# Introduction

Special hospitals for children, so taken for granted today, only began to be established in Britain in the middle of the nineteenth century. Their emergence then was mainly due to the initiative of individual physicians seeking professional advancement rather than the expression of a perceived community need. However, once established, these hospitals had no trouble attracting patients and less trouble than most other specialized hospitals in attracting funds, so demonstrating that the organized medical care of sick children was deeply appreciated once available. The question may therefore be asked, why was the introduction of such institutions so long delayed, particularly in Britain where fifty years elapsed before the French initiative, the Enfants Malades hospital established in 1802, was emulated?

The usual explanation for the genesis of paediatric hospitals involves changing concepts of the meaning and importance of childhood initiated by the revisionism of the European Enlightenment. Whereas before children had been seen as incomplete beings with a fragile hold on life in whom it was wasteful to devote too much care and attention, now a new nationalism and exposure to more optimistic theories of human development led to a perception of youth as the source of future progress so long as childhood was carefully managed. In the words of Eduard Seidler:

> The imperative of national survival, then, implied that the medical profession (working with the schoolteachers) was duty bound to help the vulnerable child raise itself to a level of physical integrity and intellectual independence sufficient to allow it ultimately to take its place in society as a responsible adult.[1]

That healthy children should be viewed as a national asset was particularly relevant to France following the revolution and the Napoleonic wars associated with enormous loss of life among conscripted soldiers. For its time the Enfants Malades was a large hospital (250 beds and 50 more in reserve) intended to receive all needy sick children who were no longer to be admitted to the general hospitals as had formerly been the custom in Paris as elsewhere.[2] By the beginning of the nineteenth century therefore the French government was sufficiently convinced of the special needs of children to dedicate a medical institution entirely to their care.

In England, however, matters were seen differently. The health of children was not a particular concern of the state which, at the turn of the century, was faced with a population explosion rather than any shortage of manpower. Furthermore, apart from supervising implementation of the Poor Laws, the central government was not expected to meddle with family and local affairs. Unlike France where centralized power had existed under the monarchy, in England since the restoration much of it was delegated to landed proprietors, who controlled, or negotiated with, their dependents much as they saw fit. Administrative pluralism at the local level, to borrow from Roy Porter, was the result of

[1] Eduard Seidler, 'An Historical Survey of Children's Hospitals', in Lindsay Granshaw and Roy Porter (eds), *The Hospital in History* (London: Routledge, 1989), pp. 181–97.

[2] G. R. Siguret, 'Histoire de l'hospitalisation des enfants malades de Paris', M.D. thesis, Paris, 1907, p. 51.

atomistic decentralization and rabid regional chauvinism.[3] Labourers and dependents might dislike their landowners but 'closed ranks with them in reflex action against such central interference as the imposition of a new cider tax, higher militia levies, or threats to tamper with the corn bounty'.[4] Had the central government decreed the establishment of hospitals and sought to finance them with new taxes, passive resistance or worse might have been the consequence. Instead, as happened in the eighteenth century, cities and towns initiated their own voluntarily funded institutions which flourished so long as the local aristocracy was visibly and continuously involved in their support. According to Brian Abel-Smith, by the 1780s there were seven general hospitals in London, and about 30 provincial towns had founded their own hospital.[5] Patronage was a hallmark of these institutions which were established and governed by people of high social standing, or by industrialists and wealthy men wishing to raise their social status while benefiting their community.[6]

Also frowned upon in Britain was the concept of state or even charitable intervention in family life to enhance the welfare of the children. Parishes were responsible for orphaned and deserted poor children, many of whom ended up as inmates of the ever growing number of workhouses although, as indicated by Pinchbeck and Hewitt, in the eighteenth century the House of Commons was repeatedly advised by its own Committees of 'the desirability of providing "in proper Places and under proper Regulations, in each County" separate institutions or "Hospitals" for the care of poor children, foundlings, and the impotent and infirm poor'.[7] However, principles of economy and non-intervention won out leaving parish guardians a free hand to institutionalize or board children out as seen fit. Where children had some kind of family support intervention was decried on the principle that it would undermine parental responsibility. Expression of this puritanical attitude would continue well into the nineteenth century serving as a rallying cry to those opposed to the private or public funding of institutions for child welfare. A more generous version of this sentiment was that children would not thrive away from their families and, as has amply been demonstrated both then and now, there was much prescience in this warning, particularly with reference to infants. However, as will be seen, the accumulation of statistics demonstrating unusually high rates of child mortality in slum districts, and descriptions of living conditions in these areas, finally threw enough doubt on the notion that home was always the best place for sick children to allow charitable institutions to be opened for the deserving poor.

In the eighteenth century one institution, the London Foundling Hospital, was successfully launched and its history illustrates the constraints of charity and how these could be circumvented. The Foundling Hospital was not created because of local demand but through the long-term endeavours of one man, Thomas Coram, a retired sea-captain, who was appalled at the number of dead and dying babies to be seen in the streets of

[3] Roy Porter, *English Society in the Eighteenth Century* (Harmondsworth: Penguin Books, 1982), p. 137.
[4] Ibid., p. 137.
[5] Brian Abel-Smith, *The Hospitals 1800–1948* (London: Heinemann, 1964), p. 4.
[6] For an analysis of the ideology underlying the establishment of eighteenth-century hospitals, see: Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth Century England', in Granshaw and Porter (eds), *The Hospital in History*, pp. 149–78.
[7] Ivy Pinchbeck and Margaret Hewitt, *Children in English Society Volume I: From Tudor Times to the Eighteenth Century* (London: Routledge & Kegan Paul, 1969), p. 191.

London. In his opinion this evil could be prevented, or at least mitigated, by foundling hospitals as already existed in Paris, Madrid, Lisbon, Rome, and other cities of Europe.[8] But he soon discovered that many of his countrymen held deep objections to such charitable institutions. In the first place, most unwanted children were assumed to be illegitimate and as such unworthy of aid. Even if the baby was perceived as the innocent victim of antisocial adult behaviour, to succour such a child was to encourage promiscuity and parental irresponsibility. For financial reasons overseers of the Poor Law did their best to avoid allowing the destitute mother of an illegitimate child to have her baby in their parish, since bastards became the responsibility of the parish where they were born rather than the place of settlement of either the mother or the putative father.[9] Thus both prejudice and law mitigated against the survival of the bastard child for, if its mother was rejected by her family and the child's father, her only recourse was the parish where she was decidedly unwelcome. Small wonder that after birth many babies were abandoned. For many people this harsh outcome seemed the lesser evil since a surviving illegitimate child was likely to be a long time burden on local rates and a permanent social outcast. Such children were living evidence of the sins of their parents and utterly despised. Only the very poor and the aristocracy tended to think otherwise, the latter because illegitimate birth was prevalent and acceptable in their own ranks. Lawrence Stone found that in the eighteenth century the bastard male children of aristocrats seem usually to have received a good education and not to have suffered discrimination with regard to career and marriage. Matters were different for illegitimate girls, however, who rarely married into the rank held by their fathers.[10]

According to McClure, beginning in 1722 Coram tried to interest members of the government and of the Anglican Church in sponsoring a hospital for foundlings but was told that a non-profit corporation sanctioned by royal charter was the only viable method of organizing and obtaining funds for his project.[11] He therefore set about canvassing members of the aristocracy for signatures to a petition, beginning in 1729 with the support of duchesses, countesses and baronesses, then moving on to obtain the assent of noblemen, prominent physicians, and justices of the peace. Petitions signed by such eminent persons could hardly fail to gain royal attention and in 1737 George II referred them to a committee of the Privy Council, which studied the provisional charter drawn up by Coram and his list of prospective governors. This list, in McClure's words, 'indicates, first of all, that nearly 25 percent of the men named were members of the nobility', and that 'wealth also seems to have been of prime importance in selecting the other

[8] Ruth K. McClure, *Coram's Children: The London Foundling Hospital in the Eighteenth Century* (New Haven: Yale University Press, 1981) p. 3; much use has been made of McClure's interpretations in writing this account. Older histories of the institution are: J. Brownlow, *Memoranda; or, Chronicles of the Foundling Hospital* (London: Low, 1847); R. H. Nichols and F. A. Wray, *The History of the Foundling Hospital* (London: Oxford University Press, 1935); and a contemporaneous account: *An Account of the Hospital for the Maintenance and Education of Exposed and Deserted Young Children*, by orders of the Governors of the said Hospital (London, 1759).

[9] Dorothy Marshall, *The English Poor in the Eighteenth Century* (London: Routledge & Kegan Paul, 1969, reissue of 1926 ed.), p. 210; M. Dorothy George, *London Life in the Eighteenth Century* (London: Peregrine, 1966), p. 214.

[10] Lawrence Stone, *The Family, Sex and Marriage in England 1500–1800* (New York: Harper & Row, 1979), p. 331.

[11] McClure, *Coram's Children*, p. 19.

governors'.[12] Women, those who had signed Coram's first petition, were frequently related to the men proposed as governors but, as would also be true for the nineteenth century, females were not expected to act as governors or directors whatever their station in life. In the paediatric hospitals they would instead exert an often powerful influence indirectly as members of ladies committees, who visited hospitals, talked to patients and nurses, took stock of complaints, general morale, and the state of the wards, then communicated their opinions to the hospital secretary or board of management.

Coram obtained a royal charter 1739 and his hospital became London's 'most fashionable charity'.[13] However, in spite of influential and wealthy patronage the hospital had insufficient funds to take in as many foundlings as could be accommodated. In a well-meaning effort to save more children from abandonment and almost certain death, in 1756, the governors appealed to the House of Commons for financial support. Ten thousand pounds were granted to the institution but on condition that for the next six months all infants requiring assistance should be accepted. More or less unregulated admissions continued until 1760 with dire consequences on survival rates. Children arrived from all over the country frequently in appalling, even dying, condition. During the nearly four years of open admission 14,934 babies were received of whom only 4,545 survived.[14] Under normal conditions infants were not kept at the London hospital but sent into the country to be wet nursed. However, the new arrivals were frequently too weakly to make the journey and so remained in the institution where they were far more likely to die than to improve in health. Furthermore, reliable wet-nurses were hard to find quickly and in sufficient numbers. Now the hospital was vehemently criticized for encouraging promiscuity and parental neglect and, in 1760, parliament ended its support of open admissions. State support for children already at the Foundling Hospital continued until 1771 when the institution reverted to its former entirely voluntary status. The number of children admitted fluctuated from year to year according to funding: 120 children a year from 1776 to 1782, then 60 a year until 1785 when the number was reduced to 40. Finances improved towards the end of the century but the hospital was able to admit and care for only a minute fraction of deserted and abandoned children.

The checkered history of the Foundling Hospital served as a model to future generations of reformers. State intervention led to the discredit of an institution that had previously been popular and fuelled an outpouring of criticism that the hospital not only encouraged irresponsibility and immorality but was also pernicious to the children reared therein.[15] The lesson appeared to be that the only viable enterprise was a small, well patronized hospital, supported by voluntary contributions, and demonstrably effective in bettering the life of the children admitted. With limited admissions, the governors of the London Foundling Hospital could make their institution one of the most exemplary in Europe, involving continuity of care until apprenticeship and beyond. This concept of a model institution for selected children was revisited in the nineteenth century when the organization of paediatric hospitals was projected.

[12] Ibid., p. 28.
[13] Ibid., p. 34.
[14] Alfred White Franklin, 'Children's Hospitals', in F. N. L. Poynter (ed.), *The Evolution of Hospitals in Britain* (London: Pitman Medical Publishing, 1964), pp. 103–20.
[15] McClure, *Coram's Children*, pp. 105–12.

As mentioned at the beginning of this chapter, the emergence of such hospitals in the mid-nineteenth century was due to individual medical enterprise but then only after decades of frustration for would be pioneers. The earliest attempt to provide structured medical care for children outside their homes ended in failure. In 1769 George Armstrong, a Scot who had studied medicine in Edinburgh but never actually graduated there, established a dispensary for children in Holborn.[16] Initially the prospects were favourable in that the institution received the sanction of the powerful College of Physicians and was attended by 140 patients during the first three months of opening. The number increased steadily until by 1776 more than 4,000 children were being treated annually. No more could be accepted since Armstrong was the sole physician in charge and funds were not keeping apace. Soon they became so scarce that Armstrong was obliged to pay most of the bills himself. To add to his difficulties the dispensary was being adversely criticized from various quarters including attacks in the press by Dr. John Coakley Lettsom, who charged that 'lives were being sacrificed to experimental mass therapy'. Since Lettsom was the leading medical activist in the establishment of general dispensaries, beginning with one in Aldersgate Street in 1770, his disapproval was a serious blow to the prospects of the children's dispensary.[17] In December 1781 Armstrong, now heavily in debt, suffered a stroke and his dispensary ground to a halt at about the same time. It was almost consigned to oblivion for when, 35 years later, John Bunnell Davis founded the Universal Dispensary for Children in London, he had no knowledge of his predecessor's work.[18] In retrospect it would seem that Armstrong made a fatal mistake in trying to run his dispensary single-handed only to become overwhelmed by the demands of administration, caring for the children, and seeking funds. It was also easier for critics to discredit one man than several physicians and a board of governors sharing responsibility.

The next physician to make the attempt, John Bunnell Davis, had a more acceptable background, having spent three years attending lectures at Guy's, St. Thomas's and St. Bartholomew's, then studying medicine at Paris and Montpellier where he obtained his M.D.[19] Returning to England he was appointed physician to the London Dispensary in 1811 and, according to Franklin, then began approaching friends about the feasibility of a dispensary for children. He waited until the end of hostilities with France in 1815 before circulating a petition and forming an organizing committee. Appealing to the compassion and to the self-interest of potential subscribers, Davis pointed out that 'by relieving the sufferings of the helpless infant poor, by studying the most advantageous means to preserve and strengthen their constitutions', one could, 'impart to them that vigour in their early days, that will ensure a healthy population, and enable the poor to support those labours from which the rich extract their competence and resources'.[20] Apart from treating sick children, the dispensary would also serve to train parents in the better care of their offspring and to educate physicians in the diseases of children while also providing

[16] This brief account of Armstrong's dispensary relies heavily on William J. Maloney, *George and John Armstrong of Castleton: Two Eighteenth Century Medical Pioneers* (Edinburgh: E. & S. Livingstone, 1954).

[17] For a history of the early dispensary movement, see I. S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, **55** (1981): 322–42.

[18] According to Franklin, 'Children's hospitals', in Poynter (ed.), *Evolution of Hospitals*, pp. 103–20.

[19] Ibid., p. 106.

[20] John Bunnell Davis, *A Cursory Inquiry into the Principal Causes of Mortality in Children* (London, 1817), p. 33.

facilities for investigation. Nor were these empty words for, when the Universal Dispensary was opened at 5, St. Andrew's Hill, Doctor's Common in 1816, pupils were enrolled, lectures given, and instructions printed for the domestic management of young children.[21]

The Universal Dispensary, with the dukes of Kent and Sussex as patrons, the Lord Mayor of London as president, and various other aristocrats and wealthy men as vice-presidents and governors, was under the medical charge of Davis assisted by three surgeons and an apothecary. The dispensary flourished until the death of Davis in 1824, then languished until 1839 when another forceful physician, Charles West, began attendance. West remained at the now Royal Universal Dispensary for ten years and during this time made strenuous efforts to convert the institution into a hospital with inpatient facilities. He did not succeed but drew lessons from failure which enabled him to acquire the necessary support and patronage for the founding of the Hospital for Sick Children, Great Ormond Street, in 1852. As will be seen, provincial cities soon followed suit with their own small but usually exclusively paediatric institutions.

Apart from the inevitable chronic shortage of funds, the main problems in running the new institutions seem to have been controlling the spread of infection and also the more human complication of finding the right kind of staff, medical and nursing. To stifle criticism, the hospitals were envisaged as showcases demonstrating hygienic, kindly, and conscientious child care. One trouble with this ideal was the difficulty in getting doctors and nurses to co-operate. Nursing 'reform' was inevitable for administrators of paediatric hospitals soon realized that the untrained and usually ignorant women traditionally hired as nurses could not, or would not, maintain the high standards of patient care expected. By mid-century the problem was a general one (much has been written about the extent to which Florence Nightingale contributed to the transformation of nursing into a profession), but the children's hospitals were in the forefront with innovation because of their pressing need to convince parents and subscribers that the young patients were getting the very best in care. Furthermore, as small institutions with limited budgets they offered lower salaries to prospective matrons than did the general hospitals, and so could obtain the services of only the least experienced. When these women proved inadequate, as was ascertained after about ten years of trial at Great Ormond Street, the management decided to experiment with a new breed of nursing supervisor, renamed lady superintendent as befitted the upper-class origin of most of these volunteers. Although originally untrained, the lady superintendents were usually far better educated than their predecessors and, perhaps more critically, belonged to the same social class and held similar values to members of the administration. Also they offered their services gratuitously which, while beneficial to budgets, meant they could not be ordered about by doctors and management as had been the custom. Management got what it wanted through negotiation but the hospital physicians often bitterly resented the nursing superintendents who now presented a challenge to the former medical dominance in patient care and the running of the wards. When quarrels ensued the administrators not infrequently sided with the lady superintendent further fuelling resentment among the medical staff. It took time,

[21] Franklin, 'Children's hospitals', in Poynter (ed.), *Evolution of Hospitals*, p. 108; *Universal Dispensary for Children: Rules for the Domestic Management of Young Children* (London, 1816), a two page pamphlet which was distributed to parents.

*Figure 1:* **Universal Infirmary for Children, 1832, engraving by J. Shury after T. H. Sheppard. (The Welcome Institute Library, London.)**



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and a new generation of doctors, to accept the lady superintendent as sole director of nursing with the realization that everyone, including patients, benefited from the resulting improvements in nursing efficiency. During the last quarter of the century, the children's hospitals organized structured training for student nurses, the probationers, as did other hospitals.

The training of nurses was one of the declared aims of paediatric hospitals when first established. The other objectives, usually prominently stated at the beginning of each annual report, were the medical and surgical treatment of poor children, and the improvement of knowledge concerning the diseases of children. This study will attempt to demonstrate the extent to which these purposes were achieved. Over the fifty-year time period covered, however, and in part because of the contributions of hospital medicine, health care became more scientific and more technical leading to changes hardly envisaged by the original founders. Taking nursing as an example, the original aim at Great Ormond Street was to train girls for a few months to enable them to be effective as children's nurses in private families. But there proved to be little demand for this amenity, while the hospital itself needed more skilled labour, so gradually training came to mean two years of study and practice on the wards punctuated by tests and crowned by final examinations before certification. Special education was needed because nursing no longer consisted simply of good bedside care as was originally true when the little patients were mainly long-term medical cases for whom little could be done apart from maintaining their strength while nature took its course. Minimal surgery was envisaged by the hospital founders who expected accident cases and those requiring urgent operation to continue to be treated in the general hospitals. Although most paediatric hospitals had a surgeon in attendance, he usually restricted himself to uncomplicated procedures such as the lancing of abscesses and the reduction of herniae. A profound change occurred, however, when major surgery became demonstrably safer, that is after the introduction of antiseptic, then aseptic, techniques in the late seventies. As will be seen, surgeons then began to tackle more complicated cases, such as children with cleft palates, and to perform elective operations, such as osteotomy to straighten legs deformed by the ever ubiquitous disease of rickets. Post-operative care could be complicated, as may well be imagined for example in a child with a sutured palate, where the wound was ever likely to break down because of tension on the stitches, and where pain and unpleasantness would rob the child of any desire to eat. To obtain the necessary skills in nursing required special training, and the development of nursing programmes paralleled the expansion of surgery.

Expanding knowledge of paediatric disease was of prime importance to hospital doctors seeking advancement. For half a century British physicians had been exposed to reports and research papers emanating from their continental peers with a paediatric hospital base. Charles West made no secret of his desire to institute similar conditions at home, and Great Ormond Street was established on the principle that, although patients with subscribers' letters should have priority, acutely sick children without recommendation could also be admitted from outpatients at the discretion of the medical attendant.[22] A conflict of interest immediately developed between an overwhelmingly lay committee of management that wanted to keep subscribers happy, and the medical staff who sought to

[22] R. A. Clavering, 'Dr. Charles West and the Founding of the Children's Hospital in Great Ormond Street' (1956, M.S. in the Great Ormond Street Archives), p. 37.

admit 'interesting' cases rather than the chronically sick or even barely ill children frequently recommended by patrons. As will be seen, at Great Ormond Street and in other paediatric hospitals, subscribers' letters became more and more irrelevant as the hospital doctors gained ascendancy in this matter. They did so not by direct confrontation but by persistence. Working in the hospital they had an advantage over management who would meet every fortnight or month only to discover after the fact that some of the patients admitted were under or over age limits, or suffered from some officially unacceptable illness. Even worse was the discovery that admitting officers were ignoring children with subscribers' letters, but regulations in this matter proved unenforceable since the medical staff could always plead that they were overwhelmed by other more urgent cases, as demonstrated by hospital outpatient statistics.

From the outset efforts were also often made to disseminate knowledge through lectures and by encouraging practitioners and students to visit the paediatric hospitals. But attendance was usually discouraging. Since acquaintance with the diseases of children was not required for qualification, medical students had other more pressing engagements and, even when courses were without charge, qualified practitioners did not rush to attend. The traditional view was that children suffered more or less the same diseases as adults and so special training was superfluous. More relevant perhaps, but hard to demonstrate, was the realization that paediatrics did not hold out the promise of being a financially advantageous speciality. Family expenses were at their highest during the period when children were being reared, and the father had usually not yet reached the peak of his career. Later, when the children had left home, the parents would have more disposable income for medical expenses, now their own, so encouraging specialities such as ophthalmology, urology and rheumatology, at the expense of paediatrics, whenever the profit motive was foremost.

The children's hospitals proved attractive to users as may be seen from the constantly increasing outpatient attendance, and from the protests of local practitioners who kept complaining that they were losing patients to the free hospital clinics. Criticism became more general in the early 1870s by which time many institutions, including the older general hospitals, were having trouble attracting sufficient funds to meet the ever swelling demand for their services and the added expenses of more professional nursing, which included providing residential accommodation for trainees. Most critical, perhaps, was the situation at the London Hospital, which by 1882 had an annual deficit of £26,000.[23] As it became obvious that escalating costs were outstripping voluntary contributions, the common reaction was to blame the user; the hospitals, it was said, were being abused by people well able to pay for private medical services or for membership to provident dispensaries. In so far as the paediatric hospitals were concerned, it would seem that such charges were mostly unfounded, although exceptions could always be found. Much depended on what was perceived as a sufficient income to afford some form of private medicine. To a large extent also the paediatric hospitals were victims of their own achievement. Why would a working-class family scrimp and save to pay for the

[23] Geoffrey Rivett, *The Development of the London Hospital System 1823–1982* (London: King Edward's Hospital Fund for London, 1986), p. 119.

indifferent services of a general practitioner or provident dispensary, when specialized health care for children was provided free of cost at an accessible paediatric hospital?

According to the Charity Organization Society (COS), formed in 1869 as a protest against indiscriminate benevolence and, as its name implies, with the aim of ensuring efficiency in charitable relief, hospital abuse could be restrained only by investigating the financial status of outpatients. In 1875 the management of Great Ormond Street asked the COS for assistance in preventing 'persons in a superior position' from using the outpatient department.[24] The COS obliged, quite successfully it would seem, but the hospital administration found that abuse had been mitigated at the cost of antagonizing subscribers, patients, and the medical staff.[25] So management reconsidered its position, and thenceforth showed little enthusiasm for allowing the COS to re-intervene in the affairs of the hospital. In general the same was true in other paediatric hospitals, where management preferred to cope with threatened insolvency by special pleas to subscribers and friends of their charities than by submitting to interference by the COS. Although some were in debt, most of the children's hospitals founded in the second half of the nineteenth century were functioning in 1900, and on a much larger scale than when originated, suggesting that their managers were right in assuming that these institutions were especially favoured by the charitable public.

When Othenin d'Haussonville, a French biographer and man of letters, surveyed the London hospitals in 1877 with particular emphasis on the paediatric ones, he was impressed by their spaciousness, good ventilation, general cleanliness, the care taken to isolate cases of fever and, at Great Ormond Street, the high quality of nursing care.[26] The revenues of this hospital seemed considerable to a Frenchman, and he had little to fault about the way it was managed except for the system of admitting children through subscribers' recommendations. The voluntary hospital's inpatients were privileged children whereas, he warned his readers, the rest of the young sick poor fared badly in the workhouse infirmaries, worse than in the state managed Parisian paediatric hospitals that admitted needy sick children without distinction. In summary:

> If I had to select the most distinctive characteristic of medical assistance in London (indeed in England as a whole), I would say that this characteristic is inequality; so true it is that the charitable institutions of a nation reflect its social and political institutions. For the recommended poor exist all the resources of science and all the well contrived refinements of private charity; for the unknown poor only the insufficiency and harshness of public charity.[27]

While in favour of the system prevailing in his own country, d'Haussonville observed that the British were constantly reviewing their hospital system which seemed more open to change than the French one with its relatively inflexible bureaucratic management. Infectious diseases, for example, continued to blight the Parisian paediatric hospital wards because of lack of isolation facilities.[28] Well aware of the proper solution, no member of

[24] *Twenty-Fourth Annual Report of the Hospital for Sick Children* (London, 1876), p. 5.
[25] *Twenty-Fifth Annual Report of the Hospital for Sick Children* (London, 1877), p. 7.
[26] Othenin d'Haussonville, 'L'Enfance à Paris, III', *Revue des Deux Mondes*, **20** (Ser. 9, 1877): 36–79.
[27] Ibid., p. 55.
[28] Othenin d'Haussonville, 'L'Enfance à Paris, II', *Revue des Deux Mondes*, **18** (Ser. 9, 1876): 575–604.

the medical staff wanted to give up any of his own beds for isolation purposes without a directive from the administration of the *Assistance Publique*, which avoided committing itself for fear of incurring additional expenses. Recently however in London, as noted by d'Haussonville, the Metropolitan Asylums Board had opened four fever hospitals, financed by a metropolitan common poor fund to which all parishes contributed, to supplement the existing private hospitals, the Smallpox Hospital and the London Fever Hospital, which had proved insufficient to cope with severe cases of infectious disease in the metropolis.[29] Since they admitted children, the new fever hospitals relieved the paediatric hospitals of much of their former responsibility, particularly with cases of scarlet fever. Before the end of the century, the publicly funded fever hospitals originally intended for paupers became open to all patients irrespective of financial status, although the suggestion kept recurring that patients able to do so should pay something towards expenses. Thus in England began the changes that would finally lead to the National Health Service and to the abolition of the two-tier system, voluntary hospital versus Poor Law hospital, apparently so deeply entrenched in the nineteenth century.

Also to be examined is the medical function of the paediatric hospitals during the nineteenth century. As mentioned earlier, the original intention was to admit medical cases and, in some hospitals, children suffering from long-standing or complicated fevers with the exclusion of smallpox, the most dreaded of diseases then considered contagious. The collection of children in hospital allowed for long-term clinical observation and the postmortem examination of patients that failed to survive. Perhaps the most important consequence of cumulative autopsies was the gradual realization of the frequency of tuberculosis as the underlying cause of so much illness in children. The isolation of tubercles in various organs of the body, when associated with previous clinical illness, revealed that formerly disparate syndromes had a common cause and that children were just as liable to tuberculosis as adults. Nevertheless these findings, and the discovery of the tubercle bacillus in 1882, while intellectually satisfying, did little to promote the prevention of tuberculosis in children. While taking extreme measures to prevent the spread of the common infectious diseases of childhood, the hospitals seem to have done little or nothing to prevent cross-infection with the tubercle bacillus. Centuries of experience had demonstrated the non-infectivity of the scrofular forms of tuberculosis (disease of the lymph glands and of the bones and joints) and, even after the discovery that pulmonary forms of the disease were probably spread by sputum laden with bacilli, no one insisted that children with phthisis should be isolated. Long-term acquaintance with the illness, its usually protracted course and its association with heredity or predisposition, seem to have induced a kind of fatalism among physicians inhibiting the endorsement of active preventive measures. Encouraging this apathy was the fact that cross-infection, although theoretically possible with pulmonary tuberculosis, was not immediately obvious (as with the acute infectious diseases), so no one thought to blame hospital care for the occurrence of tuberculosis in a child perhaps weeks or months after discharge.

Various forms of tuberculosis of the skin, bones, and joints, were also common on the surgical wards. The treatment of these children serves to illustrate the expansive and experimental nature of late-nineteenth-century surgery, given such a boost by the

[29] For details of the founding of the MAB fever hospitals, see: Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board 1867–1930* (London: Wellcome Institute, 1971), pp. 49–68.

discovery of anaesthesia followed by the establishment of antiseptic principles. Already by the 1860s there was a split between surgeons advocating aggressive treatment of tuberculosis of the joints and those favouring a minimum of operative intervention. The latter course usually entailed months or years of bed rest for the young patient and so was dismissed by more venturous surgeons as impracticable for working-class children. Instead these men sought to remove all the diseased bone and cartilage and so effect a complete cure, but condemning the child to permanent shortening of the limb if it were fortunate enough to survive such radical intervention. So large was the number of afflicted children, and so minimal were the provisions available for conservative care, that mutilating surgery could be relatively easily justified. Its most vocal opponent, Hugh Owen Thomas, was not taken very seriously by hospital based orthopaedists because, although medically qualified and a skilled practitioner with unusual mechanical aptitudes, he persistently flouted the conventions of organized medicine. The complete outsider (he never held a hospital appointment), Thomas practised among the working people of Liverpool as he thought fit and with disdain for the activities of professionally better established surgeons. In his opinion, 'articulations early diagnosed and treated by rational principles and by efficient mechanical control [absolute rest with splinting], these as a rule will never so deteriorate as to require excision'.[30] According one of his biographers, Thomas ensured proper care by visiting his patients in their homes at any time of the day or night, and castigating the family mercilessly if any of his orders had been disobeyed.[31]

The treatment of the sick child at home required professional supervision, as was accepted practice in affluent families, and many of the paediatric hospitals undertook this service when they first opened, only to give it up later because of the expense involved and because of opposition from hospital and general physicians. Independently organized district nursing emerged to meet the need to some extent but at the price of divorcing institutional practice from domiciliary care. Hospital doctors could no longer see for themselves what went on in the home, relying instead on reports from general practitioners or from the family at follow up visits to the hospital. Nevertheless, the tendency continued for hospitals to isolate themselves from the community, as also evidenced by repeated medical demands to cut back on visiting hours in an effort to reduce the risk of infection from outside. One suspects, however, that it was also proving easier to run an efficient ward without too many parents on the scene.

The problem of the chronically sick child was partially addressed by the emergence of numerous 'convalescent homes' and 'sanatoria', some being extensions of parent paediatric hospitals, while others were independent. Given the British tradition of voluntary, self-regulating charities, it was perhaps inevitable that small, even minute, hospitals should be instituted rather than the money channelled into home care for the poor on a city wide scale. The latter solution would have risked coming into conflict with the administration of out-door Poor Law relief, whereas a voluntary institution commanded independent status. The consequence of this choice, however, was the furtherance of the tendency to isolate the sick, now even children, in hospitals. By 1890 there were about 50 convalescent homes for children in England and Wales, in addition to institutions, such as

[30] Hugh Owen Thomas, *Diseases of the Hip, Knee, and Ankle Joints, with their Deformities, Treated by a New and Efficient Method* (Boston: Little, Brown and Co., 1962, reprint of 1876 ed.), pp. 168–9.
[31] Harley Williams, *Doctors Differ: Five Studies in Contrast* (London: Jonathan Cape, 1946), p. 109.

the Alexandra Hospital for Hip Disease in London, which cared exclusively for children with long term orthopaedic afflictions.[32] Furthermore, London possessed three orthopaedic hospitals (they amalgamated to form the Royal National Orthopaedic Hospital early in the twentieth century) which also admitted children as inpatients. In the early 1890s the rebuilt National Orthopaedic Hospital had beds for 62 patients of which 39 were intended for children, including a ward for infants.[33]

For, as will be seen, the original contention that babies should not be admitted into hospitals was gradually eroded. Again this was a medical decision implemented by persistence and contrary to the wishes of administrators. Unlike the rate of mortality for other age groups, that for infants did not decline during the second half of the nineteenth century fluctuating instead in a range of between 130 and 161 deaths of infants under one year per 1,000 live births.[34] The highest reported rate of 161 was reached in 1895, suggesting to physicians that the advances in medical science up to this point had achieved little that was helpful in preventing the death of babies. Generally speaking, physicians suspected that for babies that were sound at birth (that is not born prematurely, nor with congenital defects, nor injured during delivery), malnutrition was a major cause of subsequent ill-health.[35] Among the diseases presumed associated with unsuitable food were, starvation, atrophy, debility, diarrhoea, and rickets, all of which presented frequently in babies brought to outpatient departments. Quite apart from any research interest, the medical staff often admitted such children under the conviction that a well regulated hospital diet would lead to recovery, having apparently lost the fear expressed by previous generations of the ill-effects of separating an infant from its mother. Charles West remained consistently opposed to the admission of babies to Great Ormond Street but, as his influence waned, younger medical men were prepared to take the risk. The results might have been discouraging (58 deaths among the 219 children under the age of two years admitted to the North Eastern Hospital for Children in 1898) but physicians justified such statistics with the explanation that babies were often brought to the hospital in a dying state. Furthermore, the majority of annual reports did not indicate the ages of patients in listings of treatment and outcome, thus subscribers and lay managers would be unaware of the extent to which infants contributed to overall hospital mortality.

In general, therefore, the hospital came to be seen as the best place for acutely sick children, those requiring surgery and even the chronically ill. Promoters of hospital care included physicians seeking advancement and finding its amenities infinitely preferable to practice in a poor patient's home, or even indispensable as in the case of major surgery. (Minor surgery would continue to be undertaken in affluent homes long after the turn of the century.) The general public seems to have been equally enthusiastic judging by the

[32] *The Charities Register and Digest: Convalescent Section* (London: Longman's, Green, and Charity Organisation Society, 1890).

[33] J. A. Cholmeley, *History of the Royal National Orthopaedic Hospital* (London: Chapman and Hall, 1985), p. 79.

[34] B. R. Mitchell and Phyllis Deane, *Abstract of British Historical Statistics* (Cambridge: University Press, 1971), pp. 36–7. The most complete study of infant mortality at the turn of the century and its decline thereafter is Deborah Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898–1918* (London: Tavistock, 1987).

[35] 'Diet diseases', are discussed, for example, by James Frederic Goodhart and George Frederic Still, *The Diseases of Children* (London: J. & A. Churchill, 1902), pp. 68–82.

ever growing demand for outpatient services and the perceived need everywhere to increase the number of beds available. Shortage of funds was the only obvious limit to expansion. Even people who claimed hospitals were being abused did not usually suggest that paediatric institutions were not needed but rather that their patients should be required to pay for services whenever possible. By the end of the century over 30 hospitals in Great Britain were dedicated to the care of children, and this figure does not include an ever growing number of convalescent homes also specifically intended for young patients (see Table 1). In addition by this time numerous general hospitals had dedicated one or more wards for paediatric use. Yet 50 years earlier even the most dedicated promoters of children's hospitals had apparently feared that there might be little public demand for such institutions. Their success, as judged by attendance, was due to their filling a previous void in the health care of children and to the absence of serious competition since general practitioners remained essentially untutored in paediatric medicine for the duration of the nineteenth century. How the managers and staff of paediatric hospitals coped with demand, and the extent to which they took advantage of their monopoly in health care for children, will be explored in this study.