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Changing perspectives on the child at risk at the end of the nineteenth century. The Belgian Maritime Hospital Roger de Grimberghe (1884–1914) as a space of inclusion and exclusion

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In this historical-geographical approach to the Belgian Maritime Hospital Roger de Grimberghe space is introduced as a conceptual tool to deconstruct the notion of the child at risk. The starting point for the creation of the maritime hospitals lay in the immediate relationship between the idea of improving children's welfare with healthy sea air and concern about declining public health at the end of the nineteenth century, together with a need for the moral reclamation of the nation. Within this context particular attention focused on 'the child at risk', the 'abnormal child' and the 'mentally retarded child'. This research shows how the maritime hospital can be considered a battlefield on which two different discursive practices about children at risk (the political and the medical) clashed. Both practices and perspectives are characterized by mechanisms of inclusion and exclusion.

Keywords: history of disability; childhood studies; medicalization of childhood; children at risk

1. Introduction

On 2 November 1887, shortly before noon, a four-year-old girl, named Cathérine-Caroline Lauwers, arrived at the Belgian Maritime Hospital Roger de Grimberghe. The maritime hospital was located in Middelkerke, a small village at the Belgian seaside. That morning Cathérine left Brussels by train for Ostend. There she took a tram to Middelkerke. Along with five other children, a trainee medical doctor and two nurses accompanied her, all working at the maritime hospital. Cathérine was admitted by the General Council of Civil Hospices of Brussels thanks to the kind offices of Baron Huyttens de Terbecq, Clerk of the Chamber of Deputies. She was an orphan and suffered from chronic encephalitis, as diagnosed by Dr Max. He was appointed by the General Council to examine all children before they were sent to the maritime hospital. All those concerned agreed that the regular care at the maritime hospital and the healthy sea air would give Cathérine the chance to recover. However, shortly after her arrival at the maritime hospital she was sent back to Brussels, as Dr Casse, the head of the maritime hospital, refused to accept her. In the presence of the medical staff, Casse and Max became agitated during a discussion in which Casse shouted

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'that he did not accept "idiotic children" in his hospital and that if he [Dr Max] had the intention of continuing to send these children to him, he would ask the General Council to fire him'.[1] Cathérine was remitted to the Brussels Hospice for Underprivileged Children. Later, she left for an orphanage in Lokeren, where she died at the age of eight.

In this article the focus is on different perspectives regarding the growing attention paid to children at risk in Belgium at the end of the nineteenth century. These perspectives will be highlighted starting from the history of the Maritime Hospital Roger de Grimberghe at Middelkerke. A description as well as an analysis of these perspectives will be embedded within a historical-geographical framework. Geographical concepts are used more and more within the field of the history of (scientific) ideas. In the geographical approach to the history of science David Livingstone can be regarded as one of the leading authors. In *Putting science in its place. Geographies of scientific knowledge* he wrote: 'To understand the *history* of medicine, or religion, or law, then, we must necessarily grasp the *geography* of medical, religious, and legal discourses' (Livingstone 2003, 11, emphasis in original). Livingstone referred to the crucial role of the local context in both generating and consuming scientific knowledge. Ideas and images travel around the world and undergo various translations and adaptations because, every time, these ideas and images are given a place in a different way and in different circumstances. 'Treating scientific knowledge as a universal phenomenon, untouched by the particularities of location, plainly will not do if we want to come to grips with the immense power it exercises in society' (Livingstone 2003, 111). Building on these ideas today, micro-history receives special attention (Short and Godfrey 2007). In micro-history individual agency, the local, becomes a site for a consideration of wider issues. The particular is used to explore broader societal and historiographical themes. 'That micro-history offers richness and depth of analysis impossible at the national level is indisputable. In these small-scale human interactions, breaking down boundaries between public and private, economic and non-economic, and production and consumption, we deal holistically with life-in-the-round' (Short and Godfrey 2007, 46). Typical of micro-history is a recognition of the crossover between local and more national or international tendencies. The use of micro-history does not mean a one-sided attention to local histories, but it aims to combine panoramic and myopic views of history (Peltonen 2001).

In presenting our micro-history of the Maritime Hospital Roger de Grimberghe we will portray a historiographical analysis of the societal and scientific discourses on the child at risk at the end of the nineteenth century. In line with Scull, we will try to illustrate how medical discourses and institutions were 'not incidentally connected to the question of social control and to the defense of the social order' (Scull 2006, 12). The starting point for the creation of the maritime hospitals lay in the immediate relationship between the idea of improving children's welfare with healthy sea air and a concern for declining public health at the end of the nineteenth century, together with a need for the moral reclamation of the nation. Within this context particular attention focused on 'the child at risk', the 'abnormal child' and the 'mentally retarded child'. This research will show how, on a macro-historical level as well as on a micro-historical level, moral concerns about 'children at risk' can be seen as an important factor and how the maritime hospital can be considered as a battlefield on which different discursive practices about children at risk clashed. These practices are typified by mechanisms of inclusion and exclusion. We will come back to this in the conclusion.

2. A brief macro-history: degeneration and the growing attention paid to children at risk at the end of the nineteenth century in Belgium and Europe

The notion of degeneration, as applied to a society's physical and moral well-being, was widespread throughout late nineteenth-century Europe. In Belgium, for example, Jules Dallemagne, a medical doctor from Brussels, in 1894 published his book *Dégénérés et déséquilibrés* (Degenerates and the unbalanced). Using empirical materials from different fields of research, Dallemagne developed a theory of degeneration, which received an enthusiastic welcome from many politicians, philanthropists and medical doctors (Tollebeek 2003). Degeneration was regarded as a physical, intellectual and moral decline, on an individual as well as on a collective level, resulting in the extermination of the nation and the population. According to Dallemagne, if degeneration continued Belgian society would end in a state of collapse, the race would loose its strength and the nation would become destabilized and sick. Theories of degeneration paid a lot of attention to possible explanations for the actual state of society. In this, the modern city received adverse criticism. The city was considered as a place of 'nervous over-excitement', full of temptation and corruption. Within the geography of degeneration the modern city functioned as a place of evil. Cities, metaphorically speaking, represented the sick and weak parts of the social body. At the same time industrialisation, as an important process of the modernisation of society, was believed to play a crucial role in the degeneration processes. The mechanisation of work, as well as the rise of city quarters with poor living conditions, was severely criticised.

A fear of degeneration resulted in a climate of social reform and social hygiene, carried forward by a progressing social health science. In this, social health science appeared as a science of the moral fibre of the population; it was concerned with the conduct of populations in particular habitats (Driver 1988). While France and England were already in the 1820s pioneering, the Belgian hygiene movement started around 1840. These hygiene movements concentrated on the state of health of the society at large. Society was compared with a social body and all parts of this body had to be in a healthy state. Hygienists were not so much interested in the individual (sick) body, but rather in the (sick) social body, for which terms such as 'general public health' were used. Illnesses, which were previously considered as diseases of the individual, were henceforth considered illnesses of the nation. Medical men defended hygiene and public health reform as a partial solution to the nation's demographic decadence. A crucial transformation took place that had long-lasting ramifications in culture, politics and society. Notions of health and disease were socialized and nationalized and the idea that a social body or a national race not only existed but also could be healthy or sick was a significant political change (Barnes 1992). It is important to note that this growing interest in public health care can be considered not only a result of an internal medical logic or a greater scientific knowledge, but also reflected a clear fear of social disorder and moral decline. Hygienists considered cities more and more as places to be avoided by (poor) children because of the increasing numbers of people suffering from alcoholism, tuberculosis and syphilis. Thus, philanthropic and hygienist societies became more and more convinced that poor children had to be removed to healthier and more natural places for either short- or long-term stays. Hygiene, morale and education converged here.

The moral interpretation of 'the child at risk' also became reflected in new definitions and terminologies used for these children. Politicians, doctors and philanthropists

started talking about 'l'enfant moralement abandonné' (the morally abandoned child) or 'l'enfant martyr' (the martyred child). These definitions illustrate how children were no longer simply viewed as criminals, but as children at risk who not only needed protection by the state, but also required support from private philanthropic societies which would operate as legal substitutes for the children's failing parents (Dupont-Bouchat 2004).

> From the earliest articulation of the term, notions of *abandon moral* continually invoked a primal experience of lack: the child's experience of dangerous parental 'absence' from the educative process, often ironically embedded in the active presence and influence of a 'morally dangerous parent. (Schaffer 1997, 4)

The growing attention paid to the child at risk was situated within three different spaces, each showing interconnections with the other two. There were the philanthropic societies, the legal and criminal settings and the medical world (manifesting itself slightly later than the former two). Most proposals from these different contexts served a double goal (Dupont-Bouchat 2004). On the one hand, the focus was on optimising the health conditions of the working class in order to ensure their status as manpower. On the other hand, these initiatives tried to protect other groups within the population from possible epidemics. The emergence of maritime hospitals in Europe between 1860 and 1880 was part of the growing attention paid to children at risk. These hospitals were built for those children living in the poorest areas of big cities. A fear existed that these children were in danger, at both the physical and moral levels (Cooter 1992; Pilcher 2007). Therefore, these children were removed from their parental homes and were brought to the coast. The origins of the maritime cure can be situated in England (Corbin 1988). In 1791 John Coakley Lettsom established the first maritime hospital in Europe in Margate, called the Royal Sea Bathing Hospital. It instituted the construction of many other maritime hospitals, first in Italy and France, and later on all over Europe. In Belgium two maritime hospitals were built: one in Wenduine (a private initiative by a doctor from Bruges that existed from 1881 until 1899) and the Maritime Hospital Roger de Grimberghe (which was completely destroyed after World War I).

3. A political and ideological perspective versus a medical and scientific perspective in the struggle for child at risk

As mentioned, the emergence of maritime hospitals in Europe took place between 1860 and 1880. To the outrage of hygienist supporters, Belgium, however, lagged behind. At the Hygiene Congress in Brussels in 1876 those present raised this problem. Shortly afterwards, the General Council of the Civil Hospices of Brussels took the initiative. In August 1876 the Council filed a request with the government to obtain access to the plans of available plots on the Belgian coast. In addition, the architect Hendrik Beyaert (1823–1894), who shortly afterwards left for Italy to visit and study the maritime institute in Venice, was contacted. However, the General Council did not have enough money at its disposal to realise the ambitious plan of building its own maritime hospital. In the mean time, however, the General Council had been given a godsend. Viscount Roger de Grimberghe had died on 27 November 1879 in Brussels and in his will he left half a million Belgian Francs to the General Council. This amount was to be used to create 'a hospice for poor and rachitic children from the Brussels region, which will be given the name "Hospice Roger de Grimberghe"'. After

extensive discussions on the location where the maritime hospital would be built, and after conflict with the Belgian state about financial responsibility for the project, on 17 November 1882 work in the Middelkerke dunes finally got underway. One of the major reasons for choosing Middelkerke was the imminent construction of a steam tram line between Middelkerke and Ostend. This was very important for the General Council, as the children had to be able to reach the maritime hospital easily by public transport. The maritime hospital had to be located far enough from the seaside resort of Middelkerke to as much as possible avoid contact between the children and tourists (Constandt 2003). About a year later, in September 1883, the infrastructure was finished and on 6 November 1884 the first ill children were set to arrive in Middelkerke. In the meantime, on 29 February 1884, Dr Pieter Joseph Casse had been appointed chief physician and warden of the hospice.

Two discursive spaces played an important role in the construction of the Hôpital Maritime Roger de Grimberghe. First, there was a political and ideological space in which the General Council of Civil Hospices of Brussels can be regarded as the main actor. The General Council assumed financial and moral responsibility for the daily organisation of the maritime hospital, supported by several philanthropic societies and individuals. Secondly, there is a medical and scientific space, mainly occupied by 'The Belgian Royal Society for Public Healthcare'. It was this society that insisted on building the hospital. Later, Pieter Joseph Casse, doctor and head of the hospital, played a crucial role within the society and in giving the maritime hospital its scientific look. In our description of the discursive practices of both spaces the focus is on how the children in the maritime hospital were constructed as children at risk.

The General Council of Civil Hospices of Brussels

During the building of the maritime hospital in Middelkerke the Ministery of the Interior was responsible for public health affairs. However, Belgium's central administration played a rather modest role at that time (Velle 1990). It was only after World War I that the government authorities increased their sphere of action. Until then, public health was mainly the concern of local communities. The two most important local authorities were the 'Commissions des Hospices Civiles' (Council of Civil Hospices) and the 'Bureaux de Bienfaisance' (Social Welfare Council), established by the laws of 7 October and 27 November 1796, respectively (Velghe 1919).

In a circular of 15 May 1885 the General Council of Civil Hospices informed doctors in Brussels about the existence of the Maritime Hospital Roger de Grimberghe. The appeal stated for whom the hospice was intended

> We would avail ourselves of this opportunity, dear sir, to request that you entrust us with the children under your care aged between 4 and 14 years old, whose health situation prompts a stay near the seaside. The cost of the stay is provisionally established at BEF 2.50.

The target group of the maritime hospital was not very clearly identified, as most of the poor children in the Brussels region were considered potential patients. There was a double selection procedure to determine which children got sent from Brussels to Middelkerke. In the first stage the childrened needed to register with the 'Hospice des Enfants Assistés' (Hospice for Underprivileged Children). There they received information about the 'Hospice Roger de Grimberghe' and a questionnaire to be filled in by the attending doctor. The children went to the 'Hospice for Underprivileged

Children' with this questionnaire on the last day of the month, where they underwent a physical examination. When they eventually left Brussels for Middelkerke the children were examined a second time. The primary purpose of this second examination was to determine whether the children had contracted any infectious diseases in the meantime. Trainee doctors at the Hospice Roger de Grimberghe carried out this examination. They were also responsible for accompanying the children from Brussels to Middelkerke. The leaflet gave further details of the target group. The Middelkerke hospice's main task consisted of taking in needy children from the Brussels region who suffered from rachitis (a bone disease better known as rickets) or scrofulosis (inflammation of the lymph glands). The late nineteenth and early twentieth centuries witnessed an extraordinary expansion of our knowledge of rickets (Rajakumar 2003). Exposure to sunshine was regarded as an important preventative and therapeutic measure. The children were sent to the hospice by the municipal government and the local authority bore the cost of their stay. The General Council also received regular requests to admit children from more affluent backgrounds to the hospice, but these requests were not granted, as the maritime hospital only had a capacity of 80 beds. An overview report written by Dr Casse on 23 July 1889 showed that children suffering from many other illnesses were also admitted to the hospice. Often the reports mentioned children with 'a physical handicap' caused by Pott's disease. Pott's disease is a form of tuberculosis in which the spinal column weakens, often resulting in the formation of a hunchback. The General Council paid little attention to this fact. Extension of the target group was not regarded as a real problem. One could say that the General Council tried to create a hospice for children that showed all the characteristics of the majority of Belgian hospices for children at that time. They wanted the hospice to be a caring place in which women played a crucial role, as they were responsible for changing the children's bandages and for assisting them during their daily baths both inside and outside the hospital. Different philanthropic societies and individuals supported the General Council financially and morally. As in the case of Cathérine Lauwers, children were often send to the hospital on the recommendation of prominent members of the bourgeoisie. These people also often gave all kinds of gifts (food, a harmonium, prams) to the hospital.

The General Council can be regarded as a space where ideological questions and discussions often came first. This is well illustrated by the debate about the necessity of schooling in the maritime hospital, which lasted for years and years. While Dr Casse led the hospice, no schooling was given. It is not until 1901, shortly after the appointment of Gustave Gevaert, the successor to Casse, that the General Council took the organisation of schooling in the hospice to heart, although it had several opportunities to organise schooling in the hospital during the early years. In 1886 two teachers working at the maritime hospital of Wenduine offered their good offices. The General Council let them know that the maritime hospital was not in need of teaching personnel. On 18 January 1889 Casse wrote a letter to the General Council requesting permission to organise schooling in the hospice itself. Again, the General Council refused this offer. At that time the hospice's healthy children were schooled in the Middelkerke municipal school. Dr Casse had negotiated this with Middelkerke council shortly after the hospice opened. On 7 February 1885 Middelkerke council wrote to the General Council:

> in recognition of your efforts to organise a free medical consultation for the needy of our town in your hospice located here … that the children of your hospice over the age

> of six and whose health situation allows for attending school, will be admitted to the municipal school, free of charge, in as far as there are sufficient spaces available in the classrooms.

In a letter dated 17 February 1885 the General Council expressed its thanks to the city council. However, most reports of the General Council kept questioning the importance of schooling. There was an ideological reason for this. A report by Mr Velghe, the priest of Middelkerke, to the bishop explained that Casse, described by the priest as a 'viro optime disposito' (a very honourable man), regarded the catholic faith favourably.[2] However, as the will of Roger de Grimberghe clearly stated that the hospice had to be a non-denominational, non-Christian institution, this presented a problem. No such problem presented itself with Dr Gevaert.

The central idea behind the Belgian maritime hospital was clear. Children were removed from their unhealthy home environments to be immersed in a clean atmosphere. A real fear for the unhealthy and impure child accompanied these processes. These children appeared as a metaphor for the pernicious and pathogenic city. This explains the isolated nature of the maritime hospital, as well as its permanent focus on order and discipline (e.g. the rigid day's schedule). The maritime hospital was located several kilometres from the town. Contacts between the children in the maritime hospital and the inhabitants of Middelkerke was as limited as possible. In an inspection report of 20–21 February 1885 it was pointed out that on Sundays the children of the town went to the hospice and even mingled with the children there. This was considered an undesirable situation. The problem appeared to be a long-term one. In a letter dated 6 July 1894 to Dr Casse the General Council reported: 'In conclusion, we would like to add that we would demand one of the members of the medical staff to be present at the hospital at all times'. The letter was written following an inspection of the hospice during which it was discovered that 'outside children entered the grounds and even the buildings themselves'. To solve this problem the erection of a large fence around the maritime hospital was suggested.

The correspondence of the children was another worry of the General Council. A few years after the start of the maritime hospital the General Council decided 'that all the letters to the children first had to be read by the person who was in charge. The same had to occur with the letters of the children to their families'. This illustrates a common concern of the General Council, the public image of the maritime hospital. In the same period Dr Casse had some postcards of the maritime hospital printed, to be used by the children when writing to their families. These postcards supported Casse's ambition to promote a scientific image of the maritime hospital, as they pictured a sterilization kettle and the operating room. This longing for a more scientific approach by the maritime hospital will be explored in the next paragraph.

The Belgian Royal Society for Public Healthcare

In Belgium in 1877, on the initiative of the famous hygienist Hyacinthe Kuborn, the 'Société Royale de Médecine Publique du Royaume de Belgique' (Belgian Royal Society for Public Healthcare) was founded. This soon grew into an important forum in the struggle for improved hygiene. In the tradition of Adolphe Quetelet (1796–1874), the society was characterised by a strong, positivist-inspired study of social problems. Quetelet had introduced social statistics and the society members were quick to use this new scientific method. Every month the 'Tablettes Mensuelles de la

Société Royale de Médecine Publique de Belgique' (Monthly Reports of the Belgian Royal Society for Public Healthcare) were published. It mainly contained a number of overview charts of the morbidity and mortality figures for each province or region. Important points for attention were the child mortality figures and the difference in these figures between countryside and city (Debuisson 2001). One important feat was the creation of a 'Coastal Circle' within the ambit of the 'Royal Society' on 17 December 1893 (Anon. 1894). The objective was three-fold: (1) tracing causes of mortality, including elements influencing public health; (2) supporting government and local policy through scientific research; (3) outlining the medical topography of the country. This was done through statistics, meteorology, climatology and hydrology. Casse held a plea for 'a complete balance between economy and hygiene' and ended with 'It falls to you, Gentlemen, to contribute towards building this great social edifice' (Anon. 1894, 266).

In the view of Dr Casse the maritime hospital in Middelkerke was not so much a home for sick children, but a scientific medical institute. It had to be a hospital, not just a hospice. Casse was very much inspired by the *Hôpital Maritime de la Ville de Paris*, founded in 1869 in Berck-sur-Mer by the Public Assistance of Paris. This maritime hospital was well known for its medical exellence. The building consisted of 14 dormitories with 36 beds each and five nursing wards with 16 beds each. Next to this there was a large hydrotherapy room with an immense swimming pool. Although the maritime hospital in Middelkerke was not that big, Dr Casse had incredibly ambitious plans, as can be understood from his talks with Beyaert, the architect of the maritime hospital. Over several years the two men produced several proposals concerning enlarging the existing hospital in order to introduce new medical initiatives. The French example was not only inspiring for its structure and internal arrangements, but also for its medical focus. Casse pre-eminently presented his maritime hospital as an institute for science and research. An early example of this can be found in research on the influence of the maritime climate and of bathing on the human body. Casse, for example, developed a characterization of different forms of bathing for different groups of children at risk, starting with children with scrofula and ending with 'epileptic and nervous children' (Casse 1920). Casse used his characterization to give each child in the maritime hospital his/her own number. Next to these types of characterization, surgery and plaster casts were introduced. As many children suffered from Pott's disease and coxalgia, new forms of medical treatment were explored. Different kinds of orthopaedic corsets were used. The children had to wear these corsets for long periods, followed by recovery over several months. This explains why some children stayed at the hospital for years.

4. The Maritime Hospital Roger de Grimberghe: a space of inclusion and exclusion

Attention to the child at risk in the daily practices of the Maritime Hospital Roger de Grimberghe had two facets. There was the philanthropic concern of the General Council of Civil Hospices of Brussels and there was the ambition of the medical world to develop a scientific and professional approach towards these groups of children. Both perspectives resulted in mechanisms of inclusion and exclusion. The General Council of Civil Hospices of Brussels focused on all children living in poor conditions in the region of Brussels. In this, social class functioned as the main criterion for selecting children. Within this perspective 'physically handicapped children',

'mentally retarded' and 'idiotic children' and children suffering from rickets were all considered as one group. All these children were labelled children at risk. All these children therefore needed to be isolated. They were only allowed to go back to their normal life once they had completely recovered.

The medical perspective on the maritime hospital of Middelkerke, symbolized by the figure of Dr Casse, was characterised by a more differentiated approach to the group children at risk. Social class remained an important criterion of selection, but alongside the more clinical criterion of normality–abnormality. By combining both criteria Casse excluded some children from treatment in the maritime hospital. Casse held very strongly feelings on the words of Richard Russell, a British medical doctor who 'invented' the seaside cure, stating that 'It is not about healing, but is about reconstructing and creating' (Corbin 1988). Those who seemed capable of reconstruction were offered a place in the hospital. The others had to look for another place to recover. Ideas on reconstructing and creating deal not only with medical but also with educational issues. This is nicely illustrated by the discussion between Casse and the General Council about the organisation of education in the maritime hospital. It not only shows the two different perspectives on the care of children at risk, but at the same time exemplifies the possibility of mechanisms of inclusion in Casse's thinking on reconstruction.

Dr Casse, as well as his successors, spent a lot of time trying to make it clear that the maritime hospital in Middelkerke was not a place for 'mentally retarded' children. After the discussion between Dr Max and Dr Casse about refusing Cathérine-Caroline Lauwers admission Casse corresponded with the General Council over several weeks. In his letters Casse tried to convince the General Council that a distinction had to be made between children with a 'local disease' (restricted to a single area of the body) and children with a 'general disease' (affecting multiple areas of the body). Children suffering from scrofula and rickets were given as examples of the first group, while 'idiotic children', 'epileptic children' and 'children who don't even know their name' belonged to the second group. Shortly after the correspondence with Casse the General Council wrote to Max, the doctor in charge of the Hospice for Underprivileged Children in Brussels, stating that it was no longer permitted 'to send children with a general disease to the maritime hospital in Middelkerke as the maritime hospital cannot be considered a hospice for incurable children'. Casse also insisted on changing the questionnaire used to select the children to be sent to Middelkerke. The new questionnaire explicitly stated that 'children with contagious diseases', 'children with a high temperature', 'idiotic children' and 'epileptic children' were not accepted in the maritime hospital. Later, Dr Verneuil, the doctor in charge of the maritime hospital between 1903 and 1916, defended Casse's arguments. In his hand written history of the maritime hospital he supported the idea that 'idiotic children' needed a place of their own, 'an asylum and not a hospital … because it is impossible to change the nature of these unhappy children, even if they could stay in the best equipped maritime hospital ever'.

Dr Verneuil's document shows a glimpse of what is possibly really at stake when 'children with a general disease' were excluded from the maritime hospital in Middelkerke. The medical doctors in the maritime hospital worried about the possible presence of 'mentally retarded' children because of the perceived moral threat of these children compared with children with more 'local diseases'. The works of Drs Ley and Demoor, two significant Belgian authors on 'retarded children' around the turn of the century, illustrate this moral concern very well. Demoor made a distinction between

'medically retarded children' and 'educationally retarded children' (Demoor 1900, 12). 'Idiotic' and 'imbecile' children belonged to the former group and were regarded as 'the real sick children'. According to Ley these children especially showed characteristics of the degeneration of the nation as, for example, 'almost every idiotic child suffers from masturbation' (Ley 1898, 13). Furthermore, these children were talked about in terms of future criminals, thieves and vagabonds. Thus, to preserve the race and nation these children had to be treated in asylums over a long period of time to make them 'useful human beings'. In line with Ley and Demoor, the well-known medical doctor and progressive educationalist Ovide Decroly also warned the medical and educational world about what he called the 'irregular child' (Decroly 1905, 10). According to Decroly some of these 'irregular children' were educatable (but had to be sent to special education schools), but most of them where regarded as uneducatable and dangerous because of their 'intellectual lightness'. Just like his contemporaries, Decroly pleaded for the creation of asylums for these children. Since the presence of 'irregular children' was seen to have a negative influence on the development of 'regular children', bringing them together in one institution was unthinkable.

Stimulated by the subsequent professionalisation of medical science and related sophistication in classifying children, processes of inclusion and exclusion continued throughout the history of the maritime hospitals. Moreover, ignorance of the differences between boys and girls is remarkable. In discourses on the child at risk, the child within the context of the maritime hospitals appears as a gender-neutral being, 'the child'. Of course, girls and boys had their own dormitories and refectories. However, reports on different activities or treatments for the two groups of children are hard to find. Distinctions of gender rarely entered into the larger discourses that the maritime hospitals produced around their own contribution to the daily life of children. However, some practices do suggest another approach. Girls, for example, in general stayed in the maritime hospitals much longer than did boys. For girls it was not that exceptional to live in the hospital until the beginning of their twenties, while most of the boys were sent away when they reached the age of fourteen. Financial reasons can probably explain these differences. The General Council had to pay less for girls than for boys and, in addition, the older girls were often considered to be cheap labour taking care of the very young children. This finding illustrates the history of the maritime hospitals very well. It can be seen as a heated mixture of a middle class moral society with the medical hygiene movement, smoothed by the practicalities of everyday life.

5. Conclusion

In this historical-geographical approach to the Maritime Hospital Roger de Grimberghe, space has been introduced as a conceptual tool to deconstruct the notion of the child at risk. Within this spatial turn, space is understood as socially constructed, dynamic and ambiguous, claimed and contested. In line with Kitchin (1998), one could argue that the maritime hospital in Middelkerke was socially produced to exclude children at risk in two main ways: (1) to keep these children 'in their place'; (2) to convey to these children that they were 'out of place' (Kitchin 1998, 345). As we have illustrated, these forms of exclusion are constructed through individual social interactions embedded within a combination of political, ideological and medical discourses. Tuberculosis and other 'city illnesses' became by the end of the nineteenth century a metaphor for national degeneration. As the focus was upon individuals and bodily practices rather

than upon social causes of, for example, poverty, there was a need for specific places to model these individual bodies. Maritime hospitals can, therefore, be regarded as vehicles for a movement towards national renewal and moral reclamation. The founders of maritime hospitals shared with other reformers the confidence that removing children from their poor and unhygienic home environment would not only cure them of their ills but would make them better citizens. The maritime hospital was deliberately designed to segregate and protect the public from children at risk and vice versa. Thus, the medico-moral discourse at the end of the nineteenth century promoted segregated institutions sited in peaceful, healthy, rural environments (Kitchin 1998). In addition to their relationship to social reform movements, children's maritime hospitals also reflected and responded to developments in medicine. Stimulated by advancing medical science, maritime hospitals grew in effectiveness, size and complexity. A gradually more sophisticated professional staff of doctors and trained nurses little by little took command of the institutions from the philanthropists who founded them and redefined their function from saving children through moral reform to saving children through effective medical intervention (Golden 1989). Public health responses to illnesses like rickets and tuberculosis exemplify the Foucauldian assertion of medicine as sophisticatedly involved in determining the specific characteristics of social life (Rose 1994). Recognising the political role of medicine does not imply that maritime hospitals were all negative. It shows how they were part of a project in social engineering. The classification of children can be regarded as an important issue within this project. It is revealing how Casse and his colleagues looked for criteria that made it possible to number the different children in the hospital. Not only the idea of the child at risk itself, but also its several refinements are related to Foucault's notion of governmentality. The art of government demands and develops knowledge of the population, families and children. It collects and analyses data to ensure that the government is effective and capable of achieving the end of establishing a healthy and productive population.

The result of all these reforms and processes was a maritime hospital that showed all the characteristics of what Goffman has called a total institution, in which 'the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aim of the institution' (Goffman 1961, 6). The maritime hospital appears as a shadow society whose members need a great deal of sunlight in order to re-enter the space they were removed from.

Notes

1. Unless mentioned otherwise, all quotations refer to records that have been consulted in the Archives of the Social Service Department of Brussels (General Affairs, boxes 251, 252, 253 and 260). All quotations were originally in French.
2. Episcopal Archives of Bruges, collection of the parish of Middelkerke.

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