4

The Young Patients

British children's hospitals were originally intended for boys and girls aged from two to about ten years. The founders assumed that older children would continue to be treated in adult hospitals and sick babies would remain at home with their mothers. Usually however the medical staff did not take these rules too literally and soon were admitting children of all ages on the principle that very sick patients could not in all conscience be turned away. As we have seen, management committees often turned a blind eye to infringements of age regulations so long as these were not deemed excessive. At Birmingham infants under the age of one year were not admitted until the 1870s but from then on steadily became more numerous. At the same hospital, children over the age of ten were kept out until the middle seventies but thereafter their numbers also increased. Physicians naturally enough wanted their patients to cover the whole spectrum of childhood and, since there was no special hospital for babies as existed in Paris, management committees found it difficult to enforce the exclusion rule.

At Great Ormond Street 1,058 patients were admitted in 1878 of which 28, or 2.6 per cent, were under the age of two years.[1] By 1886 this percentage had climbed to 19.3, with 211 out of 1,094 patients being officially under age. As indicated by Charles West in his protest against a proposal made at that time to establish a ward specifically for infants, it was not clear how many babies died while at Great Ormond Street since the reported statistics did not include the age of fatal cases.[2] However, only infants were admitted with marasmus, or severe wasting, and West observed that all six patients so diagnosed on admission in 1886 had died in hospital, suggesting that it was not the right place for the care of severely malnourished babies (nor for any others, in his opinion). For the time being the proposal for an infant ward was shelved. Indeed, in spite of considerable medical lobbying in children's hospitals for such accommodation, only the East London had acquired a ward dedicated to the care of infants by the end of the century. The rest had to make do with mixed wards.

The mortality statistics for infants at the East London discouraged emulation. In 1893 that hospital admitted 498 children under the age of two years representing 38.6 per cent of the total intake.[3] Of the babies, 221 died while in hospital. To justify such devastating statistics, the resident medical officer stated in his report that many of the infants were extremely ill, and 32 were dying when admitted. Frightened parents arrived with their sick babies when they realized death was imminent and it would have been heartless to turn them away. But frequently the hospital could offer little hope. For some diseases none of the babies admitted to the East London in 1893 survived. Three babies came with a diagnosis of erysipelas and all died. Nor were there any survivors among the 11 infants

[1] *Thirty-Fifth Annual Report of the Hospital for Sick Children* (London, 1887), p. 23.
[2] Charles West, *A Letter to the Rt. Honble. Lord Aberdare, Chairman of the Management Committee of the Hospital for Sick Children* (London: H. Sotheran, 1887), p. 6.
[3] *Twenty-Seventh Annual Report of the East London Hospital for Children* (London: 1894), pp. 17–19.

with diphtheria, 3 with pyaemia, 3 with *cancrum oris*, 6 suffering from collapse of the lungs and 3 with pulmonary tuberculosis. Others hardly fared better; of 14 babies admitted with general tuberculosis, 12 died; of 10 with a diagnosis of hereditary syphilis, 8 died; and of 10 suffering from empyema, 9 died. So called 'simple atrophy' killed 19 of the 24 babies admitted; only 18 out of 55 infants survived bronchopneumonia; and only 26 out of 57 recovered from gastroenteritis. In spite of such statistics, the infants' ward was referred to with pride in the annual reports, as unique in the country, and as a source of special experience for trainees in the nursing of sick babies. The resident medical officer thought that many of the infants were prevented from recovering because of previous bad feeding, and sometimes what he cautiously called 'unavoidable neglect', the infants therefore being so fragile that they succumbed to even trivial ailments. There was no suggestion that hospitalization of itself might hasten death. Perhaps of benefit from all this carnage was the fact that some of the nurses trained at the East London went on to work among the poor of the neighbourhood since, as will be seen, unaided many mothers did not begin to know how to care for their children when sick.[4]

With reference to the upper age limits it was sometimes difficult to establish the exact age of a sick child. Although apparently rare this problem occurred at the Edinburgh Hospital for Sick Children when discussion arose over the propriety of admitting a girl suffering from venereal disease into a children's hospital. By the time Henrietta A. Anderson, secretary to the ladies committee, was conversant with the circumstances surrounding this unusual admission, the child had been on the ward for nearly four months. Mrs. Anderson had been informed by a nurse that the child was admitted because 'the Drs. consider it as an interesting case as a study', and that her age was recorded as 12 years. However Mrs. Anderson, and her informant, believed the patient to be at least 15 years of age, although of small stature. 'Surely this is a case for the directors to pull the Drs. up about', Mrs. Anderson wrote indignantly to John Henry, the senior hospital secretary, 'for it were known by the general public, it would give the hospital a worse name than it has already'.[5] In reply to an inquiry from the hospital secretary, which apparently included the charge that the girl had been found in a brothel, Dr. Linton, the physician in charge, stated categorically that the child had resided at home and was not removed from a brothel, wisely adding, however, that she would be well enough to be discharged within a week's time.[6] The girl had told Dr. Linton that she had contracted her illness 'while nightly engaged in sweeping out some warehouse in Potter row'. Thus one might assume she had been raped, but no further details were provided by the physician.

In the third report of the Clinical Hospital in Manchester (1859) James Whitehead gave some indication of the neglect and ignorance associated with the rearing of many of the infants and children brought to that dispensary. 'Superstitions and prejudices', in his opinion, 'operate in a remarkable manner to the detriment of infant life and health'.[7] A child afflicted with fever or other severe illness was often considered by its parents to have

[4] Ibid., p. 126.

[5] Edinburgh Medical Archives, LHB 5/22/8, Letter from Henrietta A. Anderson to John Henry, 4 October, 1879.

[6] Ibid., LHB 5/22/12, Letter from John Linton to John Henry, 6 October, 1879.

[7] *Third Report of the Clinical Hospital* (London: John Churchill, 1859), p. 14; also, E. Wheatley Jones, *A History of the Manchester Northern Hospital for Women and Children* (Manchester, 1933), pp. 35–6.

received its 'death stroke', and so they waited for death with resignation and without seeking medical aid.

> Thus, many cases of acute inflammatory and febrile affections are brought after they have existed many days or weeks, and often already in a hopeless state, with the ostensible object of obtaining medicine to soothe their last moments, but more frequently for the real purpose of being to obtain a certificate of the cause of death.[8]

The children frequently remained unwashed for the duration of illness, for fear that exposure of the skin would hasten death. Uncleanliness, according to Whitehead, was the cause of a commonly observed macular rash consisting of small, purple spots on all parts of the body covered by clothing except the feet. Children suffering from this *macula cachexia* were not washed, except for the hands and face, more frequently than once every few weeks, and then often without the use of soap. As the children got older, and were left to clean themselves, matters got worse. According to Whitehead, 'the whole body is not washed, in the vast majority of instances, once in several years'.[9] Clothing was changed and washed equally infrequently, with consequences that may easily be imagined. In perceiving uncleanliness as the single cause of *macula cachexia*, Whitehead was reflecting the horror of dirt prevalent among the educated class of his time, while a modern observer would at least consider malnourishment as a contributory factor.[10] Either way, the rash could be taken as a sign of chronic neglect especially if Whitehead was correct in saying that such a skin condition was never seen in the offspring of the clean and thrifty. More cheerfully he also observed that the latter group of children, those belonging to sober, thrifty and cleanly families, formed at least one-half, perhaps even three-fifths, of all admissions to the Clinical Hospital.[11]

But the home conditions described as typical for the one-third or so least fortunate outpatients indicate families living on the brink of destitution. The fathers were earning less than £1 a week, or were out of work and, to supplement the family income, lodgers lived with the families even when the residence was only a cellar. Thirty-five case histories were provided describing situations in which five to seven people slept in each room.[12] The 'unwholesome atmosphere' and neglect of personal cleanliness induced by such living conditions accounted, in Whitehead's opinion, for the chronic ailments exhibited by the children.

At Great Ormond Street each child was supplied on admission with a cotton or flannel nightgown and a pair of slippers. Except in cases of fever, the parents were supposed to provide two sets of 'decent' clothing, and to fetch and launder soiled linen when so directed by the matron.[13] The General Hospital for Children at Manchester had a similar

[8] *Third Report of the Clinical Hospital*, p. 14.

[9] Ibid., p. 16.

[10] Chronic skin rashes were interpreted as evidence of chronic malnutrition by Wendy L. Moore in 'The malnutrition of politics: the impact of malnutrition on the political activity of the labouring class in 19th century Britain', paper presented at the 64th annual meeting of the American Association for the History of Medicine, Cleveland, Ohio, May 1–4, 1991.

[11] *Clinical Hospital . . . Remarks on the Services of the Institution from the Publication of the Third Report to the Close of the Year 1860* (Manchester, 1861), p. 17.

[12] Ibid., pp. 11–16; six of these case histories are also reported by Wheatley Jones, *History of the Manchester Northern Hospital*, p. 36, but the original case books appear to be lost.

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

ruling.[14] When, as could happen quite frequently, parents could not or would not co-operate, the children were issued with clothing donated by friends and subscribers to the hospital. These articles were not always discards; during the 1860s Mrs. Adolf Schwabe made it a habit at Christmas to give a frock and flannel petticoat to each of the girls, and two vests and a comforter to every boy at the General Hospital for Children in Manchester.[15] All the clothing for fever patients was provided and laundered by the institutions in the hopes of diminishing the risk of cross-infection.

The hospitals were intended for the children of working-class families with incomes insufficient to afford private medical care and necessary medicaments in the face of illness. Occasionally the charitable institutions may have been abused, particularly their outpatient departments since the special services provided were attractive to parents. Instead of calling in a general practitioner who might easily have very little experience of childhood ailments, a visit to the hospital ensured getting advice from specialists for free. If financial investigation was undertaken, as happened more frequently in the last quarter of the century, and the family found to be too prosperous to qualify for further visits, at least a preliminary diagnosis was established and treatment commenced. Nothing much was lost apart from the time waiting and the possibility of exposure to infectious disease while at the dispensary, which was not yet a strong deterrent since the contagiousness of many childhood illnesses, such as whooping cough, was hardly recognized. In 1876, Dr. James Cummings, assistant to the extra-physicians who coped with most of the dispensary work, wrote to the secretary of the ladies committee of the Edinburgh Children's Hospital admitting that 'the patients who attend here are *on the average* much superior in social position to those attending the other hospitals in town'.[16] One reason was, according to Cummings, the special expertise provided by the hospital. However, if the parent unwisely mentioned having her own doctor, then she was immediately told to put her child under his care, unless she came from a distance when it would 'seem harsh and unfeeling to dismiss that patient without a word of advice, consolation or examination'.[17]

But when it came to inpatients, the vast majority of children were from needy homes. In answer to inquiries on the subject, Oliver Heywood, president of the General Hospital for Children, Manchester, told the subscribers late in January 1880, that just over 50 children had been admitted since the beginning of the year.[18] Only 10 of the 50 families had earnings over 20s. a week, and the average of these higher earnings was 26s. 6d. Furthermore, these 10 more prosperous families had 56 children to maintain between them. One father, a shoemaker, indicated that he had seven children, of whom three were ailing. Of the remaining 40 families, 10 had an unemployed father, in 5 he was dead, and the rest had to manage on less than 20s. per week. At the Edinburgh Children's Hospital inpatients seem frequently to have belonged to impoverished or even neglectful families. By the mid 1890s a brief social commentary, including the number of rooms in the house

[14] 'Rules for the Government of the Hospital', in *27th Annual Report of the General Hospital and Dispensary for Sick Children* (Manchester, 1856), p. 34.

[15] *Thirty-Third Annual Report of the General Hospital for Sick Children* (Manchester, 1862), p. 5.

[16] Dr. James Cummings to Secretary of Ladies Committee, 19 May, 1876, Edinburgh Medical Archives, LHB 5/22/2.

[17] Ibid.

[18] *Fifty-First Annual Report of the General Hospital and Dispensary for Sick Children* (Manchester, 1880), pp. 22.

and the number of people sleeping in each room, was supposed to be included in each patient record on admission.[19] The social history was frequently omitted but in 59 instances among children admitted under the classification of general diseases between 1893 and 1895 where some commentary was made, only 18 came from homes considered 'good', and 15 where conditions were described as 'fair'. The remaining 26 patients lived in circumstances variously described as 'unsatisfactory', or 'very unsatisfactory', 'poor', or 'very poor', 'home a dump', child 'neglected', and even 'utterly neglected'.[20]

Pauper children, those whose parents were on parish relief, were not supposed to be admitted to the voluntary institutions. Private charity was intended for the 'deserving' poor only and entirely separated from public relief whenever possible. Even this rule, however, was subject to compromise. In the regulations for admission to the Birmingham Children's Hospital amendments were made in 1863 which included the proviso that children on parochial relief should not necessarily be rejected.[21] The local board of guardians agreed to a subscription of 10 guineas to the hospital to cover the cost of pauper outpatients. In 1864, according to the committee of management, this subscription 'was in no degree commensurate with the benefits the paupers gained, yet the institution could not refuse relief to paupers labouring under severe maladies'.[22] Such benevolence was not without criticism. In 1867 Thomas Heslop, chief physician and founder of the hospital, was complaining to C. E. Matthews, secretary and co-founder of the institution, that too many paupers were being admitted.[23] Inquiries were made into the extent of hospital use by so-called 'paupers' but seem to have been inconclusive. For a year later the assistant secretary, James Stilliard, reported to the committee of management 'that while there may be a considerable number of what may be called the pauper class, having at some time been on relief, obtaining relief at the institution, there are comparatively few who as actual paupers obtain these benefits by means of deceit and lying'.[24] However, faced by ever increasing numbers of dispensary patients, as explained by Rachel Waterhouse, in 1871 the committee of management adopted Heslop's suggestion to discourage paupers by charging sixpence for each ticket to the outpatient department.[25] The pressure on hospital services must have been great for Heslop to have made the suggestion since at the national level he was known as a severe critic of Poor Law services for children. Thus, in 1869 he was pleading for more hospitals for sick children on the principle that the poor had no other recourse to decent medical care, the provisions made by the Poor Law being derisory in his opinion.[26] Upon investigation of the previous history of 383 children brought to him at the Birmingham Children's Hospital during six weeks, beginning 26 May, 1869, Heslop

[19] A special form with printed questions was supplied for the purpose, but the resident medical officers usually ignored the prepared form and wrote a continuous case history on blank paper. However they did usually provide answers to nearly all the officially required questions.

[20] Edinburgh Medical Archives, Disease Register for 'General Diseases' 1893–1895 (2b), LHB 5/11/3.

[21] Birmingham Children's Hospital Archives, Committee of Management Minute Books, 1861–1870, 16 November, 1863.

[22] Ibid., 14 November, 1864.

[23] Ibid., copy of letter from Thomas Heslop to C. E. Matthews, 24 May, 1867.

[24] Ibid., June 8, 1868.

[25] Rachel Waterhouse, *Children in Hospital: A Hundred Years of Child Care in Birmingham* (London: Hutchinson, 1962), p. 42.

[26] 'Dr. Heslop on Medical Attendance on Sick Children of the Poor in Large Towns', *Medical Times and Gazette*, **ii** (1869): 386–7.

found that 341 had not previously been taken to any physician; instead the parents of 154 of these children had sought advice from the local druggist, while a mere 42 had applied to a surgeon, and the rest had not been treated by anyone. The explanation, in Heslop's words, was:

> . . . that these gentlemen in our large towns [the Poor Law medical officers] do not possess the confidence of the sick poor; that mothers prefer the druggist, with his pennyworth of deadly syrup or of calomel powder, to the so-called care of the bankrupt parish Surgeon, or his utterly unqualified assistant.[27]

The reviewer in the *Medical Times and Gazette* took 'grave exception' to Heslop's blanket condemnation of Poor Law medical officers, while also praising Heslop for exposing the deficiencies of the system.[28] The latter was well aware that parish medical officers were so grossly underpaid that they could hardly be expected to provide adequate care to the sick poor. He himself had written on the subject earlier, in 1868, stating that: 'The payment of the services rendered by parish medical officers is so thoroughly contemptible as to be a disgrace to us'.[29] In Heslop's opinion medical men should refuse to work for unions offering an inadequate salary. Because the Poor Law system encouraged deficient care by underpaying its medical officers, the voluntary hospital system was overburdened with patients who should be receiving parochial medical relief. Far more hospitals were needed to cope with all the poor children in need of medical attention but, until more were built and/or the Poor Law system reformed, Heslop sought to protect the quality of care at his own institution by reducing outpatient attendance through a charge.

Other hospitals were more insistent on excluding pauper children. This was true of the Edinburgh Children's Hospital which unknowingly admitted the child of a homeless vagrant on the day it opened, 15 February, 1860.[30] The little girl, Mary Sutherland, was suffering from incurable illness and, by September, the hospital directors also realized that she had been forsaken by her mother, who had not visited the child for the past seven months. On inquiry it was discovered that no Mrs. Sutherland resided at the address given nor had she lived there when Mary entered the hospital. The hospital applied to the inspector of the poor of the parish of St. Cuthbert's (in which the hospital was situated) to request that the child should be removed to the local poorhouse. The said inspector, James Craig, went to great lengths to locate Mrs. Sutherland, discovered that her real name was Janet Campbell, that she now lived in the Cowgate and was supported by the parish of Edinburgh so that, as he had hoped, the child was the responsibility of that parish and not of St. Cuthbert's. Within a few days Mary was removed to the care of the City parish, while the hospital directors reflected on how to prevent future cases of desertion. Twelve months later they refused to admit a sick child from the Fife poorhouse, even though the parish offered payment. On consideration,

[27] Ibid.
[28] 'Hospitals for Sick Children', *Medical Times and Gazette*, **ii** (1869): 393.
[29] T. P. Heslop, 'Professional Combinations', *Lancet*, **i** (1868): 229–31.
[30] Edinburgh Medical Archives, Minute Book, LHB 5/1/1, 1859–1885, pp. 176–80.

> The Directors . . . were unanimously of opinion that the principle on which the Hospital was founded did not authorize them to receive children to be treated on payment. They farther resolved that as the admission of children from the poorhouse (who should be treated when in sickness at the expense of the Ratepayers) would occupy the accommodation required by other poor children and interfere with the principle on which the Hospital was founded—of treating children whose parents and friends can only look for their care in sickness to the voluntary charitable contributions of the public; they must in consistence with that principle decline to receive children from the poorhouse, and instructed the Secretary in future to give instructions accordingly.[31]

In principle this was the policy of all the voluntary paediatric hospitals. Like other charitable institutions they were intended for the working poor and the use of letters of recommendation from subscribers was supposed to ensure that only known and 'deserving' patients would be admitted, that is children whose fathers' earnings were too meagre to afford the services of a general practitioner and yet sufficient to provide food and housing for their families. Free care at this juncture, it was argued, would prevent the family being rendered destitute by sickness.[32] Those that were already destitute were beyond help from the limited resources of charity and were the responsibility of the Poor Law system. But with sick children the hospital staff does not seem to have been willing carefully to distinguish between 'deserving' and 'non-deserving' cases. As has been mentioned earlier, the management committees of paediatric hospitals from their inception had trouble enforcing the use of letters from subscribers as a necessity for admission, mainly because the medical staff did not co-operate. In view of persistent lapses, some hospitals changed their rules for the admission of patients to the effect of no longer requiring letters from subscribers. At Manchester this change was undertaken as early as 1856 when the dispensary was expanded to provide inpatient accommodation. The rules for the governance of the new hospital specifically stated that 'the medical officers be entitled to admit patients to the benefits of the Charity, without recommendation'.[33] Other hospitals no longer required letters in urgent cases or at the discretion of the medical officers, while still providing subscribers with entitlements. By the nineties, the East London Hospital for Children had this looser ruling with respect to recommendations, while also having a regulation that 'Persons who are able to pay for treatment, and those in receipt of parish relief, shall be excluded from the benefits of the Institution, unless in consideration of such payment as may be deemed appropriate'.[34]

The trouble, of course, was how to establish the real means of any family without recourse to investigation such as proposed by the Charity Organisation Society (COS). As we have seen, most paediatric hospital management committees did not encourage the COS to interfere in the running of their institutions. The retention of independence was also a reason for management committees to discourage the admission of pauper patients. To become involved with the Poor Law system would entail constant interference from parish and union authorities, even from government inspectors, whereas, if paupers were

[31] Ibid., p. 272.

[32] See, for example, Geoffrey Rivett, *The Development of the London Hospital System 1823–1982* (London: King Edward's Hospital Fund for London, 1986), p. 28.

[33] *Twenty-Seventh Annual Report of the General Hospital and Dispensary for Sick Children* (Manchester, 1856), p. 34.

[34] *Twenty-Seventh Annual Report of the East London Hospital for Children* (London, 1894), p. 138.

excluded, boards of management were responsible only to their subscribers and, less directly, to the local community. Patients and their families had little say since they were the recipients of charity. But, whatever the wishes of management, in practice it was impossible to ensure that pauper patients were refused admission. However, when such children were deserted by their families then the Poor Law system served as outlet for their disposal. On 4 November, 1871, the committee of management of the Evelina were faced with this problem when the parents of Geoffrey Chapman refused to take him home.[35] The committee communicated with the relieving officer of the boy's parish, and decided that, to prevent recurrence, all parents should obtain the signature of a householder who would be responsible for the removal of their child. Needless to say, this rule was hardly enforceable and, furthermore, the relieving officer of Geoffrey's parish did not prove very co-operative for, three months later the child was still at the Evelina with nowhere else to go.[36] Ten years later a Jewish child, Sarah Lewis, was also abandoned by her parents while a patient at the Evelina. She could not be transferred directly to a Jewish asylum but had first to be taken to the workhouse, thence to be moved to the home.[37] Kosky and Lunnon tell us that children abandoned by their parents at Great Ormond Street were sent to an orphanage or to the Greenwich workhouse.[38]

Differentiating between the needy poor and those on, or about to be on, relief was almost impossible at the outpatient level. So long as a subscriber's letter of recommendation was required, voluntary hospitals could be reasonably sure that a child's family was not receiving parish aid. But as the patronage system fell into disuse it became more difficult to prevent 'abuse' of outpatient departments not only by prosperous families but also by those on public assistance. As we have seen, this problem began to surface in the late sixties and was tackled most forcefully by the recently formed COS. Initially, members of this society admitted that Poor Law medical relief in London was inadequate and should be improved. Administrative change was effected in 1871 when the Poor Law Board was reduced to the status of a division under a newly created Local Government Board; however, medical policy remained essentially unreformed and a minor concern of the new administration.[39] At about the same time, the COS began putting into effect its plan of getting the free dispensaries to convert into provident dispensaries.[40] Under this scheme needy patients would seek care from a Poor Law dispensary or opt for a provident dispensary, either of which could refer those requiring special treatment to the hospitals. No longer, however, would hospital outpatient departments be used to treat all comers, since patients would now need a subscriber's recommendation, or one from a provident dispensary or a Poor Law doctor. Some free dispensaries did convert into provident ones but, overall, this ambitious COS scheme did not prosper. Also frustrating to the organisation, as we have seen, were the results of its concurrent attempt to screen hospital

[35] Greater London Record Office (hereafter G.L.R.O.), H9/EV/A2/1/1, Committee of Management Minutes, 4 November, 1871.

[36] Ibid., 2 February, 1872.

[37] Ibid., Minutes of Management Committee Meeting, 2 June, 1882.

[38] Jules Kosky and Raymond J. Lunnon, *Great Ormond Street and the Story of Medicine* (London: Hospitals for Sick Children and Granta, 1991), p. 19.

[39] Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board 1867–1930* (London: Wellcome Institute, 1971), p. 55.

[40] The medical reform objectives of the COS are discussed in Helen Bosanquet, *Social Work in London 1869 to 1912: A History of the Charity Organisation Society* (London: John Murray, 1914), pp. 205–23.

outpatients. At Great Ormond Street the COS outdid itself by qualifying fewer applicants than the hospital was prepared to deal with, to the irritation of the management committee obliged to respond to complaints from patients' families and from patrons.[41] At the end of the century, however, the COS achieved greater success with the introduction of hospital almoners who, instead of concentrating almost entirely on the detection of 'fraud', also acted as advisors to patients, giving them assistance in finding other medical and social services that might be needed and available. The first almoner, a former secretary of the COS, was appointed at the Royal Free Hospital in 1894, a move that was soon to be copied at other general hospitals in London but not, in so far as can be ascertained, by paediatric hospitals before 1900. Their governors continued to cherish independence and to be wary of interference by the COS. However, almoners would soon prove indispensable in their function as social workers, re-establishing a link between institution and home that was lost when the hospital staff no longer had time for domiciliary visits.

Parents, it would seem, appreciated the services offered by the paediatric hospitals for only very rarely, according to the records, were management committees disturbed by serious complaints. But the records may not tell the whole story. Families were expected to be grateful for the free treatment given their children and usually parents had neither the knowledge nor the confidence to protest lax care, nor the money to support legal action. While those who came furnished with subscribers' letters could get their benefactors to complain if their children were ignored, parents without sponsors had little leverage. When, in 1887, one such parent complained that her child had been brought to the Evelina three times without being allowed to see the medical officer, the committee of management decided that, since the applicant had no letter of recommendation, the medical staff were quite justified in rejecting the child in favour of more seriously ill cases.[42] Ten years later, the parents of a little girl actually brought an action against one of the surgeons at the Evelina complaining that he had operated on the wrong foot. The child had contracted tendons of both feet and the surgeon's defense was that he had first operated on the least deformed limb. However, apparently influenced by a newspaper reporter, the parents refused further surgery for their daughter and claimed £1,000 in damages. After a few months of negotiation their solicitor gave up the case, in part perhaps because it was not very promising but also because the family was too poor to continue legal action.[43] In 1882 a surgeon at Great Ormond Street was charged with having improperly interfered with the dead body of an infant by performing an autopsy without parental consent.[44] The Vigilante Society had taken up this case to test the apparent presumption of the hospital authorities that post-mortem examinations were sanctioned unless notice to the contrary was previously given in writing by the nearest relative. In this instance the mother had not been informed that an autopsy would be performed when she visited the hospital soon after the death of her child, so never had a chance to refuse consent. Indeed she was not told after the fact, only discovering the telltale incisions later at the undertaker's office. However, after a week of deliberation, the judge dismissed the

[41] Ibid., p. 210.
[42] G.L.R.O., H9/EV/A2/3, Minutes of Committee of Management, 1887–1898, 3 June, 1887.
[43] G.L.R.O., H9/EV/A40/1–4, 'Legal action following surgery'; H9/EV/A2/3, Minutes of Committee of Management, 22 September, 1897, 22 December, 1897, and 26 January, 1898.
[44] 'Charge against a hospital surgeon', *British Medical Journal*, **i** (1882): 931.

summons on the principle that an examination was essential before a death certificate could be given, since the child had died only a few hours after being admitted to Great Ormond Street. But the judge also wished that the mother had been consulted before the autopsy was undertaken. The *British Medical Journal* agreed that more consideration should be given to the feelings of relatives, while exulting that the charge was dismissed.[45]

The actual abandonment of children in hospital was rare, although many little patients were brought to the hospital by 'friends' rather than by one of their parents. Neighbours must often thus have obliged when the mother was out working, or perhaps was unwell herself. Since home conditions were on many occasions described in hospital records as 'poor', or 'unsatisfactory', children were frequently kept as inpatients for months on end instead of being sent home to apparently inevitable neglect and regression. At the Evelina the average length of stay in hospital was 54.6 days for 1874, and as high as 60 days for 1876.[46] In 1882 the average length of stay had fallen to 36 days, but rose to 47 days in 1884. In 1886 it was 41 days and by 1892 was reduced to 30 days. Two methods were used to free beds for acutely ill children. Firstly, doctors and nurses were encouraged to visit patients in their own homes after discharge but, as we have seen, doctors in particular were reluctant so to spend their time. Secondly, convalescent homes were opened in rural areas, or by the sea, to receive patients who no longer needed intensive care but were not yet considered ready to be dumped back in their own homes. By the last quarter of the century all the larger children's hospitals had their own convalescent homes where, apart from those requiring enforced bed rest, the children could lead a more active and outdoor life than was possible in the parent hospitals. Apart from reclaiming valuable beds, it was practical to separate mischievous and lively convalescent children from their often acutely ill counterparts who needed peace and quiet.

Social conditions also often regulated the type of treatment received by the little patients. As will be seen, major surgery was likely to be performed on children afflicted with tuberculosis of the joints, whereas this was usually unnecessary among children who could receive long-term bed rest and full time nursing at home. Consideration that at best following resection of the hip or knee (see chapter 7) the child would survive as a cripple, whereas a patient treated more conservatively might recover movement of the affected joint, provides some measure of the influence of social circumstances on medical judgment. One can also argue that surgeons were only too keen to perform complicated operations when not restrained by more knowledgeable parents who were aware of less traumatic options. Be that as it may, family conditions were relevant at all stages of treatment. Quite often patients would improve while in hospital only to relapse after discharge. This was particularly true when diet was the critical factor, as with rickets and with marasmus, or malnutrition, in infants. Mothers would complain that they had neither the time nor the wherewithal to manage the child as recommended by the hospital. A dramatic example may be found in the records of the Edinburgh Children's Hospital. A little girl, M.B., aged five years was admitted on 18 October, 1893, suffering according to her mother from 'want of strength and bloodlessness'.[47] The mother, who had three other

[45] 'The Charge against the Hospital for Sick Children', *British Medical Journal*, **i** (1882): 963.

[46] Actually for the years ending 30 June, 1874 and 30 June, 1876, respectively. Reorganized in 1878, from 1879 onwards the Annual Reports for the Evelina covered the calendar year.

[47] Edinburgh Medical Archives, Disease Register for 'General Diseases' 1893–1895 (2b), LHB 5/11/3, p. 29.

healthy younger children, had worried that M.B. was backward at the age of nine months but on then being told by her doctor that the baby was an idiot and would not improve, had given up and left the child to herself. Fortunately, an aunt later took charge of M.B. and seems to have finally persuaded the mother to visit the hospital. M.B. was diagnosed as suffering from 'sporadic cretinism', admitted to the Edinburgh Children's Hospital, and treated with ground thyroid gland. Treatment was complicated by digestive disturbance that so frequently occurred when raw ground thyroid was administered but the child improved slowly if unsteadily. In January 1894, M.B. developed whooping cough and was sent home for six weeks. Her doctor was asked to continue the treatment but, according to friends, never visited the child who therefore received no thyroid for about five weeks when she was re-examined as an outpatient at the request of these friends. M.B. continued to be monitored by the hospital until at least the 15 August, 1895, and was re-admitted for a month during this period as she seemed to be relapsing. Finally, however, she was progressing nicely, 'wonderfully bright', speaking well, and playing with other children. This happy outcome would not have been possible without the persistent interest of M.B.'s aunt, of friends who kept the hospital informed when the child was neglected by her doctor and her mother, and by the hospital staff who were intrigued by the dramatic effect of thyroid on a formerly hopelessly ill child.

The most tangible measure available of the general condition of the patients was weight which was beginning to be systematically recorded by the end of the century. At the Royal Edinburgh Hospital for Sick Children, the register of cases of 'general disease' in the hospital between November 1893 and April 1895, consisted of 102 records which usually included the weight as well as the age of each patient on admission.[48] Of eight boys between the ages of two and three years, the heaviest weighed 29 lbs (13.2 kilos), the lightest a mere 17 lbs (7.7 kilos), and the mean for all eight children was only 22 lbs or 10 kilos. In 1898 John Thomson, extra physician to the Edinburgh Hospital for Sick Children, indicated that an averaged sized baby at birth weighed about seven pounds, should have tripled this weight by the end of the first year, and then gain five to six pounds in the second year and about four and a half during the third year.[49] According to Thomson, therefore, the average child would weigh about 26 lbs (11.8 kilos) at its second birthday and about 31 lbs (14 kilos) at its third birthday, which was appreciably more than the mean for the eight children above. While explaining that weight is an unsatisfactory measure particularly when height is unknown, J. M. Tanner graphs modern weight standards for boys between the ages of two and three years as showing 50 per centile measure of about 13 kilos, and a 3rd centile of about 10 kilos.[50] The Edinburgh patients were so much below the modern norm that chronic malnutrition would seem to be undeniable although some account must be taken of the fact that acute sickness may have caused wasting. In one boy, who came in with typhoid fever, this may indeed have been true, but six of the remaining boys were probably chronically malnourished. In effect three of them were admitted with rickets, another boy was simply diagnosed as malnourished without any other obvious

[48] Edinburgh Medical Archives, Disease Register for 'General Diseases' 1893–1895 (2b), LHB 5/11/3.

[49] John Thomson, *Guide to the Clinical Examination and Treatment of Sick Children* (Edinburgh: William F. Clay, 1898), p. 3.

[50] J. M. Tanner, *Foetus into Man: Physical Growth from Conception to Maturity* (Cambridge: Harvard University Press, 1978), pp. 179–87.

Appendix
Weights of Two Hundred and Fifty Children
(Taken consecutively and without selection from the Hospital Books).

Age	No. Weighed	Lowest Wt.		Highest Wt.		Average Wt.	
		lb.	oz.	lb.	oz.	lb.	oz.
1 Month	1	8	0	8	0	8	0
2 Months	7	7	12	12	4	8	2
3 Months	20	6	10	25	0	14	2
4 Months	8	4	0	13	2	9	0
5 Months	7	4	10	38	0	13	8
6 Months	3	7	14	22	8	13	0
7 Months	4	7	8	13	8	11	1
8 Months	3	12	5	14	6	13	3
9 Months	1	12	8	12	8	12	8
10 Months	2	11	4	20	0	15	15
11 Months	4	10	0	13	0	12	1
12 Months	7	10	0	17	10	15	0
13 Months	7	10	0	16	8	12	0
14 Months	15	7	2	22	0	14	1
15 Months	4	17	0	18	14	17	4
16 Months	15	8	0	22	0	14	1
17 Months	4	12	10	14	0	12	13
18 Months	8	14	0	28	0	15	8
19 Months	3	13	4	19	8	16	4
20 Months	5	14	0	23	6	17	0
21 Months	2	11	8	11	10	11	5
22 Months	2	13	0	15	0	14	0
23 Months	0	–	–	–	–	–	–
2 Years	26	12	0	26	0	17	12
3 Years	21	15	4	39	12	24	0
4 Years	14	18	0	36	0	27	8
5 Years	14	23	8	44	8	29	2
6 Years	9	21	0	39	6	21	6
7 Years	13	29	0	51	0	34	1
8 Years	1	40	0	40	0	40	0
9 Years	9	35	12	46	8	38	6
10 Years	6	40	0	56	0	45	2
13 Years	5	54	0	69	8	57	4

An Average child at birth should weigh 8 lbs.
An Average child at 1 year should weigh 24 lbs.
An Average child at 6 years should weigh 48 lbs
An Average child at 13 years should weigh 82 lbs.

Source: Appendix to 'The Story of the East London Hospital for Children', by Mrs. Heckford, in Earl of Lytton (ed.), *Voluntaries: for an East London Hospital* (London: David Stott, 1887), pp. ix–l.

illness, one who came in with ophthalmia weighed only 21 lbs, and another with epilepsy weighed 20 lbs. Only one child with enlarged tonsils and eczema weighed a respectable 29 lbs. However, he was considered unusual for the admitting officer described him as 'very big for his age. Muscles very well developed'.[51] Further to confound generalizations, this boy was said to come from 'unsatisfactory surroundings', and not to be well cared for. His eczema was thought due to a skin made irritable by ingrained dirt, and the condition improved considerably after ten days in hospital.

Even worse examples of prolonged malnutrition may be found in the same hospital records. One little girl aged five years was admitted to the Edinburgh Children's Hospital in 1895 suffering from rickets and weighing only 19 lbs. An orphan, this child, according to the medical report, was 'not very well looked after. Has been getting food of practically any kind'.[52] Brought in by a woman who knew little about her, the little girl was said never to have been able to walk. In hospital she was described as improving and 'going about' (presumably walking) every day but after two weeks she was removed by her 'parents'.

To obtain funds for the East London Hospital for Children a book of essays, or *Voluntaries*, was published in 1887. Here, appended to a history of the hospital written by Mrs. Heckford (wife of the medical founder), may be found a table depicting the weights of 250 children, 'taken consecutively and without selection from the Hospital Books'. No further details were provided but the obvious purpose of the chart was to demonstrate that on average patients brought to the hospital weighed less than the average for their years, as then calculated.

We do not know for what complaints these children were brought to the East London, nor even whether they were in- or outpatients, although probably the latter. A mean weight of 8 lb at birth seems high even by modern standards, and it will be remembered that Thomson had proposed 7 lb as the average weight at birth. Also strange, and unexplained, are the recordings of a five month old baby weighing 38 lbs, and of a three month old one weighing 25 lbs. Too much value cannot therefore be placed on this mere record of figures without explanatory text. It will be noticed, however, that from the age of 12 months onwards not even the children registered as of highest weight for any given age had reached the general mean, as then calculated. In spite of distortion of the average by grossly overweight babies, some, perhaps many, of the infants included in the table may have been of reasonable weight, presumably because they were breast fed. But, beyond the age of weaning, chronic undernutrition seems to have been the norm. The hospital, situated in Glamis Road, Shadwell, close to the London docks, served one of the poorest areas of the metropolis. With its south side on the river, the parish of Shadwell was part of the Stepney Union with the rest of Stepney extending to its north east, with Mile End to the north, and St. George's in the east on its west side. The latter district, according to Charles Booth, had the largest percentage of people (48.9 per cent) living in poverty of any London district apart from Holborn, which had the same proportion.[53]

Malnourished children would not have displayed the energy and liveliness considered normal for children in developed countries today. Perhaps for this reason little mention

[51] Edinburgh Medical Archives, Disease Register for 'General Diseases' 1893–1895 (2b), LHB 5/11/3, p. 158.
[52] Ibid., p. 132.
[53] Charles Booth, *Life and Labour of the People in London* (London: Macmillan, 1892), Vol. II, Appendix, Table II.

was made in hospital records of intolerable misdemeanours although greater self-discipline and conformity to rules was usually expected in the nineteenth century. As mentioned, the nurses were expected to be patient with and kind to their little charges, but one also gains the impression that they were not frequently challenged by unruly patients. Exceptions were made with children suspected of malingering, a not uncommon diagnosis in the nineteenth century. One little girl of seven years was admitted to Great Ormond Street suffering from seizures suspected by Dr. Dickinson, the physician in charge, of being of hysterical origin. Her first convulsive attack while in the hospital was carefully observed by the nurse in charge. 'Two similar attacks which threatened to occur in the course of the same afternoon were cut short by a few smacks with a wet towel, and a sharp reprimand from the nurse'.[54] When faced with presumed 'moral' illness, physical punishment was in order. If 'immoral' behaviour was persistent, the child might be considered a bad example to others and sent home. One boy of nine, admitted to Great Ormond Street with epilepsy, was discharged unrelieved after a stay of two months because, according to West, 'he had become liable to occasional seizures of maniacal excitement, in which he attacked other patients; besides which if any circumstances displeased him, he not infrequently stripped himself and walked about the ward naked, and this although usually a perfectly well-conducted child'.[55] Far commoner were descriptions of children as 'apathetic' or even 'whingy', a word used in the northern parts of the country to mean 'whimpering', or 'whining'. Passive resistance rather than aggressive behaviour seems to have been the order of the day, although with very sick children, as many were particularly on the medical wards, this would be a natural reaction to strange hospital surroundings and customs. The records most likely painted too glowing a picture of 'cured', or 'much improved', children who had not only regained their health but also were livelier and more outgoing. Babies, on the whole, did not do well in the hospitals unless they stayed for only a short while. On the other hand, once on the road to recovery many older children who were neglected at home may have enjoyed the unaccustomed attention, companionship, regular meals, and opportunity to play, they received in hospital.

Naturally enough, speakers at annual meetings described their hospitals and patients in glowing terms. The mayor of Manchester thus described Pendlebury after a visit:

> It is a beautiful sight—all the material conditions surrounding it, the neatness and cleanliness, and the various convenient appliances, are simply admirable, and the whole atmosphere of the place is one of cheerfulness and hopefulness. The little children themselves, to a large extent, were full of smiles, and there was an air of comfort and contentment and happiness among them that was extremely pleasant, and that really it was a great privilege to witness.[56]

To the modern mind, such descriptions and the appeals for money in the annual reports, or as delivered by Charles Dickens and others, may seem couched in overly sentimental

[54] H. T. Butlin, 'Hospital for Sick Children. Cases of Malingering', *Lancet*, **i** (1871): 819–21.

[55] Charles West, 'On the Mental Peculiarities and Mental Disorders of Childhood', *Medical Times and Gazette*, **i** (1860): 133–7.

[56] *Fifty-Fourth Annual Report of the General Hospital and Dispensary for Sick Children* (Manchester, 1883), pp. 19–20.

language. But an emotional style that would seem overblown and maudlin today was quite unexceptional in the Victorian era. Furthermore, when it came to case notes the language was as detached as any now in use. Indeed, one is taken aback by the amount of pain and anguish children were sometimes expected to endure. Tonsils, for example, were routinely removed without anaesthesia. According to Ashby and Wright, 'Chloroform should be given if the child will not allow removal otherwise; there is no objection to it except that it makes the operation somewhat more troublesome'.[57] The reverse would seem more likely but the authors probably meant that the immediate post-operative stage was less troublesome with a conscious child able to cough up any accumulated blood. Furthermore, by the end of the century various kinds of local anaesthesia were being introduced to allay pain during brief interventions. Cocaine was considered too unpredictable in action for regular use in children but skin cooling with ice or various sprays was safe and effective. For example, Ashby and Wright recommended freezing the skin with an ethyl chloride spray for exploratory punctures such as required to remove fluid from cavities.[58] They also disapproved of the still current practice of repairing hare-lips in infants without general anaesthesia. Undoubtedly anaesthetic agents were used more and more liberally as the generations of surgeons, who had practised without and who expected stoicism, were replaced by men accustomed to the advantages of analgesia.

[57] Henry Ashby and G. A. Wright, *The Diseases of Children, Medical and Surgical* (London: Longmans, Green, 1899), p. 75.
[58] Ibid., p. 818; actually Alexander Wilson contributed this chapter on 'Anaesthetics for Children'.