Patients and Observers: Specific Data Collection Methods in an Interwar Transylvanian Hospital

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Facts and Contexts

After World War I, Transylvania suffered heavy losses and faced different kinds of social and economic challenges. In this transitional period, some health issues, such as venereal disease, tuberculosis, and alcoholism had been considered not just public health issues but social problems that needed to be solved. Prostitution was considered responsible for syphilis and other sexually transmitted diseases. In the context of post-armistice crisis, it affected the physical integrity of the nation. Many institutions to address prostitution were founded in this period. The problem as such was not unique to Central and Eastern European countries. In this post-war period in many European countries, prostitution became a matter of public interest, but in Transylvanian regional history, it is remarkable that the issue of venereal diseases became embedded strictly within a nationalist activist framework and took on a special meaning in the process of the Romanian medical community’s self-legitimization (see Bokor 2013).

It was in Transylvania that a number of doctors developed a series of draft bills on the prostitution problem, on the basis of which a whole range of institutions were created. One of the most important hospitals established was the Women’s Hospital of Cluj, which is the current focal point of my research.

This article is a revised version of a chapter of my book (Bokor 2013).
In the following chapter, I discuss a small part of the history of this larger transitional moment. The history of the Women’s Hospital and the broader story of medical institutionalization will be interpreted through the activities of an individual case study.¹ The specific data collection method, medical attitudes, and the doctor–patient relationship are outlined in this story as the protagonist’s task was to record and to have regular contact with the prostitutes under medical supervision. I will explain the researcher’s methods through the body politics and theoretical or ideological trends of the time. Although the study is primarily intended to be an institutional history, it concentrates on the data collector’s personage; that is why it only partially deals with interviewees’ personal life stories.

In February 1919, the Governing Council of Transylvania established a clinical outpatient network (Ambulator policlinic) in Transylvania to deal with diseases that threatened the health of the population (venereal diseases, tuberculosis, and so on) and with social problems (such as infant mortality and alcoholism). Shortly thereafter, in April 1919, they established the Women’s Hospital of Cluj, an institution that specialized in the treatment of venereal disease. While the Hospital’s Outpatient Unit offered temporary and transitional treatments, serious cases were treated during longer stays at the hospital. The Control Bureau (Biroul de control) was founded in 1921 and was set up in close proximity to the hospital and the Outpatient Unit. Its main charge was to trace independent (unregistered) prostitutes; to produce publicity about venereal disease; and to assist in the control of servants and infected persons. A similar special institution in Bucharest called Dispensarul de triaj was established in 1933. In Romanian medical language, “triaj” (sorting) denotes hospital departments which pre-selected patients who would be hospitalized. The clinic was subordinated to the morality police, and its duty was to reveal secret prostitution; provide hygiene publicity to prostitutes; and to control domestic servants. During one year, 2,000 medical controls were performed and 445 women were hospitalized.²

¹ Documents I use in the analysis are from the Bálint Zoltán Fond of the Archives of the National Széchényi Library in Budapest, Hungary: OSZK, Magyarságkutató Intézet / Teleki László Alapítvány Könyvtára (OSZK-TLI) F. 625/ K.2880/2000, 1–12.
² Dosar pentru corespondență, Arhivele Naționale ale României, București, Fond Ministerul Muncii și Sănătății [Correspondence folder, Central Historical State Archives of Bucharest, Ministry of Labour and Health], 16/1934.
According to 1921 regulation that led to its founding, the Office was designed to facilitate emergency and hospital services through the control and registration of patients infected with syphilis; and its main objective was to control and record both public and secret prostitutes; help them become productive women again; but also help them escape prostitution. “This office had to create a direct and operational connection between the hospital, the ambulance, the health office, and the police. (The office leader was Mr. Z. Balint),” wrote Dominic Stanca (1925, 62), the head of the Women’s Hospital. Elsewhere he detailed the role that this subsidiary institution was supposed to have: “The core of the institution was the Control Office; every patient had to go there, everybody was registered and kept under permanent supervision, as long as the supervision was considered necessary” (Stanca 1929b, 539).

It is also Stanca who explained that the leader of the Control Office had relationships with other organs of power (police, church, army), through which it had indirect control over individuals. For instance, it could use personal confessions as a source of information and could persuade women to undergo a medical exam (Stanca 1929a, 355).

Zoltán Bálint, who called himself Doctor Bálint, had an important assignment in 1920: he was appointed head of the Control Office, the subordinate and colleague of chief physician and manager Dominic Stanca. We might also say, referring to James Scott’s (1998, 314) concept of mētis, that he was an agent, an expert with local knowledge, who because of this knowledge was able to get close to the mētis.

His method was unique and seemed much more efficient than a simple hospital survey: he conducted complex interviews with the inpatient population, often including biographical profiles. Letters from prostitutes leaving

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3 Dominic Stanca (1892–1979) was a physician and professor at the Faculty of Medicine in the Department of Gynaecology in Cluj and head of the Women’s Hospital from 1919 to the Second Vienna Award.

4 Zoltán Bálint (1898–1978) called himself a doctor but it seems that he never received a degree in medicine. After he completed his education at the Piarist high school, he enrolled in medical school in 1916, and studied there for five and a half years. (Karády and Nastasă 2004, 159). He also studied psychology and art history at the University of Cluj. He participated in the Galileo Circle of Cluj. Later he worked as a clerk, and then a scientific researcher. He was on the editorial committees of several journals and newspapers, such as Színház és Társaság, Hétfői Hírlap, and the medical journal Clinica et Laboratorium. He participated in the founding of Cluj’s Psychological Research Society. In 1935, he joined the rural studies team of Professor Gusti.
brothels and the diaries and life stories confidently passed on to the doctor were the exclusive product of his intimate relationships with female patients.

Bálint’s work can be understood at the intersection of two main interests. The more decisive of the two was a scientific interest, mainly psychological and psychiatric, which was apparent especially in his methodical survey and guide for writing patients’ life histories. However, perhaps more important than his psychological interest was eugenics, a leading medico-scientific movement of the period defined by its intention to regenerate the body of the nation. The result of this interest was the physician’s desire to gain insight into the most hidden details of a patient’s life. The second interest was Bálint’s personal motivation, about which we know little. But it significantly defined the doctor—patient relationship in general, and specifically the intimate relationships he maintained with some of his patients. This intersection of interests summarizes several roles of the “researcher,” from that of the precise data collector, to the interpretive psychologist; from the medical student eager to know every detail, to the confident partner and lover, all the way down to the sympathetic healer. The observer who simultaneously undertakes the roles of interviewer, participant, spectator, and data collector, also takes on various attitudes.

Screening and Data Collecting: The Bálint Model

During his work, Zoltán Bálint interviewed several hundred inpatients every year using his own questionnaire, which he called the Bálint Model, consisting of fifty questions and a long series of other surveys. It contained three major sections: the first referred to general questions on life history, family situation, childhood, and present circumstances of the interviewed; the second part described the bodily traits; and the third was a psychological test.

The questions are interrogative, probative, analytical, and categorical. The questionnaire attempts to give a clinical or medical diagnosis; it penetrates the human body and breaks it apart; it rummages through past memories, trying to create the diagnosis of an “unhealthy” psyche. Thus, one questionnaire could potentially provide full access to an individual’s (medical) life story: the past (the legacy of personal behaviors and inherited features), the present (the patient’s current physical characteristics and ailments), and the future (the potential for recovery and reintegration into society).

The first chapter of the questionnaire called “General part. Curriculum vitae” deals with the patient’s life history. In addition to the obligatory reg-
istration data: the patient’s name, pseudonym, occupation, workplace, address, nationality, religion, and the place and date of birth (questions 1–4), it also elicits information about decisive life events. It asks questions about her parents’ and the family’s living conditions (questions 5–12): parents’ age and conditions of their marriage (e.g., are they cousins?), the number of her older siblings (has her mother had any abortions before the patient’s birth?), the parents’ material situation, and the circumstances of the patient’s birth (Has her mother suffered any serious psychological, physiological, or other trauma? How difficult was her birth? How did her mother feed her in early childhood?). Bálint was curious about the living conditions of the family (Whether men or strangers were sleeping in the same room with women; details about the size of the room, etc.).

Several questions are concerned with the health status of close and distant relatives, like the causes of death of deceased relatives and histories of disability in questions 13–20. This includes questions like: “do they suffer of alcoholism, syphilis, nervous or mental diseases, or tuberculosis? Are they extravagant? Deaf-mute? If they are dead, at what age did they die? What disease caused their death?” After the inventory of family relations, it surveys the “patient’s” stages of childhood development. (At what age did she start talking? Walking? When did she get her first teeth? Did she have nervous problems like epilepsy, sleeping agitation? Did she scream while sleeping? Fall out of bed? Did she have enuresis? Did she continue her studies? How well did she do at school? Did she learn easily? Was she a diligent student? What were her favorite subjects? Was she often absent from school?) (questions 21–24). Then he asks about the patient’s clinical history: which severe illnesses did she have? Was she involved in any accidents, etc.

Most questions refer to the patient’s sexual life and the initial stage of the patient’s experience as a prostitute: when, how, for how long, and with whom? (questions 26–40). Bálint included questions about her menstrual cycle; he was interested about anything related to her earlier sexual life: did she masturbate or have sexual impulses before becoming a prostitute? Who was her first lover? In what conditions did her first experience with sexual intercourse happen and why? Why did she leave the parental home and where did she go after that? Was she married? What is her husband’s age, occupation, family situation? The next group of questions refers to her status as a prostitute. For example, Bálint asks when and where she began prostituting herself? Whether she had any abortions, live births? Whether she was infected with venereal diseases or had been previously hospitalized as a result of infection.
The last few questions (41–50) inquire about the reactions of the woman to her situation, about her possible addictive behavior, and inevitable questions about criminality, suicidal behavior, drug abuse, smoking, and alcoholism. They also inquire about her savings (the amount of money put aside), and about how she might escape from her present way of life.

A formal analysis of these questions reveals that this medical survey covers even the smallest details that may have influenced the patient’s employment as a prostitute. Such inquiries were no novelty in the profession at the time. Eugenics experts including Francis Galton himself employed similar methods in his work on genealogy and biography. Galton’s data were the “autobiographical replies to a very long series of printed questions” (Galton 1874, 10). Also as a result of Galton’s eugenics, the questionnaire pays special attention to genetic and hereditary factors and the possible disorders of blood relations.

The attempt at an objective description of behavior and the findings that environmental stimuli and responses to them are interdependent show partial similitude with behaviorist psychology. This perspective suggests a rigorous, psychological view, which considers human behavior to be largely the result of external influences. These external influences are just as strong in the Bálint model as are the genetic factors, as proved by questions on the parental home, the parents’ financial situation, the circumstances of leaving the family, and reasons for becoming a prostitute, on suicidal intentions, criminality, etc.

As I have already mentioned, the second part of the questionnaire is a physiological inventory and the third part is a psychological test. The results of the physiological and psychological tests are not concerned with the causes of the patient’s past behavior, but with their effect on the present, which requires medical intervention. These methods shed even more light on the medical position, which asserts the physical and psychological degradation of deviant persons, considering them “dysgenic” like followers of eugenics.

The second part of the questionnaire is a description of the body. Its title, “Data about the Bodily Condition” shows attempts to record any anomalies in bodily proportion and size, with the implicit intention to record potential physiological signs suggesting deviance. It presents a very accurate description of the female body. After measuring the height and weight of women, all the body parts are taken into account by their description and their possible deviations or changes: the color, shape, and density of hair and body hair; the shape of the head, face, eyes, nose, mouth, teeth, ears, shoulders, and chest. Bálint makes a complete list of the internal organs as well: the respiratory, diges-
tive, urogenital, and circulatory system, along with the endocrine glands and spleen. Major attention—so it seems—was given to the body parts that carry most signs of femininity: the head, the face, the breasts, and sexual organs. The nervous system and the related physiological characteristics such as sight, hearing, smell, taste, touch, and reflexes are treated with the same interest. This is how biological and social gender connects: in a group of women living in prostitution, they had to find the common characteristic(s) that made them different both physically and psychologically from other women. The psychological analysis lists first the doctor’s conclusions based on his observation: the patient’s behavior, mood, orientation and calculation skills, moral self-evaluation, sense of shame, and relationship to peers. Then it runs experiments with exact measures on a series of psychological tests that promise genuine knowledge, like in Charcot’s “pathology museum” (Didi-Hubermann 2003).

The third chapter of the questionnaire, entitled “Psychological Portrait—Based on the Works of Dr. G. I. Rossolimo, Moscow,” contains complex psychological tests based on the methods of nineteenth-century psychologists and neurologists. On the basis of the work of Moscow-based neuro-pathologist Grigorii Ivanovich Rossolimo, Bálint also outlines the patient’s psychological portrait, which allows for the measurement of various mental processes in laboratory conditions, and then performs the Binet-Simon intelligence test on them.

The survey focuses on nine cognitive and behavioral processes: attention/concentration, willpower/endurance, memory fixation/punctuality, memory (visual, auditory memory, and number memory), perception of pictures, combination ability, invention, fantasy, and observation ability.

The tests were created for the purpose of a more thorough examination, as they promised more than simply the investigation of life conditions, as the creators of the questionnaire stated: “We think that it is only after a thorough psychological examination that we can explain the many deviances and the ease with which they perversely give themselves to anyone who desires the use of their body” (Bálint and Stanca 1924, 15).

The psychological test, in combination with the physiological test, suggests a different kind of reality than the life history interviews: that of the observer. The observed body is part of a medical and psychological knowledge that is completely different from the person’s knowledge of their own body. Bálint also used the word-assembly exercise of the internationally acclaimed neurologist Pál Ranschburg (whom he considered a model), known as the inventor of the psychological tests used on people with various disabilities.
The data collected via the questionnaires, as we have seen, served mainly to make general conclusions and generate statistics, as well as to establish a general psychological diagnosis for prostitution.

Collecting Life Histories and Love Letters

The questionnaire is completed by another, later questionnaire, which encourages the detailed description of one's biography in the form of confession. It gives the following instructions:

Take your time to think over all of your previous life, and write down everything you consider important about it. Write down your life history in such a way that you do not leave out any event, experience, or influence that had a decisive role in shaping your fate. In your writing, strive to be as honest, open, and accurate as possible. Below you will find a long series of questions. Read these through, because they are a great help in thinking over your life. . . .

Even while collecting life histories and diaries, Bálint appears as a collector, an indirect observer; yet, almost unnoticed, he guides the confession. He speaks out of the text; he repeats questions that the “patient” has already heard during the “official” hospital observation and interview, for instance, “Why have you become a prostitute? Do you desire men, frequent sexual pleasure, or was it your life conditions, the hope of an easy income, or some other interest that made you become one?”

In this context, writing is an obligation; it is a form of confession like the church confession: it is depressing, obliging, and absolving, and without it, one will face complete exclusion and punishment. The patient is therefore obedient and at times quite helpful: “And as for the completion of the questions that are part of the analysis, I’d like to answer them orally, still, it cannot be written so well. I know you’d want to know already, but wait patiently,” Médi writes in her letter.5

Writing, however, is not only an obligation, but the hope of an improvement of the situation. The patient who complies with this request thinks that,

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by revealing her secrets, she will be absolved by the force of the confession, and her cooperation with the doctor results in “healing.” “A romantic adventure happened to me as I’ll explain. Those who do not believe that sinful women are able to love now can see it,” Lola wrote in her biography.6

The intimate relationship between Bálint and his patients is quite problematic and blurred, mostly because of the lack of information. We have a series of love letters from female patients, but we do not know his replies. Ever since the advent of psychoanalysis, the intimate relationship of doctor and patient (the treating physician and the ill person) has been known, and even psychiatrists considered it to be an important part of healing. Didi-Huberman offers a new understanding of Freudian transference when assessing the doctor-patient relationship (referring to the relationship of doctor Charcot, physician of Salpêtrière, with his patient Augustine): the hysterical woman has one single benefit from her illness, that of seduction, which is the gift of the medical gaze fixed on her because of her symptoms. The examiner in this situation of transference expects the ill woman to lend herself to the doctor’s desire of knowledge (Didi-Hubermann 2003, 172).

Although in his works Bálint did not agree that only prostitutes could be held liable for venereal diseases and judged men who used the institution of prostitution, he also used his official position for personal purposes, and his personal relationships for professional aims. He proclaimed several times that men are responsible for sexually transmitted venereal diseases just like women, and they play important roles in maintaining the institutions of prostitution. “Prostitution is immoral and dangerous, and its official regulation is the legal perpetuation of this immorality and perdition. In addition, the regulation is a shameful restriction of personal freedom, and it’s even unfair and one-sided because it only lies with the woman. It’s dangerous because of the spread of venereal diseases, which are in close contact with it. Medical monitoring of registered prostitutes is by no means satisfactory. Besides, prostitutes with such diseases are not as dangerous as men who have sex outside marriage” (Bálint n.d, 1). He sympathized with abolitionist movements and said that “The abolitionist principles are further important because they warn of the consequences of men’s inherent selfish and hypocritical morality and of the women’s degradation” (1).

It is remarkable that he speaks with such disapproval about exploited sex workers, because his research models and working methods show similar features to those he criticizes. I think that the institution, the hospital management’s expectations, system, and approach, as well as well-known methods and techniques of psychology and psychiatry are certainly determinative in taking on such an omnipotent researcher role.

While women perceived this relationship as personal, Bálint played the role of the data collector: he rewrote their letters, penning most of them so as to include these arbitrarily selected texts in case studies. These transcripts usually lack the kindness of past events and thoughts referring to the women’s amorous relationship. For Bálint, the non-clinical personal details are not useful for analysis and these texts change their role. Looking at Bálint’s methodical work, which was performed with so much awareness, I think that this personal relationship was of great use in the acquisition of new data, and through their close relationship, these women—like Charcot’s Augustine—more easily accepted their roles as models of truths.

As Bálint’s hospital work shows, his personal-professional relationship is almost symmetrical to that Regina Morantz-Sanchez (2000) speaks about. These illness narratives also make a bargain between doctor and patient regarding the boundaries of health and illness; but this resolution takes place outside of the encounter between the patient and her doctor. Morantz-Sanchez does not consider this a relationship of subordination, but most often a negotiation in which both parties have approximately the same effect on the other and are mutually interdependent. In my case, however, the circumstances of those admitted to the hospital are different—nobody presents herself for examination to the Women’s Hospital of her own accord, but does so based on compulsion, and the failure to do it results in punishment. The different social status of illness and deviance further reinforces this subordinate relationship.

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