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Promoting school efficiency: Dutch school doctors and the meaning of child health (1930-1970)

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Promoting School Efficiency: Dutch School Doctors and the Meaning of Child Health (1930-1970)

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Abstract

This paper explores the meaning of child health, as applied by Dutch school doctors between 1930 and 1970, and the way it reflected the rapidly improving standard of living and the increasing importance of mental health following World War II. It focuses on both the national discourse and school doctors' daily activities. For the latter, the countryside of the province of Groningen has been studied. Despite assertions that their profession subscribed to a new, positive and inclusive concept of health, as introduced by the World Health Organization in 1948, the Groningen school doctors continued to use a negative concept of a "healthy" schoolchild until well after World War II: a child who was not bothered by diseases or infirmities or any other "abnormalities." They clung to the original aim of school medical inspection: the promotion of the school's efficiency through the reduction of possible threats to pupils' learning capacity. In the postwar years, school doctors more often associated these threats with an unfavorable school climate. Overly large classes and heavy academic loads were thought to lead to "mental overburdening." Thus, school doctors changed their concept of health by linking physical and mental health so that it became more inclusive

Key words: school hygiene, school doctors, child health, school medical inspection

Promoviendo la Eficiencia Escolar: Medicos Escolares Holandeses y el Significado de la Salud Infantil (1930-1970)

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Resumen

Este trabajo explora el significado de la salud infantil, aplicado por los médicos escolares holandeses entre 1930 y 1970, y la forma en que ello reflejó el rápido aumento del nivel de vida y la creciente importancia de la salud mental después de la Segunda Guerra Mundial. Este se centra tanto en el discurso nacional como en las actividades diarias de los médicos escolares. En relación a este último, se ha estudiado la zona rural de la provincia de Groningen. A pesar de las afirmaciones de que su profesión se había adherido a un concepto nuevo, positivo e inclusivo de la salud, introducido por la Organización Mundial de la Salud en 1948, los médicos escolares de Groningen continuaron utilizando un concepto negativo de escolares «sanos» hasta mucho después de la Segunda Guerra Mundial: un niño o niña que no había estado afectado por enfermedades o dolencias o cualquier otra "anormalidad". Estos se aferraban al objetivo original de la inspección médica escolar: la promoción de la eficiencia escolar mediante la reducción de las posibles amenazas a la capacidad de aprendizaje del alumnado. En los años de la posguerra, los médicos escolares a menudo asociaban estas amenazas con un clima escolar desfavorable. Las clases excesivamente grandes y las fuertes cargas académicas se consideraron factores que conducían a la "sobrecarga mental." Por lo tanto, los doctores escolares cambiaron su concepto de la salud al vincular salud física a salud mental para que este fuera más inclusivo.

Palabras clave: higiene escolar, médicos de escuela, salud infantil, inspección médica escolar

In the developed world, child health became a public concern at the end of the nineteenth century. School medical inspection was one of the flowers that grew from the seeds spread by public hygiene campaigns addressing the living conditions of the poor. It marked the transition from a focus on the environment to a direct concern with the individual. As such it was a component of a new welfare state policy that became urgent as a consequence of compulsory education, which brought about the incorporation of children from home environments that lacked basic hygienic provisions. The first municipal institutions providing hygienic care for schoolchildren were created in the 1870s and 1880s in cities in Europe (Hendrick, 2003). Brussels pioneered in 1874; other Belgian and German cities followed soon afterwards (Velle, 1990). The international character of the child-hygiene movement is demonstrated by the first international conferences on school hygiene in 1904 (Nuremberg) and 1906 (London and Paris) (Barona, 2008). In 1906 the British Medical Journal reported that school medical officers had been appointed in cities in at least twenty different countries, including Spain, Argentina, Chile, and the Netherlands. In some countries, such as England and Wales in 1907 and Spain in 1911, the state stimulated the development of school hygiene by legislation that enforced the establishment of municipal school medical inspection in the larger centers (Harris, 1995; Moreno Martínez, 2006).

The establishment of school medical services was first of all motivated by the wish to protect children against infectious diseases. The risk of contamination was one of the dark sides of compulsory schooling. In crowded classrooms, bacilli could circulate freely. School medical inspection was meant to combat this danger. A second reason is the one particularly emphasized by authors discussing the establishment of school medical inspection in the English-speaking world. They point to the fear of physical deterioration and degeneration of the white race, a fear that manifested itself around 1900 in Britain. It was inspired by the decline in its international supremacy and was concretized in the Interdepartmental Committee on Physical Deterioration, whose report (1904) paved the way for the introduction of free school meals for undernourished children in 1906 and school medical inspection in 1907, and indirectly for the introduction of physical education in British schools as a means to promote national fitness and efficiency (Harris, 1995).

In the early decades of the twentieth century, tuberculosis was the greatest child-killer in the Western world. Thus, school hygiene became part of the international anti-tuberculosis campaign, which inspired a set of welfare provisions for children, from health camps to open air schools. Each of these interventions linked up the social and the medical, in that the hygienic mood was fostered by a child-saving ethos that focused on the poor. Undernourished, pale, and sickly children were categorized as “pretubercular.” According to the experts, they were probably contaminated with the bacillus but “not yet ill,” a condition that might deteriorate but was likely to improve by means of more nourishing food and health-promoting conditions. Poor children’s ascribed predisposition to the disease stimulated public interest in nutrition as being essential to optimum health, necessary for fighting infectious diseases, as well as activism to combat poor nourishment, excessive (school)-work, lack of hygiene, and poor living conditions. The anti-tuberculosis campaign accelerated at the time of the First World War and slowed down shortly before the Second, when the number of victims fell rapidly because of the improved health and nutritional condition of the population (Connolly, 2004; Barona, 2008). Only in the countryside did hygiene lag behind and need to be spearheaded in future public hygiene campaigns, according to a series of reports (1931-1933) produced by the League of Nations Health Committee. In the 1920s, hygienists had revealed the backwardness and relatively high pathogenicity of rural areas (Barona, 2005).

To date, studies in the history of school medical services have focused either on their establishment and early years (Hendrick, 1992; Parker, 1998), on the development of the national institution (Harris, 1995; De Beer, 2008), or on their contribution to the “modernization” of education (Moreno Martínez, 2006). They seldom extend beyond the interwar period and usually take for granted that school doctors’ work focused on children’s physical health. Across the West, school doctors’ assignments have included the prevention of the spread of contagious diseases, vaccination, periodic health examinations of pupils and teachers, the promotion of hygienic school buildings and furniture, the prevention of health-threatening timetables, and the dissemination of hygiene knowledge among teachers, parents, and pupils. While in some countries, like England and Wales (Harris, 1995), school doctors also treated a child’s ailments, in other countries, such as

Spain (Moreno Martínez, 2006) and the Netherlands (De Beer, 2008), their assignment was limited to prevention. Everywhere, school doctors were expected to identify the health problems of individual children, like defective vision and hardness of hearing, as early as possible in order to prevent learning problems. When special provisions were available, “feble-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 onwards made mental health an increasingly important issue in education (Cohen, 1999), this is not discussed by historians of school medical inspection. Studies on 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. They emphasize their contribution to disciplining and normalizing childhood and the family (Rose, 1985; Gleason, 1999; Turmel, 2008). These studies suggest a natural inclusion of children’s mental health in school hygiene as part of a social policy that supported the developing welfare state of the mid-twentieth century. This is likely to have happened after the World Health Organization (WHO) exchanged a “negative” concept of health, “the absence of disease and infirmity,” for a positive and inclusive one, “a state of complete physical, mental and social wellbeing,” in 1948. This new concept of health was also at the heart of the Technical Report of the WHO’s Expert Committee on School Health Services (WHO, 1951).

This shift in focus may be related to the improved physical health of pupils, especially in the cities, because of postwar prosperity (Schuyt & Taverne, 2004). Did this apply to Dutch schoolchildren and, if so, in what respects did their health improve and what was considered an “improvement”? Did school doctors shift their attention away from governing children’s bodies toward a more inclusive concept of health and wellbeing? And did they shift their interpretation of health from the absence of certain unfavorable physical conditions to the presence of physical and mental conditions that were considered favorable for a child’s intellectual, emotional and social wellbeing?

The Netherlands is one of the few developed countries that did not legislate the aims and conditions of school medical inspection until the 1980s. This implies that Dutch school doctors were relatively free to choose

their own focuses of attention and interpretations of child health. This paper will explore the meaning of child health, as it was applied by Dutch school doctors, and the way it reflected the rapidly improving standard of living and the increasing importance of mental health after World War II. The focus will be on both the national and a regional level. As to the former, the analysis will encompass the discourse on standards of health and ways to promote it. The absence of a legal basis for school medical inspection implies that data about schoolchildren's health, collected by school doctors, was largely incomparable and that national data was almost nonexistent. As regards school doctors' daily activities and the concept of health that was applied in their work, the research must, therefore, focus on the local or regional level, and use archival sources. To this end, the countryside of the northern province of Groningen – a relatively poor and underdeveloped, agrarian-industrial area – has been chosen, since there is a unique and complete set of annual reports and an archive of the district school doctors available covering the mid-twentieth century (1930-1970). In this rural area, improvement of physical child health is not likely to have occurred at the same time and on the same level as in the more prosperous, urbanized regions in the west of the country. First, the paper will discuss the discourse and practice of Dutch school doctors up to the 1940s. Next, it will focus on the changes in the concept of health that became manifest in the postwar years of rapid economic growth and prosperity.

Prevention of School Diseases: School Hygiene up to the 1940s

In the Netherlands, the first school doctors were appointed in 1904 as public health officers in seven cities. Four years later, school medical inspection was available in 49 cities. The city of Groningen first appointed a school doctor in 1908. In 1929, 48% of all Dutch primary pupils were under hygienic supervision, mostly in cities. Private religious schools were free to use or not use the service, whereas public schools participated automatically. The service was free for all schools, and, if a school participated, parents were free to refuse to have their child examined. The first countryside district school doctors were appointed in 1927 in a very poor and underdeveloped peat-producing region in the province of Drenthe, just south of Groningen (De Beer, 2008). This inspired the province of Groningen to

support their municipalities in forming “groups” that could appoint a school doctor collectively. Between 1930 and 1933 four groups appointed a district school doctor, which made the province a champion of district services.

In 1942, during the German occupation, all Dutch municipalities were obliged to appoint school doctors. After the war, the Dutch government continued to subsidize the establishment of school medical services. As a result the number of participating municipalities grew rapidly, covering 80% of the country in 1947. Full coverage was not reached until 1965, when the last municipality joined a district service (De Beer, 2008). In the province of Groningen this point had been reached earlier, in 1943, when all 65 municipalities participated in one of its seven district services. Because schools were not obliged to make use of the service, this did not imply that all children were monitored by a school doctor, but for the most part they were. The acceptance of the service was high, even among religious parents who used to be afraid of state regulation of their private, religious schools – though not of state financing for these schools. School doctors in the province of Groningen continued to emphasize that their service covered all or almost all schools in their district. At first this involved mostly primary schools and schools for extended primary education. As elsewhere in the country, nursery and secondary schools were included in the services only after World War II.

The instructions for school doctors of the pioneering cities show that the prevention of diseases that could be transferred and caught at school, the so-called “school diseases,” was the prime objective of these new civil servants. Common to these instructions, which served as models for other cities, is the focus on examining for illnesses that might “harm a pupil’s fitness for education,” “impede or obstruct teaching,” or “endanger other pupils.” Reading these instructions makes clear that keeping the schools safe from contagious diseases, along with preventing deterioration of infected ears and eyes, were the main objectives (Bakker & De Beer, 2009). As in neighboring Belgium and Germany, Dutch school doctors’ work was strictly preventative. Unlike their British colleagues, 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 his or her family doctor or to a specialized clinic for treatment.

The focus on the prevention of “school diseases” in the assignment given to Dutch school doctors reflects the reasons local communities were willing to pay for the service. These and their negative impact on school efficiency had played a 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 minimize health risks at school, many politicians and hygienists argued. Child labor before and after school hours, and its detrimental effects on child health and national fitness – a major argument for the introduction of the school medical service in England and Wales (Hendrick, 1992) – did not play a significant role in the Dutch discourse. Religious groups were of the opinion that only parents had the authority to decide whether a child should attend school or work, a conviction that had made them vote against compulsory education in Parliament. The same aversion to state interference made representatives of Christian parties usually oppose the appointment of school doctors in their local councils. Any mention of the health-threatening effects of child labor on the periphery of the school day was avoided by local hygiene activists, so as not to arouse extra opposition to the establishment of a school medical service. The same seems to be true of problems of malnutrition and the lack of fitness of poor children (Bakker & De Beer, 2009), which enabled the medical profession in England and Wales to justify its claims that the health of schoolchildren should be monitored (Harris, 1995).

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 the one hand, and denominational groups, on the other. Education was heavily contested. As a result, even non-religious groups refrained from attempts to extend state regulation in education, the state’s full financial responsibility for all schools from 1920 aside. The precariousness of this balance explains also why eugenic objectives, referring to national fitness, scarcely played any role as a moving force in the history of Dutch school medical inspection. Protagonists of school hygiene were not driven by fear of physical deterioration or degeneration of the Dutch population.

In the interwar years the national discourse on school medical inspection focused on the fight against infectious diseases such as diphtheria, measles, scarlet fever, and tuberculosis. School doctors were disappointed that the Christian parties had managed to remove the obligatory vaccination of schoolchildren against smallpox from the new Contagious Diseases Act (1928). They likewise resented these parties' refusal to extend their power to close a school and ban infected children in case of a school epidemic. School doctors' options, when faced with such a threat, continued to depend on local regulations. Tuberculosis screening of all pupils by means of a Pirquet patch test was discussed as a possible extension of the school doctors' assignment, but it was practiced by only a minority of the school medical services. A positive reaction to the test indicated tubercle infection only, not the stage, the severity (active or latent), 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% of all eleven-year-old pupils in 1915 to 14% of all fourth-graders (aged ten to eleven) in 1937. The same is true of the number of deaths from tuberculosis, including children and adolescents (Bakker, 2010).

In their annual reports the district school doctors of the Groningen countryside mostly paid attention to the results of the routine health examination of pupils. They conceived of this as their most important task. As elsewhere in the Netherlands, each year they subjected about half of the pupils of the supervised schools to a medical check-up. This involved all pupils in the first grade (aged six to seven), in the final grade (aged eleven to fourteen), and of one of the grades in between, so that every pupil was fully examined at least three times. A small number of pupils was examined more closely because they were sickly and missed school often, or because the teacher suspected that they were suffering from a particular, possibly contagious, disease. Where it was suspected that a child was suffering from tuberculosis, referral was made to an out-patient clinic, where specialized doctors could further examine the child. By the 1930s, such 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 hygienic intervention, such as banning infected children from the school

and vaccination of children who had not yet caught the disease. Referrals to a general practitioner for treatment were frequently made.

One of the main focuses of attention of the health examination was the child's "nourishment status," which was established on the basis of the child's physical appearance. 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%) or "sufficiently" (32%) fed, and that only a small minority was "insufficiently" fed (7%). The Groningen school doctors participated in this survey. It turned out that, in the city, the children were more often "well" fed (64%) than the average Dutch child. In the countryside districts, however, they were more often "insufficiently" fed (12% on average) ("[Verslag over de jaren 1936 en 1937...](#)," 1938, p. 765), a finding that confirmed the international concern in the 1930s about the health of the population in the countryside. A comparison of the nourishment status of poor schoolchildren over time can be made only for a few working-class neighborhoods in Amsterdam. In 1936, despite large-scale unemployment, it turned out to have improved considerably compared to 1916 and 1920, although poor children continued to trail behind those from more well-to-do neighborhoods ("[Onderzoek...](#)," 1936).

Malnutrition could be remedied in two ways. First, poor relief could provide for extra meals through the school. However, school doctors were not allowed to select the children who qualified for these meals, since the churches dominated this work. A doctor's assessment of a child's nourishment status was only one of the criteria for admission. Instead, doctors' contribution focused on the effect of these meals in anthropometric terms. They measured the increase in weight and height of every child who was accepted into a program. In the Groningen countryside districts, the results were positive almost without exception ([Verslag ...1935, n.d.](#); [Verslag ...1936, n.d.](#)). Second, pale and undernourished children could be sent to a "health colony" for six weeks. These "colonies" were located on the coast or in the woods and were organized 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, physical education, and walking tours. School doctors selected the

children, and they strongly advocated this work, which – like other public health interventions – grew rapidly during the 1930s (Bakker, 2007).

Apart from nourishment, the routine health examination of the Groningen district school doctors focused on children's eyes, ears, teeth, chest, throat, spine, posture, limbs, skin, and the cleanliness of their hair and head. Altogether, there were eleven items of physical health and one related to emotional wellbeing, bed-wetting, which was believed to be an expression of distress at the time. The doctors found a large part of the pupils had "abnormalities," 46% in 1930. School doctors were proud to be able to report so many health deficiencies. Some added that nine out of ten of the ones "discovered" had not been known beforehand (Verslag ... Veendam ... 1932, n.d.). 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. Scoliosis, a deformation of the spine, was frequently diagnosed. It was believed at the time that this was caused by sitting at a school desk that was the wrong size or sitting slantwise, in addition to a lack of exercise. In 1935, in two districts 16% of the pupils on average were diagnosed with scoliosis. Another 14% suffered from other kinds of posture problems (Verslag ... 1935, n.d.). This high frequency explains the constant concern of the school doctors about school desks, which goes back to the mid-nineteenth century (Moreno Martínez, 2006). During the economic crisis of the 1930s, Groningen countryside schools still used to buy only a few different sizes of desks, whereas prevention of scoliosis required that each child sit at a desk of the right size, doctors insisted.

School doctors conceived of themselves as hygienic educators of the working class. That is why mothers were supposed to accompany their child during 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 (Van Voorthuisen, 1931). From the late 1930s on, the first signs are noticeable that the profession's concept of hygiene was beginning to broaden from the physical health and cleanliness of the child's body and clothes to embrace aspects of mental health as well.

These involved children's emotional wellbeing. Doctors' broadening interest is reflected in their response to questions frequently asked by mothers about how to handle their "difficult" or "nervous" children. It is no coincidence that this occurred at the time when child-rearing advice was medicalized, in the sense that it presented a "normal" child as mentally healthy and happy rather than virtuous and took psychiatric theory as its intellectual foundation (Bakker, 2006). This added to the authority of doctors in matters of child-rearing. At the same time, the one-sided physical orientation of school doctors' education was being criticized more often as inadequate to handling these problems.

A Broader Concept of Health: the Postwar Years

In the 1950s and 1960s, Dutch school medical inspection extended into two rapidly growing parts of the educational system, nursery and secondary schooling. As a consequence, the number of pupils under supervision increased rapidly. In the Groningen countryside districts, it grew for example from 16,706 pupils, supervised by three school doctors in 1940 (5,569 pupils per doctor), to 66,948 pupils, supervised by nine school doctors in 1960 (7,439 pupils per doctor). One of the consequences was that instead of half of the pupils of the supervised schools, no more than one third could be examined annually. On the other hand, from the 1950s onwards, a child as a rule was fully examined five times during his/her school career: once in kindergarten, three times in the primary school, and another time in an extended primary school or in one of the secondary schools of the Groningen countryside (Bakker, 2015).

The national organization 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 to their meetings to discuss topics like mental health, readiness for school, and behavioral problems and their causes ("Sectie Schoolgeneeskunde...", 1947; De Vries, 1949) From that time on, educational programs for school doctors included child psychology and child-rearing as new subjects. Nevertheless, in 1952, at a national conference on the future of school medical inspection, the profession was seriously criticized for not innovating their work. Scientists criticized school doctors' routines involving searching for and registering

“abnormalities” in children, regardless of whether or not these had already been identified by parents or a general practitioner. By continuing to focus on numbers of “abnormalities,” school doctors contributed 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 “psychosocial problems” children experienced, 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, along with a higher standard of living, a professor of social medicine claimed. He blamed school doctors for not having changed the nature of their work in 45 years: “mass screening of the school population aiming to find abnormalities” (“*Nederlands Congres,*” 1952, p. 74). Some critics were of the opinion that mental health had become even more important since physical child health had improved significantly in the immediate postwar years (Buma, 1954). During the 1950s, these accusations were often repeated by medical experts, confirming the low status of school doctors within the medical profession – a condition that seems to have been the major cause of the rapid feminization of school medical inspection in the post-war years (De Beer, 2008).

School doctors defended themselves by pointing to their one-sided education as physicians. They declared that they were willing to professionalize by means of courses on mental health, and emphasized their role as intermediaries between parents, teachers, and the growing number of specialized professionals, such as speech therapists, 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 routine examinations. The school doctors’ organization concluded the ongoing debate in 1960 with a report that re-established the old approach on a somewhat different basis. The concept of health was adapted to encompass the promotion of the optimal health of each individual child and the inclusion of psychosocial aspects of development, such as a young child’s “readiness for schooling.” The routine health examination, preferably five times during a child’s school career, remained the main instrument, school doctors asserted (“*Rapport der Commissie,*” 1960).

Not only did the numbers of pupils under their supervision and the number of routine examinations increase, new tasks were also added to the

school doctors' assignment. Though it was not prescribed, tuberculosis screening of all pupils became standard practice after the war. In 1957, two thirds of school doctors conducted tuberculosis screening. However, the number of children this mass screening found to be infected was very low, approached zero in the 1960s, which in turn inspired criticism. The minutes of the committees that supervised the work of the Groningen countryside district school doctors show that a single case of a "discovery" of an infected child could silence this critique for years (Minutes SPG, 1930-1970). This explains why the tuberculosis screening continued for so long, up until 1970 in the Groningen districts. From 1952 onwards, moreover, a national vaccination program for babies was started. Initially it was limited to diphtheria, but soon other illnesses were added: whooping cough, tetanus and polio. School doctors took the revaccination of schoolchildren upon themselves. This program quickly turned out to be very effective (De Beer, 2008).

At the same time, school doctors' reports and their routine health examinations were also extended. From 1948 onwards, the national Inspector for Child Hygiene limited the freedom of school doctors to report in their own way, requiring information on a list of items in their annual reports. The national results were published between 1952 and 1958. They encompassed the years 1948-1955 (*Verslagen en Mededelingen, 1952-1958*). School doctors did continue to report in different ways, but with time their reports became more homogeneous and more detailed with regard to children's "abnormalities." From the late 1940s onwards, with regard to eyesight, for example, all Groningen district school doctors recorded the numbers of children suffering from squint and color-blindness, in addition to the number of children with weak eyesight or eye diseases. From the 1960s onwards, they started to differentiate between weak-sighted children who already wore glasses and "newly found" cases. Around 1960, vaccination levels and referrals to special care, such as remedial physical education and speech therapy, became more important in the doctor's annual reports than the numbers of "abnormalities" found. This shift in focus followed the reports of the national Inspector for Child Hygiene, who stopped collecting numbers of schoolchildren's health deficiencies in the late 1950s, a decision that was not followed by the Groningen district doctors until 1971. By

adding brief summaries of collective concerns to their reports, these doctors displayed their most disquieting worries from the early 1950s.

The routine health examination itself developed from the relatively simple check-up of a child's basic bodily functions (eyes, ears, throat, teeth, posture, and spine), cleanliness (of the skin and hair), and nourishment status in the 1930s, to a much more extensive examination in the 1960s, focusing particularly on "abnormalities" in the functioning of all senses and organs, including the central nervous system. In 1960, the Groningen district school doctors reported on an average number of 23 aspects of child health, from "general physical condition" (which replaced the "nourishment status") and "eyes" to referrals to a general practitioner, more than twice as many aspects as had been covered in 1940 (Verslag ...1940, n.d.; Verslag ... 1960, n.d.).

As to the results of the examinations, throughout the 1950s and 1960s the numbers of children found "with abnormalities" by the Groningen district school doctors were some 30% higher than in 1930 (60%-68% percent as against 46%). In 1955, 68% of the pupils examined showed "abnormalities" (versus 63% in the country as a whole) (Verslag ...1955, n.d.; Verslagen en Mededelingen, 1958). Children's sight and hearing, in particular, were found to be deficient more often, and their posture and their teeth more often in bad shape: results that are consistent with the national Dutch and the English data available (Harris, 1995). The higher level of "abnormalities" was not only caused by the more detailed list of items the doctors now had to use in their postwar examinations, but also by improved screening for visual and hearing deficiencies, the growing proportion among those examined of secondary pupils (who needed glasses much more often than elementary pupils), and the introduction of school dentists.

Still, a tendency toward an overall improvement in the physical condition of the pupils can be discerned. The proportion of Groningen countryside schoolchildren whose general physical condition was insufficient fell from 29% in 1935 to 14% in 1950 (versus 5% in the country as a whole), and only 4% in 1960. More hygienic housing, better living conditions, and better-informed parents seem to be responsible for a reduction of the number of "unclean heads" and diseases of the skin, such as scabies and eczema. The 1950s saw a spectacular drop in the number of children suffering from rickets, from 12% to 3% of those examined, which is probably related to a richer and more varied diet and more frequent check-ups for babies and

toddlers at the infant health bureaus. The prosperous 1960s are likely to have witnessed the effects of more frequent physical education classes and the general availability of remedial physical education, to which school doctors could refer, since posture problems and scoliosis virtually disappeared (Bakker, 2015; Schuyt & Taverne, 2004).

Dutch school doctors had been pleased when the wartime German government had made it impossible for schools to avoid teaching physical education for lack of a gym. Throughout the 1950s, the Groningen district school doctors continued to complain about the quality of the accommodations where the lessons in physical education were taught: they were too small, too dirty, or too dark. Sometimes lessons took place outside in the mud. In the early 1960s, these complaints just about ceased, since even country schools were provided with gyms. From that point on, school doctors pleaded for more hours of physical education, preferably one hour a day. They ascribed an additional value to physical education as a means to improve the school's effectiveness. Children, they maintained, would learn more if they were physically healthy and energetic. Physical education would contribute to pupils' "mental and physical" fitness and prevent moral "degeneration". The same was said of recess outdoors: instead of one morning break, two were advised.

From the 1930s and especially in the post-war years, villages in the Groningen countryside had built outdoor swimming pools. Primary schools organized swimming lessons for their pupils in the middle grades. The ability to swim saved lives in a country full of ditches and canals and it promoted schoolchildren's physical and mental health, school doctors claimed. Like other sports it could compensate for too many hours of academic work. That is why school doctors welcomed the initiative and hoped that these lessons would soon become available for all children. Predictably, they took upon themselves the new assignment of examining all candidates for swimming lessons, focusing on children's ears, throat, and heart. The examples of physical education and swimming illustrate how school doctors succeeded in linking up physical and mental health.

In the early 1950s the Groningen district school doctors started to pay tribute to the new, positive and inclusive concept of health. They made clear in their reports that they conceived of their work as pivotal in promoting this. The province had to wait relatively long, until 1960, before a child

guidance clinic was established in the city of Groningen. Up to that point, there had been a mobile consultation clinic for parents and children experiencing child-rearing problems. The clinic held consulting hours once a week at four different places in the province. That did not satisfy the increasing need for the psychiatric treatment of “difficult” children, but even after the child guidance clinic was established, referrals of countryside children to this urban clinic and to the university clinic for child-psychiatry remained very rare. Despite school doctors’ admitted lack of psychological expertise, most child-rearing problems were taken care of during their own consulting hours, which were held at least once a month in the district centers. For testing they could refer a child to the Youth Department of the Provincial Psychiatric Service (Jeugd Psychiatrische Dienst, JPD). Referrals, which can be found from 1947 onwards, mostly concerned cases of learning problems (Bakker, 2015).

What kind of child-rearing problems were the district school doctors confronted with in their consultations? It is likely that these were the same problems they discussed in their reports: bed-wetting, speech problems, and mental retardation. Each of these was included in the Inspector’s list to be used in the routine health examination. Together, these three items comprised the bulk of school medical service’s interest in mental health. As compared to the physical ailments, these “abnormalities” particularly involved young children. Over time, bed-wetting was found more often (from 3.8% of the pupils examined in 1950 to 6.5% in 1970) (Verslag ...1950, n.d.; Verslag ...1970, n.d.). This does not indicate a growing problem but the vanishing of a taboo. Mothers gradually became less inhibited to discuss the problem and seek a solution. Although bed-wetting was not discussed often in their reports, it is clear that the doctors were aware of the complexity of the problem and convinced that it was connected to psychosocial background. During the 1950s, school doctors echoed the national discourse by considering bed-wetting a “neurotic disorder,” a symptom of mental ill-health, or an effect of “mental overburdening” of a child. They 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 did doctors refer a bed-wetting child to the psychiatric service or the child guidance clinic.

Speech problems like stammering and stuttering were likewise found more often in the 1950s, but slightly less often in the 1960s. References to speech therapy by trained professionals were made from the early 1950s when the municipalities were first compensated for the expense. It is likely that both the rise and the subsequent fall in the number of speech impediments that were identified were an effect of the availability of speech therapists. School doctors were aware of the possibility of an emotional background to speech problems, since they differentiated between impairments with and without a physiological cause and classified almost all of them in the latter category. Repeatedly school doctors called stammering a “neurotic” disorder, for which “mental overburdening” and a one-sided intellectual school climate might be responsible. Treatment, therefore, needed to be psychotherapeutic. In 1953 the district school doctors estimated that 8% to 10% of the schoolchildren needed speech therapy ([Verslag ...1953, n.d.](#)). They themselves took responsibility for the selection.

Mental retardation was by far the most important non-physical issue for school doctors of the Groningen countryside. “Backwardness” was an “abnormality” on the list of items of the national Inspector for Child Hygiene, but it was used only to estimate the need for special schools for “feeble-minded” children in districts that could not yet avail themselves of such a school and there was no national standard indicating the limits of this category. Between 1939 and 1954 in the province of Groningen every countryside district center 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 special schools. School doctors were responsible for the selection of pupils for these schools. They administered IQ-tests to children who continued to lag behind, even after having repeated a grade once or twice, and they sat on admission committees. Soon, school doctors manifested themselves as crusaders in a campaign to fight countryside parents’ resistance to having a child attend a special school. They took pains to combat what they conceived of as parental ignorance and prejudice, such as the idea that children would not learn anything at such a school or would be better off in a classroom with normally endowed children ([Verslag ...1956, n.d.](#), [Verslag ...1963, n.d.](#)). Moreover, they actively promoted separate schooling for the “feeble-minded” as a blessing for both the children concerned, and the pupils and teachers of the regular schools.

A new kind of special school for children with learning and behavioral problems (leer- en opvoedingsmoeilijkheden, LOM) but a normal IQ, introduced in 1949, did not reach the Groningen countryside districts before the mid-1960s. There, the first LOM-schools were established in 1965 and 1967 (*Verslag ...1965, n.d., Verslag ...1967, n.d.*). The timing was due to a collective plea on the part of district school doctors in 1964, arguing that such schools were badly needed in the countryside. It occurred after more than ten years of lobbying by individual school doctors to have specific learning disabilities, such as “word blindness,” recognized as qualifying for special didactic support and a mental health risk in case of continued disregard for these children’s special needs (*Verslag ...1964, n.d.*). These learning problems were sometimes referred to as an effect from the large size of school classes or of uniform mass teaching, causing “emotional conflict,” “neurotic reactions,” and inhibitions in children, as well as “mental overburdening” (*Verslag ...1953, n.d.*).

Conclusion

Despite assertions that their profession subscribed to the WHO’s new, positive, and inclusive concept of health, in their daily activities Dutch school doctors continued to use a negative concept of a “healthy” schoolchild until well after World War II. A healthy schoolchild was a child who was not bothered by diseases or infirmities or any other “abnormalities.” The child was not only fit enough to attend school and not pose a threat to the health of other pupils, but the child’s senses – particularly vision and hearing – had to function well enough so as to meet the increasingly strict norms that were determined by rapidly improving screening techniques for visual and hearing deficiencies. These stricter standards partly explain the fact that the numbers of “abnormalities” found by school doctors in their routine health examinations increased instead of decreased after the war, and that improvement of schoolchildren’s physical health cannot be inferred from these numbers.

Nevertheless, schoolchildren’s health did improve in the post-war period, even in the relatively poor countryside of the province of Groningen. Diseases of the skin and “unclean heads” became rare, a development for which more hygienic housing and living conditions seem to be responsible.

A richer and more varied diet, together with more frequent check-ups for infants and toddlers, may explain the sharp decrease of rickets in the 1950s. Scoliosis almost disappeared in the 1960s, a likely consequence of more frequent physical education and the general availability of remedial physical education, to which a school doctor could refer before serious harm to the spine could develop.

School doctors' screening and routine health examinations themselves, however, did not necessarily contribute to better health, as the example of mass tuberculosis screening shows; it was introduced when it was no longer necessary. The availability of speech therapy and the inclusion of speech problems in the Inspector's list show that screening could produce "abnormalities." The increase in dental deficiencies in the 1950s, when school dental care was introduced, is another example.

These examples make clear that school doctors clung to the original aim of school medical inspection: the promotion of the school's efficiency by reducing possible threats to pupils' learning capacity. In the postwar years these threats were more often considered to be rooted in an unfavorable school climate, where large classes and heavy academic loads led to "mental overburdening." Despite their admitted lack of psychological expertise, school doctors' concept of health became more inclusive when they linked physical and mental health, as the promotion of physical education, swimming, and outdoor recess show. Their additional value did not have to promote national fitness but needed to compensate for too many hours of learning and of sitting still.

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