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EDUCATIONAL AND ETHICAL PERSPECTIVES ON EUGENICS: IMPACT ON INDIVIDUALS WITH DISABILITIES FROM THE 19TH TO MID-20TH CENTURY

PERSPECTIVAS EDUCACIONAIS E ÉTICAS SOBRE A EUGENIA: IMPACTO EM INDIVÍDUOS COM DEFICIÊNCIA DO SÉCULO XIX A MEADOS DO SÉCULO XX

PERSPECTIVAS EDUCATIVAS Y ÉTICAS SOBRE LA EUGENESIA: IMPACTO EN LAS PERSONAS CON DISCAPACIDAD DESDE EL SIGLO XIX HASTA MEDIADOS DEL SIGLO XX

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ABSTRACT: This article explores the historical roots and development of eugenic ideologies, focusing on their impact on educational practices, attitudes, and policies concerning people with disabilities. Drawing on historical sources and relevant legislation, especially in the context of Czechoslovakia, it analyzes how eugenic thinking shaped segregated educational systems, denied access to education, and influenced public discourse on the "educability" of individuals with disabilities. It highlights sterilization and euthanasia programs and their implications for educational inclusion, social recognition, and human rights. The study also reflects on how past exclusionary practices shaped the rise of contemporary inclusive education, emphasizing the role of special education in addressing historical injustices and promoting ethical, humanistic approaches in current pedagogical theory and practice. By linking historical eugenic policies to modern educational challenges, the article deepens the understanding of the ethical foundations of inclusive education.

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KEYWORDS: Czechoslovakia. ethics. Historical perspectives. Persons with disabilities. Social inclusion.

RESUMO: *Este artigo explora as raízes históricas e o desenvolvimento das ideologias eugênicas, com foco em seu impacto sobre práticas, atitudes e políticas educacionais relacionadas a pessoas com deficiência. A partir de fontes históricas e legislações relevantes, especialmente no contexto da Tchecoslováquia, analisa-se como o pensamento eugênico influenciou a formação de sistemas educacionais segregados, a negação do acesso à educação e o discurso público sobre a "educabilidade" de pessoas com deficiência. Destacam-se os programas de esterilização e eutanásia e suas implicações para a inclusão educacional, o reconhecimento social e os direitos humanos. O estudo também reflete sobre como práticas excludentes do passado moldaram o surgimento da educação inclusiva contemporânea, enfatizando o papel da educação especial na reparação de injustiças históricas e na promoção de abordagens éticas e humanistas nas teorias e práticas pedagógicas atuais. Ao relacionar políticas eugênicas históricas com desafios educacionais modernos, o artigo aprofunda a compreensão dos fundamentos éticos da educação inclusiva.*

PALAVRAS-CHAVE: *Tchecoslováquia. Ética. Perspectivas históricas. Pessoas com deficiência. Inclusão social.*

RESUMEN: *Este artículo explora las raíces históricas y el desarrollo de las ideologías eugenésicas, con especial atención a su impacto en las prácticas, actitudes y políticas educativas relacionadas con personas con discapacidad. A partir de fuentes históricas clave y legislaciones, especialmente en el contexto de Checoslovaquia, se analiza cómo el pensamiento eugenésico influyó en la formación de sistemas educativos segregados, la negación del acceso a la educación y la configuración del discurso público sobre la "educabilidad" de las personas con discapacidad. Se presta especial atención a los programas de esterilización y eutanasia y sus implicaciones para la inclusión educativa, el reconocimiento social y los derechos humanos. El estudio también reflexiona sobre cómo las prácticas excluyentes del pasado han moldeado la educación inclusiva contemporánea, destacando el papel de la educación especial en la reparación de injusticias históricas y en la promoción de enfoques éticos y humanistas en la teoría y práctica pedagógica actual.*

PALABRAS CLAVE: *Checoslovaquia. Ética. Perspectivas históricas. Personas con discapacidad. Inclusión social.*

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INTRODUCTION

Since the end of the 19th century, a new social-philosophical movement called eugenics began to develop. It was a theory of heredity and the breeding of the human race through the purposeful selection of individuals considered fit for reproduction. Eu translates as “good” or “desirable,” and genos as “genus” or “descent”; more precisely, it referred to the science of good lineage. The origins of this theory are associated with the English physician and scientist Francis Galton (1822–1911), a cousin of Charles Darwin (1809–1882). Influenced by Darwin’s ideas and his works On the Origin of Species and The Descent of Man, which form the basis of the evolutionary theory of the survival of the fittest, Galton developed a kind of reproductive scheme. In this scheme, only healthy individuals with desirable hereditary traits were to be selected for further reproduction—a concept known as positive eugenics. Negative eugenics, on the other hand, aimed to prevent the union and reproduction of genetically “inferior” or sick individuals (Šimůnek & Novák, 2023).

As Šimůnek (2022) further notes, eugenics became a widely debated topic, attracting both strong opponents and supporters. Among its critics was the Catholic Church, which likened human society to a zoo and warned of the rise of a so-called “breeding state” (Šimůnek & Novák, 2023).

The UK, regarded as the cradle of eugenics, hosted the first International Eugenics Conference in London in 1912. The conference’s agenda included discussions on how to prevent disabled persons from reproducing. One of the vice-chairs was Winston Churchill. Although the British Home Office received numerous petitions in the early 20th century calling for laws to restrict the reproduction of the disabled, it was not until 1910—when Winston Churchill, a staunch supporter of eugenics, became Home Secretary—that pro-eugenics policies began to gain traction in Britain. By 1913, the Mental Deficiency Act was passed, mandating the institutionalization of individuals with mental disabilities to prevent their reproduction. Simultaneously, people were encouraged to consent to voluntary sterilization (Ridley, 2001).

Moreover, Galton’s original theory of eugenics intersected at the turn of the century with genetics, then an emerging science of heredity. As Šimůnek (2022) elaborates, after 1918, following the First World War, eugenics became part of modern social discourse. With the rapid growth of industrial cities in Western countries came social issues such as alcoholism, venereal diseases, prostitution, and crime. Thinkers of the time increasingly considered these pathologies—along with feeble-mindedness, mental illness, epilepsy, and congenital defects—as hereditary, drawing on the new findings of genetics.

The Church’s stance on eugenics, sterilization, and castration of disabled individuals in Europe was not uniform. Some Protestant churches supported sterilization, while the Roman Catholic Church categorically opposed it. The Catholic position on eugenics was articulated in

Pope Pius XI's 1930 encyclical (a papal circular addressed to bishops) (Šimůnek & Novák, 2023).

As Šimůnek (2012) further explains, eugenic sterilization laws were enacted in several European countries during the 1930s: in Germany (1933), Norway and Sweden (1934), and Finland (1935). In Germany, the ideas of eugenics found especially fertile ground among those promoting the superiority of the so-called Germanic race. Instead of "eugenics," the term "racial hygiene" emerged, introduced by Alfred Ploetz, founder of the German Society for Racial Hygiene (1905). Even before World War I, the society had gained significant attention, but its mission focused less on patients' health and more on serving the race (Šimůnek & Novák, 2023)

In 1933, Germany adopted the Law for the Prevention of Hereditarily Diseased Offspring (Gesetz zur Verhütung erbkranken Nachwuchses, GeVeNa). Until then, sterilizations had been voluntary (requiring the individual's consent), but this law legalized involuntary sterilizations, enabled through police coercion, and imposed a reporting obligation on doctors and nurses. It also specified the diagnostic groups targeted for sterilization: individuals with feeble-mindedness, schizophrenia, epilepsy, manic-depressive disorders, hereditary blindness and deafness, severe physical disabilities, and chronic alcoholism (categorized as "eugenic indications").

Two years later, in 1935, the Law for the Protection of the Hereditary Health of the German People was enacted, mandating compulsory medical examinations before marriage to prevent "undesirable" unions. It also permitted termination of pregnancies, up to the sixth month, on eugenic grounds (Šimůnek, 2012).

In Germany, as noted, health concerns became entangled with economic and racial considerations. As Scharsach (2001) observes, doctors sometimes classified entire families as hereditarily diseased and subjected them to forced sterilization. These measures primarily targeted people from lower social classes to reduce welfare expenditures. Authorities encouraged individuals with hereditary conditions to apply for sterilization voluntarily, presenting it as an act of responsible citizenship. This narrative masked the coercive nature of the law and highlighted its supposed voluntary character. Sterilization and pregnancy termination for eugenic reasons became widespread practices under legal sanction. It is estimated that between 300,000 and 400,000 sterilizations and approximately 30,000 terminations of pregnancy for eugenic reasons occurred in Germany and German-occupied territories, including Austria, during the interwar period (Scharsach, 2001).

In Czechoslovakia, in 1915, the year after the end of World War I, Prof. František Čáda, a philosopher and teacher at Masaryk University (1855–1918), founded the Czech Eugenics Society (ČES). The vision of the society was for eugenics to be recognized as an independent scientific field, parallel to the then-emerging science of genetics. Furthermore, the common agenda of eugenics proponents was to "participate in the creation of man." As Šimůnek (2012) observes, the members were aware that sexual selection raised numerous ethical concerns.

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During the 1920s, debates arose not only about sterilization and castration—considered somewhat radical measures in Czechoslovakia—but also about other restrictions, such as institutionalization and the so-called marriage revision. The marriage revision required, as in neighboring Germany, compulsory medical examinations before marriage to prevent individuals with hereditary diseases from marrying. In the 1930s, the basic eugenic measures were further defined, including sterilization or castration procedures, bans on marriages involving individuals with hereditary conditions, and isolation in institutions.

Karel Kadlec, a theologian and professor at Charles University in Prague, opposed sterilization, describing it as an irreversible mutilation of human beings and warning about the potential misuse of such procedures against politically inconvenient individuals. Although sterilization for eugenic purposes was one of the main goals of the Czechoslovak Institute for National Eugenics (founded in 1924), debates for and against sterilization continued throughout the 1930s. Bohumil Sekla, M.D., then an assistant at the Institute, acknowledged that sterilization was a profound infringement on human rights. He emphasized that society had a duty to care for the disabled but argued it was necessary to prevent an increase in their numbers. In his view, sterilization was the most appropriate measure to stop disabled individuals from procreating (Šimůnek, 2012).

In 1936, preparations began for drafting a Czechoslovak sterilization law by a three-member committee composed of two doctors, Vladimír Bergauer and Bohumil Sekla, and a lawyer, JUDr. Jarmila Veselá. By 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 way to prevent the further reproduction of individuals with genetic diseases. Requests for sterilization could be submitted by the affected individuals themselves or by relevant health, social, or guardianship institutions. Sterilization was to be carried out only with the consent of the person concerned and the approval of a designated committee. The draft law made no mention of forced sterilization.

The memorandum proposed four groups of the population to be subject to sterilization: individuals with hereditary feeble-mindedness, severe hereditary sensory impairments, severe hereditary nervous and mental disorders, and severe hereditary physical disabilities. Although this memorandum presented a detailed proposal for legalizing eugenic sterilization in Czechoslovakia, no such legalization took place during the interwar period (Šimůnek, 2012).

From eugenics to euthanasia

Euthanasia, meaning “a good death” or “a graceful death,” was already being discussed in Germany at the end of the 19th century within scientific and medical circles. In 1895, Adolf Jost (1874–1908), a German physician, called for medical killings as a means to preserve the state

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as a social organism. In the early twentieth century, several studies outlined the financial burden on the state for caring for the sick and the physically or mentally disabled. As early as 1920, the first outline for implementing euthanasia for the mentally handicapped was drafted. This report, titled Permission to Dispose of Life Unworthy of Living, was written by Alfred Hoche, a professor of psychiatry, and Karl Binding, a criminal law expert. Their aim was to present arguments to persuade the general public of the significance of the issue (Scharsach, 2001).

Adolf Hitler himself wrote in Mein Kampf as early as 1924 that it was impossible to allow the terminally ill to infect the healthy (Zeman, 2015). As Scharsach (2001) notes, after the Nazis came to power in 1933, many ambitious Nazis began secretly ordering euthanasia in institutions, as later testified by psychiatrist Paul Nitsche during post-war interrogations. Psychiatric hospitals became particularly dangerous places, especially for children and adolescents. These hospitals began receiving increasingly reduced rations, insufficient even for basic care. Before the war started, in Saxony, for example, patients were killed using so-called semi--sleep cures by administering Luminal.

Several events preceded Hitler's official approval of euthanasia on 1 September 1939. Husson (2009) reports that in January 1939, Hitler was approached by parents whose child suffered from an incurable hereditary disease, requesting permission to euthanize him. According to Scharsach (2001), several parents of severely disabled newborns similarly approached Hitler to request euthanasia. He granted these requests and immediately ordered the development of a comprehensive selection program for 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 euthanasia program targeting physically and mentally handicapped children. This mandate, issued in September 1939, was the only official document authorizing euthanasia. It effectively superseded existing laws and provided impunity to the selected doctors who carried out the killings. Notably, Germany never passed a formal law on euthanasia before or during the war (Kyncl, 2014)

The socalled "Euthanasia" program was established. The Reich Commission for the Scientific Approach to Serious Hereditary and Constitutional Diseases was created to identify newborns suffering from such conditions. Following Hitler's orders, maternity hospitals and pediatricians were required to report cases within three years.

The elimination of physically and mentally handicapped adults began as early as April 1939, led by Reich Commissioner for Health Leonardo Conti, who sought to strengthen his

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position and demonstrate loyalty to the Third Reich's ideology. A rivalry soon developed between Bouhler and Conti, as each strove to prove his dedication to fulfilling Hitler's intentions. This competition led to an even broader application of the extermination programs (Husson, 2009).

As Scharsach (2001) explains, Hitler's doctors implemented two separate euthanasia programs: one for disabled children and another for disabled adults. Initially, the programs were managed directly from Hitler's office. In the spring of 1940, his office rented a villa at 4 Tiergartenstrasse in Berlin. The abbreviation "T4" (Aktion T4) became synonymous with the entire euthanasia operation, covering both children and adult patients. A front organization called the Non-Profit Foundation for Institutional Care was established at this address. Under the program, children with disabilities were removed from their families and sent to hospitals and specialized facilities, where they were systematically killed (Scharsach, 2001).

Euthanasia of children

The euthanasia program targeting children and adolescents—Euthanasie der Kinder und Jugendlichen—began on 18 August 1939 with a secret order from the Reich Ministry of the Interior mandating that all disabled children, especially those under age three, be reported. The age limit was later increased to 16 years (Šimůnek, 2022). Reports were submitted to the Reich Committee for the Scientific Investigation of Severe Genetic and Hereditary Diseases using standardized forms. A red plus sign indicated a death sentence; a blue minus sign meant survival, usually to be exploited for labor (Scharsach, 2001).

According to Scharsach (2001), killings were carried out in specialized children's wards, often attached to psychiatric hospitals across Germany, Austria, and Poland. The first facility opened in Gorden near Brandenburg. Medical staff operated under strict secrecy, and medical records were falsified to hide the true cause of death. Parents were persuaded to hospitalize their children under the pretense of treatment. Some children died from starvation due to reduced food rations, while most were killed by cumulative doses of Luminal, a barbiturate sedative, which induced unconsciousness followed by pneumonia—recorded as the official cause of death (Šimůnek, 2022; Scharsach, 2000).

One of the most infamous sites was the Am Spiegelgrund ward in Vienna. As Scharsach (2001) notes, it operated as a covert killing center where children with neurological or developmental conditions were subjected to detailed examinations, including family history, photographs, and assessments of their potential for labor. Deaths were often documented as natural and confirmed by falsified autopsy reports.

In many cases, children were administered barbiturates combined with scopolamine and morphine to hasten death—particularly in overcrowded institutions. Despite the program's covert nature, the scale and systematic procedures revealed the brutal efficiency behind the child euthanasia initiative (Scharsach, 2001).

Adult euthanasia

As part of Aktion T4, the affected children were also exploited as subjects for scientific experiments. In Vienna, children were subjected to pneumoencephalography, an extremely painful diagnostic procedure where air was pumped into the brain to take X-rays. This examination often resulted in the patient's death. Other children were used in experiments to test the reliability of tuberculosis vaccines; in some cases, one group of vaccinated children and another unvaccinated group were deliberately infected with tuberculosis. Carl Schneider, a psychiatrist at the Regional Psychiatric Hospital in Wiesbaden, requested several children's brains for his research. The 20 children assigned to his project paid with their lives. Another Nazi psychiatrist, Heinrich Gross, working in a Vienna institute, amassed a collection of the brains of handicapped children in an effort to demonstrate morphological changes in the brains of the mentally disabled. Gross later became a prominent forensic psychiatrist in Austria after World War II (Scharsach, 2001).

By mid-1940, most adult patients were transferred to Hartheim for extermination under Aktion T4, while the Vienna hospital transitioned into a juvenile facility. Although documentation of these killings was meticulously destroyed after the war, post-war trials uncovered extensive evidence of activities at this Viennese killing center (Scharsach, 2001).

The T4 program, initially aimed at children, soon expanded into a large-scale, systematic extermination of adults with disabilities across German-occupied territories. An estimated 70,000 victims were initially targeted (Kyncl, 2014). According to Šimůnek (2022), the Nazis sought to eliminate individuals considered biologically inferior and economically burdensome—those diagnosed with oligophrenia, schizophrenia, epilepsy, hereditary sensory disorders, or those institutionalized long-term. While ideology drove these actions, economic motivations also played a significant role (Šimůnek, 2022; Šimůnek & Novák, 2023). The cost of care and the desire to free institutional capacity for military purposes became central propaganda themes.

Patient selection began in October 1939 through questionnaires distributed to psychiatric and chronic care facilities. A three-member medical committee, under immense pressure, decided patients' fates within minutes, primarily based on perceived work ability (Scharsach, 2001). Various execution methods were considered; poison injections were discarded in favor of carbon monoxide gas, deemed more efficient and "humane" (Husson, 2009). Kyncl (2014) describes early experiments in Brandenburg where one group of patients was injected while another was gassed. The gas method ultimately prevailed, leading to the construction of gas

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chambers at six killing centers, including Grafeneck, Hadamar, Sonnenstein, and Hartheim. Patients from Czech institutions, such as Opava and Dobřany, were transported to these sites (Kyncl, 2014).

According to Kyncl (2014), nurse Käthe Hochbarth testified that, upon arrival, patients were photographed, stripped, and told they were going to take a shower. Gassing was carried out in sealed rooms, after which the bodies were cremated. Families received delayed notifications, sometimes accompanied by urns containing ashes from unknown sources. Despite growing public awareness and resistance—including protests by Bishop von Galen of Münster—the T4 killings continued in secrecy even after Hitler's official suspension of the program on 24 August 1941 (Scharsach, 2001).

Scientific research on the brains and organs of victims persisted, disguised as medical progress. Although a few doctors attempted to protect patients, most feared political repercussions. Resistance from the Church, particularly the Catholic Church, became a significant force of opposition (Scharsach, 2001). Even after the official termination, killing methods shifted to starvation, lethal injections, and sedatives. By the end of the war, over 200,000 disabled individuals—including children—had been euthanized. Secret killings of minors reportedly continued until 1947 (Kyncl, 2014).

People with disabilities during the of Bohemia and Moravia

Since the late eighteenth century, a network of provincial institutions for the insane, or for patients with mental disabilities, had gradually developed in Bohemia and Moravia. These provincial institutions continued to operate in an expanded form during the interwar period. At that time, there were six provincial mental institutions in Bohemia and several private psychiatric facilities. In Moravia, the situation was similar: five large psychiatric hospitals existed alongside a greater number of smaller institutions, including private and church-run facilities (Šimůnek & Novák, 2023).

With the cession of the Czech borderlands to Germany on 30 September 1938, as part of the Munich Agreement, the entire administrative network of authorities had to be reorganized. Administrative functions were newly concentrated in Liberec, the center of the newly established Reichsgau Sudetenland. With the secession of the Sudeten territory, Bohemia lost forty hospitals—nearly half of its total of over ninety facilities—resulting in the loss of almost 9,000 hospital 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, health departments were established under the Reich Governor, along with a county office for public health. The three main health districts, located in Opava, Ústí nad Labem, and Cheb, were subject to the Reich Governor.

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Following the German model, state health offices were created in individual towns, where the Nazi system of public health care was introduced, including the dissemination of racial hygiene policies. Czech doctors were forced to close their practices and hand them over to German physicians, who were politically reliable members of the NSDAP (Šimůnek & Novák, 2023).

With the establishment of new borders, hospitals and institutions were re-districted. Institutional care for the mentally disabled was administered by the county government. Under the new administration, there was an effort to group and relocate psychiatric patients based on nationality. As Šimůnek (2022) further notes, after 1939, patients in the German-run clinics in Prague were predominantly of Czech nationality (Šimůnek & Novák, 2023).

In the Protectorate of Bohemia and Moravia, which became part of the Greater German Reich by Hitler's decree of 16 March 1939, health care was administered by the Ministry of Social and Health Administration (MSZS), divided into seven areas. Institutional care fell under the responsibility of the VII Department of the MSZS. All offices were controlled by politically reliable individuals—Nazis and advocates for the integration of the Czech lands into the German Reich. Šimůnek (2022) lists that between 1939 and 1943, there were 73 public hospitals in the Protectorate, offering nearly 22,900 beds, and 58 private hospitals with 6,585 beds. A critical shortage of doctors emerged, especially after the closure of Czech universities on 17 November 1939, which prevented the training of new physicians (Šimůnek, 2022).

The Reich Protector oversaw the administration of the Protectorate, with the task of defending German minority interests, including the provision of health care. The health insurance system in the Protectorate was almost identical to the First Republic model and very similar to the German system, except that German policyholders enjoyed several advantages and privileges over Czech policyholders—such as free choice of doctors and extended hospital coverage (Šimůnek & Novák, 2023).

Another feature of the Protectorate period was the reduction in hospital and psychiatric institution beds in favor of wartime infirmaries. Hospitals were overcrowded, and the health care system struggled to manage large numbers of tuberculosis patients and typhus epidemics. German officials criticized the lack of hygiene and outdated hospital conditions. These concerns prompted Reinhard Heydrich to advocate for administrative reform in health care, although it was only implemented after his death. The MSZS was abolished, and the health service was restructured along Reich lines. A so-called "health police" was established under the Ministry of the Interior. A year later, the German State Ministry for Bohemia and Moravia was created, headed by K. H. Frank (Šimůnek & Novák, 2023)

Although the T4 euthanasia program was a secret operation intended exclusively for Reich-German citizens, Czech nationals were also among the victims. This euthanasia campaign was preceded by several years of sterilization and castration targeting disabled individuals. The pre-war sterilization program applied to all Czechoslovak citizens residing in German

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territory, unless they were unable to travel. In 1936, the Czechoslovak Minister of Health issued a declaration stating that Czechoslovak citizens could only be sterilized within Czechoslovakia (Šimůnek & Novák, 2023).

After the annexation of the borderlands, a Law for the Protection of Hereditary Health was enacted in the Sudetenland. Immediately following the Munich Agreement, negotiations began for the transfer of patients based on nationality—moving Czech patients from the Sudeten borderlands to Bohemia and German patients to Reich territory. An exchange of approximately two thousand patients was planned, but it never materialized due to the establishment of the Protectorate of Bohemia and Moravia.

Sterilization of affected patients was conducted in institutions within the Reich territory, and sterilization became a prerequisite for patients to be discharged home. This condition did not apply to Czech citizens, but they were forced to leave the Sudetenland. Widespread sterilization of German mentally disabled citizens was implemented in the Protectorate, although it was limited to hospitalized patients. Heydrich pushed for the introduction of a Law for the Protection of Hereditary Health in the Protectorate as well.

This failed, and German patients were transported across the border to sterilization facilities in the Sudetenland (RZS) for sterilization procedures (Šimůnek & Novák, 2023). The occupied border territory, the Reich County of Sudetenland, was a mixed area, and it was technically very difficult to separate German and Czech patients from one another. Within the framework of the T4 action, disabled patients were gradually killed in institutions in the Sudetenland. Czech patients, who formed the majority in the institutions located in the Sudeten borderlands of northern Moravia and Silesia, were initially intended to be excluded from this operation. The largest state psychiatric institutions in the region were located in Opava and Šternberk near Olomouc.

It had been assumed that during 1940, there would be an exchange of patients based on nationality. However, as previously mentioned, this exchange never occurred. As a result, Czech and Polish patients from the Opava Institute were also included in the T4 action. Šimůnek (2022) notes that the first transport from the Opava Institute, on 9 December 1940, became a symbol of the beginning of the large-scale T4 operation in Czech territory. Two more transports followed on 10 and 12 December 1940. Although visits to the institute were strictly forbidden, relatives of patients gathered at the premises until they were forcibly dispersed by the police.

According to post-war accounts, the number of victims of these transports was estimated at approximately 500. The patients from the three December transports were gathered, loaded onto buses at the institute, and taken to the railway station, where they were crudely transferred into train wagons. If any patients resisted, guards did not hesitate to use batons or

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administer sedatives to subdue them. The victims were later gassed at the Pirna-Sonnenstein hospital near Dresden.

Since the then director of the Opava Institute, Gersche, opposed his superiors, expressed resistance to mass euthanasia, and refused to take responsibility for selecting patients for transport, the subsequent transports in April 1941 were managed directly by a T4 headquarters officer and the so-called "gassing doctor." According to later testimonies from witnesses, such as the head nurse Jauernig, between 300 and 400 individuals were taken in the spring transport, which allegedly had Hartheim Castle—another euthanasia center—as its destination (Šimůnek & Novák, 2023).

It is no longer possible to determine the exact number of victims from the Opava institution; the admission records were either lost or destroyed in many facilities. Information about numerous transports has not been preserved. Post-war witness statements also failed to provide precise numbers, as these accounts varied greatly. Many witnesses, often working only as nurses, were not sufficiently informed and lacked a comprehensive overview. According to estimates, approximately 1,000 patients may have been transported during the initial operations in December 1940 and April 1941, which, as Šimůnek (2022) notes, corresponds to the number of questionnaires sent from Opava (over 1,066). It is equally impossible to determine the patients' origins, and data on the number of Czech nationals remains inaccurate.

In his testimony, the director of the Opava Institute stated that nationality was not a factor in the selection of patients for the first transports (Šimůnek & Novák, 2023). Meanwhile, in June 1941, the institute in Šternberk—located 60 km from Opava—was seized for military purposes, requiring the transfer of its patients. A total of 902 patients were affected: 130 were taken to Saxony and Pirna-Sonnenstein, where they were killed in gas chambers; 385 were sent to Opava; and others were relocated to Dobřany hospital and the Protectorate hospital in Kosmonosy. Of the 237 patients transferred to Kosmonosy, 224 were of German nationality and the remainder Czech. None of these patients were subsequently relocated (Černoušek, 1994). There is also evidence suggesting that some patients from the Šternberk institution were taken directly to Hartheim for extermination. Those transferred from Šternberk to Dobřany were no longer included in the euthanasia transports.

Patients from Šternberk with Protectorate affiliation were later transferred from Dobřany to other Protectorate hospitals. Dobřany itself became part of the T4 action. As Šimůnek (2022) writes, six transports with a total of 342 victims departed from there in April and July 1941. The time between the completion of questionnaires, their submission to Berlin, the selection process, and the subsequent transports and killings was about five months, similar to the timeline in Opava. According to drivers' testimonies, patients were taken by bus to Hartheim and Pirna-Sonnenstein. Some transports occurred at night, leading to speculation that patients were first brought to the railway station in Pilsen and then transported by train.

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The exact number of victims from Dobřany cannot be established, as the institution also served as a transfer hub—patients were either sent to other hospitals or directly to killing facilities (Šimůnek & Novák, 2023).

At the T4 headquarters, plans were drafted between late 1940 and early 1941 for the extermination of disabled patients in the Protectorate of Bohemia and Moravia. However, there were conflicting views on the matter. Hitler's agents in charge of the euthanasia program, Philipp Bouhler and Karl Brandt, believed that Czech nationals should be excluded from the operation. Conversely, Frank, the State Secretary in the Reich Protector's Office, supported extending euthanasia to Czech patients as well. Ultimately, the decision was made to include only patients of German nationality in the T4 action within the Protectorate (Šimůnek & Novák, 2023). In 1941, an attempt was made to exchange patients by nationality, with plans to transfer Czech patients from Kosmonosy in exchange for German patients from other Protectorate hospitals.

In the territory of the Protectorate, as part of the national homogenization of hospitals, efforts were made to transfer all German psychiatric patients to a single institution: the Kosmonosy Institute near Mladá Boleslav. It was ordered that the Kosmonosy institution be turned into a luxurious German hospital with a strong reputation, where all disabled Protectorate patients of German nationality would be concentrated. This measure aimed to simplify their transfer to extermination facilities and accelerate 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 requested that their relatives be transferred to Saxon institutions. In rare cases, these requests were granted. Ultimately, 709 German patients were brought to the German hospital in Kosmonosy in exchange for 751 Czech patients (Šimůnek & Novák, 2023).

During the occupation, 3,165 patients died in the Kosmonosy institution, and deaths continued even after the end of the war. From May to December 1945, another 648 disabled patients of German nationality perished there. At the Dobřany hospital, a total of 3,714 victims were recorded by the end of the war.

At the beginning of 1941, the Reich renewed its interest in psychiatric patients of Czech nationality. Karl H. Frank, a proponent of gassing disabled individuals, advocated euthanasia for Czech mental patients under the same criteria applied to German patients.

At the height of the T4 action, in May 1941, an updated registry of German patients in the Protectorate was carried out. An additional 129 patients of German nationality were identified in five Protectorate hospitals. From late June 1941, T4 questionnaires began to be sent to provincial mental institutions in the Protectorate under the pretext of conducting a statistical survey of mentally disabled persons of German nationality. A month later, institutional visits commenced.

In Moravia, two major mental institutions operated: one in Kroměříž and the other in Brno-Černovice. Questionnaires were also sent there. Moravia was characterized by the dispersion of patients across numerous small, often church-run or private hospitals, making it difficult for the organizers of the liquidation program to register all patients.

Nevertheless, the vast majority of German patients in the Protectorate were identified and exterminated (Šimůnek & Novák, 2023).

Child patients, both Czech and German, were placed in Protectorate Bohemia at the Provincial Hospital for Mentally Disabled Children in Oparany and in three smaller church institutions in Slatiňany, Plzeň, and Prague. In Moravia, child patients were mostly housed in small hospitals operated by the church.

In August 1942, plans for the liquidation of child patients in the Protectorate were considered, and questionnaires were immediately distributed. In September 1942, Frank expressed his approval for preparing the liquidation of child patients but, for political reasons, did not recommend extending the euthanasia action to Czech child patients.

Fortunately, due to the unfolding war events, no euthanasia facility for children was established in the Protectorate in the following year, and this remained unchanged 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 integrate adolescent German patients in Kosmonosy with adult patients and subsequently include them in extermination operations (Šimůnek & Novák, 2023).

Mentally disabled patients of Jewish origin were concentrated in two Protectorate provincial institutions: in Bohnice, Prague, for the Czech territory, and in Kroměříž for the Moravian territory. In 1942, they were sent to the psychiatric ward in Terezín. This ward was located in the Cavalry Barracks building and had only 11 rooms, with an insufficient number of beds. The bare rooms were overcrowded, and the mortality rate in the ward was extremely high. Patients were continuously transported to Auschwitz for extermination. A total of 121 patients died directly in Terezín, and 498 were sent further east. In April 1944, the entire psychiatric ward in Terezín was liquidated. Both the patients and their attendants were sent to the gas chambers. Rooted in eugenics, the euthanasia program for disabled persons merged over time with the broader agenda of the "Final Solution" (Šimůnek & Novák, 2023).

FINAL CONSIDERATIONS

Special education shows us that inclusive education is not merely 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

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enrich the educational environment with new perspectives. Cooperation between students with disabilities and their peers fosters the development of empathy, tolerance, and mutual understanding—values that form the foundational pillars of modern society.

Thus, we can support the argument of Daňek and Kluger (2023), who recognize inclusive education as a tool against social exclusion. Promoting change and innovation, such as cooperative learning that replaces traditional competitiveness, plays a vital role in strengthening social bonds among students and in developing their collaborative skills (Bačová, 2024). Encouraging positive attitudes toward students, through teaching aids that have become a standard part of the educational process, and integrating them appropriately into classrooms, provides countless opportunities for both teachers and students—from engaging learners more effectively to explaining the curriculum through demonstrations and enhancing motivation (Němejc et al., 2019).

Eugenics, as a socio-biological theory, significantly influenced the lives of persons with disabilities by legitimizing their exclusion from education, institutional life, and society as a whole. The educational implications of eugenic ideology were profound: many individuals were denied access to schooling, labeled as “uneducable,” and subjected to practices that sought to eliminate rather than support their development. This legacy challenges educators and educational institutions to critically reflect on how history shapes present approaches to inclusive education.

Contemporary special education stands in sharp contrast to the exclusionary logic of eugenics. Instead of assessing human worth based on genetics or perceived productivity, inclusive education emphasizes the intrinsic value of every learner, supporting the right to education regardless of ability. Special educators play a crucial role in identifying and addressing individual educational needs, adapting methods, tools, and environments to facilitate meaningful learning and participation for all.

Recognizing education as a key mechanism of social inclusion, it is essential to integrate historical awareness into pedagogical training. Understanding the misuse of science in the name of eugenics reinforces the ethical responsibility of educators to uphold human dignity and equity. Modern educational practices—such as individualized instruction, assistive technologies, and collaborative learning—not only help overcome barriers created by historical marginalization but also strengthen social bonds and empathy within school communities.

From a special education perspective, the legacy of eugenics underscores the importance of promoting educational justice. It is not enough to include students with disabilities physically in classrooms; true inclusion requires intentional and sustained efforts to design curricula, relationships, and institutional cultures that affirm their agency and belonging.

Education, therefore, becomes both a means of resistance against oppressive ideologies and a proactive force for building a society in which diversity is not merely tolerated

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but valued. As educators, policymakers, and communities, we must remain vigilant against reductive views of human worth, ensuring that future generations learn from the mistakes of the past. By committing to inclusive educational values, we create opportunities for all individuals to live meaningful, dignified, and empowered lives—regardless of ability, background, or circumstance.

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