Witte jassen in de school. De schoolarts in Nederland ca. 1895-1965
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This study gives an account of the history of school doctors in the Netherlands. It explains how the advent of school doctors from 1904 and the development of the profession and its field of activities until 1965 should be understood in the light of the concepts of medicalization and educationalization. The study focuses in particular on the way medical practitioners have acquired tasks in schools. In the 1970s critics of medicalization alleged that – like imperialists – doctors themselves had expanded their field of activities further and further. The Dutch sociologist Abram de Swaan, on the other hand, is of the opinion that many public health tasks have been assigned to doctors by the state precisely because they were the only ones to come up with satisfactory solutions for serious problems. Did doctors enter the schools on their own initiative, with or without support from the state, or was the door already invitingly open and did they acquire tasks in close consultation with the schools and parents? Did school doctors work only as doctors in schools or also as doctors for schools? Was their work limited to medical matters or did their influence reach out further, for example to educational matters?

This study consists of three sections. Section I is about the origins of school doctors in the Netherlands. During the second half of the nineteenth century a certain group of doctors – the hygienists – became increasingly interested in the hygiene of schools, teaching and – ultimately – the pupils. Initially they concentrated on conditions like ventilation, lighting and heating in classrooms. Gradually, as physicians realized to an increasing extent that diseases spread from one human being to another, their attention shifted to the health of schoolchildren and the dangers threatening them at school. They drew attention to the contagious nature of childhood diseases such as diphtheria, scarlet fever, whooping cough and measles, the dangers of tuberculosis and other so-called ‘school diseases’ such as scoliosis and myopia, complaints which even if they were not actually caused by school attendance were at least exacerbated by it and led to children not being able to receive proper tuition.

In the late nineteenth century medical practitioners proposed that, just as in neighbouring countries, school doctors should be appointed to actively combat school diseases. This proposal was supported by a growing number of teachers
who realized that due to a lack of training in hygiene they were inadequately equipped to perform this task themselves. They hoped that medical supervision would have a positive effect on their pupils’ academic achievements and that it would reduce school absenteeism. Around the turn of the century municipal councils also began to take an interest in school doctors, partly because of the introduction of compulsory education in 1901. A frequently heard argument was that because the government was forcing parents to send their children to school, it was the government’s task to safeguard children’s health at school.

Nevertheless, there was also some opposition to the idea of school doctors. Teachers were afraid that these school doctors would meddle with educational matters as well. General practitioners were afraid of unfair competition if school doctors would be allowed to treat children, and orthodox Calvinists in particular regarded medical supervision at schools as an undesirable form of state interference with their private religious schools. Bringing up children and looking after them was a task for parents, not for the state. Catholics, who also had their own religious schools, apparently did not feel so strongly about this. In 1904 P.J.M. Aalberse, an important Catholic politician, even spoke explicitly in favour of school doctors. There was in fact no organized religious opposition to school doctors as there had been to compulsory education, mainly because the national government did not take sides on this issue. Municipal councils, which had to organize and fund the school doctors themselves, had no say as far as denominational schools were concerned.

In 1904 Zaandam was the first Dutch town to appoint a school doctor; it was soon followed by many other medium to large towns. It turned out that the first school doctors supplied a need, and they met with very little opposition, partly because municipal councils – as evidenced by the first instructions for school doctors – had clearly anticipated possible objections to the arrival of school doctors. The new professionals were not given any authority to decide on matters regarding school hygiene and were not allowed to treat children themselves. This was the councils’ way of responding to the objections of general practitioners who feared competition, and at the same time they maintained the free choice in medical matters to which denominational groups, those favouring religious instead of public schooling, attached so much importance. Parents were not obliged to let their children be examined by the school doctor, provided they could produce a health certificate from their own general practitioner. Denominational schools could decide for themselves whether or not to sign up for the municipal school medical service. Moreover, participation was free of charge.

Section II focuses on the organization of the school medical service. Unlike England and Belgium, where legislation and funding led to national networks of school medical services in the early twentieth century, in the Netherlands it took over sixty years before a school doctor was working in every municipality. This was mainly due to the absence of state legislation and funding. It was not compulsory to set up school medical supervision and municipalities themselves had to pay the costs of a school medical service. As a result, throughout the first forty years of the twentieth century the number of services grew only slowly.
Rural areas in particular lagged behind. During the Second World War the German occupying forces ordered the municipalities to set up district school medical services, either in conjunction with each other or not. Municipalities received government funding for this purpose, and as a result the number of services increased rapidly. After the war the funding regulation was maintained, but the legal regulation was abolished. Ultimately it was not until the 1980s that a new – limited – legal regulation became effective.

The reason why it took so long had to do with pillarization and the political relations in the Netherlands which were connected with it. Denominational groups did not want to be forced to have public servants come into their denominational schools and blocked any legal regulation on these grounds. By this time those in favour of religious schooling were no longer fundamentally opposed to school doctors. In 1920 the Protestant Minister of Education and the Catholic Minister of Labour even had an argument as to which of the two should be responsible for the legal regulation of this supervision. The Minister of Education thought that as part of the school the school doctors should fall under Education, whereas his fellow minister thought they should fall under Health. The school doctors themselves, who were very keen to have a legal regulation because then all schoolchildren would be able to benefit from medical supervision and because it would bring unity into the organization and working methods of the service, shared the second view. While it was true that school doctors worked in schools, they had nothing to do with education. Their work was in the service of public health and they felt that first and foremost they were doctors. During this period school doctors also tried to approach other public health practitioners. For example, in 1921 the school doctors’ association and the association of municipal doctors set up a joint public health medical journal, which appeared fortnightly from 1923 onwards under the title *Tijdschrift voor Sociale Geneeskunde*. In 1930 the school doctors’ association (Nederlandsche Vereeniging van Schoolartsen) was incorporated into a wider public health medical association.

Like the school doctors themselves, in 1920 the members of parliament were of the opinion that in the first place school doctors were part of the health care system. However, in the succeeding years no legal regulation was introduced. Political dissension as to whether or not school medical services should be run by the government or based on private initiative with funding from the state, the cheapest solution that was already practiced with the infant health centres, played an important role. After the Second World War Catholics in particular advocated school medical services funded by the government but organized by their own welfare organizations. They preferred Catholic schools to be visited only by school doctors of the same denomination, especially since school doctors now no longer limited themselves to detecting physical disorders, as they had before the war, but now also addressed children’s mental and social wellbeing. However, except in Limburg, which was homogenously Catholic, these services never eventuated, even though the Catholic People’s Party was represented in the government for decades after the Second World War. Its coalition partner, the socialist Labour Party, was not at all in favour of
this kind of regulation. This led to a stalemate and as a result it was not until the 1980s, by which time Dutch society was well and truly depillarized, that a legal regulation was passed.

School doctors worked as public servants for the municipalities. Because of the absence of uniform legislation, municipal councils decided for themselves what work their school doctors had to do and what they would pay for it. As a result school doctors' job responsibilities and the methods and criteria they used to examine children varied across the municipalities. With varying degrees of success, the school doctors as a group tried to achieve more unity. School doctors were not specifically trained for their task in the schools until the 1960s, when a postgraduate course for youth health care physicians was set up. Up to that time it had been mainly the Dutch Association of School Doctors which provided training by organizing lectures. During these meetings school doctors exchanged their experiences and tried to decide on the best approach, both to examining schoolchildren and to the organization of the school medical service.

School doctors' salaries were nearly always clearly lower than the income earned by doctors providing treatment. The fact that school doctors were not allowed to treat patients and that they were public servants meant that from the outset the profession of school doctor had little prestige among medical practitioners. The first school doctors worked part-time, in addition to positions such as municipal doctor, general practitioner or paediatrician. From the 1930s onwards these part-time school doctors made way for doctors who could spend all their time on schoolchildren. As a result, it became increasingly difficult for councils to fill vacancies. Many open positions were filled by female doctors who found opportunities in school medicine which were denied to them in other areas of medicine because of male competition.

The principal task of school doctors was the medical examination of schoolchildren. This examination changed very little over time. The main elements – examination of ears, eyes, posture etc. – and its goal – prevention of illnesses and disorders – remained the same. However, during the first sixty years of the twentieth century the health of schoolchildren changed considerably. To a significant extent this was due to improved living conditions – housing, hygiene and nutrition – and increased preventive measures – infant health care, vaccination – and as a result some of the school doctors’ tasks changed in character and intensity. Section III focuses on four important tasks and traces the development of these tasks. All four tasks – combating infectious diseases, health education, selecting children to be sent to special camps to improve their health, and serving on admission committees for schools for children with learning disabilities – had to do with medical hygiene. They served the same purpose as the medical examinations: to protect and improve the health of schoolchildren.

Infectious diseases had been an important reason to first appoint school doctors. School doctors detected not only serious infectious diseases such as scarlet fever and diphtheria, but also irritating conditions like favus capitis, and
took measures to prevent their spreading at school. However, in some cases they had insufficient power to take the measures they deemed necessary. For instance, closing a school or excluding children from school were measures they were not allowed to impose in the case of all diseases. This depended very much on the Infectious Diseases Act (1872) and supplementary local bye-laws. The profession lobbied again and again, without much success, for widening of the Act and the bye-laws. They also played a major role in raising the level of vaccination among schoolchildren. It was school doctors who drew parents’ attention to the importance of inoculation from the 1920s onwards and who also carried out inoculations themselves. Gradually, inoculation against a growing number of diseases shifted to preschool aged and was no longer carried out by the school doctor but by infant child health centres or general practitioners. However, school doctors continued to give the booster inoculations required. They also played an eminent role in the struggle against tuberculosis, the most important cause of death among schoolchildren in the early twentieth century. They used Pirquet’s skin test to determine whether children were infected with the tubercle bacillus. The school doctor then referred any suspect cases to a specialised tuberculosis clinic. This task eventually disappeared because by the 1960s the disease had become very rare.

Regular medical examination of the children meant that school doctors were in the best position to decide which children could benefit from a stay in a holiday or health camp for school children at the seaside or in the woods. Their expertise became even more vital since, after the First World War, diagnosed health trouble became a condition required for admittance to such a camp and school doctors were supposed to present the tickets. These camps were intended for children whose health was frail; their purpose was to raise resistance in order to prevent the outbreak of diseases such as tuberculosis. Because of improved living conditions, the need for them disappeared in the 1960s and with it the role of the school doctors.

In the early twentieth century school doctors became involved in the selection of pupils for the rapidly rising number of schools for children with learning disabilities. As doctors they were better able than teachers to establish whether a child’s problems with schoolwork were caused by intellectual disabilities or by a physical disorder such as a hearing disability. They introduced the IQ test, which was a better instrument than a medical examination to determine whether and to what extent a child had intellectual disabilities. After the Second World War this psychological examination was gradually taken over by new professionals such as psychologists and educationists, who were better trained for this task. Another factor was that the goal of the admission test, which had initially concentrated on determining the child’s deficiency, gradually shifted towards educational interests: the focus came to be on the child’s capacities rather than its deficiencies.

Right from the outset, providing parents with medical hygiene education and advice, for instance regarding nutrition, bedtime and physical hygiene, was an important task. By talking with parents during their child’s medical
examination school doctors disseminated what they believed to be important medical views on good health care. A good example is the campaign to control head lice, which also demonstrates that parents were not immediately convinced, especially if it meant their daughters’ long hair had to be sacrificed. To back up their recommendations, school doctors also made use of the services of school nurses who visited parents at home if need be to remind them of what the school doctor had said. Education and advice for parents remained necessary, even if only because medical insights into healthy upbringing and child care changed constantly. When the focus of attention shifted from the occurrence of disorders to promoting all aspects of schoolchildren’s health, providing education and advice possibly became even more important. On the other hand, because of improved hygiene and increased precautions the problems that school doctors spotted or that mothers wanted advice on were now sometimes different ones. Disorders with mental aspects in particular, such as bed-wetting, received more attention after the Second World War.

The advent of school doctors meant a considerable increase in the influence of medical practitioners and their expertise on the lives of schoolchildren, and in this sense it was part of the medicalization process, since the appointment of school doctors led to a significantly greater impact of medical hygiene care for schoolchildren. Previously, schoolchildren had seen a doctor only when they were ill, whereas school doctors systematically examined all the children entrusted to them, whether or not there was anything wrong with them.

The introduction of school doctors in the Netherlands was not a direct consequence of doctors’ own attempts to gain more influence and authority. A more important factor was that schoolchildren became the subject of preventive public health care because of the gravity of the dangers which threatened their health and their capacity to be instructed adequately. These dangers did not only exist in the eyes of medical practitioners; teachers and politicians shared their concerns. In other words, medical supervision in the schools came into being because society no longer accepted that children’s health was so poorly protected against the dangers of attending school. This was even more the case after compulsory education was introduced, since it meant that even in theory parents could no longer protect their children against these dangers. From this perspective it is even more relevant that it was not the national government which took the initiative to appoint school doctors, but individual municipal councils. It seems as though the very fact that the state did not regulate the introduction of school medical supervision in any way actually facilitated the advent of school doctors in the Netherlands. However, this reticent attitude did lead to a serious delay in the growth of the service. In the development of the profession of school doctor there is not to be found a trace of medical imperialism, neither with regard to the organization of the service nor with regard to the school doctor’s job responsibilities. The profession did not demand any tasks – its tasks were simply consequences of the medical examination of pupils – nor did school doctors cling obstinately to tasks that were not necessary any more.
The objective of the school doctor’s work – from the point of view of the profession itself – was certainly not educational. They were doctors and wanted to remain part of a medical professional setting. Their first priority was the health interests of the schoolchildren. The interests of education were of secondary importance. School doctors worked in the schools, but at the same time they were not part of the schools. Although ostensibly the work provided ample opportunities and school doctors worked in an educational setting, they never let themselves be tempted to opt for a more educational approach, even when after the Second World War the number of physical disorders decreased and more and more attention was focused on psychosocial problems. In this area they limited themselves to identifying problems and giving general recommendations. They referred children with more complex problems to experts. As a result new professionals such as school psychologists, special educationists and youth psychiatrists were able to familiarize themselves with large areas of this as yet undeveloped field, so that since the 1950s the care services available to schoolchildren expanded substantially. Medicalization and educationalization went hand in hand in this development. The school doctors wanted to form a link between parents and child on the one hand and between the various agencies and professionals who could provide the necessary care on the other. This was a role which they had actually fulfilled from the very beginning, although the care services provided in the early years of school medicine had been much more limited than they were sixty years later. School doctors examined schoolchildren in order to assess their health and on that basis they suggested appropriate interventions, no matter if problems were of a medical, educational or psychological nature.