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School medical inspection and the “healthy” child in the Netherlands, 1904-1970

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Abstract

Purpose – The purpose of this paper is to explore the meaning of child health as applied by school doctors in the Netherlands and the way it was adapted to the rapidly improving standard of living and the increasing importance of mental health after the Second World War. The extension of the concept beyond physical health into emotional and social well-being is particularly interesting as the school medical inspection was the only public child-hygienic service in a country where religious groups opposed the extension of public hygienic care into parenting and the family.

Design/methodology/approach – On the basis of secondary literature, the paper discusses the early development of Dutch school medical inspection from a comparative perspective. Changes in the national authority's and the school doctors' concepts of what a “healthy” child was between the 1930s and 1970 are examined using a variety of primary sources. These concern both the national discourse and sources that shed light on the daily practice of school medical inspection from the single province for which these are available.

Findings – Although they adopted a new and more inclusive concept of health in theory, school doctors in the Netherlands were reluctant to actually take up issues of mental health in their daily practice. This reluctance was inspired by the fear of losing their pivotal role in child hygiene and their status as public servants.

Originality/value – Studies in the history of school medical services have focussed mainly on their establishment and development as an institution. They seldom extend into the post-war era and do not discuss the extension of the inspection into mental health.

Keywords Child health, Mental health, School doctors, School medical inspection

Paper type Research paper

Introduction

As elsewhere in the developed world, since the early twentieth century in the Netherlands, school doctors have been responsible for the hygienic inspection of schools and their pupils. Unlike in many other countries, they did not do their work as representatives of the national state but on behalf of cities or districts. The only national standard for their work was the supervision by the Inspection for Child Hygiene, established in 1920 as a branch of the National Health Inspection. It supervised all child-health-promoting activities that were supported financially by the state, provinces, or municipalities, like maternity and infant welfare. Among these services, school medical inspection was the only public one. In the “pillarised” society of the Netherlands of the first two thirds of the twentieth century, all other child welfare was organised privately and along religious lines. Together, three “pillars” bore the nation's civil society: one orthodox Calvinist, one Roman Catholic, and one neutral for liberals and social democrats (Bakker *et al.*, 2006).

Notwithstanding the lack of a national strategy for hygienic surveillance of school children, this study explores the meaning of child health as applied by Dutch school doctors and the way it was adapted to the rapidly improving standard of living and the increasing importance of mental health after the Second World War. From 1948, the World Health Organisation (WHO) promoted a new, positive, and comprehensive concept of health: “a state of complete physical, mental and social well-being”, to which the 1951 Technical Report of the WHO's Expert Committee on School Health Services subscribed (World Health Organization (WHO) Expert Committee on School Health Services, 1951).

Studies in the history of school medical services have focussed either on their establishment and early years (Hendrick, 1992; Parker, 1998) or on the development of the national institution (Harris, 1995; de Beer, 2008). They seldom extend into the post-war era and usually take for granted that school doctors' work concerned children's physical health. It is demonstrated that across the West, their assignments have included the prevention of the spread of contagious diseases, vaccination and periodical health examinations of pupils and teachers, the promotion of hygienic school buildings and furniture, the prevention of health-threatening time schedules, and the dissemination of hygienic knowledge among teachers, parents, and pupils. Whereas in some countries, like England and Wales (Harris, 1995), school doctors also treated a child's ailments, in other countries, like the Netherlands (de Beer, 2008), their assignment was limited to prevention. Everywhere, school doctors were expected to identify health problems of individual children, like defective vision and hardness of hearing, as early as possible to prevent learning problems. In doing so, they contributed to the quality and effectiveness of teaching. When special provisions were available, “feeble-minded” children were referred to special schools or classes and “pretuberculous” children to open air schools and health camps.

Although the establishment of child guidance clinics from the 1920s made mental health an increasingly important issue in education (Cohen, 1999), it is not discussed by the historians of school medical inspection. Studies in the history of psychology, on the other hand, consider schooling an important domain where psychologists could practice testing and family guidance, and determine the limits of normality, emphasising their contribution to disciplining and normalising childhood and the family (Gleason, 1999; Rose, 1985; Turmel, 2008). Nikolas Rose (1985), in particular, discusses the reasons why in Britain the “neo-hygienist model” of social policy, administered by medical doctors and aimed at improvement of the individual, was more successful than the “psycho-eugenic programme”. The former focussed on environmental reform coupled with hygienic education of parents and the rearing of healthy children and the latter on innate and uneducable differences. These studies suggest a natural inclusion of children's mental health in school-hygienic inspection as part of a social policy that supported the developing welfare state. Does this apply to a country where religious groups successfully opposed the extension of public hygienic care into parenting and the family?

The first section of this paper discusses the establishment and early development of school medical inspection, especially the assignment and the forces behind its growth, from a comparative perspective. The second section focusses on child health, as understood and applied by Dutch school doctors between the wars, when the “social body[1]” of supervised school children expanded nationwide. The third section discusses the concept of health as understood and applied by Dutch school doctors after the Second World War. Sources include social-hygienic professional journals and the annual reports of both the National Health Inspector and the school doctors of the single province for which these and a complete archive are available: the relatively poor, agrarian-industrial northern province of Groningen. The journals reveal the issues that concerned child-hygienic professionals over time, the reports open a window towards the national authority's and the provincial school doctors' notions of what a “healthy” child was, and the archive of the Provincial School Doctors Service sheds light on the decision making as regard the daily practice of school medical inspection.

The establishment and early development of school medical inspection

In the Netherlands, the first school doctors were appointed in 1904 in seven cities. After four years, 49 cities had school medical inspection (Bakker and de Beer, 2009). The prevention of diseases that could be transferred and caught at school, the so-called “school diseases”, was the prime objective of the new civil servants. The instructions for the school doctors of the

pioneering cities functioned as models for later appointments. Common elements are the focus on the search for illnesses that might “harm a pupil’s fitness for education”, “impede or obstruct teaching”, or “endanger other pupils” (Idsinga, 1906, pp. 50-51). Reading these instructions makes it clear that keeping the schools safe from contagious diseases and preventing the deterioration of infected ears and eyes were the main focus of attention. Like in Belgium (Velle, 1990) and Germany (Hahn, 1993), Dutch school doctors’ work was strictly preventive. Unlike their British colleagues (Harris, 1995), they were not allowed to treat children’s ailments and, therefore, did not run clinics of their own. They were to refer a sick child to its family doctor or a specialized clinic for treatment.

In this way, rivalry with general practitioners was averted, a precaution that was inspired by experiences in neighbouring countries. As it turned out, instead of a loss of child-patients, general practitioners saw an increase in the number of conditions that were brought to their attention. Teachers were not tempted to oppose the entry of the new profession in the schools either, as school doctors were allowed to advise the Board of a city on matters of curriculum, timetables, and holidays, only “on demand” (Idsinga, 1906, p. 51). In the Dutch context, however, the limited instruction of the school doctors was first of all borne out of an excessive fear of “state pedagogics” among denominational groups who ran schools of their own that were partially – and from 1920 fully – paid for by the state. Advice, instead of treatment, seemed a better way to avoid an arousing religious protest against the much feared “intrusion” of the state into parents’ authority over their children. This explains also why school medical inspection was initially limited to public schools. Private religious schools could ask to be included in the service. It was free. School doctors did not threaten their autonomy or their purse. Parents, moreover, who did not want their child to be examined by a stranger could ask permission to have it done by their own family doctor. Infringement of “parental rights” would certainly have caused the opposition of religious groups. Under these conditions, the service was easily accepted (Bakker and de Beer, 2009).

The initiative to appoint a school doctor was most often taken by members of the local school or health committee, often physicians. In the local political arenas of the city councils, liberals and social democrats usually favoured the appointment of a school doctor, whereas representatives of religious parties voted against it. After the appointment, however, Calvinist and especially Roman Catholic objections against school medical inspection melted before the temptation of free use of the service. In Arnhem, Utrecht, and other cities, many Catholic schools immediately joined the service. Sometimes, a school epidemic acted as an incentive for religious schools to do so. Only orthodox Calvinist schools stiffened their backbone and refused (Bakker and de Beer, 2009). But even they gradually submitted to the hygienic regime and made their pupils part of the “social body”.

The focus on the prevention of “school diseases” in Dutch school doctors’ assignments reflects the reasons why local communities were willing to pay for the service. These and their negative impact on school efficiency had played the key role in the public debate that preceded the appointment of the first school doctors. The introduction of compulsory education in 1901 had reinforced the case of those who argued that schools ought to be a safe place. A state that forced children to attend school had the moral duty to minimise health risks at school, as many politicians and hygienists argued (Bakker and de Beer, 2009). Child labour before and after school hours and its detrimental effects on child health and fitness, a major argument for the introduction of the school medical service in 1907 in England and Wales (Hendrick, 1992), did not play a significant role in the Dutch discourse. Religious groups were of the opinion that the decision to make a child attend school or work belonged to the parents’ authority, a conviction that made them vote against compulsory education in the Parliament. Mentioning the health-threatening effects of child labour on the edges of the school day was probably avoided by local activists to not arouse extra opposition to the establishment of a school medical service. The same seems to be true of the

problems of malnutrition and lack of fitness of poor children, which have acted as vehicles for the medical profession to substantiate its claims to control the health of school children in England and Wales (Harris, 1995; Welshman, 1997).

Throughout the period under study, a precarious balance had to be kept between the two halves of the Dutch population: liberals and social democrats on one hand and denominational groups on the other hand. Education was situated in the very heart of the contested domain, with the consequence that even non-religious groups refrained from attempts to make state regulation applicable to aspects of schooling, i.e. apart from the state's financial responsibility for all schools. The precariousness of this balance explains also why eugenic motives, referring to national fitness and efficiency, hardly played a role as the moving force in the early history of Dutch school medical inspection. Protagonists of school doctors were not driven by the fear of physical deterioration or degeneration of the Dutch population, as was the case in turn-of-the-century Britain and the “white Dominions” (Gleason, 2002; Harris, 1995; Krik and Twigg, 1994). Racial issues were lying asleep, whereas religious fear of an intruding state and liberal caution to not awaken this fear were omnipresent.

School doctors and child health between the wars

In the 1920s, in the Netherlands, only cities had appointed school doctors. The countryside remained largely uncovered. The first two district school doctors were appointed in 1927 in a backward peat area in the province of Drenthe, just south of Groningen. The poor health of its children had been the subject of a report by a governmental health inspector in the previous year. The province of Groningen decided to follow this example and support municipalities to form districts that could appoint a school doctor collectively[2]. Between 1930 and 1933, with the financial aid of the province, four district school doctors were appointed (Bakker, 2015a).

In the interwar years, the national discourse on school medical inspection focussed on the fight against infectious diseases like diphtheria, measles, scarlet fever, and tuberculosis. School doctors were disappointed that the Christian parties had managed to remove the obligatory vaccination of school children against smallpox from the new Contagious Diseases Act (1928) and had refused to extend their power to close a school and ban infected children in case of a school epidemic. Their acting upon such a threat continued to be dependent on local regulations (de Beer, 2008). Tuberculosis screening of all pupils by means of a Pirquet tuberculin test was discussed as a possible extension of school doctors' assignment, but it was practiced only by a minority of the school medical services. A positive reaction to the test indicated only tubercle infection, not the stage, the seriousness (active or sleeping), or the contagiousness. Nevertheless, over the years, the scale of testing of complete school populations increased, especially during the 1930s. At the same time, the percentage of children with a positive Pirquet reaction decreased rapidly. In the city of Groningen, it fell from 65 per cent of all 11-year-old pupils in 1915 to 14 per cent of all fourth graders (aged 10-11) in 1937. The same is true of the number of deaths from tuberculosis, including children and youth (Bakker, 2010).

In their annual reports, the district school doctors of Groningen paid most attention to the results of the routine health examination of pupils. They conceived of it as their most important task. As elsewhere, each year they subjected about half of the pupils of the supervised primary schools to a medical check-up. It concerned all pupils of the first grade (aged 6-7), of the final grade (aged 11-14), and of one of the grades in between, making sure that every pupil was fully examined three times. A small number of pupils were examined more specifically because they were sickly and missed school often or because the teacher suspected them to suffer from a particular, possibly contagious disease. In case of suspicion that a child suffered from tuberculosis, referral was made to a dispensary, where specialised doctors could further examine the child. In the 1930s, these cases were already very rare.

Extra visits were paid to schools that experienced early signs of an epidemic of scarlet fever or diphtheria, which could be contained by an hygienic intervention, like banning infected children from the school and vaccination of children who had not yet caught the disease[3]. Referrals to a general practitioner for treatment were made frequently. According to the doctors' reports, the majority of the parents did actually see the practitioner with their child[4]. The district school doctors were even more content with the mothers' attendance at the health examinations. Almost all of them were present and hardly any child was kept away, all of which were interpreted as signs of acceptance of their work[5].

One of the main foci of attention of the health examination was the child's "feeding condition", which was established on the basis of the child's physical appearance[6]. In 1937, a survey by the National Inspection for Child Hygiene among school doctors showed that despite the economic crisis, the majority of the Dutch children were "well" (49 per cent) or "sufficiently" (32 per cent) fed and only a small minority were "insufficiently" fed (7 per cent). The Groningen school doctors participated in this survey. It turned out that in the city, the children were more often "well"-fed (64 per cent) than the average Dutch child. In the countryside districts, however, they were more often "insufficiently" fed (12 per cent, on average)[7].

Malnutrition could be remedied in two ways. First, poor relief could provide for extra meals through the school. School doctors were not allowed to select the children who qualified for these meals, as the churches dominated this work. Their assessment of a child's "feeding condition" was only one of the criteria for admission. Instead, their contribution focussed on the effect of these meals in anthropometric terms. They measured the increase in weight and length of every child that was accepted in a programme. In Groningen, almost without an exception, the results were positive[8]. Second, pale and malnourished children could be sent to a "health colony" for six weeks. These "colonies" were located on the coasts or in the woods and were organised by philanthropic societies, many of which were church-related. Throughout the year, they received large groups of "weak" children, who were "treated" with heavy meals of porridge and stew, gymnastics, and walking tours. School doctors selected the children and strongly advocated this work (Bakker, 2010).

Apart from feeding, the health examination focussed on children's eyes, ears, teeth, chest, throat, spine, posture, limbs, skin, and the cleanliness of their hair and head. Altogether, 11 items of physical health and one related to emotional well-being (as bed wetting was believed to be an expression of distress) were included in the examinations of the Groningen countryside school doctors. They found a large part of the pupils with "abnormalities", i.e. 46 per cent in 1930 (Bakker, 2015a). The school doctors were proud to be able to report so many health deficiencies. Some added that nine out of ten of the "discovered" ones had not been known beforehand[9]. In their view, this confirmed the importance of their work.

In the 1930s, the Groningen district school doctors most often found problems with children's posture and their spines. Particularly, scoliosis, a deformation of the spine, was frequently diagnosed. It was believed at the time that it was caused by sitting in a wrong-sized school desk or slantwise, next to a lack of exercise. In 1935, in two districts, on average, 16 per cent of the pupils were diagnosed with scoliosis, next to 14 per cent suffering from other kinds of posture problems[10]. This high frequency explains the unceasing concern of the school doctors about school desks. During the economic crisis of the 1930s, the Groningen schools still used to buy only a few different sizes of desks, whereas prevention of scoliosis required that each child could sit on a desk of the right size, as the doctors insisted[11].

School doctors conceived of themselves as hygienic educators of the working class. That is why mothers were supposed to accompany their child at the health examination. The doctors' message of cleanliness and due amounts of fresh air, exercise, rest, and healthy

food was supported by a small booklet, edited and distributed by the National Society of School Doctors. It was meant to rule out “wrong ideas” and promote bathing, swimming, a weekly change of underwear, and daily hair and tooth brushing as “modern” hygienic child care[12]. From the late 1930s, one notices the first signs that the profession’s concept of hygiene started to widen from physical health and cleanliness of the child’s body and clothes to embrace the aspects of mental health as well. These concerned children’s emotional well-being. The doctors’ widening interest appears as a response to frequently asked questions of mothers on how to handle their “difficult” or “nervous” child. It is no coincidence that it occurred at the time when child-rearing advice was medicalised in the sense that it presented a “normal” child as a mentally “healthy” and “happy” instead of a virtuous child, and psychiatric theory became its intellectual foundation (Bakker, 2006). This added to the authority of doctors in matters of child rearing. A good school doctor conceived of the child in terms of a “psychophysical unity” and knew how to advise a mother in cases of bed wetting, nail biting, and other emotional problems that were usually caused by “child-rearing faults”, according to the professional discourse. At the same time, the one-sided physical orientation of school doctors’ training was more often criticised as inadequate to handle these problems (de Beer, 2008).

School doctors and child health in the 1950s and 1960s

Unlike in Britain and the “white Dominions” (Macdonald, 2013), no national fitness campaign was launched around 1940 in the Netherlands. Instead, the German occupation brought a more positive attitude towards gymnastics and physical exercise to a country where negative, religious sentiments about the “guilty flesh” were still ubiquitous. In 1942, the Nazis obliged all municipalities to appoint a school doctor. After the war, the Dutch Government continued to subsidise school medical services. Full coverage of the country was reached in 1965 (de Beer, 2008). In the province of Groningen, this point had been reached in 1943. This explains why the province saw the greatest leap forward in terms of numbers of schools and pupils under medical supervision in the 1940s: from 151 schools in 1940 to 607 schools in 1950. In the following years, both schools for secondary and vocational education and infant schools joined the services. In 1960, the Groningen countryside counted nine districts and doctors with 696 schools and 66,948 pupils under medical supervision. Almost all schools participated. The extension of school medical inspection into toddler’s age and adolescence implied that five instead of three routine health examinations of a child during his/her school career became the rule. Another consequence was that the proportion of the pupils of the supervised schools that were fully examined in one year decreased to less than one third (Bakker, 2015a).

Although a school doctor was free to report in his or her own way, employers of a number of school doctors, like big cities and provinces, expected their staff to provide particular information. In 1948, the National Inspector for Child Hygiene standardised the required information from the school doctors in their annual reports by providing a list of items. As a consequence, the reports became more homogeneous and more detailed. In 1960, the school doctors of the Groningen countryside reported on an average number of 23 aspects of child health, from “general physical condition” (which replaced the “feeding condition”) and “eyes” to referrals to a general practitioner, twice as many aspects as had been covered in 1940. These aspects were also examined in more detail. As to children’s eyes, for example, the reports added numbers of children suffering from squint and colour-blindness to those with reduced sight. In the 1960s, they started to differentiate between weak-sighted children who already wore glasses and “newly found” cases. National results, concerning the years 1948-1955, were published up to 1958[13]. From that time, the Inspector considered collecting numbers of “abnormalities” no longer useful. Vaccination levels and referrals to special care like remedial gymnastics and speech lessons were

considered more important. Nevertheless, the district school doctors of Groningen continued to collect these numbers until 1971 (Bakker, 2015a).

The National Organisation of School Doctors was an early adopter of the positive and inclusive concept of health presented by the WHO in 1948. As early as the late 1940s, they invited speakers at their meetings to discuss themes like mental health, readiness for school, and behavioural problems and their causes (Sectie Schoolgeneeskunde A.N.v.v.S.G., 1947; de Vries, 1949). Training courses for school doctors included child psychology and child rearing as new subjects. Nevertheless, in 1952, at the National Conference on School Medical Inspection, the profession was seriously criticised for not innovating their work. By continuing to focus on numbers of “abnormalities”, school doctors did contribute data to medical statistics but they did not approach child health “positively”, and by sticking to the prevention of physical illness, they ignored the increasingly important “psycho-social problems” children experienced, as the critics pointed out. The one-sided focus on physical ill-health had outlived itself as a consequence of decreasing infant and child mortality and morbidity, a higher standard of living, and improved social security, as a professor of social medicine claimed. He blamed the school doctors for not having changed their work in 45 years: “mass screening of the school population aiming to find abnormalities” (Nederlands Congres, 1953, p. 74). During the 1950s, this accusation was often repeated by medical experts, herewith confirming the low status of school doctors within the medical profession – a condition which seems to have been a major cause of the rapid feminisation of school medical inspection in the post-war years (de Beer, 2008).

The school doctors defended themselves by pointing at their one-sided training as physicians, declared that they were willing to professionalise by means of courses on mental health, and pointed at their role as *trait d'union* between parents, teachers, and the growing number of specialised professionals to whom they could refer. They did not want to give up their traditional approach, but they were willing to include aspects of mental health in their examinations (Nederlands Congres, 1953). They were, however, aware of the complicating factor that the Roman Catholics, a 40 per cent minority, were, at the time, trying to reorganise school medical inspection into “pillarised” services. Any move towards a more pedagogical and psychological interpretation of the school doctor’s assignment would reinforce the claim to integrate school medical inspection into a Roman Catholic school support service as part of the “pillarised” school system. This was the last thing school doctors wanted, as they conceived of themselves first of all as doctors (de Beer and Bakker, 2007).

When it had become clear that the Roman Catholics would not be able to realise their plans, the school doctors’ organisation concluded the debate in 1960 with a report that re-established the old approach on a somewhat different basis. The concept of health was adapted towards the promotion of the optimal health of each individual child and the inclusion of psycho-social aspects of development. The health examination remained the main instrument. The report suggested an extra examination of the pupils of the second grade of the infant school (aged five to six), when a child’s “readiness for schooling” could be established. This could replace the examination of the pupils of one of the middle grades of the elementary school. For each of the examinations, a normative duration was determined, on the basis of which it was figured out that one school doctor could take care of no more than 5,000 pupils, a number far below the actual numbers of supervised children at the time (Rapport der Commissie, 1960).

Other new tasks were added. Though it was not prescribed, tuberculosis screening of all pupils became a standard practice after the war. In 1957, two thirds of the school doctors did so. The numbers of infected children that were found through this mass screening were, however, very low and approached zero in the 1960s, which, in turn, inspired criticism. The minutes of the committees that supervised the work of the Groningen countryside school doctors show that a single case of a “discovery” of an infected child could silence the

critique for years[14]. This explains why this screening has continued up to 1970. From 1952, moreover, a national vaccination programme for babies started. Initially, it was limited to diphtheria, but soon other illnesses were added: whooping cough, tetanus, and polio. School doctors took upon themselves the revaccination of school children (de Beer, 2008).

Next to school doctors’ tasks, the numbers of supervised pupils multiplied after the war. In the 1950s, the Groningen district school doctors were, on average, responsible for over 7,000 children. Unlike in the city, countryside school doctors had to travel a lot, and up to the 1960s they could not avail of school nurses for routine jobs, conditions about which they complained frequently (see footnote 14). During the 1950s, the municipalities spent their money primarily on new school buildings, having to deal with rapidly increasing numbers of pupils.

Throughout the 1950s and 1960s, the numbers of “abnormalities” found by the Groningen district school doctors were higher than before. In 1955, 68 per cent of the inspected pupils showed “abnormalities” (against 63 per cent in the country as a whole). This high level was an effect of the more detailed list of items the doctors used and of the introduction of school dentists. Children’s sight and hearing were found more often deficient and their teeth were more often in bad shape. Still, a tendency towards an improved overall physical condition of the pupils can be discerned. The proportion of children with an insufficient condition fell from 8 per cent in 1955 (against 4 per cent in the country as a whole) to 3 per cent in 1965. More hygienic housing and living conditions were responsible for a decrease in the number of unclean heads and in diseases of the skin. Due to a richer and more varied diet and more frequent visits to toddler health bureaus, the 1950s saw a spectacular fall of the number of children suffering from rachitis or rickets, from 12 to 3 per cent, whereas the 1960s witnessed the effects of more frequent gymnastics and of school medical inspection, as posture problems and scoliosis almost disappeared (Bakker, 2015a).

School doctors had been pleased when the German occupying regime had suspended the possibility for schools to escape the obligation to teach gymnastics for reasons of not having a gym. Throughout the 1950s, the Groningen school doctors continued to complain about the quality of the accommodation where the lessons had to be taught: it was too small, too dirty, or too dark. Sometimes, the lessons took place in the mud outside. In the early 1960s, these complaints fell silent, as even country schools were accommodated with gyms. From that time, school doctors pleaded for more hours of gymnastics, preferably one hour a day. They ascribed an additional value to gymnastics as a means to improve the school’s effectiveness. Children, they maintained, would learn more if they were physically healthy and energetic. Gymnastics would contribute to pupils’ “mental and physical” fitness and prevent moral “degeneration”[15]. The same was said of outside playtimes: two instead of one were indicated in the morning. Remedial gymnastics for children with posture problems or scoliosis were advised from the 1930s, but only after the war these lessons became part of a standard offer. School doctors became the selection authority.

From the 1930s, villages in the Groningen countryside had built outside swimming pools. Schools organised swimming lessons for the pupils of the middle grades of the elementary schools. The art of swimming saved lives in a country full of ditches and channels and it promoted school children’s physical and mental health, as the school doctors claimed. Like other sports, it could compensate for too many hours of intellectual work. That is why school doctors welcomed the initiative and hoped that these lessons would soon become available for all children. And, as expected, they took upon themselves the new assignment of examination of all candidates for the swimming lessons, focussing on children’s ears, throat, and heart[16]. The examples of gymnastics and swimming illustrate how the school doctors succeeded in linking up physical and mental health.

From the early 1950s, the Groningen district school doctors paid tribute to the new, positive, and inclusive concept of health. They conceived of their work as pivotal in promoting it.

However, the province had to wait relatively long, until 1960, before a child guidance clinic was established in the city of Groningen. Up to that time, there had been a bureau for parents and children with child-rearing problems, established in 1928 by the professor of paediatrics of the local university. In the 1950s, this bureau focussed particularly on toddlers, giving advice once a week at four different places in the province (Brandenburg, 1956). But that did not satisfy the increased need for psychiatric treatment of “difficult” children. As elsewhere, the Groningen child guidance clinic treated children with emotional problems from a psychoanalytic perspective and acted as a training ground for child psychiatrists and psychiatric social workers, as well as a centre of expertise and examination for youth welfare and protection services (Bakker, 2006). Referrals of children to this clinic and to the university child-psychiatric clinic from the countryside districts were, however, very rare. Despite school doctors’ admitted lack of psychological expertise, most child-rearing trouble at school age was taken care of at their consulting hours, which were held at least once a month in the Groningen district centres.

Before the child guidance clinic was established, a Groningen district school doctor could refer a troublesome child to the Youth Department of the Provincial Psychiatric Service (*Jeugd Psychiatrische Dienst*, JPD). The first referrals date from 1947[17]. The province was one of the pioneers in providing specialist social-psychiatric help to children. It was argued that the targeted children had the same lower-class background as the adult clientele (Kraft, 1962). Referrals of children to the JPD continued after the child guidance clinic had opened up. The service seems to have acted as a more practical alternative for the time-consuming, multi-disciplinary approach of the clinic and especially for its psychoanalytical “talking” cure, from which “mentally deficient” children were excluded and which did not fit the profile of the primarily lower-class countryside parents. The JPD provided testing of all sorts to diagnose mentally disturbed or deficient children. For this end, it was frequently used by the district school doctors.

Three items on a long list

As regard the health examination, no more than three items concerning children’s intellectual and emotional normalcy were included in the National Inspector’s list that was used from 1948. These concern bed wetting, speech problems, and mental retardation. As compared to the physical ailments, these “abnormalities” more particularly concerned young children. In the Groningen countryside districts, bed wetting became a regular subject of examination from 1945. With time, it was found more often, but this does not indicate a growing problem but the vanishing of a taboo. Mothers gradually lost their fear to talk about it and ask for a remedy. Although it was not discussed often in their annual reports, it is clear that the doctors were aware of the complexity of the problem and convinced of its psycho-social background[18]. During the 1950s, the school doctors echoed the national discourse by calling it a “neurotic disorder”, a symptom of mental ill-health, or an effect of “mental overburdening” of a child[19]. The doctors agreed that bed wetting was a hard-to-combat ailment, for which the right therapy had not yet been found. Only in very serious cases doctors referred a bed wetting child to the JPD.

Speech problems like stammering and stuttering were likewise systematically sought out from 1945 by the Groningen countryside school doctors. Numbers of children found with these problems grew substantially: from 1.3 per cent in 1950 to 4.8 per cent in 1960 (Bakker, 2015a). References to speech therapy by trained professionals were made from the early 1950s. It is likely that the rising number of speech impairments that were identified was an effect of the availability of speech therapists. School doctors were aware of the possibility of an emotional background to speech problems, as they differentiated between impairments with and without an organic cause and classified almost all of them in the latter category. Repeatedly, school doctors called stammering a “neurotic” disorder (see footnote 19). Treatment, therefore, had to

be pedagogical or psychotherapeutic. In 1953, the provincial school doctors estimated that 8-10 per cent of the school children needed speech therapy[20]. They themselves were responsible for the selection.

Mental deficiency was by far the most important non-physical issue for countryside school doctors. “Backwardness” was on the list of items, but it was used only to estimate the need for special schools for “feeble-minded” children in districts that could not yet avail of such a school and there was no national standard. Between 1939 and 1954, in the province of Groningen, every district centre established at least one special school for these children, except for two towns near the city of Groningen. They continued to use the city’s provisions. School doctors turn out to have acted as crusaders in a campaign to fight parents’ resistance to having a child attend a special school. They took pains to combat what they conceived of as parental ignorance and prejudice, like the idea that children would not learn anything at such a school or would be better off in a classroom with normally gifted children[21]. They, moreover, actively promoted separate schooling for the feeble-minded as a blessing for both the children concerned and the pupils of the regular schools and their teachers.

Throughout the period under study in Groningen, as elsewhere in the Netherlands, school doctors were responsible for the admission of pupils to a school for feeble-minded children. They sat in the admission committees, next to the head master of the special school and, from the mid-1950s, next to the psychiatrist-director of the JPD. IQ-testing was done only after a child had repeated a grade one or two times and continued to be behind at school and, consequently, upon a teacher’s request. It could be done by the school doctor or the JPD. From 1957, a newly appointed school psychologist took over most of the testing. Unlike in many other countries, testing of whole school classes was not done regularly and IQ-testing was no part of the health examination or the selection for secondary schools either. This may explain why school psychology, which developed only from the 1950s, remained an underdeveloped specialism in the Netherlands. Unlike school medical inspection, the new profession was, moreover, quickly integrated into “pillarised” school support services (Bakker, 2015b).

Around 1950, to speed up the process of convincing local authorities of the need for a special school, the Groningen district school doctors have diverted several times from the normal procedure by IQ-testing large numbers of children and reporting a high percentage of pupils with mental deficiencies. In several cases, they, moreover, had all pupils of the two lower grades of a number of primary schools IQ-group-tested by the JPD and presented the percentage of these pupils that were found mentally deficient as the proportion of children in need of special schooling in their district. Local authorities let themselves be convinced by these numbers. Each time this procedure was applied, a special school was established within a few months, and each time the school doctor reported in the next year that it flourished and “provided for the needs of the district”[22].

The next step, the differentiation between classes or schools for only slightly mentally deficient children and pupils with a very low IQ-score, proceeded along similar lines. One or two special schools in a district had to flourish before a school doctor could make this suggestion by complaining that the presence of the seriously handicapped “imbeciles” had a negative influence on the parents’ willingness to have their feeble-minded child educated in the special school. “Imbeciles” would chase away other children. They were, moreover, said to be left without any instruction in case of an overcrowded school for feeble-minded children. We see these arguments being used successfully in 1950 and 1953 in the two towns, far away from the city of Groningen, that had also pioneered in establishing a special school[23]. A new kind of special school for children with specific learning and behavioural problems (*leer- en opvoedingsmoeilijkheden*, LOM) but a normal IQ, introduced in 1949, did not reach the districts before the mid-1960s. The first LOM-schools were established in the same two towns[24]. The timing was due to a collective plea of the provincial school doctors that such schools were badly needed in the countryside in 1964. It occurred after more than

ten years of lobbying by individual school doctors to have specific learning disabilities like “word blindness” recognised as qualifying for special didactic support and a mental health risk in case of continued disregard of these children’s special needs[25].

Conclusion

The National Organisation of School Doctors in the Netherlands was an early adopter of the positive and inclusive concept of health presented by the WHO in 1948. They adapted their standard of child health almost immediately and on their own accord towards the promotion of the optimal health of each individual child and the inclusion of psycho-social aspects of development. They did so after the interest in mental next to physical health had grown within the profession since the late 1930s in response to the medicalisation of child rearing. However, the National Inspector’s list of items used in the health examinations of pupils from 1948 included few mental health issues. Moreover, in the post-war years, school doctors’ workload became much heavier, as the number of children under supervision grew rapidly, the health examinations extended into infant and secondary schooling and became more detailed, and mass screening of tuberculosis and revaccination were added to their assignment. This may explain why, despite assertions that they subscribed to the new concept of health, the district school doctors of Groningen continued to pay most attention to dangers threatening pupils’ physical health.

In doing so, they show the same reluctance as the profession as a whole to actually take up issues of mental health in their daily practice. It was inspired by the fear of losing both their pivotal role in child hygiene between parents, teachers, and the growing number of specialists to whom they could refer, and their status as public servants by being incorporated in a non-medical school support service, organised along religious lines. Dutch school doctors conceived of themselves as hygienic educators of the working class, fitting neatly in the neo-hygienist model of a social policy. Apart from the German occupiers’ love for gymnastics, there was no competition from a eugenic or national fitness programme as the moving force behind their activities. Even the doctors’ promotion of special schooling for feeble-minded and learning-disabled children appears as part of a social policy to serve the best interest of the child by fighting what they conceived of as parental ignorance and prejudice.

In the Foucauldian sense, school doctors’ protagonism of special schooling and classification of special-needs children produced feeble-mindedness and learning disabilities in the way the availability of speech therapy and tabooing of imperfect speech produced stammering and stuttering. This and the increasing number of “abnormalities” they found, as well as the enlarged hygienic supervision and screening in times of decreasing health risks and an overall improving physical health, due to a richer diet and more hygienic living conditions, provide a clear case of progressive state-supported, neo-hygienist surveillance of childhood and the family. At the same time, as they were pushing forward the extension of their assignment with new tasks, school doctors clung to what had always been the basis of their legitimacy and acceptance as public hygiene officers in a religiously divided country: the ideal of supporting and promoting the school’s effectiveness by reducing possible dangers threatening pupils’ learning capacity and, increasingly, their mental well-being. With the aid of their work, in the 1960s, health was both more common for a schoolchild than ever before and, like normalcy, less easy to attain.

Notes

1. This concept is derived from M. Foucault: Cooter (1992).
2. Archive of the School Doctors Service of the Province of Groningen (Schoolartsdienst Provincie Groningen, SPG), Groningen Archives, No. 1236, I, 2.
3. For example, *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand en Veendam over het jaar 1939*, Groningen, p. 22.

4. For example, *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand en Veendam over het jaar 1939*, Groningen, p. 22; *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand en Veendam over het jaar 1940*, Groningen, p. 25.
5. For example, *Verslag van den Schoolartsdienst in de groep Hoogezand over het jaar 1930*, p. 14; *Verslag van den Schoolartsdienst in de groepen Hoogezand, Veendam en Winschoten over het jaar 1933*, Riks, Wildervank, p. 17.
6. Between 1920 and 1940, several attempts were made to construct a quantitative, science-based measure to establish this condition, all of which failed to generate the general support of school doctors: de Beer (2008, pp. 222-228).
7. *Verslag over de jaren 1936 en 1937* (1938, p. 765).
8. For example, *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam en Winschoten over het jaar 1935*, Sappemeer, p. 4; *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam en Winschoten over het jaar 1936*, Sappemeer, pp. 7-8, 27-8.
9. *Verslag van den Schoolartsdienst in de groep Veendam over het jaar 1932*, Keizer, Veendam.
10. *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam en Winschoten over het jaar 1935*, Sappemeer.
11. For example, *Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand en Veendam over het jaar 1939*, Groningen, p. 36.
12. A. van Voorthuijsen (1931⁵). *Nu uw kind op school gaat*, Archive ANVSG, IISG, No. 1.
13. *Verslagen en Mededelingen betreffende de Volksgezondheid 1952-1958* (1955-1962), The report on 1959 (issued in 1962) was the first that left out these numbers.
14. Archive SPG (GA) No. 1236: II, 1-12 (see note 2).
15. *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1965*, p. 96.
16. For example, *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1949*, Groningen, p. 23; *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1959*, Groningen, pp. 5-7.
17. *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1947*, Groningen, p. 64.
18. *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1949*, Groningen, p. 55.
19. For example, *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1950*, Groningen, p. 66.
20. *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1953*, Groningen, pp. 5-8.
21. For example, *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1956*, Groningen, p. 49; *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1963*, p. 120.
22. For example, *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1949*, Groningen, pp. 23, 32-33; *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1950*, Groningen, p. 105; *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1952*, Groningen, p. 37.

23. *Verslag van de Schoolartsendienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1950*, Groningen, pp. 16-17, 96-97; *Verslag van de Schoolartsendienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1953*, Groningen, p. 33.
24. *Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1965*, pp. 71, 101; *Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar, 1967*, p. 57.
25. *Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1964*, pp. 5, 27, 71. The first proposal to establish a LOM-school was made in 1953: *Verslag van de Schoolartsendienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1953*, Groningen, p. 33.

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