

## RESEARCH ARTICLE

# Medical decisions influenced by eugenics: Hungarian gynecological practices during the 1910s

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## Argument

This study contributes to the discussion on the development of eugenics in Central-Eastern Europe by tracing the way that eugenic ideas entered into medical decision-making in Hungary. Through a case study that reviews the professional argumentation of the gynecological management of tuberculosis pregnancies, this paper shows that the subordination of individual reproductive rights to state interests was influenced by the ideas of eugenics, which had begun to enter into the professional public health discourse. A eugenically informed morality was envisioned, to guide decision-making in the interest of the Hungarian “race.” This biopolitically important morality can be viewed as an early influence on the formulation of biological citizenship. Leading figures were divided on how to ensure such morality: some scholars argued that education is the key, others thought that the state, and state actors, should act radically in the interest of the population and decide on behalf of the individual. Radical methods, such as the termination of pregnancies and sterilization of women, were among the practices of gynecologists. Although abortion and sterilization were not widespread and never became official therapeutic solutions for tuberculosis pregnancies, they were nonetheless part of a discourse that preceded the eugenic institutions of the interwar years.

**Keywords:** eugenics; public health; biological citizenship; reproductive rights

## 1. Introduction

Critical scholarship has been published regarding the development of medical sciences around the 1900s in Hungary. Marius Turda has published extensively on the developments of Hungarian eugenics and its fusion with a racialized nationalism (Turda 2003; 2006a; 2007; 2010; 2013; 2014). Emese Lafferton has contributed to this discussion by pointing out the intertwining of racial ideology with national politics in the disciplines of ethnography and physical anthropology (Lafferton 2007; Buklijas and Lafferton 2007; Lafferton 2016). Kinga Szűcs studied the influence of German medicine on Hungarian medical thinking and practice (Szűcs 2003). She concluded that the German and Austrian medical discourse largely influenced the direction of Hungarian developments.

According to Lafferton (2007), the dominant race concept in Hungary in the early twentieth century was centered on the ethnographic view of race (i.e., it was culturally understood). However, this perspective carried biological and medical consequences as well, with the result that the dominant understanding of race marginalized other ethnicities that exhibited other cultural traits. Although an explicitly racial discourse was not developed and directed against other racial groups in this early period, the focus of public hygiene and eugenics was on the development of *Hungarian* health standards, thus implicitly marginalizing the health interest of other ethnic communities.

This study contributes to the discussion on the development of eugenics in Central-Eastern Europe by tracing the way that eugenic ideas entered into medical decision-making in Hungary. The eugenics discourse of early twentieth-century Hungary portrayed degeneration and inheritance as two sides of the same “problem” introducing the implied notion of “transgenerational responsibility.” The perceived relationship between individual and state responsibility meant that moral considerations were considered important and relevant factors in population management. Constructions of disease and risk groups were also crucial in shaping medical debate. This paper therefore analyzes how industrialization, poverty, class identity, and gender shaped the targets of medical intervention, showing how individual reproductive rights were subordinated to state interests in medical decision-making concerning the handling of tuberculosis pregnancies of working-class women.

One of the central questions that is discussed in this paper is how citizenship was shaped by medical actors who played a key role in defining what kind of bodies were valuable from a medical-political perspective, and how citizens were influenced to become responsible members of Hungarian society. Maria Björkman (2015) suggests extending the use of the concept of biological citizenship—developed by Carlos Novas and Nikolas Rose (2000)—by exploring how collective responsibility was influenced by eugenic and racial hygienic ideas in the past. In the discussions that took place in the first two decades of the twentieth century, medical professionals contributed to the articulation of a very repressive and exclusionary discourse that defined individual responsibility in terms of a racial future. Drawing on the work of Björkman, this development can be viewed as an early attempt to influence medically and biologically responsible decision-making.

## 2. Eugenics: The ideology that shaped the public health discourses of the twentieth century

Both the discourse of eugenics and the eugenics movement originated in nineteenth-century England, and historians attribute the term itself to Francis Galton (1883); but even in its early stages, the cultural reception of eugenics in different parts of the world was already significantly different (Stepan 1991). Historians of eugenic thought have pointed out the various ways that eugenic policies were enacted in different European countries (King and Hansen 1999; Sonn 2005; Cleminson 2003; Brandhorst 2003; Schneider 1982; Cassels 1964; Larson 2010). Although it is a relatively straightforward task to define the start of the eugenic discourse, it is a much harder exercise to mark the end of eugenic thought. Alison Bashford, relying on the work of Nikolas Rose (2006, 252), argues that it is better to research the “history of eugenics as a continuous modern discourse of the long twentieth century” (Bashford 2010, 553). This is why it is important to study local eugenic practices to understand how eugenic thinking has existed and remained part of different social contexts (Paul 1995; Agar 1998; Duster 2003).

Roll-Hansen (2005, 259–260) argues that British and Scandinavian countries were affected by two waves of eugenic thought: the first wave took place in the years prior to World War I, while the second wave took place in the interwar period and lasted until the end of World War II. A similar argument could be made in the case of Hungary. As described by Turda (2014), Hungarian eugenic thought first peaked in the early 1910s. These eugenic ideas were primarily concerned with the degeneration of the Hungarian race, and the most influential eugenic discourses that were affecting the Hungarian movement were the British, German, and French schools of thought. Its second wave took place during the interwar period.

Kovács (2012) argues that one can mark the beginning of a racist eugenic discourse with the *numerus clausus* law that went into effect in 1920. This law was the first anti-Semitic law that excluded Jewish Hungarian citizens from university education. Rhetorically, it purported to be about giving equal opportunities to various nationalities based on their respective ratio in society,

but it was the first law that took away rights from a group of citizens based on their racial identity. This law was followed by twenty-one more over a period of twenty-four years, all of which aimed at marginalizing Jewish citizens in the country (Karsai 2005, 141–143). Although all of these laws were designed to make sure that Jewish citizens were politically and economically disempowered, the one passed in 1941 is the most explicitly biology oriented, because it established the grounds for controlling the reproduction of citizens based on race by prohibiting intermarriage between Jewish and non-Jewish citizens.

During the first wave of eugenics, sterilization laws based on race hygienic ideas were passed only some states in the United States. None of the European countries enacted laws that would forcibly sterilize its citizens (Roll-Hansen 2005, 262). Hungary was no exception from this perspective: coercive sterilizations were not allowed. However, individually requested and “medically indicated” sterilizations were performed. During the 1910s, for example, doctors surgically sterilized working-class women who lived in poverty, whose “nature” was viewed as overtly sexual and who were deemed incapable of restraining themselves, thus causing risk for themselves and for society in the case of tuberculosis pregnancies.

### 3. Public healthcare as a vehicle of modernization during the Austro-Hungarian dual monarchy<sup>1</sup>

Because this work focuses on the intersection of eugenics, public health, and tuberculosis pregnancies in the second decade of the twentieth century, it is important to review the modernization efforts of the Hungarian state. The spread of tuberculosis had intensified during the nineteenth century, and it was only after the Compromise of 1867, when it became possible for Hungary to tackle the problem on a larger scale (to engage in a structurally meaningful response). This was the time when the organization of public healthcare was introduced, and at the turn of the century European ideas about eugenics started to spread in academic circles. In order to provide a meaningful context to this case study, the structure of the public healthcare system will be briefly reviewed, including the doctors’ role in this system and the importance of midwife training, because these contributed to the control of tuberculosis and the numerical increase of healthy live births.

The modernization of Hungary started in the 1850s. This was the time when industrialization took place, when the citizenry started to move into the cities, and when the bourgeoisie came into being. During this period, the formation of the economic, intellectual, and political elite took place, although it is important to note that the members of this last group mostly inherited their privileges. However, it is also noteworthy that a new society was forming, in which citizens became much more socially mobile (citizens were able to cross class-based boundaries), because society overall began to respect and value personal achievements in addition to inherited status and wealth (Gerő 2010, 93–94). These developments contributed to the consolidation and broadening of the middle-class in cities. But what did modernization mean in nineteenth-century Hungary?

During the dual monarchy, it primarily meant undertaking various projects designed to make the country more “civilized.” One major aspect of this was infrastructural development, in order to connect distant parts of the country, so that travel could take place in a civilized manner, according to the world’s technological advancements (road and railroad construction, tram lines and the underground train in Budapest etc.). Another important aspect of civilization was concerned with the improvement of the people’s mentality in various fields of culture (Gerő 2010, 133–34).

<sup>1</sup>The Austro-Hungarian dualist monarchy was a union between the Austrian Empire and the Hungarian Kingdom that was formed by Franz Joseph I, Emperor of Austria and King of Hungary. During this period, the two states shared the management of foreign affairs, as well as their ministry of war and ministry of finance. After the Hungarian Revolution of 1848–1849 was crushed, the Hungarians organized passive political resistance that lasted until the Austro-Hungarian Compromise of 1867, when Franz Joseph I was officially crowned as Hungarian king. The Dualist period lasted from 1867 to 1918.

Regarding this latter aspect of modernization, the development of scientific thinking, the improvement of education, sport, fashion, and the development of health-conscious thinking and behavior were a main concern.

In order to facilitate health-conscious thinking and behavior among the people, it was top priority to make healthcare services widely accessible. Although this was an important goal, in reality there was a huge difference between the people who were living in villages and those who were living in cities (especially in Budapest)—in terms of health-consciousness and of course in terms of the available healthcare services (Geró 2010, 140–41). The fact that public health occupied a central place in modernization is signified by the increase in the number of medical doctors after the Compromise, and also, by the exponential increase in the number of hospitals across the country (this latter number had increased by 90 percent after 1867; altogether 400 hospitals had been built before 1914, of which 360 were built during the Dualist period). Pharmacies underwent similar developments during this time. Despite these efforts, infant and child mortality rates dragged down the success of modernization. In addition to these numbers, roughly 50,000 people died each year of tuberculosis. Thus, systematically reorganizing public health services to counter these problems was seen as paramount.

After 1867, all public health tasks were placed under the authority of the Ministry of Internal Affairs. Here, two departments handled healthcare issues: (1) the national philanthropic fund, and (2) the public health department. In 1894–95, this structure was changed by Kornél Chyzer, who was the head of the public health department. He created three sub-departments, which dealt with epidemiology, public health administration, and hospital care. This was slightly changed a year later, when only the latter two departments remained. Another modification occurred in 1903 when Gyula Bölcs, Chyzer's successor, established four departments where epidemiology, tuberculosis sanatoriums, and mid-wife training were still central questions (Pálvölgyi 2006, 11–13). This structure did not change until 1914. Another important aspect of healthcare development was the education of doctors, where they were trained, where they practiced their profession, and how many doctors were in the country, and in what distribution.

After the Compromise, the social class of medical doctors thought that the first priority was to adequately settle the requirement of university education for physicians, and to pass legislation to address the country's public health issues. It is notable from the reforms that the anachronistic barber-surgeon training was terminated, and instead of this, the education of surgeons and obstetricians was increased—both in their numbers and in terms of the medical knowledge taught to them during their university studies (Antall and Kapronczay 1989). By the mid-nineteenth century, the population of doctors in the country was 2207 (according to an 1841 census). They had all received their education in universities. Their number can be distributed according to their professional training in the following manner: 804 were university-trained medical doctors and the rest were barber-surgeons and obstetricians—similarly university trained, but in a shorter, 3-year period. Most of the doctors working in Hungary were trained in three universities: in Budapest, in Vienna, and, from 1872, also in Kolozsvár (Cluj-Napoca). Their number increased to 5500 by 1876: 3000 medical doctors, 2541 surgeons and obstetricians, and 1500 midwives working across the country (Kapronczay 2010, 161–162).

The doctors fundamentally worked in two ways. First, many of them worked as part of the public healthcare system (in the ministry, in the municipality, or in townships). Many of these positions were vacant, however, because these types of jobs were not paid well. One of the most urgent problems around the turn of century was precisely this: how to reform the system, to make these positions more attractive, and so make healthcare services more accessible to the public. Those who did not work in the public system worked in private practice, simply because this provided a good income. During an epidemic, private doctors were required to take part in public healthcare work (be on duty, work in hospitals, or administer vaccinations). It was also their duty to provide emergency care if it was needed, and to provide further care if there was no other doctor in their precinct (Pálvölgyi 2006, 61–62).

Although by the end of the nineteenth century the distribution of the doctors across the country developed significantly, lack of medical care was still a problem in rural areas (Pálvölgyi 2006, 82–83). It was similar in the case of midwives. The public health law stated that midwives are part of the public health staff of townships, and like general practitioners, they were responsible for their own precincts. This meant that towns with a population below 1500 had the right to have a shared midwife with other similarly populated towns in a given territory. Because the country was not capable of training an adequate number of midwives, the law permitted non-university trained (so called peasant-midwives) to work also. Despite this, many rural areas were still short of midwives (Pálvölgyi 2006, 87–89). To solve this problem, the 1908 statute modified the previous act about midwives, and mandated that all towns and villages with populations of at least 800 must employ one. In order to ensure that giving birth proceeded in a secure manner, and to improve the poor infant mortality rates of the time, it was necessary to institutionalize the education of obstetricians and midwives and to improve their integration into the public healthcare system.

The developments discussed above were primarily influenced by the fourteenth public health law of 1876. This law made it possible to improve patient care and develop hospitals. Another important change occurred as a result of the reform: free of charge medical services were made available for the poor, alongside the private services paid for by the middle and upper classes. These were all necessary improvements that helped to bring about changes in the care of tuberculosis patients, and to decrease infant mortality rates—two problems that were deemed amongst the most urgent of the country's public health issues. The appearance of free medical services was important because it signaled that making public healthcare more accessible for a larger segment of society had become a government priority. In order to make sure that the poor could really use these services, the fifty-eighth paragraph of the 1876 law stated that public hospitals must take on any patient asked for medical care in the facility, until there were no more free places in the institution (Antall and Kapronczay 1989). Initially, the expenses were covered by taxes. Part of the state's income was allocated for this purpose, and the necessary amount was supplemented by public funds and charities. Later, in 1898, the National Patient Care Fund was set up to institutionally regulate the state's role (Kapronczay 2007).

The 1876 law was also groundbreaking from a professional responsibility perspective. According to paragraph forty-seven, doctors were allowed to choose the therapy they deemed best for their patients. No one could restrict their choices, and they were only responsible to the state in cases of medical malpractice (Pálvölgyi 2006, 61). This legal change provided great professional freedom in their practice.

Although tuberculosis was a relatively well-known disease in Europe by the nineteenth century, in Hungary it only became a serious concern during its second half. Data had been collected about tuberculosis infections since 1859: these statistics tell us that in that year there were 700 deaths, which was 12.75% of the country's overall mortality rate. But this number went up to 3182 by 1884, which was 25% of the overall death rate. It was Frigyes Korányi, physician and university professor, who initiated the broader social movement: he published a call on April 13<sup>th</sup> in 1896 in the *Pesti Hírlap*, and on the 14<sup>th</sup> in the *Pester Lloyd* daily papers, in which he urged the population to support the fight against tuberculosis. In addition to this, on May 8<sup>th</sup>, he spoke in Parliament, asking for the government's support (Kapronczay 2010).

The first provisions by the state were connected to the 1898 statute on the topic of tuberculosis protection, passed by the Ministry of Internal Affairs, which stated the main directives that were supposed to manage this serious public health problem (see Pálvölgyi 2006, 245 n. 1079). This statute ruled that the fight against tuberculosis should not only focus on the disease itself, but it should enlighten people as to what they could and must do in order to protect themselves and their fellow citizens from the deadly effects of the disease. Ordinary people, the statute assumed, thought that tuberculosis was lethal, lived in cramped places with bad ventilation, spat on the floor, and did not know that alcoholism influenced the disease for the worse (Pálvölgyi 2006, 245–246). These bad habits were therefore the focus of contemporary knowledge about tuberculosis.

This was the time when civil societies were established to fight tuberculosis, and these organizations greatly influenced the creation of the first tuberculosis sanatoriums. The first smaller sanatorium was opened in 1897 in Szentendre (with fifteen beds). It was followed by another one in Békés County in 1899, then a larger one was opened in Budapest in 1901. The first dispensary was opened in Szombathely in 1906, and from this year, the National Patient Care Fund covered the expenses of therapies in these institutions. This was an important development, because the disease affected the population disproportionately: in slum districts, 40–50% of the population was infected with tuberculosis. Because therapy was possible in the form of outpatient care, dispensaries were established following the Belgian-French model. Dispensaries were necessary, because sanatoriums were inaccessible for most of the working-class population. They simply could not afford to leave their jobs for weeks or months. It was notable that, owing to the efforts of the state, in 1913 the establishment of thirty-one more dispensaries was funded, and a statute passed in 1912 made it possible to fine those citizens who knew about people suffering from tuberculosis but failed to report them to the authorities to facilitate the disinfection of their homes (see Kapronczay 2010, 102). These measures were successful only in the sense that the number of tuberculosis patients and the death rate did not worsen during the dual monarchy, but the First World War halted further developments (Pálvölgyi 2006, 247–252; Kapronczay 2010, 100–103).

#### 4. The appearance of eugenic ideas in the Hungarian context

The interpretation of public health in the nineteenth century was an integral part of modernization. It was thought that the preventive approach to public health would play a role in the protection of the population's health, and that this, in turn, would allow for social development and welfare. This process was supported by the doctors, who were convinced that they must play a role in promoting the health of the population. This was viewed as the only way that Hungary would remain competitive economically and militarily with other developed European countries (Rudisch and Tóth 2019). This approach to public health was the foundation for bringing eugenics and prevention together. In other words, this medical discourse, understood in Foucaultian terms, established the possibility of subordinating individual interest to state interest. In the following, this shift towards preventive and racially conscious decision-making will be reviewed.

Events in the 1910s signify a wider interest regarding the subject of eugenics in Hungarian society. This interest can be traced to the first public discussion, called the Debate on Eugenics, in 1911 (for an extensive analysis see Turda 2014). The Hungarian Academy of Sciences had organized the debate, in which leading health professionals and social scientists of Hungary presented their views on eugenics. A significant number of contributors questioned the new “scientific” claims of its proponents, articulating their doubts from the perspective of public hygiene and the laws of inheritance. These lectures were published in article format in the progressive social science journal *Twentieth Century* (Huszadik Század, 1900–1919).

Despite the tensions, some common ground was established in these debates. Such was the need for reforms in the field of public hygiene that these ideas were taken into account when the Committee for Racial Hygiene was founded in 1914. According to István Apáthy<sup>2</sup> the establishment of the committee was advocated by the Royal Medical Association of Budapest and the Association of Public Health. The committee extended its profile and changed its name in 1917 to the Hungarian Society for Racial Hygiene and Population Policy (Turda 2006a; 2007). The physicians took an active part in the formulation of eugenic ideology, and in its theoretical fusion with public health policy. The fact that the physicians played a major role in setting the agenda of the eugenic movement makes it necessary to explore their professional contribution to the ideology of Hungarian racial hygiene. Furthermore, exploring the heterogeneous views of medical

<sup>2</sup>István Apáthy (1863–1922), zoologist, university professor, corresponding member of the Hungarian Academy of Sciences.

professionals on eugenic ideas will provide a more nuanced picture of how eugenic values were integrated into medical practices.

In an article published in 1910, József Madzsar,<sup>3</sup> who was a leading figure in the Hungarian eugenics movement, presented an interpretation of eugenics that stood in contrast to the conservative-humanist discourse that believed that the key to social development lay in technological advancements, public hygiene, education, and in positive economic changes. He argued, contrary to these assumptions, that the scientific knowledge on inheritance proved that changes in the environment or education would not advance the well-being of the Hungarian “race.” He claimed that it was proved that certain diseases were inherited with the germplasm, and therefore there was no room for change in the lifetime of the progeny. Although Madzsar did not see artificial selection of the “unfit” as a viable option in his own time, he urged that at least the sterilization of the “unfit” should be adopted as institutional practice, with positive assistance being given to the “fit” to reproduce (Madszar 1910, 115–116).

Zsigmond Fülöp,<sup>4</sup> a similarly eager eugenicist, introduced the “new science of eugenics” for the Hungarian readers of *Twentieth Century* in a later issue printed in the same year (Fülöp 1910). He set out the goals of eugenic thinking, and he explained in this piece the biological knowledge that eugenicists relied on at the turn of the century. He used several definitions to identify the main tenets of eugenics, but found most useful the definition of Erich Becher, a German philosopher and psychologist, who claimed that eugenics is the science which aids humanity to become physically stronger, to gain outstanding mental capacities and, in general, to be born with better characteristics (Fülöp 1910, 161). Fülöp argued for the importance of comparing quantitative data with qualitative data, claiming that “eugenetics” was crucial for future generations because though cultural development had increased the population, it had generated qualitative problems regarding the population’s genetic stock (*ibid.*). He interpreted this as a simple result of human control over natural selection (the weaker can survive as a result of medical intervention), but he also noted that this must be replaced by artificial selection to improve the quality of the population. The amount of empirical evidence, argued Fülöp, supported the introduction of “eugenetically” motivated social policies. Eugenics was posited as a social “necessity” because of the large-scale industrialization of societies and also because of the degenerative effects of contagious diseases such as tuberculosis and venereal diseases.

International examples (from France and Switzerland) were used by the proponents of eugenics to prove the increasing numbers of degenerates in those countries and to argue that those same problems would appear in Hungary as well—it was only a matter of the development of the welfare state. For Madzsar, for example, the problem lay within the political ideology of the welfare system. He claimed that as modern states developed, they transcended the process of natural selection, but the problem was that modern social structures did not introduce artificial selection mechanisms to improve the health standards of the population (Madszar 1911). He believed it was necessary to acknowledge that both social and health problems are inheritable problems, and he discussed criminals, the mentally handicapped, alcoholics, hemophiliacs, and patients with diabetes and tuberculosis from the same perspective. This position meant that improvements could only be achieved after the essential and inheritable nature of these ills was adopted as a common stance; it also meant that eugenicists had begun to fuse social issues with public hygiene concerns.

By 1914 eugenics and hygiene were quite explicitly conflated by the Hungarian contributors to the polemic. Nevertheless, perhaps Géza Hoffmann’s<sup>5</sup> suggestion still stands out. He proposed,

<sup>3</sup>József Madzsar (1876–1940), trained physician, who later in his life became a left-wing radical activist and politician. An active member of the anti-alcohol movement, he was the chairman of the Social Science Society.

<sup>4</sup>Zsigmond Fülöp (1882–1948), translator, editor, assistant master of chemistry, and natural science writer.

<sup>5</sup>Géza Hoffmann (1885–1921), internationally acknowledged expert of eugenics, Austro-Hungarian Vice-Consulate to the United States (Turda 2006b, 109).

following Apáthy, to use the German Rassenhygiene as the starting point in understanding the science of eugenics, and suggested the use of race hygiene as the Hungarian equivalent of the term. He argued that it was the business of race hygiene to understand, locate, and take social-hygienic measures against those who were deemed “unfit” or “unworthy” for reproduction from the perspective of the health of the race (Hoffmann 1914, 97). It was basically its task to weed out the bad elements and promote the reproduction of the good, and because of this aim the fertility rates of a society were necessarily linked with the practices of eugenics.

In order to allow public space for eugenic discussion and articulate a common eugenically informed stance on health problems, the Race-hygiene Branch of the Hungarian Association of Social Sciences was established on January 24<sup>th</sup>, 1914. Their first meeting was held in joint collaboration with the National Public Health Association on the same day. The opening speech was given by Apáthy, who repeated his position on the most important direction that racially conscious hygienists could suggest to improve the future generation: to control reproduction as closely as possible. One option, he argued, was to identify those who should be allowed to reproduce and prohibit the reproduction of those who were biologically harmful for the race. To this end, he suggested that the state should take the following steps: (1) provide medical assistance to those who want to reproduce by protecting their reproductive health, (2) detect those signs that aid medical professionals in understanding the reproductive fitness of individuals, (3) prohibit the reproduction of those who were deemed “unfit” (Apáthy 1914, 165–166).

In terms of the development of eugenic “morality,” the ideas shared by Apáthy during the first meeting of the race-hygiene society in 1914 were a culmination of the discussions that eugenicists had been having during the previous years, starting with the Eugenic Debate. Apáthy considered it to be the most important task of society to create a social, or racial, morality that would help achieve eugenic goals, because racial morality should be understood as the equivalent of ethical eugenics. This ethical perspective viewed the biological and social development of the race as the most important value—a view which supposed that all individuals should subject themselves to the interest of the race (Apáthy 1914, 166–170). Apáthy thus divided the most important tasks into five groups: (1) the foundation of a social ethics that helps the integration of eugenic ideals into individual identities; (2) institutionalization of preventive eugenics; (3) diagnostics from the perspective of racial health; (4) prohibition of reproduction in those deemed “unfit” (this he classified as normative eugenics, and it entailed marriage counselling, sterilization, prostitution, and immigration control); (5) understanding the relationship between the various “ethnic races” living in Hungary and governing their mixture from an eugenically informed perspective.

## 5. The health of the patient or the health of the “race”? Abortion and sterilization in the medical discourse on tuberculosis

Because, the eugenics movement influenced the field of obstetrics and gynecology, the medical interpretation of the relationship between pregnancy and tuberculosis during the 1910s is highly pertinent to this case study. In order to accomplish this goal, three prominent medical journals were analyzed, and the result of the analysis is presented below. The *Medical Weekly* (Orvosi Hetilap, 1857-), *Good Health* (Jó Egészség, 1902-1938), and the *Budapest Medical Journal* (Budapesti Orvosi Újság, 1903-1949) are three professional journals that had significant readerships and influenced the professional discourse by introducing Hungarian and international cases, techniques, therapies, book reviews, and conferences. These were the professional public spheres where doctors discussed their experiences and views regarding the healthcare problems of their age. My analysis of their contents showed that doctors were not homogenous in their conceptualization of the relationship between individual responsibility and state interest in favor of eugenic ideas regarding tuberculosis pregnancies, although eugenic decisions appeared in their everyday medical practice. The analysis addresses three interrelated issues: (1) the doctors’ understanding



the spread of tuberculosis and susceptibility to the disease, (2) their perception of the relationship between pregnancy and tuberculosis, (3) their opinion regarding medical indications for abortion and sterilization.

Despite the fact that eugenics gained momentum in gynecology, there were numerous doctors who advocated conservative therapies. Although they shared the view that eugenics must inform their professional practices, so that they could ensure that the process of giving birth would be healthier and that healthier babies would be born, they believed that state intervention must be rejected, and that only through education and the dissemination of scientific knowledge should doctors influence their patients (Rotter 1912). Such eugenic influence can be detected in the example of Geszti (1914, 336), who emphasized that the doctor must prevent—if it is in their power—the marriages of young women suffering from tuberculosis, because married relationships (that is, sexual relationships, that potentially result in pregnancies) were dangerous for both the women and for the state as well.

The fact that eugenic thinking gained momentum is evident in the acknowledgement that the number of abortions suggested by doctors had grown by 1918. Multiple explanations were provided to interpret this change: it is true that medical knowledge had improved regarding what could harm pregnancies, but it is also true that in many cases abortions were indicated on non-medical grounds, and that even race-hygiene played a role in the justification of the termination of pregnancies. An article by Georg Winter, the German gynecologist, in which he argues that it is not medically warranted to indicate abortion on the grounds of social hardship, eugenics, or forced pregnancy (Winter 1918), implicitly proves that procured abortions were being influenced by the race-hygienic discourse, and medical doctors felt the need to counter such scientifically baseless practices.

Through the analysis of the articles in the above-listed journals, it is possible to capture a slice of the professional ideology that allowed eugenic ideas to creep into the decision-making processes, at least at the micro-level, by the mid-1910s. Social categories of gender, class, and race had shaped the concerns of practitioners: these categories were tacitly used in medical thinking to locate problematic groups and formulate procedures that, in the case of tuberculosis pregnancies, deprived women of reproductive agency by reason of economic hardship supported by a stereotypical view of their uncontrollable promiscuity. State interests were also included in their argumentation: some medical practitioners argued for responsible decision-making by connecting individual problems to national economic and health interests.

## 6. Susceptibility factors and the spread of tuberculosis

Based on empirical experience, it was concluded that the disease was rarely inherited. It was observed that fathers could not transmit the condition; only mothers could pass the disorder to their newborns. The general view was that children could only inherit susceptibility to the disease, but as this was not observed all the time, this understanding was combined with environmental factors. Therefore, doctors placed emphasis on hygienic environments, healthy diet, and clean fresh air. It was argued that if these environmental factors were taken care of, the disease would not be transmitted to the children, and even adults would have a better chance of recovering from tuberculosis (Nagy 1915b, 81). In order to ensure that children would not contract the disease, it was advised to place the children of sick parents into a healthy environment where they could be raised without the fear of infection. Others also suggested that there are three basic ways of contracting tuberculosis: (1) inhaling, (2) droplet infection, and (3) through blood (Nagy 1915a, 60). Closed spaces were similarly emphasized as dangerous places where one could contract tuberculosis easily as it spread through the air (Nagy 1917a).

Researchers were interested in ascertaining whether children inherited the disease or not, so extensive tuberculin tests were performed on newborns to clear up theories about inheritability

(Nagy 1917b, 44). Most of these tests produced negative results, and proofs against inheritance accumulated. Indeed, the belief in inheritability was scientifically rejected during the 1910s. For quite some time physicians had thought that inheritance was key, and tuberculosis must be managed in view of that. According to Friedrich this had changed by 1919, when it became widely accepted that there are congenital biological characteristics (i.e. general health) and acquired susceptibility factors (Friedrich 1919, 20–21). Most physicians thought that the latter, such as poverty (poor housing conditions, poor diet), bad hygienic conditions, harmful working conditions, smoking, and alcoholism were much more important in the contraction and course of the disease.

## 7. Conceptualizing the connection between tuberculosis and pregnancy – medical versus eugenic indications of abortion and sterilization

The question of how pregnancy influences tuberculosis and how tuberculosis influences pregnancy were among the most pressing problems of the 1910s. The gynecologists Géza Királyfi and József Frigyesi<sup>6</sup> co-authored a paper that explored the relationship of these two processes regarding the situation of the mother suffering from tuberculosis, and also of the fetus that might contract the disease *in utero*. They discussed the issue from three different perspectives: (1) whether it is important to intervene in the normal process of pregnancy; (2) if intervention is needed, when it should be carried out; (3) what kind of intervention is necessary (Királyfi & Frigyesi 1911a, 699–701). By 1911, they explained, the view that tuberculosis is a risk factor in pregnancy was generally accepted, and this is especially the case during the puerperium. Because of this existing knowledge, gynecologists and physicians tended to advise the termination of the pregnancy on the grounds of protecting the lives of mothers.

Egmont Baumgarten, a university professor, argued that the medical profession is divided into three groups regarding when it is indicated to terminate pregnancies in mothers with tuberculosis (Baumgarten 1912, 6). The first group does not view abortion as a possible medical solution for the mother, because it is not clear whether doctors will be able save her life, but it is possible to save the life of the newborn. In the second group, doctors argued that abortion is medically indicated in the first trimester of the pregnancy, since after this period the disease worsens and the life of the woman is endangered by giving birth and during the puerperal period. Finally, the third group accepted abortion only in cases of eclampsia, heart problems, and laryngeal tuberculosis, and in cases of severe tuberculosis.

Some physicians went further than the three views covered by Baumgarten, and even advised sterilization for women. There were doctors who sought to establish criteria for when the pregnancy itself endangers the life of the mother and tried to save both mother and child, and there were others who not only terminated the pregnancy but also sterilized the woman, if they deemed it necessary to ensure her recovery (Királyfi & Frigyesi 1911a, 702). These last argued that an abortion itself is very dangerous for the life of the mother, so a mother who suffers from tuberculosis must be protected from further risks. However, this practice was criticized by those physicians who thought that, because it is possible to recover from tuberculosis, it was a grave mistake to take away the right of the woman to become pregnant and give birth later, when her health would allow it.

Based on the review of international literature and their own observations, Királyfi and Frigyesi formulated a position that supported abortion only in the first half of the pregnancy – stating that in the third trimester it should only happen if the woman's life was in danger. What they added to this position is how they viewed the economic factor in medical decision-making (Királyfi & Frigyesi 1911b, 726). They stated that even in milder cases of tuberculosis, bad social

<sup>6</sup>József Frigyesi (1875–1967) was a gynecologist and university professor. He started his career at the II. Women's Clinic, then in 1929 became the director of the I. Women's Clinic both in Budapest. He was a corresponding-member of the Hungarian Academy of Sciences from 1946 and in 1949 he became an advisory member.

environments could influence the recovery of women for the worse, so they viewed lower socio-economic status as a vital indicator for the termination of pregnancy. They further stated that in some cases, when tuberculosis was severe, the right of the woman to abortion should be more restricted, because if the woman's life could not be saved, gynecologists and physicians were obligated to prioritize the life of the child.

Baumgarten discussed several cases to underscore a similar point regarding when it is medically warranted to advise abortion in the case of laryngeal tuberculosis. Perhaps the strongest is his first description, of a case in which a pregnant woman suffered from laryngeal tuberculosis, he advised the termination of her pregnancy, but she refused it, and she died after spontaneous abortion. In another case, a young woman was similarly advised by her doctors to abort her pregnancy, and after doing so, she managed to recover from tuberculosis. In the last case, he introduced a Viennese patient, who died after giving birth to her child. Baumgarten found it important to note that, although this child survived, she had multiple medical issues, but doctors managed to cure her, and she even grew up, married and gave birth to her own child (Baumgarten 1912, 7). He agreed with the conservative position that the state must not deny tubercular women the right to marry, but argued that doctors must warn their female patients that pregnancies could cost them their life. He further stressed the point that, although there were children who grew up and had a healthy life, it was very rare, since children of parents suffering from tuberculosis, in 70 to 80 percent of cases, died.

Other physicians also observed that in 75 percent of the cases, carrying a pregnancy to term and delivering ultimately cost tubercular women their life. Therefore, Bardeleben (1913), for example, suggested performing abortion in those cases when it was possible to clinically determine that the woman suffered from tuberculosis (i.e. in severe cases). But he did not recommend the termination of pregnancies when tuberculosis was latent, or when the women had already recovered from the disease. In his view, these pregnant women had to be observed closely to make sure that they delivered their children safely.

Vilmos Müller, who was a surgeon and the head of a tuberculosis sanatorium, also stated that gynecologists must abide by the principle to protect the life of the woman when they were in a position to choose between the life of the woman or her fetus. He cited an interesting example: he explained a situation in which the husband of the pregnant woman pressured him to try to save the life of his child when the life of the woman was in danger. Müller said that even in such cases, when a man views *his own wife* solely as a "childbearing medium," gynecologists must resist this type of objectification and protect the life of the woman (Müller 1913a, 119). In his view the legitimacy of abortion in the case of pregnant women suffering from tuberculosis is questionable, because it was not scientifically settled whether the mother transmitted the disease or not. After Müller had thoroughly analyzed twenty-two cases, he concluded that the process of tuberculosis affected the pregnancy only in very severe cases, when the symptoms of the disease suggested deterioration. He thought it was possible to establish a connection between a miscarriage and the disease only in these cases, and argued that abortion could only be indicated in such circumstances (Müller 1913b, 143–144). He was convinced that with long enough treatments in sanatoriums, tuberculosis patients with mild or average symptoms would recover, so the medical termination of their pregnancies could not be justified on scientific grounds.

The majority of the medical doctors agreed that the course of pregnancy has harmful effects on tuberculosis, and radically hinders healing from the disease. These observations were used in explaining spontaneous abortions. However, there was a minority position that questioned the universality of its harmfulness, because it was also observed that the health of pregnant women improved after four or five months. But this improvement was not stable, since most women had died after giving birth. Their health status quickly deteriorated during the puerperal period and they often died. Therefore Frigyesi (1914) took a preventive stance, arguing that physicians must inform their patients about the risks of pregnancies, and if they could, advise young women suffering from tuberculosis to refrain from marriage, or at least avoid becoming pregnant.

If pregnancy occurred during the course of tuberculosis, Frigyesi suggested that the most important task of the physician was to heal the patient to the point when the disease was considered inactive. The problem, he emphasized, was with poor women, who could not remain long enough in sanatoriums to have their disease cured. In such cases, when the disease was severe, and it was reasonable to expect that the patient would heal, he advised that an abortion be performed. He insisted that this was only an option after a physician had consulted with a gynecologist and they both agreed, and after the patients themselves had consented to the surgery. He found it important to add that after an abortion it was vital for women suffering from tuberculosis to refrain from sexual activity, and because it was very hard to keep to such medical advice for many, a significant number of physicians advised sterilization. Frigyesi himself only performed sterilization in life-endangering cases, when women already had children, when it was possible to prove that their previous pregnancies had influenced tuberculosis negatively, when there was no other way to prevent conception, and most importantly, when both parties—husband and wife—agreed to the procedure.

In line with the arguments for sterilization, Jenő Konrád placed emphasis on the health risks to the women and on the death rates of children born with tuberculosis. He presented the latest findings and medical views on the transmission of tuberculosis through intrauterine processes to the fetus. He reviewed the international literature that contributed to the understanding of the process. He argued not only that most of the professionals accepted the transmission of tuberculosis as a fact, but that most gynecologists and physicians favored the most radical intervention when they were confronted with tuberculosis pregnancies, supporting sterilization primarily in the interest of the woman. They reasoned, he claimed, that women who suffered from tuberculosis were likely to die after giving birth because of the deterioration of their disease (Konrád 1914a, 641–642). He emphasized the life-prospects of children born with tuberculosis by noting: (1) that 70 percent of children died in their first year of life, and (2) that only 12–15 percent of those remaining lived up to their twentieth birthday or thereabouts. Thus, Konrád proposed that the medical decision regarding the termination of the pregnancy and the sterilization of women should be guided by eugenic ideas and prevention. He framed his proposition as a eugenic and preventive measure because abortion and sterilization would protect the population from further infection, and thus would contribute to better health standards. The question he posed was three-fold: (1) is it in the best interests of the race to prevent the birth of children with such a serious disease; or (2) should gynecologists only terminate each pregnancy without sterilization; or (3) should they not intervene at all?

Konrád began the elaboration of his position from the shared standpoint of physicians and gynecologists: doctors working in each of these medical professions supported the termination of the pregnancy to protect the mother and avoid the “burden” of further tuberculosis cases. They were divided, however, on the issue of sterilization. Most of the physicians were against the sterilization of the women because they had observed the complete recoveries of patients from tuberculosis, hence they would not choose to take away the women’s reproductive right. And this is the point where Konrád’s view added a new layer to the discussion (Konrád 1914b, 661). He argued for sterilizing all tubercular women who were from the lower classes, since they would not have the economic means to relocate themselves into healthy environments and afford healthy food, and thus they would never recover from tuberculosis. Aside from this, he added that such men and women had less self-discipline in comparison with middle-class people, so their libido would put them at risk of having to terminate additional dangerous pregnancies. He based his arguments on statistical data, describing the ratio of “valuable” lives (i.e. those worthy of living) to “non-valuable lives” (those that had been affected by tuberculosis) as 10 to 90 per 100 births. Thus, he claimed that sterilization was not only good for the women (because they had the chance to recover, or at least not to die from tuberculosis) but for society as well, since the practice would have prevented the spread of further infection. Konrád was convinced that until major economic developments were achieved, and the environmental circumstances of the poor were sufficiently

developed, this radical measure was the only viable option to prevent the spread of tuberculosis and ensure the biological improvement of the Hungarian “race.”

## 8. Conclusion

Medical professionals integrated eugenic ideas into public-health discussions by initially connecting individual health problems to shared health issues, such as contagious diseases like tuberculosis, and then used the economic argument that those who were sick represented a burden to the healthy part of society. In addition to this, they drew on nationalist sentiments to the effect that those who were sick would pass on biological disadvantages to their progeny, who would then potentially become sick spread disease in society while they lived. All of this was interpreted as a biological cause that would negatively influence the genetic future of the Hungarian “race.” Thus, they suggested measures to counter these tendencies by, for example, medically indicating the termination of tuberculosis pregnancies. At the same time, a group of these doctors advocated the sterilization of working class women who suffered from tuberculosis in order to save them from themselves—from their sexual promiscuity and misguided decision-making—as well as to save the rest of the society from further tuberculosis patients incapable of work and thus a burden on the state budget. Social scientists, politicians, and natural scientists took part in formulating the ideas that allowed a medical discourse about women from the lower economic classes, who, they argued, were ignorant of the most developed scientific knowledge about personal and public hygiene, and therefore in need of decision-making on their behalf. At the core of this discourse was the eugenic idea of racial enhancement by avoiding racial degeneration in the present. With this logic, it seemed rational to subordinate individual interests to state (or racial) interests and allow a type of medical practice that violated the reproductive autonomy of these women. This type of thinking provoked the sensitization of citizens toward their own biological heritage: it was understood that citizens were responsible for their health in view of their common interest in the enhancement of their race.

**Acknowledgements.** This article is based on my PhD research, which was funded by the Central European University. Here I would like to express my gratitude towards my supervisors Andrea Pető and Judit Sándor who tirelessly helped the articulation of my ideas during my work. I am indebted to Colin Swatridge for proofreading and discussing my drafts. And I also thank to two anonymous peer reviewers who gave very valuable feedback before the publication of this paper.

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