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Civilization Boundaries
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EUGENICS AND EUTHANASIA IN CZECHOSLOVAKIA (1914 – 1945): HISTORICAL, SOCIAL, AND EDUCATIONAL CONTEXTS

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Abstracts. The article analyses the historical development and impact of eugenic ideologies in Czechoslovakia between 1914 and 1945, with an emphasis on their influence on education and social policy towards people with disabilities. It examines the tension between medical aspirations for preventive eugenics and democratic legal traditions, as well as the effect of Nazi occupation policies, including sterilisation programmes and Aktion T4. Special attention is given to the role of segregated educational systems shaped by eugenic thinking and the ethical dilemmas arising from these practices. The study provides a critical assessment of the historical legacy of eugenics and its implications for contemporary inclusive education.

Keywords: Eugenics; education; persons with disabilities; social inclusion; sterilization; euthanasia; Czechoslovakia; ethics; historical perspectives

Introduction

Since the end of the 19th century, a new social-philosophical movement called eugenics has been developing. It was the theory of heredity, the breeding of the human race by the purposeful selection of quality individuals suitable for reproduction. *Eu* translates as „*good, desirable*" and genos genus, more precisely the science of good descent. The origins of this theory are associated with the English physician and scientist Francis Galton (1822 – 1911), a cousin of Charles Darwin (1809 – 1882). Galton, himself influenced by the ideas of his cousin Darwin and his works On the Origin of Species and On the Origin of Man, on which his evolutionary theory of the survival of the fittest is based, developed a kind of reproduction scheme where only healthy individuals with good hereditary traits were to be selected for further reproduction, this was so-called positive eugenics. Negative eugenics, on the other hand, was supposed to prevent the union and further reproduction of genetically poor and sick individuals (Šimůnek, Novák 2023).

As Šimůnek (2022) further writes, eugenics became a debated topic, it had its opponents and its supporters. Opponents of eugenics, which included the Catholic Church, compared human society to a zoo and feared the emergence of a so-called breeding state (Šimůnek, Novák 2023).

The UK, the cradle of eugenics, also hosted the first International Eugenics Conference in London in 1912. On the agenda of the conference was how to prevent handicapped persons from reproducing. One of the vice-chairs was Winston Churchill. Although the British Home Office received several petitions in the first decade of the twentieth century demanding the passage of a law to restrict the reproduction of the disabled, it was not until 1910, with the accession of Winston Churchill, a staunch eugenics supporter, as Home Secretary, that pro-eugenics policies could more easily be enforced in Britain. As early as 1913, the Mental Deficiency Act was passed in Britain. As Ridley writes, the Act mandated the hospitalization of persons with mental disabilities, thereby preventing their further reproduction. At the same time, people were persuaded to consent to voluntary sterilization (Ridley 2001).

Moreover, Galton‘s original theory of eugenics intersected at the turn of the century with genetics, then a new science of heredity. As Šimůnek (2022) further elaborates, after 1918, i.e. after the end of the First World War, eugenics became part of modern society. Due to the growing large industrial agglomerations in Western countries, social pathologies, alcoholism, venereal diseases, prostitution, and crime were massively spread. Thinkers of the time identified these social pathologies, along with feeble-mindedness, mental illness, epilepsy, and congenital developmental defects, as hereditary, relying on the findings of genetics.

The Church‘s attitude to eugenics and the sterilization and castration of disabled individuals in Europe was not unambiguous. Supporters of sterilization were from among the Protestant churches, but the Roman Catholic Church was categorically opposed. Its position on eugenics is expressed in the 1930 encyclical (papal circular letter addressed to bishops, author‘s note) of Pope Pius XI (Šimůnek, Novák 2023).

As Šimůnek (2012) further states in his study, eugenic sterilization laws were adopted in many European countries during the 1930s: in 1933 in Germany, a year later in Norway and Sweden, and in 1935 in Finland. (Šimůnek 2012) The ideas of eugenics fell on the most fertile ground, especially in Germany, among those who proclaimed the superiority of the Germanic race. Instead of the term eugenics, the term racial hygiene began to be used in Germany, introduced by Alfred Ploetz, founder of the German Society for Racial Hygiene (1905), which had already received a great deal of attention before the First World War. However, its main mission in Germany was not the health of patients but the service of the race. (Šimůnek, Novák 2023)

In 1933, the „*Law to Prevent the Conception of Hereditarily Handicapped Offspring*“, called GeVeNa (German: Gesetz zur Verhütung erbkranken Nachwuchses), was adopted in Germany. Until now, it was a matter of voluntary sterilisations (with the consent of the person concerned), the law also legalised involuntary sterilisations, with police coercion, and introduced a reporting obligation for doctors and nurses. It also defined the various diagnostic groups of the population to be sterilised: these were persons suffering from feeble-mindedness, schizophrenia, epilepsy, manic-depressive conditions, hereditary blindness and deafness, severe physical disabilities and alcoholism (eugenic indications). Two years later, in 1935, the „*Law for the Protection of the Hereditary Health of the German People*“ was passed in Germany, which introduced compulsory medical examinations before marriage to prevent unwanted unions. It was allowed to terminate a pregnancy, also for eugenic reasons, until the end of the sixth month of pregnancy (Šimůnek 2012).

In Germany, as already mentioned, health considerations were intertwined with economic and racial considerations. As Scharsach (2001) notes, doctors sometimes labelled entire families suffering from hereditary diseases and forced them to be sterilised. These were mostly people from low social classes; the aim was to reduce the number of people receiving welfare benefits. It was desirable for people with hereditary diseases to apply for sterilisation themselves, as conscious citizens. This disguised the coercive nature of the law and emphasised the voluntary nature of this step. Sterilization or termination of pregnancy for eugenic reasons became a common practice covered by the law. It has been estimated that between 300,000 and 400,000 sterilizations and approximately 30,000 terminations of pregnancy with eugenic indications were performed in the interwar period in Germany and German-occupied territories, including Austria (Scharsach 2001).

In Czechoslovakia, in 1918, Prof. František Čáda, a philosopher and teacher at Masaryk University (1855-1918), founded the Czech Eugenics Society (ČES). The vision of the society was that eugenics would be understood as an independent scientific field, parallel to the then-new science of genetics. Furthermore, the common agenda of the proponents of eugenics was to „*participate in the creation of man*“, and as Šimůnek (2012) states, the participants were aware that sexual selection touched on a number of ethical issues (Šimůnek 2012).

During the 1920s, there were debates not only about sterilization and castration, which were considered somewhat radical measures in Czechoslovakia, but also about other restrictions, namely, placement in institutions and the so-called marriage revision, i.e., a change in the legal regulation of marriage. The Marriage Revision mandated, as in neighbouring Germany, compulsory medical examinations before marriage in order to prevent persons with hereditary diseases from marrying. Then, in the 1930s, the basic eugenic measures were defined, namely the so-called sterilization procedures involving sterilization or castration, bans on marriages between those affected by hereditary diseases, and isolation in institutions. Karel Kadlec, a theologian and professor at Charles University in Prague, spoke out against sterilizations, considering sterilization to be an irreversible mutilation of a human being and warned of the possible abuse of the procedures against politically inconvenient people. Although sterilization for eugenic indications was one of the main goals of the Czechoslovak Institute for National Eugenics (founded in 1924), debates for and against sterilization continued in the 1930s. Bohumil Sekla, M.D., at that time an assistant at the Institute, admitted that sterilization was a profound interference with human rights and stated that it was society‘s task to take care of the disabled, but in his opinion it was necessary to prevent their future increase. He considered the most appropriate measure to prevent disabled persons from procreating (Šimůnek 2012).

In 1936, preparations began for the drafting of the Czechoslovak sterilization law by a three-member committee consisting of two doctors, Vladimír Bergauer and Bohumil Sekl, and a lawyer, JUDr. Jarmila Veselá. In mid-1937, the committee submitted a draft law to the Ministry of Public Health and Physical Education. In the Memorandum, eugenic sterilization was described as the most effective means of preventing further unwanted reproduction of persons with genetic diseases. The request for sterilization could be made by the sufferers themselves or by the relevant institutions, health social or guardianship. Sterilisation had always to be carried out only with the consent of the person affected and with the approval of a committee appointed for that purpose. The draft Czechoslovak sterilisation law did not mention forced sterilisation. The Memorandum proposed four groups of the population to be affected by sterilization, with the following disabilities: hereditary feeble-mindedness, severe hereditary sensory defects, severe hereditary nervous and mental diseases, severe hereditary physical defects. Although the Memorandum was a very elaborate proposal for the legalization of eugenic sterilization in Czechoslovakia at the time, the legalization of eugenic sterilization did not take place in Czechoslovakia in the interwar period (Šimůnek 2012).

Eugenics and the sterilization debate in interwar Czechoslovakia

In interwar Czechoslovakia, eugenic ideas developed in the unique environment of a democratic state that emphasized social modernization and scientific progress. In 1915, František Čáda founded the Czech Eugenic Society, whose goal was to establish eugenics as a legitimate scientific discipline, not just an ideology. The society organized lectures and published studies that emphasized the preventive and health aspects of eugenics.

There were intense discussions in professional circles about the sterilization of people with hereditary diseases. While some doctors and biologists, such as Bohumil Sekla, advocated sterilization as a legitimate public health tool, some lawyers and church authorities warned of ethical risks and potential abuse. Karel Kadlec of

Charles University described sterilization as irreversible damage to human dignity. These debates led to the drafting of a bill on eugenic sterilization in 1937, which a three-member expert committee submitted. Although the bill defined sterilization as a voluntary act requiring consent and commission approval, the law was not passed.

A significant feature of the Czechoslovak environment was the relatively limited public support for eugenic measures compared to Germany. The media and political representatives often presented eugenics as a preventive health measure rather than a radical ideology of racial hygiene. Eugenic ideas were partly reflected in discussions about social care and institutional care for people with mental disabilities, but there was no widespread public acceptance of sterilization or segregation measures. The prevailing attitude in Czechoslovak society respected the ethical limits of interference with individual reproductive rights.

From eugenics to euthanasia

Euthanasia, or a good death, a death from grace, was already a subject of discussion in Germany at the end of the 19th century, in scientific medical circles. In 1895, Adolf Jost (1874 – 1908), a German physician, issued a call for medical killing to maintain the state as a social organism. In the early twentieth century, several studies were produced listing the costs to the state of caring for the sick and physically or mentally disabled. As early as 1920 is the year when the first outline of the implementation of euthanasia for the mentally handicapped was drawn up. The report, entitled Permission to Dispose of Life Unworthy of Living, was written by Alfred Hoche, a professor of psychiatry, and Karl Binding, an expert in criminal law. Their work aimed to present arguments that would convince the general public of the importance of the subject (Scharsach 2001).

Adolf Hitler himself wrote in his Mein Kampf as early as 1924 that it is impossible to let the terminally ill infect the healthy. (Zeman 2015) As Scharsach (2001) states, already after the Nazis came to power, in 1933, as psychiatrist Paul Nitsche testified in interrogations after the war, many ambitious Nazis gave orders to carry out euthanasia in institutions secretly. Psychiatric hospitals became a dangerous place, especially for children and adolescents. Psychiatric hospitals received lower and lower rations that were not even sufficient for routine care; food rations were also reduced. Before the start of the war, for example, in Saxony, patients were killed by semi-sleep cures, by administering luminal. Several events preceded the Führer‘s approval of euthanasia on 1 September 1939. Husson (2009) reports that in January 1939, the Führer was approached by parents whose child suffered from an incurable hereditary disease and asked the Führer to euthanize him. According to Scharsach (2001), several parents of severely disabled newborns approached the Führer to ask if euthanasia could be granted. The Führer granted their request and immediately thereafter ordered the development of a global selection program and the extermination of so-called „*lives unworthy of living*“ (Husson 2009).

Action T4

In February 1939, two of Hitler‘s personal physicians, Karl Brandt and Philipp Bouhler, received a mandate from Hitler to assemble a group of doctors and assign them to implement a program of euthanasia for physically and mentally handicapped children. This famous „*authorisation*" or mandate of September 1939 was the only official document to initiate euthanasia, which in a way superseded the law and guaranteed impunity to the selected doctors carrying out the killing. Germany did not pass a law on euthanasia before or during the war (Kyncl 2014).

The „*Euthanasia*" program was created. The Reich Commission for the Scientific Approach to Serious Diseases Due to Heredity and Physical Constitution was established. The commission aimed to find newborns so afflicted. On the Führer‘s orders, maternity hospitals and paediatricians were to report on affected children within three years. The elimination of physically and mentally handicapped adults was initiated as early as April 1939 by the Reich Commissioner for Health, Leonardo Conti, to consolidate his position and demonstrate his commitment to the ideology of the Third Reich. Each politician wanted to achieve a position of influence, hence the rivalry between Bouhler and Conti, each wanting to prove to the best of his ability how he was fulfilling the Führer‘s intentions. This rivalry between them led to an even greater expansion of the number of people affected by the extermination programs. (Husson, 2009) As Scharsach (2001) states, Hitler‘s doctors made two euthanasia programs: one was for disabled children, the other for disabled adults. The administration of the programs was initially managed from the Führer‘s office; in the spring of 1940, the Führer‘s office rented a Berlin villa at 4 Tiergartenstrasse. The designation of this address with the abbreviation „*T4*" (Aktion T4) became the name of the entire euthanasia program for child and adult disabled patients. A non-profit organisation called the Non-Profit Foundation for Institutional Care was based at this address. Under the program, children with disabilities were removed from their families and placed in hospitals and children‘s hospitals where they were disposed of (Scharsach 2001).

Euthanasia of children

The whole programme of the liquidation of disabled children, more precisely the euthanasia of children and adolescents: Euthanasie der Kinder und Jugendlichen (Šimůnek 2022), was started as early as 18 August 1939. A secret decree of the Reich Ministry of the Interior made it mandatory for all doctors and medical personnel to report all children with disabilities, and for selected groups of disabled newborns and children under the age of three. The age limit for these children was later raised to 16 years. (Šimůnek 2022) The reports were submitted to the Reich Committee for the Scientific Investigation of Severe Genetic and Hereditary Diseases on a special form. All forms were uniform and then went to a three-member medical committee, which then made life-and-death decisions without having seen the child before.

A form marked with a red plus sign signified treatment equating to death, while a blue minus sign signified survival, or the child‘s use, despite his or her disability, in the workforce. (Scharsach 2001) As Scharsach (2001) describes, the killing of children was carried out in specialist children‘s wards, specially set up for this purpose. The first such facility was established in Gorden near Brandenburg, as a place with supposedly the best therapeutic practices according to the latest scientific research. Other facilities were set up in psychiatric institutions and children‘s hospitals in Germany, Poland and Austria, wherever politically reliable doctors worked. All staff were sworn to secrecy and instructed to act in secret so that there would not be the slightest suspicion that the deaths were purposeful. The word euthanasia or killing was never allowed to appear in the patients‘ medical records. (Scharsach 2001) The parents of the children had first to be convinced of the necessity of hospitalizing the child. Doctors raised the parents‘ hopes for the child‘s cure. A large number of children died without the administration of lethal substances, merely by starvation. As a result of reduced food rations, children became weak and died of common, untreated diseases. The great majority of children, however, were disposed of by the administration of large doses of luminal, a sleeping powder, which was added to food or injected into the child by enema. As Šimůnek (2022) writes, single doses of luminal were not fatal. What was harmful was their accumulation in the body, where luminal metabolized. The children fell into permanent unconsciousness and subsequently died of natural causes. Scharsach (2000) reports that within about five days, the children developed pneumonia, which was the cause of 90 per cent of the deaths. Letters were sent to the parents during the course of treatment, and information was given about the deteriorating health of the child. This was followed by a report of the child‘s death. (Scharsach 2001)

Among the thirty-seven facilities for child euthanasia, the Specialist Children‘s Ward Am Speigelgrund in Vienna also occupied a prominent place. The ward was, as Scharsach (2001) writes, a discreet killing facility. Children with various neurological symptoms, brain disorders and paralysis were admitted here. This was followed by a careful initial examination, recording a family history going back several generations, and adding to the documentation the patient‘s full-body photographs and a detailed description of the disability with a prediction of the degree of ability to work. This was followed by a detailed description of the patient‘s condition during treatment, ending with an autopsy report describing the cause of death. In most cases, it was pneumonia. (Scharsach 2001) Also in Vienna, as in other liquidation facilities, the children‘s food intake was reduced, and at the same time, they were given barbiturates, luminal, and later, to hasten death, a mixture of scopolamine and morphine by injection. The acceleration was carried out because of overcrowding in the institutions.

As part of the T4 action, the affected children were used as guinea pigs for scientific purposes. In Vienna, children were experimentally given pneumoencephalography, a very painful diagnostic test where air was pumped into the brain to take an X-ray. This examination often ended in the death of the patient. Other children were tested for the reliability of the tuberculosis vaccine and experiments were carried out in which a group of vaccinated children and a group of unvaccinated children were infected with tuberculosis. Carl Schneider, a psychiatrist at the Regional Psychiatric Hospital in Wiesbaden, asked for several children‘s brains for his research. The 20 children assigned to his research project paid with their lives. Another scientist collecting a collection of brains of handicapped children was the Nazi psychiatrist Heinrich Gross, working in an institute in Vienna, who tried to demonstrate morphological changes in the brains of mentally handicapped children. Gross continued to be one of Austria‘s successful forensic psychiatrists after World War II. (Scharsach, 2001) In mid-1940, most of the adult patients were transferred to Hartheim for liquidation as part of Operation T4, and the Vienna hospital became a juvenile hospital. Although all documentation on the killing of patients was carefully destroyed after the war, the post-war trials have produced a wealth of material on the activities at this Viennese killing facility (Scharsach 2001).

Adult euthanasia

The launch of the big T4 event was not just about the disposal of paediatric patients, although these were scheduled in the first wave of disposal. It was a carefully planned action of mass murder of all disabled people. For the sake of racial purification, every citizen of German nationality who bore the marks of physical and mental illness was to be eliminated, not only on German territory, but in all territories administered by Germany. The initial estimate of the number of victims was seventy thousand. (Kyncl 2014) As Šimůnek (2022) writes, the Nazis fanatically wanted to eliminate everything they considered biologically impure and also economically burdensome. The liquidation included patients suffering from oligophrenia, bipolar disorder, schizophrenia, epilepsy, Huntington‘s chorea, as well as severe hereditary sensory disorders, hereditary deafness and blindness, and severe physical malformations, as well as patients who had been in institutions for more than five years. (Šimůnek 2022) As Šimůnek (2022) further states, it was not only ideological fanaticism with the desire to purify the German race, but some historians consider the basis of the mass murder of patients to be primarily economic reasons. The Nazi government formulated its own medical ethics – not to expend resources to keep hopelessly incurable and unproductive patients alive, a drain on the state treasury. The cost of caring for mentally and physically disabled patients became one of the main arguments of propaganda. Another aspect was obtaining sufficient operational capacity to run military infirmaries. (Šimůnek, Novák 2023) Similar to the selection of child patients for euthanasia, the selection of adult patients began with registration forms, which were given to all psychiatric hospitals, hospitals, and sick houses (homes for the chronically ill) in October

1939. The forms were designed to appear to serve scientific purposes. As in the case of child euthanasia, the decision to put patients to death was made by an expert three-member medical committee, which worked under great pressure as the questionnaires became more numerous and the hospitals were overcrowded. The decision to live or sentence to death, therefore, took only a few minutes. The criterion was the ability or inability to work productively. (Scharsach 2001) The most important issue of the program became the method and procedure of killing. Reinhard Heydrich was entrusted with working out the technical details of the execution in cooperation with the Criminal Technical Institute. Since the doctors refused to kill by injection with poison, the most feasible way to quickly kill such a large number of patients was sought. At first, the use of hydrogen cyanide was considered, but carbon monoxide poisoning seemed the most humane means of killing. In early 1940, the first attempt was made to kill with carbon monoxide. (Husson 2009)

Kyncl (2014) writes about a group of thirty men who were selected for the experiment. It happened in an institute in Brandenburg. The men were divided into two groups, with one group of men receiving a lethal injection and the other group being locked in a gas chamber where lethal gas was piped in from steel cylinders placed outside the room. After twenty seconds, the men began to fall asleep, and after forty seconds, they slumped to the ground. The entire event was witnessed by the T4 management, with the director of the institute, and they all became convinced of the high reliability of the carbon monoxide method of killing. The decision was made. Immediately afterwards, the construction of the lethal gas chambers began. During 1940, euthanasia by gassing began to be carried out en masse in Germany in six medical institutions where gas chambers were set up. The first such facility was Grafeneck Castle near Stuttgart. The gas chamber was located in a shed near the castle. Other locations were Brandenburg, Sonnenstein near Pirna, Hadamar near Limburg, Bergburg and Hartheim, as well as Linz. Disabled people from the Sudeten German border area, from the clinics in Opava, Dobřany and Sternberg in Moravia, were brought to Hartheim and Sonnenstein. Each clinic had three to four drivers who drove omnibuses and picked up and brought patients from other institutions. Some patients refused to get on the omnibuses and had to be forced. Since the insiders of the whole deadly operation were bound by confidentiality, the directors of the institutions from where the patients were transported to the gassing facilities had no idea where their charges were being taken (Kyncl 2014).

Kyncl (2014) also provides the testimony of one of the nurses, Kathe Hochbarth, who accompanied patients during transfers. Hochbarth described how patients were admitted to euthanasia centres. Upon arrival, patients were undressed, photographed, and informed that they needed to take a shower. These were usually groups of forty to fifty people, equipped with soap and a towel, and herded into a gas room of approximately 20 m2 furnished as communal showers. The chamber was closed and sealed. The head of the institution carried out the gassing by opening the gas taps. (Kyncl 2014) Each hospital performing euthanasia had its own crematorium. Survivors were informed of the death of their relatives, usually with a time delay, and if they expressed interest, an urn with the ashes, which usually did not belong to that particular person, was sent to them. On several occasions, the urns contained dirt or were filled with hay. (Kyncl 2014)

More and more people learned of the deadly action and public opposition grew. However, this did not change the fact that the actors of the T4 action zealously continued, at that time already, the routine selection and liquidation of the affected person and, as Scharsach (2001) writes, mass murder was not associated with guilt. On the contrary, they began to defend the whole program of euthanasia of the disabled with fanatical fervour. Paul Nitsche, one of the leading actors in the extermination operation, proposed to make a documentary film that would explain the moral importance of this action and show the humane way in which a merciful death was provided to the patients. The film depicted the actual gassing of patients in the Sonnenstein psychiatric hospital. This horrifying documentary was never shown to the public. Fearing a public backlash, Hitler prevented the film from being shown in cinemas. He subsequently refused to sign the euthanasia law. (Scharsach 2001)

Yet euthanasia‘s psychiatric advocates, convinced of the scientific approach of their work, continued to pursue scientific research into the brains and removal of the internal organs of victims. This so-called concept of modern, reformed psychiatry was based on reducing the number of incurable and incapacitated patients and supposedly improving the quality of medical care for those who survived. In the summer of 1941, a wave of protests against euthanasia arose, both from the families of the victims and the medical community, and especially from leaders of the Catholic Church. Doctors themselves were afraid to publicly express their opposition to the killing of psychiatric and disabled patients. They were well aware that their refusal to do so would brand them as politically unreliable, which would have been the end of their careers, to say the least. Many of them at least tried to save some patients from the gas chambers. But the opposition from within the churches was unstoppable. In mid-1941, Catholic bishops began reading a pastoral letter during sermons giving courage to protest the killings. Bishop Galen of Münster warned against any contact with people committing euthanasia; whoever did so would become an accomplice and stand before the judgment of God. Galen‘s sermons were handed out in printed form in churches, and even crashed by British planes. Galen thus appealed to the general public, including peasants. And the resistance of the population was the strongest. At the end of the summer, on 24 August 1941, Hitler gave the order to stop the T4 action. (Scharsach 2001) Officially, the euthanasia program was terminated, and some of the gas chambers were dismantled and shipped to the East, where they continued to operate. The killings continued, no longer under the name of the T4 action. The staff of the extermination facilities were not dismissed and some gas chambers in treatment centres such as Hartheim, Bernburg and Sonnenstein were left in operation. Deaths by gassing were fewer, and killing by reducing the amount of food, lethal injections and the administration of luminal were resumed. (Scharsach 2001) During the course of the T4 action, more than seventy thousand patients were gassed in psychiatric hospitals. By the end of the war, more than two hundred thousand disabled persons were euthanized. The selection and killing of disabled children also continued throughout the war, in secret, until 1947 (Kyncl 2014).

Educational Policies, Institutional Care and Eugenic Thought in Czechoslovakia (1914 – 1945)

Eugenic ideas, which penetrated the discourse of medical, legal, and pedagogical fields in the first half of the 20th century, also had specific manifestations in the Czechoslovak environment in the areas of schooling and educational policy. Although eugenics was not explicitly codified as part of educational legislation, its influence was evident in the concept of care for people with mental disabilities and in the concept of special education, which was formed on the borderline between health and educational institutions. In interwar Czechoslovakia, the system of education for people with mental or physical disabilities was largely determined by contemporary ideas about heredity and the social dangerousness of certain populations. As Šimůnek (2012) notes, professional societies, in particular the Czech Eugenic Society, supported the idea of „*preventive segregation*“, which was intended to prevent the spread of allegedly undesirable hereditary predispositions and at the same time protect society from the social consequences of „*unproductive individuals*“. This preventive segregation was most often implemented in the form of placing children in institutions and special schools, where they were subjected not only to educational supervision but also to health monitoring and assessment of their employability.

Unlike in Germany, where eugenics was gradually transformed into the ideology of racial hygiene, Czechoslovakia maintained a more professional and medicalized and less nationalistic approach, which nevertheless influenced the attitudes of educators and school legislators. Special schools were built mainly at institutions for the mentally disabled and often operated as semi-boarding schools or residential institutions. According to Act No. 226/1922 Coll. on institutions for the mentally ill, children with „*severe mental deficiency*“ were usually placed in permanent institutional care, where education played a rather formal role and focused on basic work habits and hygienic stereotypes. These institutions also served as centers for genealogical monitoring and evaluation of family histories, reflecting an effort to distinguish cases of „*congenital degeneration*“ from „*environmental consequences*.“ At the same time, however, there were also more progressive trends in special education, influenced by humanistic and inclusive currents. For example, some schools for children with sensory impairments emphasized individual educational plans and preparation for employment outside the institutional environment. Nevertheless, the overall framework was dominated by a paternalistic and segregating model, which corresponded to the belief that people with more profound deficits were incapable of „*full integration*". This model was further reinforced by contemporary statistics and professional literature, which repeatedly pointed to the „*danger of transmission*" of mental defects to future generations (Roubalová 2024).

Eugenic ideas also found resonance in education policy through so-called health inspections of schoolchildren. Health examinations in the first years of primary school were an opportunity to detect cases of mental deficiency, epilepsy, and other conditions considered to be genetically determined. Children with confirmed diagnoses were recommended for placement in special schools or institutions. In some regions, especially in the Sudetenland after 1938, these processes were directly influenced by the German authorities and their racial hygiene agenda, which led to even more pronounced separation and registration of „*undesirable*" children. From an educational point of view, eugenic concepts thus contributed to the maintenance of a parallel education system in which regular schools and special institutions were sharply distinguished from each other. This model was legitimized not only by professional arguments about the „*level of educability*", but also by social pressure to prevent socially pathological phenomena. Eugenics thus became one of the important frameworks that helped shape ideas about the appropriate organization of educational opportunities for children with disabilities. Contemporary special education must reflect on this historical experience not only as a thing of the past, but as a source of knowledge about the mechanisms of stigmatization and social exclusion. As Daněk and Klugerová (2023) point out, even today, inclusion is often threatened by persistent ideas about „*normality*" and „*economic usefulness*", which have their roots in eugenic ideologies. Therefore, a key task of contemporary education is not only to develop professional and didactic competencies, but above all to strengthen ethical sensitivity and respect for the individual value of every human being.

People with disabilities during the Protectorate of Bohemia and Moravia

Since the end of the eighteenth century, a network of provincial institutions for the insane, or for patients with mental disabilities, was gradually built up in Bohemia and Moravia. These provincial institutions continued to function in an expanded form in the interwar period. At that time, there were six provincial mental institutions in Bohemia and several private mental institutions. In Moravia, the situation was similar; there were five large psychiatric hospitals, but there were a larger number of smaller psychiatric institutions, in addition to the private hospitals, mainly church-run institutions (Šimůnek, Novák 2023). With the cession of the Czech borderlands to Germany after 30 September 1938 as part of the Munich Agreement, the entire administrative network of authorities had to be reorganised. The administrative organisation was newly concentrated in Liberec, the centre of the newly established so-called Reichsrat Sudetenland (Reichsrat Sudetenland). With the secession of the Sudeten territory, Bohemia lost forty hospitals, out of a total of more than ninety, which amounted to less than nine thousand beds. Germany took over the psychiatric hospital in Dobřany as well as the educational institute for youth in Kostomlaty. In the new county health administration there were established health departments, subordinate to the Reich Governor, and a county office for public health. The three main health districts, located in Opava, Ústní nad Labem and Cheb, were subject to the Imperial Governor. Following the German model, state health offices were established in individual towns, where the imperial model of public health care was introduced, including the dissemination of the ideas of racial hygiene. Czech doctors had to close and hand over their practices, and their places were taken by doctors of German nationality, politically reliable members of the NSDAP (Šimůnek, Novák 2023). With the establishment of new borders, hospitals and institutions were re-districted. The county government administered institutional care for the mentally disabled. With the new administration, there was an effort to group and move inpatient psychiatric patients by nationality. As Šimůnek (2022) further writes, after 1939, the patients in the German clinics in Prague were predominantly of Czech nationality (Šimůnek, Novák 2023).

In the Protectorate of Bohemia and Moravia, which became part of the Great German Reich by Hitler‘s decree of 16 March 1939, health care was administered by the Ministry of Social and Health Administration (MSZS), which was divided into seven areas. The agenda of institutional care was assigned to the VIIth Department of the MSZS. All the offices were controlled by reliable people, Nazis and supporters of the Czech lands belonging to the German Reich. Šimůnek (2022) lists the hospitals; in 1939 – 1943, there were 73 public hospitals in the Protectorate with almost 22,900 beds and 58 private hospitals with 6,585 beds. There was a critical shortage of doctors, especially after the closure of the Czech universities after 17 November 1939; new doctors were not forthcoming (Šimůnek 2022). The Reich Protector was put in charge of the management of the Protectorate, whose task was to defend the interests of the German minorities, including the provision of health care. The system of health insurance in the Protectorate was almost identical to the First Republic system and very similar to the German system, with the difference that German insured persons had many advantages and special treatments compared to Czech Protectorate insured persons (free choice of doctor, coverage of hospital costs for a longer period of time) (Šimůnek, Novák 2023). Another feature of the Protectorate period was the reduction in the number of beds in hospitals and psychiatric institutions in favour of wartime infirmaries.

Hospitals were full, and the health care system was faced with large numbers of patients infected with TB and epidemics of typhus. German officials criticised the lack of hygiene and the backwards hospital conditions. This was also the reason for Reinhard Heydrich‘s advocacy of medical administrative reform, which only came into practice after his death. The MSZS was abolished and the health service was administered along the lines of the Reich. The so-called health police were created under the administration of the Ministry of the Interior. A year later, the German State Ministry for Bohemia and Moravia was established, headed by K. H. Frank (Šimůnek, Novák 2023).

Even though the T4 euthanasia program was a secret, exclusively Reich-German program and only German citizens of the Reich were to be included in the killing operations, the victims were also of Czech nationality. The euthanasia program was preceded by a several-year period of sterilization and castration of disabled persons. The pre-war sterilisation programme also included all citizens of Czechoslovakia who lived in German territory, unless they were unable to travel. In 1936, the Minister of Health of Czechoslovakia issued a declaration that Czechoslovak citizens could only be sterilized in Czechoslovakia (Šimůnek, Novák 2023). After the seizure of the borderlands, a law to protect hereditary health was also passed in the Sudetenland. Immediately after the Munich Agreement, negotiations began on the exchange of patients according to nationality. The transfer of patients of Czech nationality from the Sudeten border territory to Bohemia and, conversely, of patients of German nationality to the territory of the FRG. An exchange of approximately two thousand patients was planned, which, due to the declaration of the Protectorate of Bohemia and Moravia, never took place. The sterilisation of the affected patients was carried out in institutions on the territory of the FRY. Sterilisation was also a condition for the discharge of patients home. This did not apply to citizens of Czech nationality. However, they had to leave the territory of the Sudetenland. The sterilisation of German mentally disabled citizens was to be carried out on a widespread basis in the territory of the Protectorate, which was achieved only in the case of hospitalised patients. Heydrich pushed for the introduction of a law to protect hereditary health in the territory of the Protectorate as well. This failed, and German patients were transported across the border to sterilization facilities in the Sudetenland (RZS) for sterilizations (Šimůnek, Novák 2023). The occupied border territory, the Reich County of Sudetenland, was a mixed territory and it was technically very difficult to separate German and Czech patients from each other. In the framework of the T4 action, the disabled patients were gradually killed in the institutions in the Sudetenland. The Czech patients, who were the majority in the institutions in the Sudeten borderlands of northern Moravia and Silesia, were to be excluded from this action. The largest state psychiatric institutions were located there, namely in Opava and in Šternberk near Olomouc. It was assumed that during 1940, there would be an exchange of patients according to nationality, which, as already mentioned, did not happen. As a result, Czech and Polish patients from the Opava Institute were also included in the T4 action. Šimůnek (2022) states that the first transport from the Opava Institute, on 9 December 1940, became a symbol of the beginning of the great T4 action on Czech territory. Two more transports followed on 10 and 12 December 1940. Although visits to the institute were forbidden, relatives of the patients gathered at the institute until they had to be dispersed by the police. According to post-war accounts, the number of victims of these transports was estimated at 500. The patients of the three December transports were rounded up and transported by buses from the institute to the railway station, where they were crudely loaded onto wagons. If any of the patients struggled, they did not hesitate to use batons and drugs to calm them down. The victims were gassed at the hospital in Pirna-Sonnenstein near Dresden. Since the then director of the Opava Institute, Gersche, had contradicted his superiors, expressed his opposition to mass euthanasia, and did not want to take responsibility for the selection of patients for the transports, the following transports in April 1941 were managed directly by the T4 headquarters officer and the so-called gassing doctor. According to later testimonies of witnesses, such as the head nurse Jauernig, 300 – 400 persons were taken in the spring transport and the destination was allegedly Hartheim Castle, another euthanasia centre (Šimůnek, Novák 2023).

It was and is no longer possible to find out the exact numbers of the victims from the Opava institution; the institution‘s books on the admission of patients have been lost or destroyed in many institutions. Information on many transports has not been preserved. It was also not possible to determine the number of victims from the post-war witness statements; the witness statements varied greatly and the witnesses, often working only as nurses, were not sufficiently informed and did not have a complete overview. According to an estimate, around 1,000 patients may have been transported in the first transports, i.e. in December 1940 and April 1941, which, according to Šimůnek (2022), corresponds to the number of questionnaires sent from Opava (over 1,066). It is also impossible to determine the origin of the patients. The data on the number of patients of Czech nationality is inaccurate. In his testimony, the director of the Institute in Opava stated that nationality was not important in the selection for the first transports (Šimůnek, Novák 2023). At the same time, in June 1941, the institute in Šternberk, located 60 km from Opava, was seized for the needs of the army and it was necessary to transfer the patients from there. In total, 902 patients were affected. 130 patients were taken to Saxony and Pirna-Sonnenstein and were killed in the gas chamber. Some patients were transferred to Opava (385 people), others were transported to the Dobřany hospital and the Protectorate hospital in Kosmonosy. 237 patients were taken to Kosmonosy, 224 of whom were German, and the rest were of Czech nationality. None of these patients were transferred anywhere else (Černoušek 1994). There is also a suggestion that some patients from the Sternberg institution were taken directly to Hartheim to be killed. Patients arriving from Sternberg to Dobřany were no longer included in the transports for euthanasia. Patients from Šternberk and having a Protectorate affiliation were later transferred from Dobřany to Protectorate hospitals. Dobřany itself was a part of the T4 action, from where, as Šimůnek (2022) writes, six transports with a total of 342 victims were dispatched in April and July 1941. The time from the completion of the questionnaires, sending them to Berlin, selection to the subsequent transports and liquidation took, as in Opava, about five months. According to the testimony of the drivers, the patients were taken by bus to Hartheim and Pirna-Sonnenstein. Some of the transports were carried out at night, and it is believed that they led to the railway station in Pilsen and from there onwards by train. The exact number of victims at the Dobřany institution cannot be ascertained, as the institution also served as a transfer point for patients, from where they were either transported to other institutions or directly to killing facilities (Šimůnek, Novák 2023).

At the headquarters of the T4 action, plans were being prepared at the turn of 1940 and 1941 for the liquidation of those affected, also for the territory of the Protectorate of Bohemia and Moravia, but so far, there were two opposing views. Hitler‘s agents in charge of the euthanasia programme, Philipp Bouhler and Karl Brandt, believed that the action did not concern patients of Czech nationality. K. H. Frank, State Secretary in the Reich Protector‘s Office, who also supported euthanasia for Czech patients. As a result of the decision, only patients of German nationality were included in the T4 action in the Protectorate of Bohemia and Moravia (Šimůnek, Novák 2023). During 1941, it was possible to exchange patients according to nationality in the Protectorate, the intention being to exchange Czech patients from Kosmonosy for German patients from other Protectorate hospitals. In the territory of the Protectorate, as part of the national homogenization of the hospitals, an effort was made to move all German psychiatric patients to one institution, which was the Kosmonosy Institute near Mladá Boleslav. It was ordered to turn the Kosmonosy institution into a luxurious German hospital with a good reputation, where all the disabled Protectorate patients of German nationality would be concentrated, to simplify their transfer to the liquidation facilities and to speed up the process of their killing. Many German families living in the RZS who had relatives in the Kosmonosy institution found it difficult to visit them across the border, so they asked for their relatives to be transferred to one of the Saxon institutions. In rare cases, they were granted. In the end, 709 German patients were brought to the German hospital in Kosmonosy in exchange for 751 Czechs (Šimůnek, Novák 2023). During the occupation, 3,165 patients died in the Kosmonosy institution, and patients continued to die there after the end of the war, when, from May to December 1945, another 648 disabled patients of German nationality died. In the Dobřany hospital, there were a total of 3,714 victims by the end of the war. At the beginning of 1941, the Reich again became interested in psychiatric patients of

Czech nationality. Karl H. Frank, as an advocate of the gassing of the disabled, advocated euthanasia for Czech mental patients according to the same criteria that applied to German patients.

At the height of the T4 action, in May 1941, an update of German patients in the territory of the Protectorate was carried out. An additional 129 patients of German nationality were discovered in five Protectorate hospitals. From the end of June 1941, T4 questionnaires began to be sent to the provincial mental institutions in the territory of the Protectorate under the pretext of a statistical survey of mentally disabled persons of German nationality, and a month later visits to the institutions began. In Moravia, two main mental institutions were in operation, in Kroměříž and in Brno Černovice. Questionnaires were also sent there. Moravia was characterized by a dispersion of patients in small either church or private hospitals, which made it difficult for the actors of the liquidation action to register the patients. However, the vast majority of German patients in the Protectorate were selected and liquidated (Šimůnek, Novák 2023). Child patients, both Czech and German, were placed in Protectorate Bohemia in the Provincial Hospital for Mentally Disabled Children in Oparan and in three smaller church institutions, in Slatiňany, Plzeň and Prague. In Moravia, child patients were mainly in small hospitals run by the church. In August 1942, the liquidation of child patients in the territory of the Protectorate was considered and questionnaires were immediately sent out. In September 1942, K. H. Frank expressed his approval for the preparation of the liquidation of child patients. Still, for political reasons he did not recommend that the euthanasia action be extended to Czech child patients. Fortunately, due to the development of war events, a facility for euthanasia of children was not established in the Protectorate in the following year, and it remained so until the end of the war. In the Protectorate, child patients of German nationality were included in the exchange transports between Oparany and Kosmonosy. The purpose of these exchanges was to classify the adolescent German patients in Kosmonosy among the adult patients and then to liquidate them (Šimůnek, Novák 2023).

Mentally disabled patients of Jewish origin were concentrated in two Protectorate provincial institutions, in Bohnice in Prague for the Czech territory and in Kroměříž for the Moravian territory. During 1942 they were sent to the psychiatric ward in Terezín. It was located in the Cavalry Barracks building and had 11 rooms, where there were not enough beds. The bare rooms were overcrowded and there was a high mortality rate in the ward. Patients were continuously transported to Auschwitz for liquidation. 121 patients died directly in Terezín and 498 were sent further east. In April 1944, the entire psychiatric ward in Terezín was liquidated. The patients and their attendants were sent to the gas chambers. Based on eugenics, the program of euthanasia of disabled persons merged and gradually became a program of the question of the final solution (Šimůnek, Novák 2023).

Conclusion

Eugenics as a scientific, social and political phenomenon profoundly shaped the lives of individuals with disabilities in Czechoslovakia between 1914 and 1945. Unlike in Nazi Germany, where eugenics became the ideological foundation of racial hygiene and mass murder, Czechoslovak society maintained a more ambivalent approach that combined medical preventive thinking with ethical reservations. The debates surrounding the proposed sterilisation law illustrate the tension between scientific aspirations to improve public health and the democratic tradition that prioritised individual rights.

The complex interplay of medical discourses, legal initiatives and institutional practices created an environment in which people with disabilities were subjected to systematic categorisation, segregation and sometimes coercive measures. The wartime occupation and the imposition of Nazi policies, including Aktion T4, led to unprecedented violence and the deaths of thousands of patients in psychiatric institutions. The forced transfers, the involvement of local medical personnel and the gradual alignment of Protectorate practices with Reich policies are essential elements in understanding this tragic period.

From an educational perspective, eugenic ideas had a significant impact on the organisation of special education and institutional care. The belief in hereditary determinism contributed to the consolidation of segregated educational systems and the legitimisation of lifelong institutionalisation. Although some progressive pedagogical approaches emerged in interwar Czechoslovakia, aiming at social rehabilitation and the development of individual abilities, these initiatives were marginalised by the dominant narrative of deficit and danger.

This historical experience highlights the need for a critical reflection on the ethical foundations of special education. Contemporary inclusive approaches must be understood not only as a pedagogical innovation but as a corrective to past practices that systematically devalued the lives of people with disabilities. The lessons of eugenics warn us against reducing human worth to biological utility and remind us of the importance of protecting the dignity and autonomy of all individuals.

We take for granted the daily encounters with people with disabilities today - we see them in schools, workplaces, and communities. These people, although facing various obstacles, have dreams, goals and aspirations. Modern special education focuses on supporting them not only academically, but also in the practical skills needed to live independently. This changes not only their lives but also society‘s view of inclusion and equality. From a special education perspective, it is important to stress that inclusion is not just about physical presence in schools or workplaces. It is a process that involves adapting environments, teaching methods and approaches to make them truly accessible to all. It involves working with teachers, families and communities who play a key role in promoting the inclusion of people with disabilities.

Today, when technological advances in genetics again pose complex ethical challenges, education remains a key sphere where respect for diversity and the principles of social justice are formed. Inclusive education, based on the recognition of individual potential and equal participation, offers the most effective response to the historical legacy of exclusion and discrimination. It is through critical awareness and ethical commitment that educators and societies can prevent the repetition of past mistakes and build environments where every person can live a whole and meaningful life, regardless of health status or ability.

Special education shows us that inclusive education is not just a matter of rights, but also a benefit for society as a whole. When we enable individuals with disabilities to receive an education and develop their abilities, we not only support their personal growth but also enrich the educational environment with new perspectives. Cooperation between students with disabilities and their peers leads to the development of empathy, tolerance and mutual understanding – values that are fundamental pillars of modern society. Thus, we can support the idea of Daňek and Klugerová (2023) who recognize inclusive education as a tool of social exclusion. Promoting change and innovation, for example, cooperative learning that replaces traditional competitiveness, plays a vital role in strengthening social bonds between students and developing their collaborative skills (Bačová 2024). Promoting attitudes towards students, for example, through teaching aids that have become a standard part of the educational process and their appropriate integration into education provides countless opportunities for both teachers and students, from activating students, better motivating them to learn, explaining the curriculum through demonstrations and many more (Němejc, Smékalová, & Kříž 2019).

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