised. It was shown that the consistency of the use of prescribed medications decreased significantly once the patient had left the sanitorium. Of the patients treated on an outpatient basis, approximately 43 percent did not use PAS, and 18 percent did not use isoniazid, while of the hospitalized patients, 14 percent did not use PAS and 4 percent did not use isoniazid. There were many reasons why patients did not take the drugs: unpleasant taste, actual or presumed side effects, a negative attitude to treatment, distrust, indifference, etc. If the doctor found the patient to be lax regarding treatment, he or she could opt for controlled administration in a center or under the supervision of a nurse. It was essential for a patient to take the exact doses of all the prescribed medications for the treatment to be effective, which was also pointed out in contemporary educational brochures.[56]

Notwithstanding some cases of unruly patients who refused to adhere to the medication regimens prescribed by their doctors, antituberculotic therapy was in general successful, leading to a decrease in the number of patients. Since the idea of modern treatment was incompatible with long-term isolation in a specialized hospital, the number of sanatoriums also began to decrease. In the 1960s and 1970s, many of the sanatoriums ceased to function or began to focus on lung diseases and respiratory problems in general. The field of phthisiology, which was established during the First Republic and which strove for years to provide the most effective care possible for individuals with tuberculosis and their families, also disappeared. Rudolf Křivinka commented on the defeat of tuberculosis as follows: "In the 1960s, all epidemiological indicators for tuberculosis decreased significantly. Phthisiological cadres began to flee the field.

55 Křivinka, "K otázce boje proti tuberkulose," 32.

56 See *Užíváte je správně?*, non-paginated. Brochure issued by the Central Health Education Institute.

I discussed in the relevant places that our field will be an extension specialization for the first degree of internal medicine, and that it will be expanded to include respiratory diseases."[57] Tuberculosis thus came to be ranked among other respiratory diseases and was replaced by cancer and cardiovascular diseases as the most deadly physical ailments. The battle that started at the end of the nineteenth century was definitely coming to an end, and tuberculosis could finally be successfully treated.

The development of the fight against tuberculosis after 1948, when the Communist Party seized power and it was necessary to strengthen the institutional enshrining of care for tuberculosis patients, is illustrated by the tables below (Table 2 and 3). Between 1948 and 1955, the number of tuberculosis sanatoriums gradually increased, while in 1956 and 1957, it stagnated. However, antituberculotics had already been put into practice by this time, and this fundamentally changed the fight against disease, so the establishment of additional institutions was no longer necessary.[58] Mass X-raying helped reveal many cases in which the initial symptoms had not yet manifested themselves or were negligible, thanks to which the chance of treatment increased. The number of newly discovered cases fluctuated during the period under observation, reaching its maximum in the case of pulmonary tuberculosis in 1955, when 23,497 patients were discovered, and in the case of other forms of the disease in 1957,[59] with 3,357 cases. Between 1955 and 1957, however, the statistics did not change rapidly.[60]

Table 2. Tuberculosis sanatoriums in Czechoslovakia between 1948 and 1957

Tuberculosis sanatoriums in Czechoslovakia between 1948 and 1957[61]										
Year	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957
Institutions	30	34	41	42	45	48	49	51	51	51
Beds	7,554	8,165	9,090	9,811	10,621	10,798	10,908	11,251	10,786	11,020
Medical positions	Not filled in	146	194	236	277	282.4	282	312.2	307.1	318.9
Beds per doctor	Not filled in	56	47	42	38	38	39	36	35	35
Patients admitted	21,190	23,483	25,922	33,058	31,712	31,976	28,827	29,390	26,576	25,324
Treatment days in 1,000	2,530	2,830	2,997	3,507	3,683	3,803	3,822	3,952	3,799	3,832

57 "Rozhovor s tradíciou," 496.

58 See Table no. 2: Tuberculosis sanatoriums in Czechoslovakia between 1948 and 1957.

59 Only preliminary data was available for this year, so the final figure may have differed.

60 See Table no. 3: Number of cases of tuberculosis in Czechoslovakia between 1949 and 1957.

61 *Statistická ročenka Republiky československé 1958*, 367.

Table 3. Number of cases of tuberculosis in Czechoslovakia between 1949 and 1957

Number of cases of tuberculosis in Czechoslovakia between 1949 and 1957[62]									
Year	1949	1950	1951	1952	1953	1954	1955	1956	1957[63]
Total pulmonary form cases	Not filled in	20,180	22,469	20,424	22,396	21,315	23,497	23,277	23,267
Total cases involving other organs	Not filled in	1,539	1,543	2,136	2,120	2,411	3,050	3,345	3,357
Pulmonary TB per 100,000 inhabitants	Not filled in	162.9	179.3	161	174.7	164.6	179.5	176	174.2

Tables 4 and 5 below show the situation between 1964 and 1966, when the number of tuberculosis sanatoriums visibly decreased. However, during this period, patients with respiratory diseases were also admitted to the sanatoriums. The fact that roughly the same number of patients were admitted in this period as had been admitted in the 1950s is explained by the institutions' focus on other respiratory problems in addition to tuberculosis. This data therefore includes all respiratory diseases, and it is not possible to determine retrospectively what proportion of those admitted were tuberculosis patients.[64] However, data on new cases clearly shows that the number of patients with the pulmonary form of tuberculosis decreased significantly. As for tuberculosis affecting other organs, the decrease compared to the 1950s was not as noticeable.[65] Nevertheless, this data clearly shows the gradual decline of tuberculosis, which ceased to represent a society-wide threat during the second half of the twentieth century.

Table 4. Tuberculosis and respiratory disease sanatoriums between 1964 and 1966

Tuberculosis and respiratory disease sanatoriums between 1964 and 1966[66]									
	Czechoslovak Socialist Republic			**Czech regions**			**Slovakia**		
Year	1964	1965	1966	1964	1965	1966	1964	1965	1966
Institutions	45	44	38	32	31	26	13	13	12
Beds	10,100	9,914	8,997	6,082	5,835	5,109	4,018	4,079	3,888
Medical positions	274.6	279.1	260.4	160.8	159.6	144.8	113.8	119.5	115.6
Beds per doctor	37	36	35	38	37	35	35	34	34
Patients admitted	23,193	22,772	22,469	13,439	13,079	12,854	9,754	9,693	9,615
Treatment days in 1,000	3,238	3,069	2,882	1,878	1,754	1,615	1,360	1,315	1,267

62 Ibid., 383.

63 Preliminary data.

64 See Table 4. Tuberculosis and respiratory disease sanatoriums between 1964 and 1966.

65 See Table 5. Number of cases of tuberculosis between 1964 and 1966.

66 *Statistická ročenka Republiky československé 1967*, 514.

Table 5. Number of cases of tuberculosis between 1964 and 1966

Number of cases of tuberculosis between 1964 and 1966[67]									
	Czechoslovak Socialist Republic			Czech regions			Slovakia		
Year	1964	1965	1966	1964	1965	1966	1964	1965	1966
Total pulmonary form cases	14,192	13,594	13,199	9,240	8,571	7,936	4,952	5,023	5,263
Total cases involving other organs	2,493	2,365	2,187	1,608	1,540	1,461	885	825	726
Pulmonary TB per 100,000 inhabitants	101	96	92.7	95	87.6	80.8	114.4	114.8	119.2

Conclusion

Although a sophisticated plan for the fight against tuberculosis began to be successfully formed under the First Czechoslovak Republic, with a strong institutional foundation in the form of a wide range of preventive and therapeutic institutions, the disease began to spread rapidly again following the outbreak of World War II, and the main problem proved to be a persistent shortage of beds and tuberculosis sanatoriums. The creation of new institutions for tuberculosis patients with adequate, properly trained staffs was one of the Czechoslovak Republic's most important tasks after the February 1948 coup. Communist ideology strongly affected the area of healthcare. Public healthcare became one of the banners of the regime, and the fight against tuberculosis was used as a propaganda tool. The communist propaganda painted a pejorative picture of previous periods and characterized tuberculosis as a capitalist disease caused by the constant exploitation of the working class. The elimination of social inequalities was therefore directly linked, according to this propaganda, to the ultimate suppression of tuberculosis. Only a classless society was free of all injustices, of which tuberculosis was one.

In the second half of the twentieth century, there were three basic pillars in the fight against tuberculosis: vaccination, finding the sources of infection, and isolation and treatment of patients. Abreography, which was performed systematically in all regions of the country using mobile X-ray machines, was used to detect new cases of the disease. This method made it possible to examine a large number of individuals in a short time and reveal the disease in its beginnings. The BCG vaccine helped prevent initial infection, and it was used

67 Ibid., 519.

in newborns and other people at unusual risk of exposure or mortality. While vaccination had been voluntary and had only been administered to children from families with tuberculosis or living in areas heavily affected by this disease, as of 1948, children and adolescents ages 0 to 20 were vaccinated on the basis of Act no. 61/1948 Coll. Subsequently, in January 1953, across-the-board vaccination of all newborns and persons to 30 years of age with a negative tuberculosis test was introduced. Revaccination of selected age groups was also newly introduced.

Many protective measures were declared and enshrined in law. The most important laws included the aforementioned Act no. 61/1948 Coll., on Certain Protective Measures Against Tuberculosis and Resolution of the Government of the Czechoslovak Republic of December 21, 1955, no. 3593, on Measures in the Fight Against Tuberculosis. The main points were the mandatory reporting of all cases of illness and death from tuberculosis, reporting of change of residence, disinfection of the infected person's home and property, isolation, and mandatory treatment. If found to be infected with tuberculosis, the individual was now obliged to undergo treatment in a specialized institution, where the state provided free care for all patients. It should be stressed that a legislative measure regarding tuberculosis was already being prepared in the 1920s, but persistent doubts about the need for a tuberculosis law and the subsequent outbreak of World War II prevented it ever from being adopted.

Ultimately, antituberculotics solved the persistent problem of high morbidity. Treatment with these drugs was first performed in a medical institution, but because the medications made people infected with the disease less contagious, patients could continue treatment in an outpatient form and go to work as usual. Although treatment lasted at least one year and in most cases even longer, morbidity gradually decreased, and in the 1960s tuberculosis became a successfully treatable respiratory disease.

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Every Child According to Its Pace: School Maturity between Expertise, State Policies, and Parental Eigensinn in Socialist Hungary

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It is widely known that socialist states such as Hungary attempted to increase social mobility through a compulsory elementary school system. While the research on socialist education is vast, the relevance of school maturity to an egalitarian education system is still understudied. By the end of the 1950s, lack of preparedness for school among children had captured the attention of Hungarian experts in medicine, psychology, and pedagogy, who were hoping to ensure that first-year students would begin their schooling under roughly the same conditions. In response, in 1965, local initiatives started experimenting with corrective (remedial) classes. The aim of these initiatives was to overcome class differences by offering targeted support and helping children who were less prepared for institutional schooling catch up and transfer into the standard school system later. During the first half of the 1970s, the Hungarian Ministry of Education adopted this pedagogical experiment on a national level. In this article, I put two distinct methodological approaches into dialogue, the sociology of expertise on the one hand and *Eigensinn* on the other. By doing so, I shed light on the complex interplay of state policies, concepts of expertise, and parental agency. As I show, corrective classes reflected persisting social inequalities, thus children from the lower middle classes and the Roma minority were overrepresented in these classes. Ultimately, I explore how bottom-up initiatives had unintended consequences that were often disadvantageous for the children who were in principle the intended beneficiaries. These initiatives thus worked against rather than for the quest for social equality. In the discussion below, I show how pediatricians, psychologists, pedagogues, and parents shaped the school system, working within, taking advantage of, and thus limiting efforts for social transformation despite asymmetrical power relations.

Keywords: state socialism, socialist education, school maturity, remedial class, equality

Like the other socialist states, Hungary made concerted efforts to transform radically the public education system to meet the needs and achieve the vision of a new political system. Once the socialist government was firmly in power, the

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government created a compulsory elementary school system in which every child was expected to attend school for eight years to avoid preserving or intensifying existing social stratifications. General school education was seen as a powerful tool by which to do away with class divisions and pave the way for social equality. Also, the turn to industrialization and the modernist project more generally required a skilled workforce, and a growing bureaucracy needed educated cadres sympathetic to the socialist project.[1] In short, the project of building a modern socialist state relied heavily on an inclusive, well-designed school system.

In the fight against social segregation and inequality, it was pivotal that every child be able to build on the same foundations when entering school. In this context, first graders' physical, mental and social maturity was essential. However, by the end of the 1950s, experts were alarmed by an increasing dropout rate, which according to their estimates was due to a lack of preparedness among eight to ten percent of first graders. Experts repeatedly pointed out that the notion of school immaturity did not include disabilities of various kinds but referred rather to children who developed more slowly than their peers or were only lagging behind in several areas but were intellectually sound. Since these children tended to show "unstable ability to focus, possible speech deficits […], emotional underdevelopment, and consequent infantile behavior, increased mobility, lack of 'work maturity,' and lack of task awareness," they could not fully develop at school and usually fell behind, and this had a negative effect on their psychological states.[2]

Experts who had been advocating an egalitarian school system were alarmed, as these differences among children were clear indications that the children were not equally prepared for school from the outset. Since the issue of school maturity was a condition that required screening from a medical, psychological, and pedagogical perspective, experts in various disciplines contributed with their research in the hopes of arriving at a nuanced and practical understanding of the issue. The comeback of psychology as an independent discipline at research institutions and universities during the process of de-Stalinization had an especially decisive impact on how practices regarding screening and treatment

1 There is growing scholarship which questions the success of efforts to further social equality through the socialist school system. Hanley and Matthew, "The Persistence of Educational Inequalities"; Millei et al., *Childhood and Schooling*.

2 Pál Szabó, "Kísérlet."

of school immaturity developed.[3] There is a solid body of scholarship on the relationship between psychology and education in socialist Hungary, according to which the 1960s was a decade of heightened collaboration between the two disciplines.[4]

Despite the pivotal role of the psychological turn, school maturity was a decisively interdisciplinary topic, with the disciplines involved relying heavily on one another's findings. Growing expertise on the subject also had an impact on the governmental level. To prevent children from falling behind due to their relative overload, the Ministry of Health and the Ministry of Education settled on a new school enrolment system in 1964. From then on, school-age children had to undergo a compulsory examination, which included psychological screening, with the responsible pediatrician. The only option pediatricians and psychologists could offer parents was simply to delay a child's entrance into school, and this solution was not popular among parents, but in 1965, Budapest launched a pilot project involving the introduction of corrective classes.[5] These separate corrective classes, which spread quickly throughout the country, made school entry possible for children at the age of six even if they assessed as immature. In small classes, specially trained teachers worked with the children on catching up with their peers and switching into regular classes as soon as possible.[6] Pedagogues linked corrective classes to the project of raising general school education. One teacher, cited by the newspaper *Népszava* (The People's Voice), was optimistic about the role of special classes for the future school trajectory of children who were lagging behind: "We have already achieved so much that the number of unexcused absences and truancies has dropped significantly compared to before. And this should help us get more of them to complete the eighth grade."[7]

Although experts saw many positive results, non-Roma parents were reluctant to accept having their children put in these corrective classes due to the stigma

3 Pléh, "Intézmények"; Kovai, *Lélektan*; Szokolszky, "Hungarian Psychology"; Máriási, "Remembering"; Lászlófi, "Work as a Cure."

4 Laine-Frigren, "Emotionally Neglected"; Kovai, ""The Social Roles"; Darvai, "A Szocialista neveléslélektan"; Sáska, "A pszichológia."

5 Literature on remedial classes from a historical perspective is still rare. See e.g., Hjörne and Larsson, "Beyond Teaching."

6 Although the technical term in English is "remedial class," for analytical reasons, I settled on a close translation of the Hungarian wording "korrekciós osztály" and therefore use "corrective class" throughout the article.

7 Szenes, "A tankötelezettséghez."

of taking part in a program in which the Roma minority was overrepresented. Eszter Varsa and János Géczi have recently examined the precarious situation of Roma children within the Hungarian school system more systematically. At the beginning of the 1980s, the number of immature schoolchildren rose. Never before had there been such a pressing need for corrective classes, but limited financial means, the dwindling support of the school management, and insufficient numbers of special teachers made the corrective classes seem an outdated model. This happened during a more general drive towards decentralizing the education system during the last decade of state socialism, as Melinda Kovai and Eszter Neumann have pointed out. Very much against the advice of medical, psychological, and pedagogical experts, the Ministry of Education decided in 1987 to bring the corrective classes program to an end.

By taking school maturity in children as a point of departure, this paper traces the influence of medical, psychological, and pedagogical expertise on reformist politics while also considering the role of social interaction between experts and parents. In the spirit of Gil Eyal, I understand shifts in notions of expertise as the result of shifting networks of expertise. These networks consisted not only of people but, as Eyal has observed, also of concepts and devices used by experts. Furthermore, institutional settings and spatial arrangements impact how experts understand problems and develop possible solutions. Eyal also describes how, in the case of the "autism pandemic," parents began to appear alongside the traditional networks of experts as a "new set of actors," exercising agency and blurring "boundaries between parents, researchers, therapists, and activists," with parents becoming "experts on their own children." While Eyal analyzes broader parental networks as a middle-class phenomenon in a democratic, liberal society, individual cases show how parents in socialist Hungary similarly cast themselves as (lay) experts in the perceived interests of their school-age child, opposing the views of professional experts.[8] Using Eyal's methodological insights, the paper will consider the circulation of expertise across the Cold War divide and within the "socialist bloc."

Since these expert-like practices in a socialist society are equally linked to members of the middle class defined by its education, I trace them from the angle of *Alltagsgeschichte*. Drawing on an array of sources, starting with expert discourses in specialized journals, archival material reflecting the party's position, administrative practices on the local level in Budapest, discourses published in

8 Eyal, "From a Sociology of Expertise."

the state media, and caricatures, this paper investigates how the conclusions of experts in various disciplines clashed with parental expectations by tracing *eigensinnige* ways of coping with conflicts of interest between the state, human science experts, and families with school-age children.[9] Expert writings offer a window into everyday life by depicting the authors' struggles to consider *eigensinniges* parental behavior without jeopardizing positive developments in a child deemed not adequately mature for school. While the sources used do not express the direct voices of parents, they nonetheless reveal what kind of strategies parents developed to cope with the pressures of the socialist school system, showing the impact of social interaction between experts and parents on the promise of equality. Furthermore, the introduction of corrective classes as a state measure serves as an excellent case study for a discussion of the possible tensions between the medical authorities and the Roma minority and the ways in which ethnicity and class intersect more generally. While experts and state sought to overcome previous class divisions, it is not at all clear that the egalitarian initiatives launched by the state indeed served the intended purpose or, on the contrary, they recreated and solidified social differences. Ultimately, the discussion below casts light on the ways in which pediatricians, psychologists, and parental practices shaped the school system, used and perpetuated asymmetrical power relations, and put limits on efforts to further social transformation.

Screening Children to Determine Levels of School Maturity

As early as 1887, Hungarian medical experts mentioned for the first time the importance of school maturity for a child's school trajectory. The issue attracted more and more scholarly attention during the first decades of the twentieth century, and emphasis was placed on the potential harmfulness of physical and mental immaturity, which showed in "low intellectual development, underdeveloped language skills, social immaturity, and a lack of task awareness."[10] During and after World War II, heightened psychological research pointed to the alarming fact that seven to ten percent of Hungarian schoolchildren were not mature enough to begin school. Consequently, up to 10 percent of young students suffered short-term and long-term consequences, often leading to higher dropout rates and lower educational levels.[11]

9 On the concept of *Eigensinn,* see the edited volume Donert et al., *Making Sense of Dictatorship*.

10 Pál Szabó, "Tízéves."

11 Ibid.

After the establishment of the socialist state, however, the introduction of compulsory education renewed scholarly interest in the issue of school maturity. Since psychological expertise significantly lost institutional representation during the Stalinist period, it was not until the gradual return of psychology to academic institutions from 1958 onwards that school maturity was more widely discussed in its full complexity.[12] This coincided with the preparation of an inclusive eight-year elementary school system. At the end of the 1950s, pediatricians, psychologists, and pedagogues alike increased their research activities in the quest to overcome previous class structures through educational efforts. After all, physically and psychologically immature children will "find it difficult, if not impossible, to fit in with the schools' rigid timetable, and they are unable to learn together in groups."[13] Hence, the admission of immature children into school was not only traumatic for the child but also challenged the utopian project of engineering social equality.

With the establishment of an inclusive school system in 1960, human sciences experts began to become increasingly alarmed about the levels of school immaturity among Hungarian schoolchildren. A group of psychologists led by György Aczél demonstrated in their research in a neurological clinic in Győr that the percentage of school-immature children within their sample of 3,511 children showed an increase from 7.9 percent in 1958 to 13.4 percent in 1961. In each case, the psychologists recommended that the child postpones school entry by staying in kindergarten for another year. Since the numbers were indeed worrisome, the authors diligently highlighted that the change "does not mean a real increase, but rather that parents and schools are paying more attention to retardation," meaning delays in the children's physical and mental development.[14] Gradually, parents had become increasingly aware of the question of school maturity, which compelled psychologists to become more insistent on the importance of systematic assessments of children's mental preparedness for school. From the early 1960s, when psychology was back in full swing and taught as an independent subject at university again, psychological testing methods of mental and emotional maturity were discussed and tried on Hungarian children. Psychological experts were, in fact, arguing for the pressing need for these

12 However, child psychology survived even the 1950s, when the State Institute of Child Psychology (Állami Gyermeklélektani Intézet) became the Institute of Psychology at the Hungarian Academy of Sciences, conducting independent research without major interruptions.

13 Szabó, "Tízéves."

14 Aczél et al., "A retardatio."

evaluations when they wrote that "the difficult educational situation of first graders nationwide and the consequences of this situation for the other grades call for a realistic assessment of school readiness."[15] Psychologists discussed the importance of complex assessment practices from medical, psychological, and pedagogical angles, which also required close cooperation with parents. Indeed, experts deemed an interdisciplinary approach vital for schoolchildren who were expected to manage a high curricular load, both in teaching hours and content.[16] "Nowadays," as they argued, "in line with our social development, we solve or try to solve much less important issues than school readiness with scientific justifications, which is why it is necessary to determine and decide on school readiness through complex scientific research and to clarify the concept of school readiness in general." Or in other words, socialism was going to provide scientific conditions for solving societal issues hitherto neglected in modern Hungary.

The urgency of the matter was not ignored on the governmental level.[17] The Ministry of Education started addressing the situation of first graders by expressing the need for extraordinary measures. These measures revealed the understanding that school maturity examinations were part of a necessary response by state officials to increasing pressure from experts in various disciplines.[18] As a result, the Ministry of Health and the Ministry of Education and Culture settled on a new school enrolment system in 1964 for assessing school maturity levels in children.[19] From then on, a pediatrician examined a given child's level of physical development and overall health from the perspective of a successful school start. Unfortunately, this turned out to be insufficient as a means of screening for more complex matters of school maturity, especially regarding the child's psychological state. Since psychology had only recently been introduced as an independent university discipline and there were very few professional psychologists, it was not actually possible to involve them in the enrolment examinations. Psychologists did express concerns, however, saying "that only psychologically school-ready children should be referred by the school doctor. A child not ready for school is at risk of neurological and psychological health problems, partly due to overload and partly due to school

15 Lőrincz et al., "Adalékok."
16 Lőrincz et al., "Az iskolaérettség."
17 Gláz et al., "Négy-ötéves."
18 Lőrincz et al., "Adalékok."
19 Gláz et al., "Négy-ötéves."

failure. It also interferes with the progress of his peers." To tackle the issue, psychologists developed a test to be conducted by pediatricians. This test was supposed to help pediatricians identify children who needed further screening. Experts saw this kind of a compulsory examination as a tool with which to determine the primary reason for any developmental gap, whether physical, intellectual, emotional, or social.[20] This would also determine the necessary therapy that would be organized by the locally operating educational guidance centers *(nevelési tanácsadók)*.[21]

With the introduction of compulsory screening of preschool children from the perspective of preparedness for school, experts discussed the examination critically. While there was consensus that children who were not ready for school despite their age needed institutional and individualized support, pedagogues raised the issue of the reliability of the school doctors' assessments, specifically regarding the psychological state of the child. László Faragó, a pedagogue at the Ministry of Culture and Education, stated, "we are aware of researcher's tests of school readiness and their procedures. Still, we do not consider them suitable for compulsory psychological testing of children entering school."[22] Mrs. György Horányi shared similar thoughts in the central journal of pedagogues, *Köznevelés* (Public Childrearing), noting that "most doctors do not have the specialized psychological knowledge to identify children who are delayed due to psychological factors. No obvious standardized testing procedure can be used to assess the maturity of many children quickly and with sufficient certainty." Pedagogue László Vincze took the criticism even further when describing the practice of school maturity testing as an outdated relic of a bourgeois political order, unworthy of a progressive socialist society. In his assessment, "children must be sent to school and taught in the way appropriate to their general and individual, childlike, age-related characteristics so that they can develop their general and individual characteristics and abilities."[23] Thus, according to Vincze, it was not the child who was supposed to adapt to the requirements of the school system, but the teacher who needed to adapt teaching methods and pedagogical attention to the child.

While studies of the rates of school immaturity in Hungary differed significantly, parents had most possibly no knowledge of those controversial

20 Réti, "Az iskolaérettség."

21 On the role of educational guidance centers, see e.g., Laine-Frigren, "Encountering."

22 Faragó, "Megjegyzések."

23 Vincze, "Még egyszer."

expert discussions.[24] However, parents chose to make their own decisions, showing a noticeable amount of *eigensinniges* behavior once their child had been assessed as not ready for school. This was due to their specific parental mindset and the social pressure they felt from family, friends, and acquaintances. In this context, one expert pointed out "public opinion considered it a disgrace if a child was not enrolled 'on time.'" People also tended to feel that a child was "losing" a year if not enrolled in school before its seventh birthday. Because of the social climate, parents often opted to use personal connections to get a recommendation certificate, which would overrule the rejection. In this case, the school had to accept the child into first grade.[25] What started as a measure taken in the child's interest was often questioned and even contradicted by parental practices. Yet, these practices provided noteworthy anecdotal evidence integrated by the experts into their discourse. The aforementioned László Faragó reported that a sizeable number of children assessed as not adequately prepared for school completed the first class successfully. This was because the parents enrolled the child in school despite the expert assessment, which in their view was inaccurate.[26] Faragó took this as sufficient evidence that the examinations were not without fault, particularly when dealing with borderline cases.

Parents also contradicted the assessments of experts in other cases, especially when psychological factors had been identified as the primary cause for a child's unreadiness for school. Experts widely agreed that those children were, in most cases, harmed by their environment, for which the parents were decisively responsible.[27] For instance, a child growing up in a milieu with little or no intellectual stimulation would have a developmental delay of one or more years. In other cases, the care provided by overprotective parents caused separation trauma in children who ultimately attended school.[28] Other experts identified damage caused by the environment at home as a dominant feature in children who were not ready for school, citing West German psychologist Klaus Schüttler-Janikulla, who found that half of these cases could be traced back to the home.[29] With the discourse on the importance of the home environment, class made an implicit and, at times, explicit entry into the discussion surrounding

24 László Faragó writes of results ranging between six and eight percent and 41 percent. See on this Faragó, "Megjegyzések."

25 Horányi, "Az iskolaérettség."

26 Faragó, "Megjegyzések."

27 Pál Szabó, "Az iskolaérettség."

28 Horányi, "Az iskolaérettség."

29 Szabó, "Az iskolaérettség."

preparedness for school. Faragó reports that "educators reported a vast number of cases [of children] from disorderly, broken families, a debauched, drunken father, a parent who did not care for the child's upbringing, a mother who could not take care of the given child because of the large number of children, and illiterate parents (e.g., in the case of Roma pupils)."[30] This is how expert voices linked social and emotional deprivation in families to children's readiness for school, bringing socioeconomic factors back into the discussion surrounding egalitarian approaches.

Rehabilitation Instead of Separation: The Emergence of Corrective Classes

The question of how the school system could compensate for such disparities became a burning issue. After all, the examinations used to assess children's preparedness for school made the problem visible and measurable, but they hardly offered clear solutions. The only solution in use at the time was for the child to spend another year in kindergarten, but this could be difficult if there was no kindergarten close by, and parents did not have to send their children for the extra year of kindergarten, as attendance was not compulsory. Faragó asked of these children, "[w]hat will be their fate? What will the exemption, the one (or two) years of inactivity, mean for them?" With these questions, he pointed to shortcomings within the school system which he thought needed urgent attention.

It was precisely this worry expressed by experts about school-immature children without a realistic chance for targeted support that prompted state officials and experts alike to seek a sustainable solution. Only one year after the introduction of compulsory preschool screening, the Department of Child and Youth Health of the National Institute of Public Health (Országos Közegészségügyi Intézet, OKI), with the help of the Ministry of Education and the Budapest City Council, agreed to start a pilot project in the Hungarian capital. The experimental undertaking, which was pushed by a broad range of experts, such as physicians, pedagogues, and psychologists, included introducing three small primary school classes.[31] Since first graders usually shared a class with 30 to 40 other children under one class teacher, small pilot classes *(kísérleti osztályok)* with a maximum of 15 children allowed for the pedagogue to devote

30 Faragó, "Megjegyzések."

31 Szabó, "Az iskolaérettség."

more individualized attention to every child. The hope was that children coming from a background with insufficient "stimulation" would receive what they sadly had been missing out on at home.[32] Experts expressed their vision for this pilot project, saying that "the small size of the classes allows the teacher to get to know the children's personalities and their immediate environment and to choose the most appropriate methods with which to achieve results." As these classes ran parallel to existing classes in elementary school, children who caught up could switch into regular classes later. Although such classes were found in other socialist states, Hungarian experts were explicitly inspired by the prolific West Berlin-based school psychologist Klaus Schüttler-Janikulla.[33] However, teachers of the first small classes were sharing their experiences with other teachers in Czechoslovakia and the Soviet Union.[34] This was another case of knowledge circulation that proves the notion of the insurmountable "iron curtain" wrong and shows a selective approach towards expert exchange on school-maturity issues within the "socialist bloc," sidelining the alleged dominance of the Soviet Union over its "satellite" states.

These small pilot classes, which were launched in elementary schools across Budapest, produced convincing results in helping school-immature children catch up with their peers. Five years after the opening of the first experimental class, a decree by the Ministry of Education made it possible for elementary schools in Budapest to organize such small classes, now under the name "corrective classes" *(korrekciós osztályok)*. As a result, 16 small classes started in the school year 1970/71, and within ten years this number had risen to 92 in Budapest alone. However, the geographical distribution of the classes had clear socioeconomic implications. Most of them were found in the districts III, X, and XV, while the traditionally bourgeois districts I and II offered the least of them. Parallel to these developments, psychological and pedagogical expertise became more significant in the so-called complex enrolment examination introduced in 1971. This system included, for the first time, thorough psychological and pedagogical tests once kindergarten teachers or a pediatrician suspected that a given child was not ready for school. In 1974, another decree by the Ministry of Culture and Education regulated the conditions for organizing rural remedial classes and the

32 Psychologist Pál Szabó, who was highly involved in the pilot project of small classes, contended that 76 percent of the children attending these classes in 1965 came from a "destabilizing family environment." See on this Szabó, ibid.

33 Szabó, "Kísérlet."

34 Szabó, "Tízéves."

complex enrolment examination, adapting the local, urban experiment to rural school conditions across the country. As a result, the number of such classes increased dramatically, and by the beginning of the 1980s, there were 321 such classes across the country.[35] In the context of discussions of preparedness for school, experts also wrote of their alleged humanistic quest for equality, which motivated their efforts. As psychologist Pál Szabó wrote,

> However, we cannot ignore the slower developing, less gifted, and even mentally disabled children, whose talents require much pedagogical effort. Everything possible must be done to help them reach their full potential! This is not only important from the point of view of the school, not only from an economic point of view, but also from a psycho-hygienic point of view, as it is a fundamental condition for the harmonious development of their personalities.[36]

While experts and state officials regarded the new possibilities for children who were not ready for school as progressive, parents often reacted to their children's placement into corrective classes with reluctance. Ironically, many of those parents were responsible for a home environment that was far from ideal for the mental and behavioral development of their child. Thus, reform-oriented pedagogues recognized the need to include parents in the therapeutical efforts to help the child. Pedagogues held more meetings with parents than was required and visited families at home in more complex cases, educating parents on the factors contributing to school readiness and explaining to them how they could create a home environment in which their child could develop and mature. At first, many parents "feared that they [corrective classes] would not ensure the same knowledge and credentials as large classes," but as a result of the pedagogue's efforts, "parents' initial aversion to small classes gradually disappeared."[37] However, it proved much more difficult to convince parents to allow their children to take part in the corrective classes in the first place. Pál Szabó reported on talks with parents after their children had been assessed as not adequately mature for school. When they spoke about their children possibly taking part in corrective classes, one-third of the parents did not wish to follow the experts' proposal. Many saw "some kind of stigma" or disadvantage in enrolling their child in a small class.[38] Both cases show that experts needed to

35 Szabó, ibid.
36 Szabó, ibid.
37 Szabó, "Kísérlet."
38 Szabó, ibid.

engage in intense communication with parents to convince them of what they saw as fitting for the positive development of the child in question.

Given the importance of communication on the matter, experts identified a need for propaganda efforts in media outlets to foster acceptance of the new institution. However, early communication in media outlets on the matter seemed to feed the prevailing prejudices than challenge or discredit them. A 1967 article published in the aforementioned trade-unionist newspaper *Népszava* refers to corrective classes rather than classes with over-age children because "it is not simply the over-age children who need to be grouped, but children who are similarly disadvantaged and difficult to educate, because we achieve relatively better results only by modifying the standardized pedagogical process and correcting it in a targeted way."[39] While this exploration might have strengthened the perception among parents of corrective classes as a source of shame for the child and family, later communication aimed at parents had more inclusive undertones:

> The main goal is to help children in small classes catch up as quickly as possible, to become 'ready for school,' and to return to regular classes. Everyone is working on this: teachers, doctors, speech therapists, psychologists, and that is why parents need to be more involved in their child's schoolwork and thus in his or her development. Don't be alarmed if your little one is placed in such a preparatory group, the rate of development varies considerably.[40]

This passage offers an example of how public discourse started to normalize different developmental paces and collectivized efforts to identify and meet individual needs in children. By associating corrective classes with positive prospects for the children who attended them, the author tried to do away with the widespread understanding that these children were second-class students and artificially segregated from their peers.

While parents needed to be continuously convinced of the advantages of corrective classes, experts explored the many benefits of the new institution, which was spreading throughout the country in the 1970s. As early as 1971, pediatrician Sándor Kövér stated that children who enter school one year later still show weaker results than the average student in their first year. He stressed the urgent need for further corrective classes, especially outside Budapest,

39 Szenes, "A tankötelezettséghez."

40 bel, "Megy a gyerek, iskolába," *Esti Hírlap*, 16 March 1970, 2.

where structured support would positively influence the child's development.[41] Pedagogue Mihály Berkics was similarly adamant about the relevance of using one year productively, and he pointed to the advantage of social mobility in line with socialist ideas of equality. Using the example of English society, where school classes were formed based on measured abilities in children, calling it a "complete pedagogical dead end," he understood the English school system as a "direct reflection of their class position." Corrective classes, in contrast, separated the weaker students and gave them the opportunity to catch up with their peers and return to the standard classroom as quickly as possible. Instead of often long-life separation, the Hungarian system would seek rehabilitation of children deemed not ready for school.[42] But the question then arises: did the corrective classes in socialist Hungary actually help further a social transformation towards equality?

Corrective Classes and the Haunting Shadow of Socioeconomic Differences

Corrective classes were supposed to do away with socioeconomic differences among children by ensuring similar start positions. Instead, socioeconomic differences reemerged in expert discourse on corrective classes, serving as a magnifying glass for societal realities. As a pedagogical case study on the children of skilled manual workers in an elementary school in the district VII of Budapest shows, the overwhelming majority of students in corrective classes was of working-class origin. Although the material conditions of working-class families differed significantly among the children at school and were often good, the children still were at a disadvantage. This, the study states, was because "their demand for culture and knowledge was much lower than that of [children from] educated families which may even have lower incomes." The author stresses, however, the critical importance of corrective classes as a means of furthering equal opportunity for the children and, thus, social equality.[43]

At the educational guidance center of the first district in Budapest, neurologist József Niehiebel drew a much bleaker picture of the parents of children who had been deemed unready for school: "[…] the parents of the children who appear here are all seeing a neurologist, or at least should do so. If not, the neurologist should indeed deal with the parents and convince them to

41 Kövér, "Beiskolázás."

42 Berkics, "Nagy József: Iskolaelőkészítés."

43 Z. Á., "Fizikai dolgozók."

get themselves examined. The problems are mostly social: bad housing, drunken husband, etc." While this summary of work experiences drawing a connection between immature school children and their problematic parents was not supposed to reach the public, a study published in the central pedagogical journal on the developmental stage of children aged four to five explicitly considers socioeconomic factors in relation to school maturity. With the help of a newly designed complex testing method, the researchers showed that, in the case of a group of 120 children, "90.3 percent of the 104 better-off children met the requirements, and only 9.7 percent were problematic, while 62.5 percent of the 16 socially vulnerable children did not show the required level of maturity." However, the worst possible combination was when the children were both from a poor socioeconomic background and did not attend kindergarten: none of the children of whom this was true showed sufficient levels of maturity.[44] While kindergarten attendance did not compensate for the disadvantage of coming from a lower socioeconomic background in all cases, it was undoubtedly alarming when children did not attend kindergarten at all, since this left them with little chance of having a positive start at school.

By the end of the 1970s, the discussion about the influence of socioeconomic conditions on school education gained new momentum. Pedagogues published an extensive study in the academic journal *Valóság* (Reality) on the inner stratification of several elementary schools in the highly industrialized district XVIII of Budapest, casting doubts on the egalitarian nature of the eight-year school-for-all project. They assessed the corrective classes and arrived at the conclusion that these classes were on a lower level within the inner school hierarchical structure. Although the small size of the classes made it difficult to generalize, the authors of the study were struck by the fact that none of the children in these classes were from families belonging to the managerial and high-ranking intellectual elite, while children of white-collar workers, production supervisors *(közvetlen termelésirányítók)*, and skilled workers were overrepresented. Even more strikingly, children of unskilled workers were underrepresented in these classes and overrepresented in special schools. Considering these results, the authors noted that "social factors other than 'biological' factors play a significant role in determining who 'meets' the requirements of primary school."[45] In another study published only two years later, some of the same authors adopted

44 Gláz et al., "Négy-ötéves."

45 Csanádi et al., "Az általános iskolai."

a decisively gendered approach when stating that "children whose fathers were qualified and whose mothers were in unskilled physical occupations were over-represented in the remedial classes."[46] This suggests that experts attributed a more decisive role to the mother's education than the father's.

While the children in the corrective classes in Budapest schools came from a broader range of socioeconomic backgrounds, the official discourse on the corrective classes in schools outside of Budapest suggests that the students in these classes came from relatively similar social backgrounds. In the schools outside of Budapest, school immaturity seemed almost exclusively to be caused by a lack of cultural stimulation at home. An interview with two teachers of a corrective class in Tapolca, a city in the upper Balaton area, described the challenges they faced when working with children who predominantly came from families with little to no cultural or educational stimulation at home. To make matters worse, some children had parents who were alcoholics or were illiterate. But where grim prospects reigned, corrective classes could make a positive difference, at least so went the discourse. One of the teachers made the following remark concerning her experience, "[p]erhaps the most shocking thing is that these children are bewildered by fairy tales. It is not until the end of the year that the magic of the fairy tale reaches them, that the excitement and anticipation are already on their faces."[47] What for most children was a routine and intellectually stimulating part of growing up for these children it was something they experienced only after having begun school.

While the public discourse on the issue of school maturity repeatedly addressed socioeconomic conditions and parents who failed to stimulate their children sufficiently, the ethnic background of children attending these classes was not part of the presentation of the program to the public. In expert discourses, however, Roma children who had been assessed as inadequately developed for school only shortly after the introduction of compulsory school examination made a noticeable appearance. Faragó highlighted the problem that many children did not acquire basic skills such as the ability to read and write or do basic math because of their repeated absences. Based on data from Tolna County, many of these children were members of the Roma minority. Many assessments of Roma children used the word "cigány" or Gypsy (instead of Roma) and contained critical references to the conditions the children faced

46 Csanádi and Ladányi, "Az általános iskolai."

47 Imre Hamar, "Segítség az induláshoz," *Veszprémi Napló*, 23 July 1980, 5.

at home. According to one, for instance, the child in question was of "Gypsy origin, sub-standard home conditions; parents' ignorance is the reason for poor progress. There are four children in the family." According to another, the boy "is also a child of a Gypsy family, they wander a lot, the care provided by the parents amounts to zero."[48] Unlike the assessments of other children who had been deemed school immature, in the assessments of Roma children, the dominant tenor is about how these children are problematic and do not fit into the school system because of their problematic upbringing, usually caused by parental neglect.

From the mid-1970s on, the question of Roma first graders gained new momentum. Experts saw the complex school maturity examination as a welcome opportunity to assess school maturity among Roma children more reliably. Statistical evidence showed that Roma children were disproportionally placed in special schools when they mostly suffered from a delayed development rather than physical or mental disability.[49] While inadequate placement within the school system was increasingly criticized, experts proposed the establishment of separate corrective classes for Roma and the establishment of boarding schools exclusively for Roma children. They thought that only separate education tailored to the needs of these children would provide the conditions which would allow the children to catch up with their peers.[50] Indeed, many argued that it was not the children who were problematic but the school system, which did not allow the children to assimilate because "in practice, the school system classifies them as unsuitable for adapting to school life. Only a small percentage of them consider further education, and they have almost no chance of obtaining an upper-secondary qualification (and the social benefits that come with it). The current school system is therefore not favorable to Gypsies."

Non-Roma children came from various socioeconomic backgrounds, and this was true of Roma children, too. As experts pointed out, however, housing conditions were usually worse than with even the most problematic non-Roma child, and these conditions were cited as the cause for recurring, often respiratory-related illnesses, which led to high truancy rates.[51] Also, due to their insufficient command of Hungarian, Roma children were far more likely to be deemed

48 Faragó, "Megjegyzések."

49 "A tankötelezettségi törvény végrehajtásának tapasztalatai," 7 July 1976, Budapest Főváros Tanácsa Végrehajtó Bizottsága üléseinek jegyzőkönyvei, BFL XXIII.102.a.1.

50 Trust, "Töretlen utakon."

51 Pik Katalin hagyatéka, 1940-2001, MNL OL P 2224. 9–11. tétel.

inadequately mature for school, especially children of unskilled workers. There was a direct correlation between the parents' occupational category and their children's future at school: the higher the parents' qualification, the better the children's outcome on school maturity examinations. Specifically, the children of skilled workers were more likely than their peers to attend the standard first-term class than to need corrective education.[52] To be sure, although absolute numbers were higher among Roma children, the reasons why children were unprepared for school were mostly the same across the board. A countrywide study concluded by the mid-1970s on school entry arrived at the following conclusion: "[...] we can say that school readiness is not Gypsy specific. In other words, the causes of low rates of school readiness (except for speaking technique and comparative vocabulary) are to be found elsewhere. More specifically, Roma children achieve lower or higher levels of school readiness for the same reasons as non-Roma children."[53]

At the turn of the 1980s, experts and state officials alike noticed rising levels of children deemed unprepared for school across the country. According to a report by the Department of Education at the Budapest City Council, "the number of school-immature pupils who either are exempted for another year or need remedial help is increasing year after year."[54] In part as a consequence of insufficient numbers of elementary school teachers, working conditions for pedagogues worsened as they dealt with more over-age children, high dropout rates, and children needing to repeat the first grade. Although differences between counties were stark, rising alcoholism among parents and increasing divorce rates took a toll on children, affecting their levels of development negatively.[55] The literary and political magazine *Élet és Irodalom* (Life and Literature) also pointed to specific conditions in Hungary, where a legalized second economy was thriving, especially since the beginning of the 1980s, leaving parents with less time to engage with their children.[56] Other networks of experts, e.g., medical doctors involved in school maturity assessments, also rang the alarm. In an interview in the magazine *Munka* (Work), a Budapest school doctor expressed concerns over recent developments: "Unfortunately, many children are falling behind due to lack of environmental stimuli. I emphasize that this is due to poor stimulation,

52 Csongor, "Cigánygyerekek."

53 Mihály Berkics, 'Nagy József: Iskolaelőkészítés és beiskolázás', *Magyar Pedagógia* 75, no. 3 (1975): 380–83.

54 "A főváros közoktatási fejlesztési koncepciója az ezredfordulóig," September 1983, Fővárosi Tanács VB Művelődésügyi Főosztálya, BFL XXIII.102.a.1. A.

55 Kerekes, "Az általános iskoláról."

56 Albert, "Életünk Szörnyei."

not mental retardation. The children do not understand basic concepts. They do not know their colors, they do not know their address, let alone their mother's name. But they are clearly in possession of the most expensive toys." These children did not seem to suffer economic hardship. On the contrary, they enjoyed a surprising level of affluence, but they were deprived of parental attention. The involvement of 75 percent of Hungarian families in the second economy as a means of ensuring a stable income in the face of dramatic inflation left its imprint on the next generation of children.[57]

While the need for corrective measures had never been greater than it was at the time, a controversy over corrective classes arose in expert circles. Sociologist Katalin Pik, who was critically engaged in pedagogical questions both in theory and in practice, examined the prospects of former children who had attended the corrective classes. While the corrective classes were largely effective as a means of dealing with school maturity issues, Pik explored the problems that arose when these children left the familiar social environment of the corrective class to enter the standard first-year or second-year class. Pik's data show that the children who had been in corrective classes and who, at the age of eight or nine, suddenly found themselves in a new school environment did not perform as well as children who had entered the class from a different school. They often did not catch up academically, prompting Pik to draw the pessimistic conclusion conclude that these children "end up in a very unfavorable position in the micro-milieu of the second grade, with no prospects for their future school careers."[58] While corrective classes were also socially relatively homogenous at least outside of Budapest, parents seemed to react predictably to the stigma attached to these classes when looking for ways to keep their children out of them.[59] The article, a mix of scientific study and opinion piece, needs to be seen in the context of the pedagogical research of Mrs. Zoltán Báthory and Vera Kántás, published only a few months earlier. Their article also examined the stigma attached to corrective classes, though they arrived at slightly different conclusions. While they agree with Pik on discrimination against children in corrective classes, their study shows that the "'corrective past' is by no means as decisive a handicap as we had assumed." They saw the main culprit for the lack of positive development in parents and schools alike: the outcome was especially unfavorable when both parents and teachers were impatient and uncomprehending in their attitudes

57 Bodnár, *Fin de Millénaire Budapest.*

58 Pik, "A korrekciós osztályok."

59 Ibid.

towards corrective classes.[60] More generally, various experts stated during the controversy that they saw the success rate of corrective classes at 65 to 70 percent. This was also underlined by psychologist Pál Szabó, one of the main proponents of school maturity examinations and corrective classes.[61]

While a controversy among experts is far from unusual and perfectly in line with their investigative role, it seems remarkable that in the case of the issue of children's school maturity, the experts took parental practices in their assessments of the strengths and weaknesses of corrective classes into account. One year before the controversy, the state media reported on how hesitant parents were to send their children to corrective classes, perceiving them primarily as a potential disadvantage when the children would move on to the standard school system, where classmates might be prejudiced against them.[62] Indeed, as a caricature in the satirical magazine *Ludas Matyi*[63] shows, parents saw the issue of school maturity as central and stressful at the same time. The scene shows the first day at school for first graders. Parents are patiently watching as their children move slowly into the classroom under a sign which says, "we are learning for life." A boy, one of the last ones to enter the classroom, is taken aside by his father, who asks him, "Why don't you push the others aside? Otherwise, they might think that you are not school-mature!" As the cartoon suggests, school maturity was a measure of a child's ability to meet the requirements of the school system. However, in the eyes of the parent portrayed, solely fitting in was insufficient. One ruthlessly had to put oneself ahead of one's peers, to their potential detriment. As a critical comment on contemporary society, the caricature shows that the question of a child's preparedness for school was understood as pressure to meet a necessary precondition for success in school, even when this involved circumventing (and defeating) socialist egalitarian principles.[64]

To be sure, many parents opted to have their children attend the regular classes rather than suffer the stigma of being put in the corrective classes, even when this hampered the child's development. The Executive Committee *(Végrehajtó Bizottság)* at the Budapest City Council discussed the issue in the mid-1970s during a meeting with one of the participants. According to the committee,

60 Báthory and Kántás, "Korrekciós osztály."

61 Horányi, "Az iskolaérettség vizsgálatáról."

62 F. J., "Iskolába jár a gyerek...."

63 This title is a reference to a somewhat satirical epic poem by nineteenth-century Hungarian author Mihály Fazekas. The title could be translated into English as "Mattie the Goose-boy."

64 N. N., "Évnyitó."

> some parents are averse to this [having their children put in corrective classes], some for reasons of prestige alone, others because of the longer travel time to the corrective class within the district. There are one or two places [for these classes] in a district. The parent is asking for their child to be excused rather than put in a corrective class. In many cases, the education authorities grant these requests, which we do not approve of because in fact this child will later become over-age. They need to be given the right education to catch up with the others, and if they do not get it, they will become over-age, and this will bring the specter of failure, of falling behind.[65]

Even with the opening of many more corrective classes throughout Budapest and a certain normalization of corrective classes, at least in the capital, the educational guidance center of the district I reports in 1983 on how parents were going against the conclusions of medical, psychological, and pedagogical assessments and were finding ways to circumvent the recommendations.[66] Other experts reporting on their experiences in the district II, another well-to-do part of Budapest with a high proportion of academically educated inhabitants, noted that parents felt the stigma of corrective classes even more intensely.[67]

Experts who had these experiences on the ground addressed the issue in state media for communicating to parents via a different channel, independently from individualized cases regarding their children. While experts did not tire of stressing that corrective classes were not for disabled or intellectually limited children (a perception still present in Hungarian society) but only for children who were not adequately developed for school, they did acknowledge that the name "corrective classes" might have unfortunate associations. However, as psychologist Zsuzsa Flamm pointed out to the broad readership of *Népszava*, a "corrective first class is not recommended by experts without justification, and therefore if parents, ignoring expert advice, enroll their unschooled child in a large class [standard class], they must take responsibility if the child starts the school year with a failure that may well mark the next eight years."[68] While reminding parents of their role as responsible caretakers, the author stresses

65 "A tankötelezettségi törvény végrehajtásának tapasztalatai," July 7, 1976, Budapest Főváros Tanácsa Végrehajtó Bizottsága üléseinek jegyzőkönyvei, BFL XXIII.102.a.1.

66 "Az I. ker. jelentése: a felmentettek és iskolaéretlen gyermekek helyzete számarányuk növekedéseinek okai," November 1983, Nevelési Tanácsadó, I. kerület, BFL VIII.3709.b.

67 Szurdi, "A korrekciós."

68 Flamm, "Ami nem önérzeti probléma." The parental guidance book by well-known pediatrician László Velkey makes similar statements, cf. Szabó, "Dr. Velkey László." Earlier publications also point to comparable issues, cf. the parental guide by Szabó, *Iskolás lesz a gyermekünk*.

another responsibility of parents: nurturing the intellectual abilities of their children to avoid lack of school maturity in the first place.[69]

Parents were not the only ones who needed to be continuously convinced of the positive impact of corrective classes on children who had been deemed unready for school. Pedagogues were sometimes also found to be problematic. In the magazine *A tanitó* (The Teacher), published mainly for pedagogues, an article reports on a successfully run corrective class in a Budapest elementary school precisely at the time when criticism and discrimination on the ground were at their heights. While some critical undertones chimed in with respectful if not admiring descriptions of the corrective classes they had attended, the author note that the school did not label the class corrective. It was simply called "1e," in line with the overarching method of naming classes. Although the designation used for the class did not reveal its purpose, one's impression of it changed once in the classroom. The interior reflected both the support and freedom needed by children who were not yet mature enough for regular schooling. As the author noted, "one side of the room has a carpeted floor, which serves as a play area. Small wicker armchairs, tables, and a game shelf make this a realm of free play. When I visited the classroom, the children played after their morning session. Mostly board games and indoor board games were available, but anyone who wanted could draw." Due to the varied functions of the classroom, the refurbishment of such classes was drastically more expensive than it was for regular classes, but the school management put the needs of the class first. The teacher "radiates kindness, attention, and care," and the overall school climate contributed to the children not being excluded or even stigmatized, even when they eventually joined the other children in the standard classes.[70] In fact, the child-centered approach of corrective classes was so convincing that Dr. Gyula Mezei, an expert and high-ranking state official in the Ministry of Education, stated at the end of the 1970s that "if we had more money, more classrooms, more teachers, it would be ideal if all children could start their primary education in such classes, because this form of education provides a good transition between kindergarten and primary school."[71] This citation shows that the existence of separate corrective classes was also an implicit critique of the existing school system, with its streamlined, traditionally scholastic approach.

69 Flamm, "Ami nem önérzeti probléma."

70 Varga, "Látogatás."

71 Mezei, "Vakáció után."

School-Immature Children and the Abolition of Corrective Classes

At the end of the 1980s, when the need for individual assistance for children who were not prepared for regular schooling had never been greater, institutional support decreased, very much against expert advice. Since corrective classes had been struggling to win sufficient acceptance among parents and pedagogues alike, the Ministry of Education decided in 1987 to bring the program of corrective classes to an end. Among the official reasons was the contention that "these classes could not eliminate individual disadvantages to the extent expected, in many places they were given the worst accommodation and the least suitable teachers instead of the best conditions, and the name itself has become stigmatizing."[72] As a result, the Ministry shifted responsibility from the district administration to individual schools, which were free to offer so-called small-sized classes *(kislétszámú osztályok)* as a replacement for corrective classes.[73] Parallel with the abolition of corrective classes, the Ministry moved the date according to which the year of child's age would be measured for compulsory school attendance from September 1 to May 31, meaning that only children who had completed their sixth year of life by the end of May would leave kindergarten and enter school. As a result, the number of children in the first grade who had been born in the summer (i.e., who were younger by many months than their peers) decreased, and the schools soon benefitted "from having older, more physically and mentally developed children in the first grade."[74]

New regulations enabled parents to exercise more agency and freedom of choice during the process. While kindergarten teachers played a decisive role in assessing children's developmental stage, the final decisions had to have the support of the parents. If kindergarten pedagogues and parents could not reconcile their views, only then would the educational guidance center act as a mediator and ultimately have the last word.[75] However, experts from the guidance centers were now obliged to share their findings with the parents, allowing parents better to comprehend the evidence on which the experts' recommendations were based. It was then up to the parents to decide if they wanted their children to stay in kindergarten or attend a small class. Effectively, parents had a larger role in the decisions that were made concerning their children's schooling.[76]

72 Koncz, "Kényelmetlenné vált."

73 Ibid.

74 Horányi, "A fejlettség szerinti"; Hamrák, "Tanulási képességek"; Koncz, "Kényelmetlenné vált."

75 Horányi and Kósáné Ormai, "A nevelési tanácsadás."

76 Horányi, "A fejlettség szerinti."

While the emphasis on the positive integration of parents into the decision-making process was intended to help resolve earlier tensions, experts saw the abolition of corrective classes and diminishing state support for these kinds of measures critically.[77] Many schools did not plan to have small-sized classes. Or, more precisely, where there had been no infrastructure for corrective classes, it was hardly likely that small-sized classes would be introduced. Even in schools in which corrective classes had been held, school management thought twice about holding small classes, which required increased infrastructure, personnel, and financing.[78] This problem became even more pronounced as the number of children recommended for these classes rose. In 1987, ideally 18.4 percent of schoolchildren would have attended small-sized classes on the basis of the recommendations of experts. In 1988, this figure had risen to 21.7 percent.[79] Experts also pointed out that among the children who remained in kindergarten for an additional year, many still struggled with below average learning abilities.[80] This also became prevalent among children deemed unready for school who sometimes even ended up in special schools.[81] Additionally, parental *Eigensinn* could be an issue, especially when parents pressured kindergarten teachers (sometimes even violently) to let their children attend a regular school, which led to predictable problems for the children and the school.[82] At the end of the 1980s, during the last breaths of Hungarian state socialism, decentralization and liberalization around the question of school maturity produced many uncertainties for which the state no longer accepted full responsibility. A growing number of children deemed unprepared for school and their parents could no longer rely on widespread structured support. This happened precisely at a time when visible social inequalities became widely accepted in society.

Conclusion

The modern project of building an egalitarian socialist utopia set the tone for creating the conditions for equal opportunity through collective state institutions, such as the educational system. However, the case of children's school maturity and the institutional solution of corrective classes shows how the egalitarian

77 Ibid.
78 Koncz, "Kényelmetlenné vált."
79 Horányi, "A fejlettség szerinti."
80 Hamrák, "Tanulási képességek."
81 Horányi, "A fejlettség szerinti."
82 Ibid.

project of a comprehensive school system reached its limits. I have shown how corrective classes ultimately mirrored social differences already present in socialist Hungary, making the corrective classes something of a magnifying glass for societal realities. In these special classes, children from the lower middle classes and the Roma minority were overrepresented. To be sure, experts and state officials alike were devoted to seeking solutions to give these children the best conditions possible. Different networks of experts, mainly physicians, psychologists, and pedagogues, approached the problem of school maturity from various angles and worked towards possible solutions. Interestingly, knowledge circulation based on citation practices revealed, at least in the case of the topic of school maturity, that the notion of the impenetrable "iron curtain" is untenable. Instead, it shows a selective approach to the exchange of ideas among experts on school-maturity issues within the "socialist bloc," sidelining the alleged dominance of the Soviet Union over its "satellite" states.

While all actors had in common that they wanted the best for the children who were deemed immature for school, opinions diverged on how to achieve this. I have shown how the state, experts, and parents shaped the system of school maturity assessment and corrective classes, and I have called attention, in particular, to the fair amount of parental agency in this process. As the practices of willful parents revealed, parents had some space for maneuver, even in opposition to the opinions of experts, as they were able to use their more intimate knowledge of their own children. Not surprisingly, parents were influenced by popular perceptions, such as the stigma attached to corrective classes, as well as social pressures, for instance with regard to class background. Ironically, state measures, introduced as a tool with which to further social equality, created concern in parents that corrective classes would leave their children at a social and cultural disadvantage. In the eyes of experts and state officials alike, the role of parents, however, could be problematic in two ways. First, parents were often seen as the cause of the child's delayed development before anything else, especially in the case of social and emotional deprivation. Second, parents were often opposed to corrective measures for reasons of (loss of) social prestige or for practical reasons of convenience. These parents were thus caught between exerting agency on the one hand and being part of the problem themselves on the other, showing the limits of socialist transformation.

The discontinuation of corrective classes at the end of the 1980s went against societal needs and most experts' opinions, and the process of democratization and decentralization gave parents more opportunities to influence decisions

concerning their children's schooling. This was not always in line with the interests of children who were not yet sufficiently developed for schooling, and it created problems both for these children and for the responsible experts. While the rates of school immaturity in children preparing to leave kindergarten and attend the first grade was never as high as it had been in the 1980s, state support vanished. As part of a more significant trend shaped by a financial crisis and drastic economic reforms throughout the decade, the state implemented austerity measures. However, contrary to the secondary literature, according to which decentralization tendencies were dominant in the 1980s, corrective classes were intensely experimental and linked to local developments throughout their history from the mid-1960s onwards.[83] Although the Ministry of Education adopted the Budapest pilot project between 1971 and 1974, it was mainly up to individual schools to open corrective classes. The fact that corrective classes were not ubiquitous in the educational landscape shows a specific fragmentation of an otherwise centralized school system, strongly linked to the individual initiatives of school management, pedagogues, and local educational guidance centers.

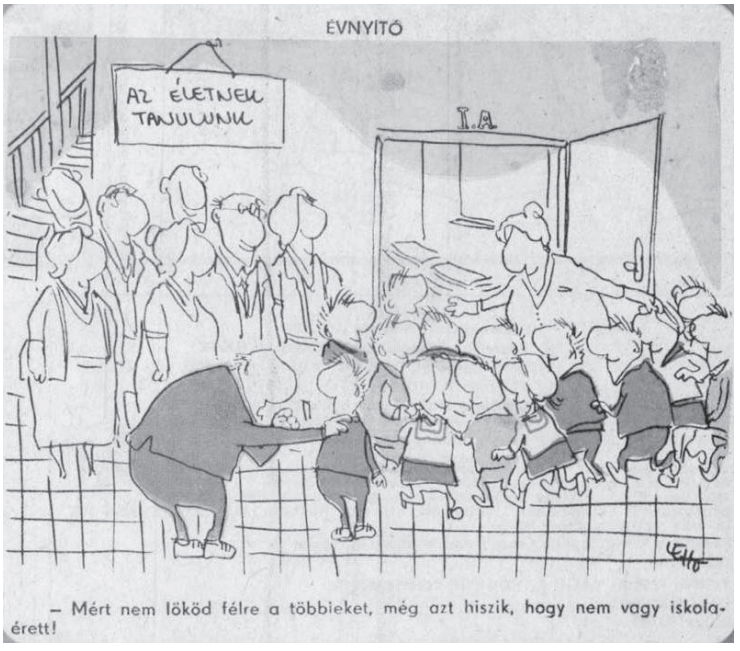

Fig. 1. N.N. "Évnyitó." *Ludas Matyi*, 25 August 1983. "Why don't you push the others aside? Otherwise, they might think that you are not school-mature!"

83 Cf. for example Kovai and Neumann, "Hová lett," 75.

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Women Facing the Committee: Decision-Making on Abortion in Postwar Hungary

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In this article, we examine the medical, legal, social, and political context of abortion in Hungary after the Second World War, with special attention to the decision-making process of the so-called abortion committees. These committees collected data on the social and medical status of women to support their decision on whether to permit the operation or not. In the first half of the 1950s and after 1973, the committees were given a relatively free hand in making their decision on whether to allow an abortion. Women had to appear in front of these committees in person, and the process was a performance of demonstrating compliance with the law by stating a legally acceptable reason to terminate the pregnancy. In our article we analyze how the hierarchical-paternalistic structures of healthcare were reproduced and operated in the frequently changing abortion regimes within a state socialist legal and political framework. We also explore how these phenomena affected women's requests and the options available to doctors at the micro level of decision-making on abortion. The study shows how women and doctors were forced to make efforts to comply with the changing normative framework and how different forms of paternalism (e.g., institutional, medical) shaped this process. The main purpose of the various laws was to regulate abortion and population policy by monitoring the measurable circumstances of pregnancy. In the early 1950s, the focus was on the health of the mother, whereas in the 1970s it was more on the living conditions necessary to raise a child. Despite the detailed regulations based on the paternalist structure of the healthcare system, it was left to doctors and other members of abortion committees to implement the norms at the local level. In some cases, doctors utilized this paternalist framework and patriarchal techniques characteristic of the healthcare system to circumvent the intentions of population policy. The article demonstrates these phenomena by analyzing the medical records of Pesterzsébeti Szülő- és Nőbeteg Otthon (Gynecological and Maternity Hospital of Pesterzsébet) and the documents of the abortion committee of Pécs.

Keywords: Abortion, abortion committee, population policy, legal and medical paternalism

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In state-socialist Hungary, paternalism had many meanings, and it had a strong impact on those areas of medicine that dealt with women's bodies. In all areas of medicine and health care, before the development of bioethics, paternalism permeated the doctor-patient relationship. This relationship was hierarchical, the institution of informed consent was not respected in practice, and even the treatment chosen was not necessarily communicated to the patient. Physicians gave orders to the patients and the patients complied with them. This institutional hierarchy of medical paternalism was combined with a patriarchal form of paternalism in gynecological and obstetrical practice. Although more and more women became doctors in line with the emancipatory intentions of the Communist party-state, these fields remained male-dominated throughout the era of state socialism. In gynecology and obstetrics units, almost exclusively male doctors examined women and made decisions about their bodies which in some cases affected women's lives irreversibly.

After the socialist transformation of health care, female patients in obstetrics and gynecology units became the subjects of a third form of paternalism that characterized all services provided by the state. From the late 1940s, the Party's goal of equal and free access to health care was essentially twofold. The Stalinist Constitution of 1949 included free health care among the basic rights of workers, symbolizing the Party's unlimited concern for the previously neglected layers of society.[1] Accordingly, by 1961, with the extension of health insurance, 91 percent of society was eligible for free health care, and by 1972 free health care was accessible to all.[2] To achieve this goal, the regime thoroughly centralized the health care system in the early 1950s. Hospitals were nationalized and healthcare

1 1949. évi XX. Törvény 47. § (1) A Magyar Népköztársaság védi a dolgozók egészségét és segíti a dolgozókat munkaképtelenségük esetén. (2) A Magyar Népköztársaság ezt a védelmet és segítséget széles körű társadalombiztosítással és az orvosi ellátás megszervezésével valósítja meg (in English: Act X of 1949, Article 47 (1) The Hungarian People's Republic protects the health of workers and helps workers in the event of their inability to work. (2) The Hungarian People's Republic implements this protection and assistance through extensive social insurance and the organization of medical care.)

2 In Hungary in the 1950s, a significant number of peasants held onto their land and continued to work as independent farmers without insurance. Only the third attempt at collectivization, from 1958 to 1961, was successful, so most agricultural workers were not insured until the 1960s. (*Statisztikai évkönyv*, Gaál et al., *Szociálpolitikánk két évtizede*, 25.) Health Act no II of 1972 § 24 (1) "Effective measures must be taken to improve the health of the population, and the effects of these measures must be continuously monitored and evaluated. The causes of morbidity and mortality must be monitored regularly.(2) The method of care must be used in curative and preventive care, and it must be gradually extended to persons who are in need of it and who are exposed to the risk of illness due to their health or other reasons, or—based on the provisions of the law—to the entire population."

workers became state employees. The standardized, efficient operation of state institutions was prioritized over individual concerns, enabling the party-state to extend its control over the body of each and every individual. These changes also clearly embodied, on the institutional level, the notion that the state (in the form of state-funded hospitals and state-employed doctors) knew better than individuals what was good for their wellbeing. In this system, the patient was a passive recipient of medical treatment with little say in the process, which was controlled and managed by a powerful state institution and doctors. We argue that, although abortion regimes changed over time, the complex structure of paternalism in abortion decision-making remained. In practice, however, the paternalistic attitudes of doctors and institutions did not imply full compliance with the law, but allowed doctors to facilitate abortions in some cases where the legal requirements were not fully met. Such assistance, however, did not reduce women's vulnerability to male doctors and state institutions.

In this context of mainfold paternalism, in this paper we examine the medical, legal, and socio-political landscape of decision-making on abortion in Hungary after the World War II. We focus on how these hierarchical structures were (re)constructed and functioned in the frequently changing abortion regimes within a state socialist legal and political framework. We also consider how these phenomena affected women's requests and the options available to doctors at the micro level of decision-making about abortion. The study shows how women and doctors were forced to make efforts to comply with the changing normative framework and to shape their arguments and decisions to meet the medical, legal, and social requirements for abortion. The main purpose of the various laws was to regulate abortion and population policy by monitoring the measurable circumstances of pregnancy. In the early 1950s, the focus was on the health of the mother, whereas in the 1970s it was more on the living conditions necessary to raise a child. Despite the detailed regulations based on the hierarchical structure of the healthcare system, it was left to doctors and other members of abortion committees to implement the norms at the local level. In some cases, doctors used the various forms of patriarchy within the healthcare system to circumvent the intentions of the population policy.

Previous research has shown how political and expert (medical, social scientific, sexological, theological) discourses and the multiple actors who influenced these discourses shaped the legalization and prohibition of abortion, the regulation of various contraceptive methods, and the transformation of gender roles in state socialist societies in the second half of the twentieth

century. These studies have highlighted the various ways in which experts could influence population policies and measures and, most importantly, shape the state-party's biopolitical thinking.[3] However, the roles of the different forms of paternalistic tendencies, which were inherent characteristics of state socialist systems and the field of medicine more generally, have not yet been profoundly examined in these works. There has also been little focus on the constraints and opportunities for women to assert their interests and the extent to which gynecologists were able to facilitate or hamper women's efforts to assert their medical interests at the local level of reproductive control. Our study attempts to do this by analyzing some concrete examples.

In examining this phenomenon, we analyze the legal framework of abortion and the implementation of the law in the cases of two abortion committees. We mainly analyze changing legislation (ministerial decrees, statutory regulations, etc.) as the legal basis of these phenomena. We focus on the legislation itself rather than the legislative process, because it was the law that framed the possibilities for women who requested abortions and the prerogatives of the doctors who decided on the requests. We examine the medical records of the Pesterzsébet Maternity Hospital from 1954 and 1956, which include the minutes of the meetings of the abortion committee concerning cases when the requests were accepted, and the documents of the abortion committees of Pécs from 1974, which offer examples of both approvals and rejections. We have about 2,000 cases from Pesterzsébet. From Pécs, we have 631 applications received by the abortion committees. Since neither the documents produced by the committees (e.g., the women's applications or the reports on living conditions) nor the medical documentation of the patients who underwent abortions had to be handed over to the archives, the types of sources included in our analysis are rarely available in the Hungarian context.[4]

3 See e.g.: Nakachi, *Replacing the Dead*, 59. Lišková, *Sexual Liberation, Socialist Style*; Lišková, "History of Medicine in Eastern Europe"; Doboș, "Whose Children?"; Varsa, "Sex advice East and West"; Ignaciuk, "In Sickness and in Health."

4 For this reason, the sources examined are fragmentary, but they do offer glimpses into the two years of the 1950s when, after a period of severe restrictions, abortion was increasingly permitted for a variety of reasons. Thus, they provide insight into how women adapted to the rapidly changing legal environment of the period. Between 1956 and 1973, the committees remained in place, but they lost their importance as a result of liberalizing tendencies and only regained their relevance in 1973.

Abortion Policy in the Rákosi Era and the Creation and Makeup of Abortion Committees

Abortion became a political issue and thus a matter for the whole country three years after the communist takeover. The slogan of the time was "childbirth for a girl is an honor, for a woman it is a duty." Three ministers of health served during the period of the strict abortion regime from 1952 to 1956, but the unpopular measures of this regime have come to be associated with the name of the only female minister of the Rákosi era, Anna Ratkó.[5] The birth of many unwanted children was attributed to her, and the country associated the "abortion law" with her.[6] Anna Ratkó did not ban abortion, as induced miscarriage was already forbidden unless carrying the pregnancy to term endangered the life or health of the mother. Under her ministerial tenure, abortion was allowed, but the conditions under which it could be performed were enshrined in law, outdated practices were abolished, and health considerations were upheld.[7]

The new policy therefore aimed to enforce the existing but practically ignored norms and bans and control several aspects of pregnancies and all circumstances of their termination, with the active participation of different bodies of the state (including medical authorities and law enforcement). The abortion policy and its drastic measures were supported and endorsed by the top leadership of the Hungarian Workers' Party. The few circumstances under which abortion was allowed became a political issue and a matter of law enforcement. The police took harsh measures against medical professionals who were performing illegal abortions. As a result, people with no medical qualifications (referred to in the public jargon as "angel makers") took over the activities of doctors and midwives. This only increased the death toll, and the rising death toll provided an additional justification in the fight against illegal abortion. Moreover, unscrupulous "profiteering" physicians were banned from their profession, and women who had abortions were pilloried sometimes in local newspapers and within their proper community (e.g. workplace).

The campaign against illegal abortions also relied on the active participation of gynecologists and obstetricians working in the nationalized health institutions.

5 Szabó, "Abortusztilalom anno,"137–58.

6 However, this is not an entirely fair evaluation, since Anna Ratkó was only Minister of Health for a brief period, between April 18, 1951 and April 18, 1953. In the changed national political situation after Stalin's death, she fell out of favor and was replaced by Sándor Zsoldos.

7 Pongrácz, *A Ratkó-korszak*, 1–4.

The reasons for this were both medical and political. Illegal abortions posed a high health risk, so doctors, who had become state employees in the early 1950s, were expected to support the party's political goal on a professional basis. Accordingly, the Ministry of Health Order No. 8100-2/1953 defined professional leadership in the fight against abortion as the task of the head of gynecology in every department in the country.[8] (See Table 1.) The campaign against illegal abortions primarily targeted midwives, quacks, and women who had self-induced abortions, so doctors involved in illegal abortions were less likely to be convicted. By contrast, doctors were also required to report illegal abortions that had come to their attention or face punishment. They were thus less motivated to participate in illegal abortions or conceal cases of which they had become aware. As a result, doctor-patient trust was damaged and women were less motivated to tell their doctors the truth, even if they were in a life-threatening condition after the procedure.

Table 1. Number and distribution of self-induced abortions in 1952[9]

		Accusations	Prison sentences				
			Less than 1 year	suspended	1–5 years	more than 5 years	All
From April 1 to December 30 1952	**Doctor**	30	2	1	3	1	6
	Midwife	44	13	4	27	1	41
	Charlatan	204	56	3	68	71	130
	Self-induced abortion	120	103	55	2	–	105

The new abortion regime not only prosecuted illegal abortions and required doctors to be loyal to the regime rather than to their patients, it also actively built on the paternalistic structures of the doctor-patient relationship. Decree No. 81/34/1952 EüM of May 29, 1952, of Minister of Health Anna Ratkó provided for the procedure for the termination of pregnancy and the establishment and functioning of first and second-instance abortion committees. In a report on the health awareness-raising work two months later, Deputy Minister Miklós

8 MNL OL M-KS 276. f. 96. cs. 3. ő. e. Jelentés a Magyar Dolgozók Pártja Központi Vezetőség Adminisztratív Osztálya részére az Egészségügyi Minisztériumnak az abortusz elleni küzdelemben végzett munkájáról [Report to the Administrative Department of the Central Executive Committee of the Hungarian Workers' Party on the work of the Ministry of Health in the struggle against abortion].

9 MNL OL M-KS 276. f. 96. cs. 3. ő. e. 1952. Feljegyzés a magzatelhajtás bűntette miatt indított büntetőeljárás alakulásáról 1953. január 1-től január 30-ig terjedő időben [Record of the Criminal Proceedings for the Crime of Abortion from January 1, 1953 to January 30, 1953].

Drexler wrote that the committees were established "to eliminate laxity in adjudication" and consisted of trusted professionals. He also noted that, to strengthen supervision, only designated institutions were allowed to perform induced abortions. The ministry considered it necessary for the existing abortion committees to take a "fair" position, as this would make them "more popular, which would be a means of effectively fighting illegal abortion." However, these committees were made up of doctors and held their hearings in public health facilities, so their very structure made it difficult for women's interests to be represented and for their claims to be fairly assessed.

According to the procedural rules of Decree No. 81/34/1953 of the Minister of Health, the termination of a pregnancy was only permitted during the first 28 weeks if the termination was necessary to save the life of the pregnant woman or if the life of the unborn child was in serious danger of being harmed. The pregnancy could only be terminated with the pregnant woman's consent and only in one of the medical establishments listed in the annex to the decree, with the permission of the first or second-instance committee organized for this purpose.

These laws contained the two important features that characterized all abortion laws of the state socialist period, reflecting the party's intention to gain active control over reproductive decisions. First, like any other basic right, the right to abortion was not regulated by parliamentary acts but by lower-level legal measures, such as decrees issued by the council of ministers (government decrees) or ministerial orders.[10] These decrees and ministerial orders introduced and amended rules on the circumstances under which an abortion could be performed. And as subordinate norms, they could easily be changed according to the shifting intentions of the party's population policy and its measures.

Secondly, women's opinions and wishes were considered secondary to demographic and ideological concerns, so the regulations concerning abortion mostly focused on the technical issues of who could request an abortion and under what circumstances such a request could be granted. This also meant that the moral and legal positions and arguments characterizing abortion debates in the Western literature a few decades later (such as pro-life[11] vs. pro-choice,

10 Sándor, "From Ministry Orders towards the Constitutional Debate."

11 Karrer, "The National Right to Life Committee." Even the ruling in the famous *Roe v. Wade* class action case brought before the U.S. Supreme Court allowed states to regulate abortion as a pregnancy progressed. After a fetus reached viability, the state could even prohibit abortion, except when necessary to protect the health or life of the mother. Protection of human life is a compelling state interest.

liberal vs. conservative, or moderate) did not apply to the practice of regulating access to abortion in postwar Hungary. Neither the issue of the legal status of the embryo or fetus (as a living being protected by the law or not) nor women's rights to bodily self-determination played any role in shaping the legal policies on abortion.[12] In other words, once moral and philosophical arguments were removed from legal deliberations on reproduction, the dominant discourse framing abortion became demographic and population policy, so that access to abortion could be granted mainly on material and medical grounds and could be rigorously controlled and constantly reassessed by the state.

This transformation of the law and the practice of abortion was part of the process of Sovietization. Abortion committees had been operating in the Soviet Union since 1936, with similar functions and similar numbers of members. These institutions existed in other socialist countries too, such as Czechoslovakia from 1952.[13] The first-instance committee was tasked with establishing the presence of certain pregnancy conditions and authorizing the termination of a pregnancy. An application for permission to terminate a pregnancy had to be submitted in writing or verbally to the head of the competent first-instance committee, and records were kept of these applications. At the verbal hearing, minutes were taken and, if the pregnant woman was under medical or hospital treatment, the minutes were accompanied by the report(s) issued by the treating physician. The first-instance committee made its decision within five days of the application being submitted on the basis of the medical reports submitted and the necessary examinations. If the pregnancy could not be established beyond doubt, the committee could refer the pregnant woman to a hospital for a maximum of eight days, and the committee made its decision based on the report issued by the hospital after the examinations had taken place. The committee kept minutes of the procedure, recording the medical history, examination results, diagnosis, and indications, in addition to the personal details of the pregnant woman. The committee considered whether to approve or reject the request for permission to terminate the pregnancy based on all this information.

12 The moral view of abortion was not monolithic in Western countries. Dagmar Herzog's analysis shows that in these countries, abortion was genuinely a subject of moral debates, but this moral aspect of the problem was treated differently in West Germany, Switzerland, France, Great Britain, and Italy. Cf. Herzog, "Christianity, Disability, Abortion." In the Hungarian context, there is no trace of such arguments in the minutes of either the Council of Ministers or the Party's Central Committee. Nevertheless, a more profound study of the different laws and the various political initiatives coming from different political and social agents has not been done.

13 Nakachi, *Replacing the Dead*, 59; Lišková, *Sexual Liberation, Socialist Style*, 100–2.

If the committee did not grant the request, the applicant was informed immediately, and if she found the committee's decision objectionable, she could appeal and submit her request to the second-instance committee. The committee sent the minutes, together with the examination report, to the head of the second-instance committee within 24 hours and, after the facts of the given case had been considered, a decision was made whether to overrule the decision of the first committee.

Women whose applications were rejected were subjected to increased surveillance throughout prenatal period, making it impossible for them to terminate a pregnancy illegally. They were granted "heightened protection" by the maternity advisor in the pregnant woman's place of residence. This rejection also had to be recorded in the pregnant woman's medical record and her pregnancy booklet. These pregnant women were required to submit themselves to visits by the visiting nurse (who was always a woman) at least six times. When the pregnancy ended, whether in birth or miscarriage, this had to be reported to the council's health department and, in the case of a birth, information on the status of the baby had to be provided.

If the first-instance committee approved a request to terminate a pregnancy, it sent the minutes together with the results of the examination to the designated hospital and referred the pregnant woman to the same institution. The hospital was required to carry out the termination of the pregnancy immediately after the pregnant woman was admitted, to hospitalize the patient for at least three days, and to report the termination to the chief district obstetrician. The minutes and reports sent by the committee had to be lodged and kept in the hospital's record office.

The structure of the committees reveals their essential political function, which was to determine the medical necessity of abortion or, more precisely, to control the process by which such decisions were made. The first-level abortion committees consisted of three members and had to be set up in every health institution that had a gynecological department. The chairman was the chief gynecologist of the institution, the permanent member was an internist appointed by the city council, and the third member was chosen by the chairman and the permanent member. The second-level committees were organized in the leading hospitals of each county and Budapest and in the gynecological clinics at the universities. They also had three members, all three of whom were doctors.[14]

14 Decree No. 81/34/1952 EüM.

This form of state control over reproductive decisions by abortion committees had a significant impact on the status of women seeking abortion in the whole state-socialist period. Women who requested permission to terminate their pregnancy did not have the same status as patients who wanted the best available treatment. Instead, they were viewed as applicants who wanted something that needed to be assessed and monitored. Consequently, moral and emotional considerations were not listed among possible grounds for termination of a pregnancy. The acceptable reasons for requesting an abortion were only "objective" concerns: health problems and, after 1954, poverty or material deprivation, lack of accommodation or inability to raise children, and health conditions. From 1954, these conditions were assessed by nurses who wrote official reports on the living conditions of the person or people requesting an abortion. These reports were highly subjective, since the state authorities asked only two main questions: who lived together and how many rooms they had in their dwellings. The other parts of the reports were based on the visiting nurses' subjective assessments. While this lack of regulation could have created opportunities to help women who were seeking abortions, it made the inspection process unpredictable. A visit by one of the nurses was an intrusion by a representative of the state into the intimate sphere of the family or the women, and the nurse could present anything she found as an argument for or against abortion. The committees thus not only exercised control over the bodies of women seeking abortions but also had some control over their broader social environment.

Medicalization of the Social? The Decision-Making Process in the Abortion Committees until 1956

The secondary literature points to two trends in the operation of the abortion committees. First, in the 1950s, the legal framework gave the committees considerable autonomy in their work. Second, on the basis of the statistical data concerning applications and approvals, "women who applied to the first-instance committees were mostly assured of a positive decision."[15] Approximately 80 percent of applications were approved by the first-instance or second-instance committee, even in the early period after the committees were established. In general, however, the secondary literature is unclear about precisely what is

15 Pető and Svégel, "A háborús nemi erőszak," 57.

meant by the autonomy of the committees and how this autonomy might have worked in practice in the context of the inherent hierarchical and paternalistic structures of the medical field. In the following section, we take this lacuna in the secondary literature as a point of departure and examine whether this autonomy could have offered opportunities to help women in need. We also examine how women maneuvered among these intentions and hierarchies to secure abortions.

Although the committees were strictly regulated, their decisions were made on the basis of professional knowledge, which allowed them to decouple their work to some extent from political intentions. However, this local autonomy did not mean that their decisions were not made in a paternalistic manner. If we take a closer look at how the role of anemia as a medical reason for abortion changed in the medical records of Pesterzsébet, we can see how doctors with decision-making power on the committee could use certain diagnostic categories to facilitate abortion for women in difficult social situations before 1954 and in the first half of that year.[16] Anemia was included in the regulation as a legitimate reason for abortion, but it was left to the committees to decide whether cases were serious enough to pose a risk to the life of the mother and fetus and therefore to justify abortion.[17] Anemia was one of the relatively rare causes of abortion at the national level, along with rubella and Addison's disease. In the Pesterzsébet cases, while anemia and mental illness were among the accepted reasons for abortion in the first few months of 1954,[18] in the second half of the year, the first-instance committees rejected applications in which anemia was used as a reason for abortion (see Table 2). After a request for permission to terminate a pregnancy had been rejected, the case was sent to the second-instance committee and approved without exception, but on social rather than medical grounds.

16 Ibid.

17 MNL OL M-KS 276. f. 96. cs. 3. ő. e. 1952. Az I. és II. fokú Bizottságok munkájáról szóló jelentések értékelése. Anemia is a reduction in the number of red blood cells in the blood and the amount of hemoglobin (the protein that carries oxygen) they contain. The link between this problem and malnutrition was known before the 1950s. See: Barta, "Az anaemia felosztása," 386.

18 We have no medical records from 1953, but in March and April 1954, five out of 19 requests for permission to terminate a pregnancy were authorized partially or fully on the grounds of anemia in Pesterzsébet. BFL VIII.1144 Pesterzsébet Város Szülő- és Nőbeteg Otthona irata, vols. 21, 22, 23.

Table 2. Number and reasons for abortion in 1954 in Pesterzsébet[19]

Month	All abortions	Number of abortions based on social grounds and this number as a proportion of all abortions	Number of requests submitted on medical reasons, then accepted on social bases and this number as a proportion of all abortions	Number of requests submitted on the basis of psychiatric diagnoses, then accepted on social bases and this number as a proportion of all abortions	Number of requests submitted on the basis of anemia, then accepted on social grounds and this number as a proportion of all abortions
1954 January	11	0	0		0
1954 February	13	3 (25%)	0		0
1954 March	4	2 (50%)	0		0
1954 April	15	7 (46.7%)	2 (13.4%)	1 (6.7%)	1 (6.7%)
1954 May	13	12 (92.3%)	5 (38.5%)	2 (15.4%)	3 (23.2%)
1954 June	23	14 (50.1%)	0	0	0
1954 July	25	22 (88%)	6 (24%)	3 (12%)	3 (12%)
1954 August	40	25 (62.5%)	8 (20%)	2 (5%)	4 (10%)
1954 October	72	50 (69.4%)	9 (12.5%)	1 (1.14%)	5 (6.94%)
1954 November	55	49 (89.1%)	15 (36.7%)	0	13 (23.6%)
1954 December	63	53 (84.1%)	(7.9%)	1 (1.7%)	2 (3.2%)
All	334	237	50	10	31

In the case of anemia, the social causes of the disease explained the interchangeability of medical and social reasons of abortion. Poverty and resulting malnutrition were major causes of anemia, but while this diagnosis was an acceptable reason for abortion even under the strictest abortion regimes, poor social conditions did not become acceptable until 1954. The devastation caused by World War II and the poor economic policies of the State Party in the early years of state socialism had affected a large segment of society. Food shortages, the lack of basic necessities, and inadequate housing became parts of everyday life. This put women in a particularly difficult situation. With the birth of another child, a family had an extra person to feed, pushing them even deeper into poverty.[20] Under such conditions, anemia was often present, and this offered doctors a medical basis for allowing abortions. In other words, this

19 BFL VIII.1144 Pesterzsébet Város Szülő- és Nőbeteg Otthona irata, vols. 17–38.

20 Valuch, *Everyday Life*, 213–314, 416–29.

diagnosis functioned as a kind of medical metaphor for poverty. Thus, when abortion became legal for social reasons, it lost its function.

It is not clear, however, whether the diagnosis of anemia was serious enough to justify the termination of a pregnancy strictly on medical grounds. As early as the 1930s, Hungarian medical journals had published studies describing the uncomplicated but successful treatment of anemia in pregnant women.[21] These articles presented cases from both urban and rural public hospitals, indicating that the method was available to a broader segment of society, not only the elite.[22] Although archival documents show that Hungary suffered a shortage of medicines in the 1950s, this shortage did not affect the treatment of anemia. [23] Therefore, the professional and legal duty of doctors should have been to treat the patients, not to terminate their pregnancies. What the existing treatment could not change was the social and economic environment in which the disease developed and in which its patients had to live. Consequently, if doctors could ignore certain professional norms and forms of treatment, they could use the diagnosis of anemia to medicalize a devastating material circumstance and help women in a difficult situation.

The excessive medicalization of the different types of problems was not only a tool to help women in need; it also highlighted how difficult it was to adapt to the changing legal environment in practice. When the second-instance committees were allowed to authorize abortion on social grounds, the new role of the first-instance committees was not redefined. Consequently, the medical and social reasons became strictly separated, but in practice it was not possible to draw such a clear distinction between the two categories. From April 1954,

21 The housing shortage was a prominent problem in postwar Budapest, and it was not solved until the 1970s, when new architectural technologies (such as panel construction) were applied. For more details on housing conditions during the first period of state socialism, see: Keller, *Szocialista lakhatás?* These social problems could have been more visible among the patients of the Pesterzsébet Maternity Hospital. This institution was responsible for the women of the 20th (Pesterzsébet), 21st (Csepel) and 23rd (Soroksár) districts of the capital, which were among the poorest areas of Budapest. Pesterzsébet was hit by several bombings during the war, and reconstruction progressed slowly. Many of the remaining housing facilities were without utilities. In the late 1940s, 72 percent of its population (25,000) were members of the working class. The working class played an important role in Csepel and Soroksár as well, as both areas were dominated by heavy industry factories and suffered from a lack of housing. (Ránki et al., *Csepel története*, 466–68, 483–86, Bogyirka, *Pesterzsébet története*, 290–96.)

22 Korányi and Tauffer, "Anaemia és graviditás," 583; Stefancsik, "A terhességi anaemia perniciosa kérdéséhez."

23 MNL OL M-KS 276. f. 96. cs. 19 ő. e. A gyógyszerellátás problémái [Problems with medication supply].

several cases were referred to the second-instance committee in which the reason for the first-instance rejection was the diagnosis of neurasthenia. The decision was not surprising. While the consideration of mental problems as a reason for abortion was not far from the Party's thinking or the general tendencies toward abortion, neurasthenia was not mentioned as a legitimate reason for abortion in Decree No. 1004/1953 (II.8.) of the Minister of Health.[24] The process of diagnosis, however, did not follow the legal and medical requirements. Instead of entrusting the decision to a specialist (a psychiatrist) and taking his or her opinion into consideration, the committees had made the diagnoses during the hearing. Why did the first-instance committee find it important to establish an unacceptable diagnosis as the reason for the abortion when it was highly probable that the request would be granted on social grounds?

The answer lay both in the specific situation of neurasthenia in the Hungarian health care system and in the situation of the first-instance committees in a changing legal environment. The contemporary scholarship used neurasthenia as a substitute for medically unexamined and untreated problems. This diagnosis has been criticized, since patients with chronic fatigue, dizziness, headaches, loss of appetite, or nausea (symptoms which could not be easily attributed to a specific disease) were diagnosed with and treated for neurasthenia instead of being subjected to further testing. These symptoms also occur in the early stages of pregnancy.[25] From a psychiatric point of view, neurasthenia could also have been caused by nervous exhaustion as a result of a lifestyle of deprivation and difficult social circumstances, which affected a large part of society. [26] Neurasthenia, therefore, had both medical and social causes, but it was not determined by adequate testing or expert opinion. In other words, the distinction between social and medical categories was not as clear in medical practice as it was in law. The role of the first-instance committees diminished as

24 In the first few months of the new abortion regime, neurological and psychiatric problems were responsible for nine percent of all abortions, ranking them as the third most common reason for termination. (MNL OL M-KS 276. f. 96. cs. 3. ő. e. 1952. Az I. és II. fokú Bizottságok munkájáról szóló jelentések értékelése.)

25 Szakcsoportközi Bizottság, "A neuraszthénia betegellátási és társadalombiztosítási vonatkozásai," 679.

26 Csorba, *Neurosisok*, 481–82. The constructed nature of madness and psychiatric diagnoses has been pointed out by various scholars, including Michel Foucault. According to Foucault, these diagnostic categories, unlike other diseases, are not established on the basis of symptoms or organ dysfunction, but rather by taking into account the person's life history and social problems. As a result, the diagnosis is much more socially constructed than it would be in the case of organic diseases. Foucault, *Le pouvoir psychiatrique*, 171–98.

more applications were made on social grounds, leaving them more capacity to deal with minor medical problems. A diagnosis of neurasthenia could justify a hearing on medical grounds.

The role of neurasthenia and anemia is comparable and shows how the same paternalistic diagnostic process could lead to very different outcomes. In both cases, the diagnosis was based on conditions that were not necessarily medically pathological. However, the diagnosis was not questioned by anyone because it was made by doctors in a position of professional and social authority.[27] In the case of anemia, this helped women in need to have an abortion. In the case of neurasthenia, doctors made a psychiatric diagnosis which was not curable, and which did not present symptoms that might have had a major impact on social integration, but which, as a psychiatric diagnosis, could lead to social stigmatization.

These local decision-making practices show that women had to be familiar with a number of circumstances in addition to the changing legal environment in order to negotiate their requests for abortions successfully. In the course of our research, we found 25 letters written to the committees by women seeking abortions between January 16 and December 15, 1954, during a period when poor social conditions were becoming a legitimate reason for abortion.[28] These letters show that although women were apparently able to adapt their claims quickly to the changing legal environment, they had little chance of knowing with any degree of certainty whether their requests would be approved. 20 out of the 25 letters included social reasons for abortion. In the arguments used in these letters, poor housing conditions and low income are recurring elements which highlight the shortcomings of the party-state's social policy and illustrate the fact that, despite the propagated prioritization of population policy and the wellbeing of previously neglected social groups (e.g., workers), the party was not able to create adequate economic conditions for many women to have children. Another element of the law is also reflected in the letters. 24 out of the 25 applications mentioned a medical reason as grounds for the request for permission to terminate the pregnancy.

In addition to the social and medical reasons, the letters described the women's emotional difficulties. These emotional aspects of the narratives

27 This authoritative aspect of medical knowledge extended beyond the boundaries of health care. For more details see: Lászlófi, "Doctors into agents."

28 Although they were required to attend the hearings in person, they could write to the committee if they were unable to be present.

are the most revealing from the perspective of the precariousness of the women's circumstances, even though they appear in only about 20 percent of the applications. The fear of not being able to spend enough time with a sick child, the intense grief over the death of parents, or, in two cases, the emotional distress and vulnerability caused by an unfaithful husband were cited as specific reasons. From the perspective of privacy, the inclusion of these kinds of details allowed the committee members to invade the women's most private spheres. It suggests, furthermore, that the women did not fully trust that their requests would be considered according to the rules and felt that they were protecting themselves by presenting their situations as matter for individual consideration.

The letters show that women were not sure how their requests would be treated, even if they were living under challenging material circumstances that gave them reason to expect a positive response. This suggests that even though they were aware of the changes in the law, they had no trust in a predictable decision and used any possible reason in the hopes of securing permission to get an abortion. The distrust expressed in the letters did not diminish over the course of the year, and the accumulation of arguments in support of requests did not decrease in the slightest.

Abortion Policy after 1956

A turnaround in the regulation of abortion came when, in Decision No. 1047/1956 (VI.3.) of the Council of Ministers, the "insistence on abortion at all costs" was added, alongside illness and social reasons, to the justifications for seeking an abortion.[29] Interestingly, this reasoning appears as an explanation in various time periods in the doctor-patient relationship, together with a slogan frequently cited by gynecologists according to which, "women would do everything to be a mother and not to be a mother." In his memoir, Zoltán Papp, a professor of gynecology and obstetrics and head of the Teaching Hospital at the Medical School in Budapest, also cites this phrase,[30] and although he mentions

29 In this period, fetal health concerns were also raised in Western countries. Starting from the late 1950s, thousands of babies were born with severe birth defects after their mothers took the morning sickness drug thalidomide while pregnant. Following the thalidomide scandal, an epidemic of rubella, or German measles, appeared. Babies that survived rubella in utero were often born with a wide range of disabilities. At the end of the 1960s, these serious health issues were also prompting more lenient approaches to abortion based on medical reasons in the Western world. (A rubella vaccine did not become available until 1971.) Malacrida, "Dangerous Pregnancies."

30 Papp, *Egy szülészorvos naplójából*, 26.

several issues of the doctor-patient relationship in the context of gynecology, such as the questions of *in vitro* fertilization, caesarean section, and the genetic condition of intersexuality, he spares only one sentence on abortion by stating that the doctors simply have to accept the fact that at times women insist on having abortions.

Parallel to the dissolution of the Rákosi era in Hungary after Stalin's death but only a few months before the outbreak of the 1956 Revolution, the ban on abortion was abolished by a decree of the Council of Ministers, and abortion was liberalized according to the Soviet model. This change was part of the relaxation following the 20th Congress of the Communist Party of the Soviet Union in February 1956. At this congress, the cult of personality and the dictatorship of Stalin were denounced. This critical tone of the Soviet regime had an impact on the situation in Hungary. Although the process had already begun in 1954 with the acceptance of poor social conditions as a reason for abortion, the further relaxation of abortion regulations can be seen in this context. This transformation was linked to József Román, Minister of Health at the time, who introduced the decision by stating that "women's perseverance in all areas of our economy, their advanced self-awareness, and their sacrificial attachment to family and child, typical of the great majority, have created a moral basis for women to decide for themselves on the question of motherhood."[31] This phrasing also put the responsibility on women, but most likely this turn acknowledged the sad fact that the combination of a lack of adequate family planning and the repressive abortion policy created many victims of illegal abortions and unwanted children. Based on the Health Minister' s decree no 2/1956. (VI. 24.) on the regulation of the procedure related to the termination of pregnancy, the committee authorized abortions if it was necessary to save the life of the pregnant woman or to protect her from a serious illness or further aggravation of an existing illness or if the unborn fetus was in predictable danger of serious damage. The committee was also authorized to allow the termination of a pregnancy if it was justified by personal and family circumstances that deserved consideration or the applicant insisted on the termination of the pregnancy even after having been informed about the consequences. In practice, this meant that anyone could terminate a pregnancy by the end of the first trimester.

The new law may give the impression that the state had been forced to revise its pronatalist intentions. However, in the context of the expanding

31 *Népszava*, 27 May 1956, no. 124, 5.

welfare policies of the 1960s, the new law could be seen as a change on the level of policy rather than a fundamental change in pronatalist aims. Until 1956, the main objective had been the birth of every child conceived. Then, and especially from the 1960s onwards, the party sought to encourage the deliberate bearing of children. Instead of banning abortion, the new reproductive regime encouraged women to pursue pronatalist goals and to cooperate with the state. Compared to the first decade after World War II, the community care systems (health care, children's institutions) were expanded from the beginning of the 1960s. New forms of support were also introduced, such as the childcare allowance from 1967 and a national network of specialist counsellors to help young mothers. State control over reproduction was maintained through the expansion of state assistance and financial support for childrearing, rather than through the hierarchical and paternalistic structures of state-funded health institutions and the doctor-patient relationship.

Although state socialist Hungary, like other states in the Soviet sphere of interest, legalized wide access to abortion before capitalist countries, timing was not the only difference between the two political camps in Cold War Europe. In the USSR from 1955, in Bulgaria, Poland, and Hungary from 1956, and in Czechoslovakia and Romania from 1957 women did not have to meet any social or medical criteria to terminate their pregnancies.[32] In Great Britain, France, Italy, and other Western societies, women were not legally allowed to have abortions until the late 1960s and 1970s, when modern contraception was more widely available and new regulations had emerged from social movements and bottom-up feminist initiatives.[33] As a result, the right to abortion in state socialist states was seen as given by the state party, which also meant that restrictions on abortion were in the hands of the party-state and that the situations of women seeking abortions were different from the situations of women seeking abortions in the West. This became apparent from the mid-1960s, when the negative impact of high abortion rates on population numbers became central to political discourse in these countries. As a result, abortion in Hungary was again made subject to stricter medical and social conditions in 1973, as the position of those opposed

32 The only exceptions among the socialist countries were the GDR and Albania, where abortion remained banned. Although liberalization took place at almost the same time in these socialist countries, it seems that different political motivations preceded the decision. While in the Czechoslovak case the impact of the ban of abortion on individual lives was assessed through research prior to legalization, no such evidence was found in the Hungarian case; the decision was made purely on political grounds (Lišková, *Sexual Liberation, Socialist Style*, 102–7; Lišková, "History of Medicine in Eastern Europe," 182.)

33 Herzog, *Sexuality in Europe,* 155–61.

to allowing a pregnant woman almost complete freedom in the decision to have an abortion.[34]

Abortion Policy after 1973

By the end of the 1960s, the number of abortions had increased dramatically in Hungary. In 1960, the average abortion rate was 66.3 per 1,000 women of reproductive age, rising to 76.5 by 1968.[35] Policymakers were eager to find a way of bringing this number down. A new, stricter law was adopted: Decree No. 4/1973. (XII. 1.) of the Minister of Health.[36] According to this decree, there were ten reasons for which a pregnant woman could be given permission to have an abortion.

The Health Care Act of 1972, passed a year before the new abortion legislation, changed the hierarchical doctor-patient relationship to some extent. It was a high-level and comprehensive law, which included the duty to provide care and the obligation to share some basic information with patients. It was not very detailed, however, when it came to patients' rights, as it focused mainly on the duties of the physicians. A special Section was dedicated to the protection of women and mothers.

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34 Although the introduction of stricter regulations seems to have been motivated specifically by the results of demographic research in Hungary, similar trends can be observed in other countries in the socialist block. While the influence of the Soviet example was undeniable during the liberalization process, the tightening was influenced by the different relationship between society, the political leadership, and experts in each country. In Romania, abortion reappeared in political discourse as a cause of population decline as early as the mid-1960s, leading to the recriminalization of abortion in 1967. In Poland, in contrast, abortion was recognized from the 1970s as a harmful alternative to contraception and an obstacle to the spread of modern contraceptive methods. Parallel to the discourse on contraception and the modernization of sexual life, abortion was no longer seen as a solution for women in a poor social situation, but rather was perceived as a means of getting rid of sick, "biopolitically useless" offspring, who would have been a financial burden to the state. In the Hungarian case, both arguments can be observed to a certain extent. While in the rhetoric of some sociographers (e.g., Gyula Fekete), the visions of abortion, population decline, and national death are linked. Eszter Varsa's research shows that in the Hungarian context, the promotion of healthy offspring gained priority in the 1970s. This goal was supported by experts, and the instruments of social policy were more and more directed towards promoting childbearing among highly educated women. Doboş, "Whose Children?" 88; Varsa, "Sex advice East and West," 659–60; Ignaciuk, "In Sickness and in Health," 93–95.

35 Szabó and Kalász, *Egészségügyi helyzet 1971*, 39.

36 The Decree No. 4/1973. (XII. 1.) EüM on the evaluation of the application for termination of pregnancy enumerated grounds for an abortion.

Article 29 of the Act stipulates that, "[t]he state also ensures the protection of the mother and the fetus with modern health care, as well as the preparation of the pregnant woman for motherhood. In order for the women to give birth to a healthy child, women must be provided with the necessary care and medical care, as well as counseling to resolve specific issues related to marriage and family planning."

In the second paragraph of this Article, the law orders that "[t]he pregnant woman must be provided with curative and preventive care appropriate to her physiological condition, within the framework of which the pregnant woman is taken into care, the appropriate screening tests, the necessary treatment and counseling. The care must ensure the protection of the pregnancy and the health and development of the unborn child, taking into account the physiological state of the pregnant woman, possible illness, age, and working and living conditions."

It is striking that in the Parliamentary Act only a short sentence refers to induced abortion: "Termination of pregnancy is permitted only in cases and in accordance with the provisions of the law. The pregnancy must not be terminated if the termination of the pregnancy endangers the woman's life or may cause serious health damage."[37]

Looking at the detailed regulatory grounds included in Decree No. 4/1973 of the Minister of Health on requests for abortions, the bulk of the reasons for which an abortion could be granted involved financial grounds, or the so-called "social reasons":

Article 1. Artificial termination of pregnancy may be performed upon the written request of the pregnant woman, based on permission. The application is judged by the committee established for this purpose.

Article 2 (1) The committee grants permission for the artificial termination of pregnancy if:

a) a medical reason existing in the parents, or the probable medical condition of the unborn child justifies it,

b) the woman is not married or has been living separately for at least six months continuously,

c) pregnancy is a consequence of a crime,

d) the pregnant woman, or her spouse, does not have her or his own apartment that can be moved into or an independent rented apartment,

37 Article 29 (4) of the Health Care Act of 1972.

e) the pregnant woman has three or more children or has given birth; or has two living children and has also had at least one obstetric event,
f) the pregnant woman has reached the age of 40.

(2) In addition to the reasons listed in paragraph (1), the committee may grant permission to terminate a pregnancy if:
a) the pregnant woman has two living children, but the viability and development of the unborn fetus is expected to be at risk from a health point of view,
b) the spouse of the pregnant woman performs long-term regular or special service in the armed forces or bodies, and at least six months of that time remains to be served at the time of submitting the application,
c) the pregnant woman or her spouse is serving an enforceable prison sentence of at least six months,
d) other social reasons strongly support it.

The committee could authorize the termination of a pregnancy if the pregnancy had not exceeded the twelfth week. Furthermore, permission could be granted to terminate a pregnancy in the case of a minor up to the eighteenth week of pregnancy.

This transformation was the result of a recurring social concern according to which abortion was seen not only as a difficult private decision with an emotional and moral element but rather as an economic decision.[38] In sharp contrast with the cases in which women tried to seek help in the 1950s and stated multiple reasons for seeking abortion, often emphasizing their poor health, in cases after 1973, when women applied for permission to terminate a pregnancy after the law restricted their access to abortion once again, they were often stating simple economic reasons. Quality of life had improved in general, and health conditions that had dominated the period after the war, such a tuberculosis, polio, and typhus, had gradually disappeared, but a certain level of material wealth seen as adequate to create a home environment in which a healthy child could be raised was regarded as necessary, including a dwelling

38 Fears of demographic and national decline have existed since the beginning of the twentieth century. One cause was the individualization brought about by modernization. After 1920, when the Treaty of Trianon led to the annexation of significant parts of Hungary's territory and population by the neighboring states, these fears intensified. Criticism resurfaced in the 1960s, but the concerns were based on consumer lifestyles and female employment. Majtényi, "A Kádár-korszak társadalma," 178–87; Fekete, *Éljünk magunknak?*

or a salary. Although oral contraceptives were already available in the 1970s, abortion was still considered a family planning method for many women. To obtain a prescription for contraception, women had to visit a doctor, which also involved informal payment (so-called *hálapénz*, or "gratitude money"), but regular gynecological checkups were not compulsory.

From Medical to Social? The Functioning of Abortion Committees after 1973

The new regulation contained new elements. First, in contrast to the Ratkó era, the new law was based not only on a quantitative but also on a qualitative goal: it sought to make abortion more difficult for those who were wealthier. Better financial status could also mean that parents were more respected members of socialist society, so encouraging them to have children was also a tool to shape society and increase the number of individuals with politically and socially appropriate values. Second, in contrast to the period after 1956, different forms of financial support were no longer considered sufficient to motivate people to have children, and prohibitions were again used as an instrument of population policy. In order better to monitor the social and material situation of a pregnant woman as a reason for abortion, the regulations on abortion committees were substantially amended. While in the 1950s, all three members of the first-instance abortion committee had to be doctors, in 1973, only the chairmen of the committees had to be physicians, and although they were doctors, they were chosen by the city's political leaders.[39] Consequently, their selection for the role could be influenced by their political rather than their professional qualifications. The second member was a representative of the city council, also politically appointed, and the third was a visiting nurse. The committee members were thus personally connected to the political leadership, but at the same time, the participation of the visiting nurses on the committee added a female perspective to the decision-making process (as noted earlier, these nurses were always female). Abortion has undoubtedly become a social and material issue rather than a medical one, and the new composition of the committee shows that the party's thinking on who had the right to decide on abortion and on what basis had changed over the course of the 13 years that had since elapsed.

39 Female doctors could be members of the committees, in principle. However, the printed and archival materials consulted in the course of our research reveal not a single example of a female physician serving on one of the committees.

The standardization of the application form and the report on living conditions was a crucial element of this change. All women were required to provide information about their family's financial and housing situation, details concerning previous pregnancies (if any), and the contraceptive method that they were using. In cases in which women applied for an abortion on social grounds, an official report on their living conditions was requested to prove that their situations were difficult.[40] The medical records of Pesterzsébet already contained some reports on living conditions from the Rákosi era, so the practice was not new, but in the 1950s, only a few applications had included such documents.

The report on living conditions was based on a series of questions, each of which had to be answered prior to the interview during a personal visit by a visiting nurse, so there was no way of limiting the invasion of privacy by the state. The visiting nurse had to gather information according to an official list of questions. She asked about the condition and size of the dwellings, who the women lived with, what they wore, whether they had credit, and the quality of the family's diet. The nature of these questions illustrates the declining importance of medical data and the rise of personal information in decision-making. As a result of this shift in the application and decision-making process, medical paternalism was replaced by other forms (social, political) of paternalistic control.

How did this new structure of decision-making control abortion at the institutional level, and what impact did these new practices have on women's applications? To answer these questions, we examined the applications discussed by one of the abortion committees in Pécs in 1973. Under state socialism, Pécs became one of the most important industrial centers of Hungary. Ore extraction, especially coal and uranium, grew rapidly. As a result, the population of the city increased dramatically. Pécs became one of the four largest municipalities in Hungary, with more than 100,000 inhabitants by 1960.[41] The city had two abortion committees, one at the Medical University and the other at the County Hospital. The records of the latter committee have been preserved only from the year immediately following the introduction of the new regulation.

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40 This process is part of a larger trend that Michel Foucault and Dominic Memmi, among others, have called the "emergence of biopolitics" in the second half of the twentieth century. The essence of this shift is that the expanded management of biological issues has become subject to societal and political considerations. While Foucault emphasized that the emphasis in state policies regarding previously criminalized bodily practices (homosexuality, abortion) has shifted to consistent control rather than discipline, Memmi argues that in addition to control, states provide material incentives to encourage citizens to behave in a manner seen as proper by the state. Cf. Memmi, "Governing through Speech," 645–58.

41 *1970. évi népszámlálás*, vol 1, 24.

Among the documents from Pécs, there are some applications where the standardized procedure was not applied. In these cases, the visiting nurse member of the committee only verbally confirmed the poor conditions at the hearing without an actual report on living conditions, and this confirmation was enough to prompt or allow the committee to approve the application.[42] The primary role of these women as public servants was to provide professional, government-funded assistance to mothers providing care for their newborns.[43] From the perspective of the committee, the nurses' verbal testimony about the social conditions of their former clients seemed credible and saved time by allowing the committee to forego any actual report on the circumstances in the applicant's home. Despite the different motives, the verbal testimony of the visiting nurses could successfully support the women's credibility in the decision-making process and ultimately spare women any physical intrusion into their homes.

The interpretation of social reasons also changed to some extent between the 1950s and the 1970s. While poverty and poor housing conditions dominated this category, personal intentions to meet the new expectations placed on the ideal socialist woman also emerged. A new trend was the expression by women of the intention to continue their studies. Since women's education and social mobility were important social goals of the system, pregnant women could see this insistence on the importance of their educational aspirations as an acceptable justification, as it touched both on their personal lives and on the political and social goals of socialism.

Although the new regulation emphasized standardized decision-making, the committees retained considerable autonomy in their work. As a result, it was not certain that a reason which was seen as acceptable in one case would be adequate in another. The first two columns of Table 3 are illustrative. While a 19-year-old unmarried woman with a steady income would be allowed to terminate her pregnancy to continue her education, this was not an acceptable argument for a girl in a similar situation without a steady income. The difference cannot be explained by the law, which would not have allowed abortion in either case. Nor does the financial situation of the women explain the differences, since a woman without a steady income was denied in both cases. Similarly, a change in

42 MNL BAML XIII. 158e Pécs MV Tanácsa VB Terhességmegszakítási Bizottság iratai, 1974. I.II. félév. [Documents of the Abortion Committee of City Council, Pécs]

43 On the history and complex role of visiting nurses in mothers' lives and in society, see: Neményi, *Egy határszerep anatómiája*; Kappanyos, "Hajlékában kell felkeresnünk őt."

the composition of the committee cannot justify a different decision in similar situations, since the members of the committee were elected for a few years.

Table 3. Two examples of how the committees treated similar cases differently [44]

Age	**19**	**19**	**30**	**27**	**20**	**26**
Mother's salary (in Hungarian forint)	1,300	(the pregnant woman has no income; her parents' income is 4,500)	2,700	2,150	1,500	1,600
Father's salary (in Hungarian forint)	—		2,700	2,000 (unemployed for 2 weeks)	2,300	3,800
Number of children	—	—	1	—	—	2
Reason for termination	**"She is single and wants to continue her studies"**	**"She wants to continue her studies, also not married"**	**"She wants to continue her studies"**	**"Her husband is ill and left her 3 days ago"**	**"She is separated from her husband"**	**"Does not get along well with her husband"**
Has she tried to prevent the pregnancy?	Fertility awareness	no	Fertility awareness	no	no	condom
Authorized by first-instance committee	X					
Refused by first-instance committee		X	X	X	X	X
Authorized by second-instance committee				X		X
Refused by second-instance committee		X			X	
Cost of the procedure	1,000	-		1,000		1,000

The most reasonable explanation seems to be that the committee did not even try to be consistent, and it judged each situation individually. Due to different perceptions of individual situations, already controversial issues, such as the situation of women graduates, could be judged differently in each case. Political support for women's participation in higher education was an argument

44 MNL BAML XIII. 158e Pécs MV Tanácsa VB Terhességmegszakítási Bizottság iratai 1974. I.II. félév.

for accepting such petitions. At the same time, women's intellectual aspirations were not always accepted, nor did they always enjoy unambiguous support among various segments of society.[45]

There were also cases in which the reasons for abortion authorized by the ministerial decree were overruled by the committees. Separation offers a good example. The committees could authorize abortion for separated couples, but only if the man and woman had been separated for at least six months. In practice, as the third column of Table 3 shows, the committee could authorize an abortion after three days of separation without considering other reasons, while for another couple, a longer separation might not be seen as an adequate justification for an abortion. In another example, where there were two children, separation was not even necessary. The mention of an allegedly bad marriage was sufficient grounds for an abortion. These requests were discussed within a year, a relatively short period of time, showing that, as had been the case in the first half of the 1950s, women seeking abortions could not be sure of the outcome when they applied for permission to terminate a pregnancy. This also suggests that the bureaucratization of the application process and the standardization of the measurement of social deprivation did not make the process fully transparent. Despite their reduced medical character, the committees, as state institutions, were still able to exercise effective control over women's bodies, in some cases in ways that differed from the party's intentions. These committees thus offered women no clear assurance of the outcome of their requests for permission to terminate an abortion and also sabotaged, at least to some extent, the regime's population policies.

Conclusion and Legacy

We have explored in this article how different regulatory regimes were based on different forms of paternalism and how they influenced the practice of abortion at the local level of health services. The frequent changes in legislation suggest that the State Party in Hungary gave abortion regulation a decisive role over other means of achieving population growth. The constant legal transformation reflects uncertainty about whether a ban on abortion or more permissive regulation combined financial incentives for women to have children would achieve this objective. However, empirical sources show that, from the early 1950s on, the

45 Majtényi, *A tudomány lajtorjája*, 199–203.

new population policy not only built on the paternalistic structures of the medical encounter but also placed doctors at the center of the anti-abortion struggle by making them state employees and establishing abortion committees. To a certain extent, this also allowed gynecologists and obstetricians to sabotage the state's population policy by exploiting their freedom of judgement and their status as representatives of the medical sciences whose knowledge was beyond dispute. The paternalistic logic of these decisions did not change over the course of the state socialist period, despite the standardization of the procedure in the 1970s. The involvement of visiting nurses and council members in the work of the abortion committees from 1973 onwards also failed to reduce the arbitrariness of the decision-making process. This made the system unpredictable and placed women in an even more vulnerable and uncertain position.

After the regime change in 1990, a new abortion law was adopted.[46] The fierce debate between 1991 and 1992 in Hungary, which was not without some extremes, finally concluded with the drafting of a law based on compromise. A law with such a profound influence on the lives of people and families should, in our assessment, remain in force for a longer period of time in order to create a predictable environment in which legislation can be consistently applied. A country's abortion law cannot be changed over and over again. In addition to lasting and predictable legal regulation, the requirement of legal certainty also includes the harmony among laws, so that the answers to a given legal question provided by different laws are coherent. In 1992, a new Parliamentary Act was adopted in Hungary, the first regulating the termination of pregnancy in a law that was adopted by the Parliament. The title of the act is somewhat confusing as it refers to the protection of fetal life.[47] According to the law, "pregnancy may only be terminated if it is endangered or if the woman is in a severe crisis situation, under the circumstances laid down in the present act."[48] The law defines the severe crisis situation as "a situation that causes bodily or psychological disarray or renders the woman's social existence impossible."

Marital rape was only criminalized in 1997 by Parliamentary Act No LXXIII., which went into effect on September 15, 1997. In the same year, a new Health Act[49] was adopted that included explicit patients' rights, including more detailed provisions on informed consent and some reproductive rights.

46 Levine and Staiger, "Abortion Policy and Fertility Outcomes," 225.

47 Parliamentary Act No. LXXIX of 1992 on the protection of fetal life.

48 Ibid. 5. § (1)

49 Parliamentary Act No. CLIV of 1997 on health care.

In Hungary, abortion continues to be a subject of biopolitical debates. Recently, in a measure that hearkens back to socialist times with the adoption of a low-level legal norm, the Appendix of a decree prescribed new conditions for abortion in 2022 which included compulsory examination of fetal life signs, such as a heartbeat.[50] This measure again disrupts the doctor-patient relationship in the vulnerable field of reproductive rights. Although the abortion committees were dissolved even before the regime change and relatively broad access to abortion was granted in the 1992 Parliamentary Act, paternalism still dominates the field of reproductive rights, which operates with laconic but significant changes to the law which are symptomatic of legal and medical paternalism. In addition, pronatalist policies also took the form of patriarchal policies that include not only propaganda but a certain level of coercion. Although women now do not have to stand in front of abortion committees, they have to go through a double consultation process of which paternalism is still very much an element.

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Hungarian Historical Review 12, no. 3 (2023): 524–526

BOOK REVIEWS

Buda oppugnata: Források Buda és Pest 1540–1542. évi ostromainak történetéhez [Buda oppugnata: Sources on the history of the sieges of Buda and Pest in 1540–1542]. Edited by Péter Kasza. Budapest: Bölcsészettudományi Kutatóközpont Történettudományi Intézet, 2021. 571 pp.

"The science of history in Hungary is fortunate if such ambitious volumes can be created as a by-product of various projects." These words were spoken at the book launch of this volume in Budapest, and rightly so. This publication is the product (one might say, the unexpected fruit) of two research undertakings., Péter Kasza's NKFIH project *Buda oppugnata – Wolfgang Lazius elfeledett történeti műve* (Buda oppugnata – the forgotten historical work of Wolfgang Lazius) and *Mohács 1526–2026. Rekonstrukció és emlékezet* project (*Mohács 1526–2026. Reconstruction and Memory* project).

The volume is a monumental edition of a text which fills an important lacuna in the historical scholarship and can perhaps best be compared to the volume *Örök Mohács* (Eternal Mohács) in the abovementioned series. While the latter collected and published in Hungarian translation the contemporary and later sources on the Battle of Mohács, the volume under review here makes the predominantly contemporary sources on the sieges of Pest and Buda between 1540 and 1542 available to a wider audience. The range of sources is broad, both linguistically and in terms of genre, but even the sources published here show some variation in their date of origin and reliability. The palette ranges from eyewitness accounts (such as those offered by Wolfgang Lazius and Hans Ungnad) to writings by secondary users of sources, with a mix of pro-Habsburg and anti-Habsburg authors and even narratives representing the Ottoman perspective are included. The sources of the published texts were predominantly accessible, but they were nonetheless unknown. Indeed, until now it has been customary to discuss the fall of Buda on the basis of five or six texts (first and foremost, the texts by Sebestyén Tinódi Lantos and György Szerémi and the *Memoria rerum*), so thanks to this new and more complete edition of texts, historians can now begin to deal with the subject in a more meaningful way, analyzing and comparing a broader array of sources.

After a close reading of the sources, Kasza divides the military events of the three years in question into eight phases, but he finds it preferable to organize

these eight phases into three larger chapters. The first covers the period between 1540 and April 1541, from Leonhard von Vels' campaign to the Turkish siege of Pest. The second examines the campaign of Wilhelm von Roggendorf and the Turkish invasion of Buda, i.e., the events of 1541. In the third, Kasza examines the sources on Joachim of Brandenburg's campaign, i.e., the efforts in 1542 to retake Buda and Pest. Unsurprisingly, the second part contains the most sources. The ominous antecedents to the fall of Buda, the failed attempts to avoid tragedy (such as the attempted treason by the citizens of Buda), and the tragic outcome are interwoven into an almost seamless story. Given the manner in which Kasza has divided the narrative into three phases, the presentation of the longer sources is broken at the pivotal points, but at least the descriptions of events that took place at the same time are placed side by side and thus can be more readily compared. Each of the almost 30 sources is a valuable and interesting reading on its own, but together, they make an even more engaging narrative.

As for the merits of this edition, the sources published here will not only provide important points of reference for researchers of the period but will also be of interest to the lay readership. Should a reader weary of the details offered in the sources, he or she can enjoy the rich array of sumptuous illustrations. The volume includes 33 high-quality illustrated supplements, including both maps of the sieges (Virgil Solis's engravings in high resolution) and portraits of the characters in the book. Military historians, historians, and literary historians will be perhaps the most pleased with this volume, as it offers new information on, for example, the Saturday Gate or the Vienna Gate, several different narrative perspectives on the same events, and meticulous editing and rhetorical elaboration of the texts and the use of ancient topoi, which allows for a number of new interpretations. The different points of view come together like the pieces of a mosaic: the capture of Buda and the ruse used by the Ottomans, familiar to the Hungarian reader, are not even mentioned in the account of Sultan Suleiman and Djalalzade Mustafa of Jalalzaade, for example. It dwells, rather, only the battle and the flight of August 21–22. The reception of little John Sigismund by the Sultan is mentioned in the account by Lütfi Pasha, but this narrative does not resemble the account found in the Hungarian and Western (Piotr Porebski's report) sources. In Lütfi Pasha's text, Isabella sent her son with gifts, while in the version more widely known in Hungary, the widow only wanted to send gifts, and it was the Sultan who insisted that she also send her son.

It is also worth pausing to note the genres of the sources. They include historical works, fragments of letters (by Elek Thurzó, Andreas Kolár, and

Lucas Górka), and lyrical works, such as poems and narrative songs and even a fragment from a drama (an excerpt from Daniele Barbaro's *Tragedia della regina Isabella*). Five different poetic works in four different languages (by Johann Lange, Klemens Janicius, the aforementioned Sebestyén Tinódi Lantos, and Mavro Vetranović) offer narratives of the fall of Buda. It is interesting to note how the genre of sources changes over time. The earliest sources are letters, reports, and new announcements, while the tragic events only later began to appear in the narratives in popular genres, such as Barbaro's drama (1548), Lange's *Pannoniae luctus* (1544), and Janicius' Tristia (1542) in the collection *Pannoniae luctus,* Vetranović's poem (*Budavár panasza*), and Tinódi Lantos' historiographical songs (c. 1553 and 1554). The events of the summer of 1541 seem to have been the only ones dramatic enough to have found expression in a variety of genres and then to have been deemed worthy of recording in narrative in later years. This is interesting if one keeps in mind that the events leading up to 1541 were also full of ominous twists and turns foreshadowing the impending tragedy (such as the attempt by the burghers of Buda to "bail out"), but the focus in the sources remains on the events of late August 1541.

The texts in this volume are mostly translations into Hungarian, some of which have been published now for the first time. The translations are, in general, admirable successes and make for pleasant reads. In compiling this body of texts, Kasza used existing translations (by historians such as Pál Fodor, József Bessenyei, László Juhász, Dezső Tandori, and László Geréb), but he also assembled a wonderful team of translators. Almost all the most prominent scholars of the period (including neo-Latinists, historians, Germanists, Turkologists, etc.) took part in the project. The thorough but not overwhelming accompanying notes and the reader-friendly translations enable readers to immerse themselves in the history of the sieges of Buda and Pest in 1541–1542.

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Maria Theresa: The Habsburg Empress in Her Time. By Barbara Stollberg-Rilinger. Translated by Robert Savage. Princeton–Oxford: Princeton University Press, 2021. 1104 pp.

In connection with the 300th anniversary of the birth of Maria Theresa of Habsburg (1717–1780), many biographies were published. Among them, the work of Barbara Stollberg-Rilinger, a professor of early modern history at the University of Münster, stands out for its excellence. Stollberg-Rilinger's biography was originally published in German in 2017 and then in English in 2021.

As one of the leading representatives of the German school of political and cultural history, Stollberg-Rilinger places great emphasis on the symbolic communication of Maria Theresa and her court, but she keeps in mind that her protagonist was also a private person with a private life. She bases her panorama-tableau of Maria Theresa's life on an excellent selection of sources, mainly correspondence, reports of ambassadors, travelogues, contemporary diaries, and visual sources. Stollberg-Rilinger analyzes numerous visual artworks and literary sources related to the mentality of the time and the ways in which Maria Theresa presented herself to the world around her as a ruler. As she explains, Stollberg-Rilinger adopts an "ethnological" point of view towards her main character. She tries to avoid anachronisms, rejecting depictions of Maria Theresa as a family mother and ruler-heroine such as the monument to her in front of the Hofburg in Vienna and the characterizations offered by the historians of the successor nation states of the former Habsburg Monarchy.

In the chapter entitled "The Heiress Presumptive," we learn about the childhood and youth of the Habsburg Archduchess. Stollberg-Rilinger refutes the popular view according to which Maria Theresa was not prepared to rule. In fact, she was educated by Jesuit teachers in the subjects usual for male princes of the time. Stollberg-Rilinger outlines the context of the Viennese court of Emperor Charles VI. She pays attention not only to the monarchy's foreign policy and the dynastic chess games, but also to the logic of favor in the Baroque court. Analyzing the details of Maria Theresa's marriage to Francis Stephen of Lotharingia, Stollberg-Rilinger examines the point of view of the ways in which this union of two ruling houses was portrayed the public.

The next chapter deals with the war of the Austrian succession. In addition to the most important military and diplomatic events, Stollberg-Rilinger also covers the leaflet and propaganda campaign that accompanied the conflict. Due to the conventions of the time and her frequent pregnancies, Maria Theresa

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could not play the role of a warlord, but she was able to use her identity as a woman as part of the propaganda, primarily the topoi of the brave and warlike heroine and the beautiful woman and loving mother who, at the cost of numerous territorial losses, managed to protect her throne from the aggressors. Maria Theresia very strategically separated her biological gender from her role as a ruler. The manner in which she presented herself at the coronation of the Hungarian king at the Diet of 1741 offers a good example of this. She wore a crown for a man, performed as a king *(rex)* in a ceremonial sense, and was depicted with a sword and on horseback, not as a queen *(regina)*.

The chapter "Empress, Emperor and Empire" presents the coronation of the emperor in 1745, his subordinate position in relation to her wife, and Maria Theresa's policy regarding the Holy Roman Empire of the German Nation. According to Stollberg-Rilinger, we cannot speak of a German imperial policy that was independent of the dynastic power games of the Habsburg House. Maria Theresa was skeptical about the practical value of the imperial title. The imperial institutions were practically paralyzed by the Habsburg–Hohenzollern rivalry and the constant disputes over precedence.

In the fifth major unit ("The Reforms"), Stollberg-Rilinger outlines the history of the reforms in the hereditary lands introduced by Friedrich Wilhelm Haugwitz in 1748–49 and the reforms proposed by State Chancellor Kaunitz in 1761. She places great emphasis on the presentation of the process of transition from the traditional administrative system based on provincial privileges and customary rights to the rationalized-centralized state bureaucracy. In her view, the reforms created new problems, the solutions to which required repeated amendments, so this started a mechanical chain reaction of reforms, while Maria Theresa's rule was still based on personal presence. In order to overcome the new challenges, the aging monarch increasingly relied on others and the new elite at the top of the state machine, which was becoming increasingly bureaucratic and required a high degree of professionalism.

In the next two chapters ("Body Politic, Distinctions" and "Refinements"), we read about the body politics of the era of the empress, i.e., the history of depictions of beauty, the court norms of sexuality, the empress' conservative opinion and decrees on libertinage, and finally about Maria Theresa's births and family life. Stollberg-Rilinger refutes the widespread legend according to which Maria Theresa lived an almost petty-bourgeois family lifestyle. In fact, she did not spend much time with her children. In her daily life and in her treatment of her children, she followed the harsh aristocratic customs of her time.

Chapter eight on the Seven Years' War follows the war's military and diplomatic events and analyzes the mechanisms and aims of wartime propaganda. Stollberg-Rilinger comes to the conclusion that the patriotic German press, which was launched in these years and was more successful than the Austrian press, destroyed the reputation Maria Theresa had managed to acquire in the previous years. As a result of the "diplomatic revolution," the empress, who allied with the "archenemy" (the French), became the aggressor. Frederick the Great of Prussia, in contrast, shone as the defender of the Protestants and the German nation. In addition, according to Stollberg-Rilinger, the overall balance of the war was negative for Maria Theresa. She did not achieve her political goal (the recovery of Silesia), and her government reforms also failed, and state debt continued to grow rapidly.

The chapter "Capital of the Dynasty" focuses on the family and dynastic politics of Maria Theresa. Stollberg-Rilinger considers the queen's children, from the perspective of their marriages, as victims of dynastic politics, whom Maria Theresa, like her ancestors, saw as means of increasing the family capital and acquiring territory. The care she provided as a mother extended not only to ensuring that her children had an excellent education, but in order to protect their lives, in an almost exceptional way among European ruling dynasties, she also administered the vaccine against smallpox, which was considered the latest discovery.

In "Mother and son," Stollberg-Rilinger presents the period during which Joseph II reigned as co-ruler *(corregentia)*. One observes, during this period of two and half decades, the collision of two worldviews and styles of governance. While Maria Theresa was ruler by the grace of God, Joseph, raised in the ideology of the Enlightenment, assumed the image of the first servant of the state and its subjects. The next three chapter (Chapters 11, 12, and 13) deal with various domestic political aspects of Maria Theresa's reign. Chapter 11 examines religious policy, Chapter 12 the relationship with the marginal social communities, and Chapter 13 Maria Theresa's relationship with the subjects of public order and her measures related to the peasantry. Her Catholic religiosity was characterized by her rejection of the idea of religious tolerance, which led to the persecution of the secret Protestants in Austria and the measures taken against Jews in Bohemia and Moravia. This is hinted at by the fact that the rationalization of religious practice and the restriction of the prerogatives of the Catholic Church began under her rule. On the one hand, she regarded the subjects of public order as useful taxpayers and an important human resource

for the military, rather than as citizens with rights, and on the other hand, she also regarded the peasantry's deplorable status as an ethical matter that troubled her conscience. Stollberg-Rilinger presents the queen's controversial relationship with the peasantry based on an example, the history of the peasant uprising in Bohemia in 1775. The last chapter ("The Autumn of the Matriarch") focuses on the history of the relationship between the old empress Maria Theresa and her distant, married children. We observe in these relationships different degrees of maternal influence, emotional blackmail, and the search on the part of the children for independence.

All in all, Barbara Stollber-Rilinger manages, in her biography of Maria Theresa, to merge the many contradictions into a whole. In the epilogue, she describes the empress as a ruler who was "out of step" and who lived on the border between the traditional religious-baroque and the Enlightenment, as reflected in her way of thinking. Not only did she manage dynastic politics with stereotypically masculine determination, make strategic use of the symbolic languages of the baroque court, zealously practice her Christian faith, and prove a master of written and oral communication, with her reforms, she saved the Habsburg Monarchy from military and financial collapse and set her society on the path toward modernization. Stollberg-Rilinger is perhaps among the biographers of the empress to apply new approaches, such as considering the role of propaganda, the functions of the images of Maria Theresa as a female ruler, and the history of emotions. She omits discussion of many smaller issues (e.g., the role of the Kingdom of Hungary and the Hungarian elite), but since the publication of the 10-volume work by Austrian historian Alfred Ritter von Arneth, who lived in the second half of the nineteenth century, Barbara Stollberg-Rilinger's biography of Maria Theresa is certainly the most versatile, extensive, and problem-sensitive narrative of the life of the empress and her time.

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The 1868 Croatian–Hungarian Settlement: Origin and Reality. Edited by Vlasta Švoger, Dénes Sokcsevits, András Cieger, and Branko Ostajmer. Zagreb–Budapest: Hrvatski institut za povijest–MTA BTK TTI, 2021. 304 pp.

Hungarian and Croatian historians have developed a productive routine of cooperation. One of the relatively new results of this cooperation is a reexamination of the settlements: the 1867 one between Hungary and Austria, and more emphatically, its "little sister," the Croatian–Hungarian Settlement of 1868. The foundations of this common endeavor were laid during a conference in 2018, commemorating the 150th anniversary of the settlement between the two Transleithanian parts of the Habsburg state. This discussion revealed that East Central European research findings have had little impact on international dialogue about Austria–Hungary. The publication of these findings in English is thus a particularly welcome contribution to an already dynamically changing field.

Indeed, research on late Habsburg Central Europe was recently reinvigorated and enriched by new critical viewpoints of the so-called imperial turn, transnational and global perspectives, and new subdisciplines, such as the examination of knowledge transfer, environmental history, and new military history, just to mention a few. These fresh new outlooks may yield new findings related to Transleithania too. The book under review attempts first to offer a comprehensive description of the system called subdualism to lay the groundwork for new research and, second, to inform scholars the world over about new findings from the region.

To fulfill its first ambition, the book offers thorough descriptions of the political and legal antecedents of the Croatian–Hungarian Settlement and the political and economic history of the entire period until 1918 (in the chapters by Željko Holjevac, Stjepan Matković, and Mariann Nagy). As a neuralgic point in the long-lasting coexistence of the two nations and their only military clash over the course of eight centuries, the events of 1848 received an independent chapter (by Róbert Hermann).

In addition to the comprehensive writings, the book offers insights into more specific questions as well, such as the exciting analysis of the Croatian satirical press of the time by Jasna Turkalj and András Cieger's chapter about the visual symbols of the subdualist system. Both studies ask questions about how the broader public interpreted visual signs used in the (pro-government

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and oppositionist) propaganda. By zooming in on micro-historical details, Dénes Sokcsevits and Vlasta Švoger present personal stories and biographical additions about a fervent Hungarian opponent of the Settlement (Frigyes Pesty) and an enthusiastic Croatian proponent (Ignjat Brlić). A richer understanding of their standpoints helps further a more nuanced grasp of the tenacious national stereotypes concerning the Settlement's reception on both sides.

These more narrowly-focused investigations shed light on the importance of individual agency when it came to interpreting the Settlement, a treaty which in its legal terms was rather vague or, to put it differently, offered a flexible framework open to different readings. Several chapters deal with this flexibility, which gave room for maneuver to politicians, depending on their personal ambitions. This was particularly true in the case of the minister of Croatia–Slavonia–Dalmatia without portfolio in Budapest. The minister's competencies were never precisely defined, and as a result, he was sometimes a nearly invisible presence during negotiations in Vienna, Zagreb, and Budapest, and in other cases, he was the person who overrode decisions made by important figures, including even the ban (a figure somewhat like a viceroy), as one can read in the study by Ladislav (László) Heka. In his chapter, Ádám Schwarczwölder offers an even more penetrating study of some of the grey zones in the functioning of the Settlement system as he investigates the flows of money coming from Vienna or Budapest more or less openly aimed to influence Croatian political power relations. It was of course impossible to keep official accounts of these sums, so Schwarczwölder examines the various tricks used in the budgets to shed light on these machinations.

A closer look at political parties can tell just as much as it did in the case of ministries. Branko Ostajmer's analysis of the Croatian National Party, pejoratively dubbed the "magyarón" party by contemporaries and often imagined as a monolithic and anti-national unit, shows that this political community was in reality a heterogeneous group. Close cooperation with the Hungarian leading circles was motivated by an array of varying factors, from ideological convictions to realpolitik and the disillusionment caused by Austrian neo-absolutism. However, as Ostajmer observes, these considerations were never accompanied by a desire to strengthen Hungarian domination over Croatia, or in other words, to change the status quo. There are thus limits to any historiographical reassessment one could offer of this political party.

Reassessment is key, however, in the chapter by Imre Ress dealing with a widespread misconception that has been dominating the secondary literature

on Austria-Hungary since the 1910s. Robert William Seton-Watson offered an infamous and politically influential assessment of the Hungarian Kingdom as an aggressively nationalist country. His assessment became something of a historical commonplace and shaped the way in which Hungarian–Croatian relations at the end of the nineteenth century have usually been seen. Ress convincingly disproves a contention cited in most of the English-language and German-language secondary literature, according to which the Croatian–Slavonian ban was a simple executor of the Hungarian prime minister's will. Ress meticulously reconstructed the procedures according to which bans were chosen and shows that, in general, the emperor appointed the ban personally, sometimes even specifically against the candidate recommended by Budapest.

The comprehensive, informative descriptions of the Settlement system, the well-chosen microhistories, and the long-needed reassessments make this volume a valuable contribution to the lively discussion about the late Habsburg state. As Imre Ress emphasizes in his chapter, the Croatian–Hungarian Settlement played a crucial legal and political role in the Dualist system, as it was an obstacle to any trialist transformation and thus stabilized the status quo. It is therefore not only an interesting addition to the history of the multiethnic composite state but also a key to a more subtle understanding of its working.

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Family, Taboo and Communism in Poland, 1956–1989. Polish Studies – Transdisciplinary Perspectives 36. By Barbara Klich-Kluczewska. Berlin: Peter Lang Verlag, 2021. 264 pp.

Most of the secondary literature on the former Soviet Bloc and communism maintains that the postwar period brought about radical change compared to the interwar period. *Family, Taboo and Communism in Poland*, however, takes a different position. Focusing on a single aspect of social history, it proposes that the continuity of the traditional family model was prevalent, despite the modernizing endeavors imported from the Soviet Union. This volume is the English translation of Barbara Klich-Kluczewska's habilitation thesis "Rodzina, tabu i komunizm w Polsce (1956–1989),"[1] in which she explored the concepts of family and taboo in a more comprehensive sense and their intersections, for instance in cases of unmarried mothers, divorce, family violence, and abortion in communist Poland. Based on archival materials (court and police files), private sources (letters, life writings), popular culture (films), and an examination of secondary sources (mainly scholarship in sociology), Klich-Kluczewska concentrates on the institutions and psychology of social control and the subjective perspectives of "lived history." I offer here a brief summary of this important volume on the history of the Polish family, which challenges the discontinuity narrative concerning communist societies by focusing on under-researched taboo subjects, such as single motherhood, divorce, domestic violence, and abortion.

Using the methodology of "anthropological history"[2] in the first chapter, Klich-Kluczewska follows the evolution of taboo concepts and argues for a modernized interpretation based on the works of twentieth-century British social anthropologists (Alfred Radcliffe-Brown, Mary Douglas) as a research category and an informational tool for "socially designating what does not fall in the line with the prevailing structure" (p.18). Taboo is understood as a consensus and a means of organizing social order via the examination of public discourses. It can be an indicator of social change or the lack of social change. However, the observed phenomena can scarcely be taken as taboos in the sense of something that needs to be silenced. Rather, they were seen simply as immoral or socially

1 Published in 2015. https://ruj.uj.edu.pl/xmlui/bitstream/handle/item/35028/klich-kluczewska_rodzina_tabu_i_komunizm_w_Polsce_2015.pdf?sequence=1&isAllowed=y (Last accessed on August 3, 2022)

2 See Barbara Klich-Kluczewska, and Dobrochna Kałwa, eds., *From Mentalités to Anthropological History: Theory and Methods*, Krakow: Towarzystwo Wydawnicze "Historia Iagellonica," 2012.

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unacceptable actions, and it is therefore doubtful that this framework adds a significantly novel perspective.

Chapter two provides a general picture of postwar Polish sociology, with presentations of the most influential schools (Poznań, Lublin, Cracow) and scholars (Zbigniew Tyszka, Jan Turowski, Danuta Markowska, Barbara Łobodzińska) and their relationships to the communist state. As was the case in other Eastern European countries, sociology in Poland was supervised by the state, and from the 1970s on, family sociology followed a grand narrative of crisis and change. Klich-Kluczewska challenges ideas adopted from American sociology, according to which the modern nuclear family became the norm, and she notes that the traditional mentality and conception of the family proved remarkably durable, despite industrialization and urbanization. She also calls attention to "schizophrenia in the sociological studies." The family is cast in this scholarship either as a monotypic, ideal social unit with the help of which communism could be built or as a form of deviance associated with domestic violence and alcoholism. While the urban model of the nuclear family with separate households appears to be a model never adopted by most of the population, the Nowa Huta research also set up an idealized, homogenized picture of rural society. This chapter formulates questions concerning representativeness and the dilemmas of the fragmented historical knowledge by the examples of knowledge production in communist Poland. It seeks, moreover, to address lacunae in the secondary literature by deliberately focusing on marginalized research topics and the work of (mostly female) academics who are more likely to be omitted from the history of science.

The next chapter begins with an excerpt from a radio broadcast on single motherhood as a social problem in the 1980s. Here, the crisis narrative dominates the discourse. Unmarried mothers were frequently compelled to migrate from rural to urban environments, creating a social burden and moral crisis for the state. Regarding social security, Klich-Kluczewska offers a hybrid model in which the family turns out to be responsible for the upbringing and education of children, not the socialist state. The chapter also includes statistical data on single mothers and children born out of wedlock, suggesting concerns about visibility and the credibility of these data. The elimination, in the terminology, of the status of "illegitimate" as a term referring to children born out of wedlock is presented as a political measure rather than as a step in support of women's social emancipation. In 1946, women outnumbered men by more than two million in Poland, but the postwar "matriarchy" did not fundamentally change

gender roles, and motherhood remained the primary role for women (pp.87–88). Klich-Kluczewska contends that there was no real breakthrough in terms of women's social roles.

The most convincing part of the book is the fourth chapter, which examines divorce. It opens with the study of an educational film from 1975. The legislative changes from the interwar period up to the communist divorce law are summarized, offering a broader historical perspective on divorce in modern Poland. The narrative of crisis and criminality also defines the breaking of family bonds, like all other matters characterized as "deviance." However, the statistical data reveals that the number of divorces in communist Poland was comparatively low compared to the other countries of the region, and there were significant differences in divorce rates in rural communities versus urban communities. It is important to take the mentality of the rural population into consideration to the extent that the sources permit, as a more nuanced understanding of this mentality could strengthen and enrich the continuity-narrative of mental patterns and further a more subtle grasp of the processes of knowledge and attitude transfers between cities and small settlements. Klich-Kluczewka maps the discourses on divorce in two frames. Until the 1970s, the annulment of marriage was characterized as a deviant act. This only changed in the second half of the socialist period.

In the next chapter, which addresses the issue of domestic violence, court and press documents are utilized to elaborate on the social acceptance of domestic violence. The widespread acceptance of abuse within the family raises the question of whether this abuse can be regarded as taboo or not. Klich-Kluczewska encounters many problematic points in this part, specifically, if violence as a means of addressing everyday conflicts is a socially acknowledged method, what do the available sources imply about "non-extreme" cases? The chapter opens with a case study involving the story of an eight-year-old girl who was abused by her parents, especially her stepmother. As this case makes clear, the line between socially tolerated methods of punishment and legally or socially condemned abuse is extremely thin. Moreover, the fact that the stepmother figures as the principal accused raises questions about the concepts of motherhood and the social images of cruel women concerning the normative discourses about the feminine nature. Klich-Kluczewska then outlines social imaginaries of physical violence in educational and legal discourses, with particular focus on corporal punishment in schools. Alcoholism appears as a facilitator of domestic violence, the victims of which were usually women and children, but extensive

alcohol consumption did not in itself explain family abuse. Reading the chapter, one might find also it problematic that the hierarchies underpinning domestic violence are not adequately emphasized in the analysis. The records on domestic violence at the end of the chapter are also presented in a relatively normative or stereotypical way. The case of a "lazy housewife" is implicitly framed on the spectrum of the socially accepted female roles but without any recognition of gendered hierarchy or the power relations of the couple. This part ends with an analysis of magazine correspondence about domestic violence and a short, thought-provoking subchapter on male victims of domestic violence.

The last chapter, which examines the issue of abortion, covers the period between 1948 and 1956, which does overlap neatly with the era specified in the book title. One might find this decision anomalous, since it is not explained convincingly by Klich-Kluczewska. She offers a case study of an illegal abortion from 1948 induced by a *babka* (abortionist). Though some remarks were made on the relationship between family planning and the Catholic church, the absence of the Church perspective is the most perceptible in this chapter. Particularly in the light of recent legal changes concerning abortion in Poland, it would have been progressive to present some of the recent scholarships on the subject.

Although Klich-Kluczewska refers to her scattered source base as a negative element, it could encourage a more complex interpretation of the socialist era. The corpus of secondary literature is likewise a valuable foundation, since these social theories are usually not handled as historical sources but as scientific data. Nevertheless, narratives such as letters to public institutions and life stories documented for journal competitions should not be mistaken for sources that reveal private thoughts, no matter how personal they might appear. Public narratives are always susceptible to influence by state narratives or are structured, whether deliberately or not, according to strategies which might give them agency to shape the events in favor of their authors. And these strategies are more likely to reflect state discourses on family life and its taboos than personal attitudes. Yet, the didactic nature of press narratives was only emphasized in chapter four in a discussion of the experiences of female divorcées.

This book is an impressive experiment aiming to discredit the social transformation myth of the family in communist Poland by examining several interlinked taboo phenomena within the (socialist) family. Alongside explicit comparisons of the interwar and the socialist periods, this volume offers implicit explorations of continuity and discontinuity by applying a long durée perspective. It challenges the concepts of Polish family sociology on the fundamental

transformation of traditional society. In light of Hungarian ethnographic data on informal social relationships connected to family life, it would be compelling to conduct comparative research in post-socialist countries, as the continuity of social patterns may well turn out to be a regional phenomenon. This book also foregrounds the intersections of private mentality and perceptions of gender roles in light of single motherhood, divorce, and domestic violence. Moreover, it stresses the importance of scientific knowledge production by female scholars in socialist Poland. Still, the far-reaching conclusions are based on a fragmented source base, as Klich-Kluczewska herself acknowledges (pp.24–28), and there are significant gaps in the analysis. The last two chapters do not fall in line with the premises of the book, so if it comes to taboo as understood by Klich-Kluczewska, it is rather to be discovered in phenomena connected to marriage: single motherhood and divorce. Social transformations, she contends, occurred to some extent, especially in cities, but (heterosexual) marriage as the foundation of the family and thus of Polish society remained a widely accepted part of the social imaginary. Though she is aware of the fractured nature of historical knowledge, the volume in all does not offer a comprehensive (counter)narrative about the Polish family between 1956 and 1989. This volume seems to follow the scientific transformations of Central European countries from gender studies to family studies, omitting, however, discussion of the political nature and criticism of the gender hierarchy from its study of the private sphere.

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Socialist Yugoslavia and the Non-Aligned Movement: Social, Cultural, Political, and Economic Imaginaries. Edited by Paul Stubbs. Montreal & Kingston: McGill–Queen's University Press, 2022. 393 pp.

The emerging literature on the "Cold War from the Margins," to borrow Theodora Dragostinova's title, expanded our understanding of the post-1945 world by transcending the focus on the power dynamics of the superpowers and focusing on the role of small states and non-Western international organizations in their attempts to transform the Cold War order. In addition to Dragostinova's book (2021) on Bulgaria's global cultural entanglements, Csaba Békés' *Hungary's Cold War* (2022) investigates the role that Hungary played in shaping relations among the superpowers. Similarly, in his superb book *Cold Wars* (2020), Lorenz Lüthi shows how local and regional histories affected the Cold War. Lüthi also devoted appropriate attention to "alternative world visions," which included efforts by the Non-Aligned Movement (NAM) to transform the global political and economic order. Jürgen Dinkel provided a comprehensive account of NAM history, including Yugoslavia's critical role in shaping and sustaining the movement from its inception in 1961 to the late 1980s.

As early as the 1970s, Yugoslavia's role in the Cold War and NAM attracted scholarly attention, beginning with Alvin Rubinstein's seminal work *Yugoslavia and the Nonaligned World*. This work was continued by a new generation of historians like Tvrtko Jakovina, whose *Treća strana hladnog rata* (The Third Side of the Cold War, 2011) significantly broadened our understanding of Yugoslavia's unique role in the Cold War and NAM. A welcome addition to this literature is a "radically interdisciplinary volume" (p.27) edited by Paul Stubbs, senior research fellow at the Institute of Economics in Zagreb. Stubbs' aim is to challenge "a kind of amnesia about the role of socialist Yugoslavia in the Non-Aligned Movement without ever lapsing into uncritical nostalgia" by providing different and sometimes, as he admits, conflicting "fragments" (p.26). A truly diverse group of scholars provide distinctive perspectives on these issues in 14 chapters divided into five different parts addressing various issues including the economy, multilateralism, cultural exchanges, migrations, and the problems of agency.

Part I, titled "Agency and Structure," establishes different frameworks of Yugoslavia's policy of non-alignment. In the field of research dominated by the focus on the impact of great men (Tito, Nehru, Nasser, Castro, etc.), the chapter by Chiara Bonfiglioli offers a refreshing analysis of gender and NAM by focusing on Yugoslav "encounters with non-aligned female subjects." Bonfiglioli argues

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that Yugoslav women's revolutionary experience and participation in postwar recovery allowed them to identify with their non-aligned counterparts (p.53).

With Bonfiglioli turning her gaze from great men, Peter Willetts further questions the role of foundational figures of NAM. In his chapter, Willetts shatters some of the widely accepted myths concerning NAM. Notably, he scrutinizes what he calls the "orthodox history of NAM," which claims that NAM had its roots in the 1955 Bandung Conference. Moreover, Tito, Nasser, Nehru, Nkrumah, and Sukarno—figures often depicted as the "founding fathers" of the movement—merely provided "an alternative history to the myth that the origins of the Non-Aligned Movement lie in the Bandung Conference" (p.71). Instead, according to Willetts, there were only two founders, Tito and Nasser, who "each provided leadership that was recognized and respected in both Africa and Asia" (p.71).

Gal Kirn establishes new frameworks for an understanding of nonalignment through ten theses which illuminate similarities between anti-fascist and anti-colonial histories. Kirn suggests that these histories should be understood through "ruptures" defined as historical events with "strong consequences" that "resonate across societies" (p.85). Kirn points out that partisan struggles and NAM shared many similar worldviews, notably belief in the creation of a new world (p.98). In his chapter, Tvrtko Jakovina shows that NAM was not just an ideological project but also suited Yugoslavia's national interests. Jakovina argues that the "role of Yugoslavia was understood pragmatically, although always within an idealistic framework" (p.121). Jakovina praises Yugoslavia's diplomacy in the last decade of the country's existence as "modern, rational, pragmatic, and idealistic." Yet, "things were falling apart at home," and this made NAM irrelevant (p.122). Jakovina's nuanced approach is thought-provoking and a good starting point for any discussion on ideology and pragmatism in Yugoslavia's NAM policies.

Part Two goes beyond traditional political and diplomatic histories of Yugoslavia's nonalignment and focuses on cultural politics. Bojana Videkanić points out that art and culture are often subordinated to political work, arguing that cultural struggles were essential to state-building projects (p.135). Bojana Piškur and Đorđe Balzamović concur that culture was important in NAM. Yet, they argue that nonaligned art largely followed Western cultural canons (p.156). Using a graphic novel format, they demonstrate that nonaligned art, despite its failure to "produce… a new international narrative in art," created opportunities to discuss art outside the Western canon (p.136). Similarly, Ljiljana Kolešnik

claims that Yugoslavia's cultural exchanges with the nonaligned world were impeded by Eurocentrism of the Yugoslav culture and educational system as well as cultural prejudices (p.179). Mila Turajlić expanded on her pioneering work on the visual history of nonalignment by creating "an inventory of the image(ry) debris floating around the city [Belgrade]," notably using unseen reels from Filmske novosti but also from the movie depositories abroad. As Turajlić concludes, "The film archives are not merely a means for recalling the past but become a medium in which the past continues to exist and reconfigure itself in new constellations." (p.229).

In Part Three, Jure Ramšak and Dubravka Sekulić discuss economic relations between Yugoslavia and NAM. Ramšak looks at similar efforts by nonaligned Yugoslavia and neutral Austria to expand their economic and political influence in the "Third World." Even if Bruno Kreisky of Austria and Edvard Kardelj of Yugoslavia shared some ideas about the importance of North-South rapprochement, joint action was largely absent because of different priorities (Yugoslavia) and domestic pressures (Austria). Sekulić focuses on Energoprojekt, a company which served as the vehicle for Yugoslavia's economic influence in the Global South. She analyzes large infrastructural projects in which Energoprojekt (with its joint ventures) was involved, concluding that these projects, paradoxically, created debt and thus "neocolonial enclosure" (p.274). Although Energoprojekt's endeavors did not create nonaligned architecture, Sekulić argues that they formed the most tangible materialization of ideas expressed during summits (p.263).

In Part Four, Agustín Cosovschi discusses the limits of Yugoslavia's nonalignment by focusing on Yugoslavia's political and diplomatic initiatives in Latin America. Yugoslavia's failure to establish influence in Latin America enables Cosovschi to provide a critical assessment of nonalignment. According to Cosovschi, after the Cuban Revolution, Yugoslavia's "'herbivore' conception of nonalignment" had little appeal in Latin America (p.297). If realities of Latin America stymied Yugoslavia's foreign policy objectives there, Africa provided the space for affirmation of Yugoslavia's global role. Nemanja Radonjić in his chapter argues that Africa was an "ideological creation" which served as a metaphor for nonalignment as well as the "ideal continent" for Yugoslavia's global activism (p.303).

The final part of the book deals with the concepts of mobility and migrations during socialist Yugoslavia and in its aftermath. Leonora Dugonjic-Rodwin and Ivica Mladenović trace the trajectories of students from Africa and Asia

in Yugoslavia and in the post-Yugoslav space. Relying on archival sources and interviews, they emphasize personal experiences instead of top-down policies. They invite us to look at the presence of international students not as a "by-product" of the policy of nonalignment but as complex phenomena of identity building and accumulation of cultural capital. David Henig and Maple Razsa examine the links between nonaligned Yugoslavia and the Muslim world from 1961 to the Balkan route, providing the "affective history of Yugoslav non-alignment" as a possible alternative to dominant Eurocentric and Yugocentric understandings of NAM (p.363).

Looking at these empirically, thematically, and methodically diverse chapters, one wonders how this volume would look if the voices from scholars (and archives) from the nonaligned world were included in it. Stubbs promises to dismantle the "Yugocentric" approach, namely studying NAM "primarily through the lens of the study of socialist Yugoslavia" (p.23). Yet the book in many respects remains "Yugocentric" in its outlook (beginning, ironically, with its title). This is not necessarily a bad thing, because with Yugoslavia at the center of its scholarly inquiry, the book achieves a coherence that is often missing in edited volumes. The book's main strength rests in its diversity. Even when in disagreement, the contributors are in conversation with one another, and the assembly of different "fragments" finely captures multifaceted and often contradictory and contested roles that Yugoslavia played in NAM. This book will be indispensable to those who are studying the history of Yugoslavia's nonalignment and NAM more broadly. Theoretically and methodologically innovative, it will be a valuable source but also an inspiration to scholars interested in international and transnational connections between the so-called Second and Third Worlds.

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