Conclusion

Within half a century hospitals for children had become established features of the British medical landscape. By 1900, the formerly entrenched notion that sick children would not prosper away from home had given way to the other extreme. Now, it would seem, children required to be isolated in institutions entirely dedicated to their care. As Roger Cooter has indicated, there was a 'gradual disappearance towards the end of the nineteenth century of hospitals for both women *and* children, and the subsequent rise of special institutions for each'.[1] He suggests that hospitals for women embodied distinctive conceptions of femininity while those for children 'implicitly embodied social and moral notions of childhood'. If so, perceptions of childhood had appreciably changed from those extant in early Victorian times when babies had been considered inseparable from their mothers and older children, if hospitalization was inescapable, as best cared for in the women's wards.

When, in spite of such misgivings, small paediatric hospitals were instituted it appeared that in the main neither parents nor children much minded being apart. Modern psychiatric theory would suggest that appearances were deceptive, and that signs of depression and separation anxiety in the patients were being ignored or misunderstood. Charles West was rather exceptional in insisting that babies did not belong on hospital wards. Most other British physicians assumed that irreversibly serious physical illness was the main cause of death among hospitalized infants and that improved knowledge, associated with earlier admission, would prove beneficial. Older children, sometimes hospitalized for months or even years, usually resigned themselves to institutional life. Under the most favourable circumstances the nurses, themselves not much older than their charges, made life as pleasant as possible for the children. As has been noted, the ratio of nurses to patients was high, almost one to two at Great Ormond Street in 1891, allowing for more leisurely relations than in the usual general hospital. However, informal entertainment by nurses, parents and friends, and lady visitors was the only occupation for the patients since, as far as can be made out, during the nineteenth century British paediatric hospitals did not employ teachers even for long stay older children. Furthermore, as the century progressed, visiting hours were steadily restricted ostensibly to reduce the risk of infection but also, one suspects, because the hospital wards ran more smoothly when unencumbered by the presence of relatives. For similar purposes in 1894 notices were placed in the outpatient department of the East London Hospital for Children to the effect that henceforth only one adult would be allowed into the hospital with each patient, whereas formerly two or more 'parents and friends' had frequently accompanied each child to its cot.[2]

Mixed institutions, for example the Manchester Clinical Hospital, and the East London Hospital, Shadwell, usually only 'admitted' women as dispensary patients. The Bristol Hospital for Children originated in 1866 with a similar policy but ten years later opened a small ward for women requiring surgery, and by 1888 this had expanded to two wards for

[1] Roger Cooter, 'Introduction', in Roger Cooter (ed.), *In the Name of the Child: Health and Welfare, 1880–1940* (London: Routledge, 1992), pp. 1–18.

[2] Queen Elizabeth Hospital for Children Archives, Minutes of Medical Committee, East London Hospital for Children, 9 March, 1894.

gynaecological cases.[3] Twenty-two women were admitted to the hospital that year as opposed to 632 children. No notes of recommendation were required from anyone but charges were made for all outpatient visits (women and children) and for women admitted as inpatients. Bristol, therefore, became more 'mixed' as the century wore on, in part to help balance the hospital budget without overdependence on subscribers. Yet, even in the more usual circumstances where women were treated simply as outpatients, difficulties arose. At the East London Hospital, Shadwell, the medical committee complained 'that a large proportion of the women casualties are alcoholic cases and coming at night disturbing the necessary rest of the already hard worked residents'.[4] No proper accommodation was available for the treatment of such cases which anyway, according to the medical committee, was outside the original description of the hospital. The medical staff wanted women to be excluded as casualties and for adult outpatients to be limited to mothers bringing their children as patients to the hospital. Three years later the hospital doctors were still having trouble with drunken women, often it would seem, accompanied by equally drunken, and more violent, men.[5]

For such reasons, and many others, it was simpler and apparently more effective to run institutions entirely dedicated to the care of children. The relatively small paediatric hospitals, with 50 to 200 beds by the end of the century, restricted their maintenance costs to drugs, diets, surgical appliances, beds, linen and furniture suitable for the young without the need also to cater for adult requirements. Funds were easier to attract when donors were certain that their contributions would be spent on the welfare of innocent, helpless children rather than on adult patients perceived as more likely to be responsible for their own ill health. The possible loss of contributions was also advanced as a reason for not introducing pay beds in children's hospitals. In 1897 the medical committee of the East London Hospital for Children declared itself entirely opposed to payments by inpatients even though funds were so strapped that the house surgeon and physician received no salary. It was deemed out of line with the constitution of the hospital to charge for inpatient care and so exclude a number of poor children, of whom there were so many in the neighbourhood. Another possible factor, unstated however, was that children from more affluent families, and their parents, would be more demanding. The uncomplaining gratitude expected of families of patients on charity would give way to expectancies associated with fee for service.

Although the great majority of acute paediatric hospitals had the same policy as the East London, some left open the possibility of getting extra funds through paying patients. Thus the rules of the Hospital for Sick Children, Nottingham, required parents to sign a 'declaration of poverty', but allowed children of 'not poor' parents to be received on full payment of expenses.[6] Furthermore, the newer, and usually much smaller, convalescent and chronic care homes often did charge for services. By 1890 a weekly payment of from 5s. to 10s. was usual although free beds were often available for needy cases. Here again

[3] Charles J. G. Saunders, *The Bristol Royal Hospital for Sick Children* (Bristol, 1960), p. 11; *Twenty-Third Annual Report of the Bristol Hospital for Sick Children and Women* (Bristol, 1889), p. 3.

[4] Archives at the Queen Elizabeth Hospital for Children, Medical Committee Minutes, East London Hospital for Children, 6 March, 1891.

[5] Ibid., 22 June, 1894.

[6] *4th Annual Report of the Free Hospital for Sick Children at Nottingham* (1873), p. 6 and p. 17.

the Charity Organization Society played its part not only in verifying statements of financial distress but also in ensuring that assistance, once determined upon, was adequate.[7] Some of the convalescent hospitals were extensions of city based children's hospitals, as Cromwell House, Highgate, was set up to receive recovering patients from Great Ormond Street, but an even larger number were small, independent institutions, established for a variety of reasons. Some were for poor city children in need of country air, others for convalescents, for chronically sick children or for orphans needing a change of environment. All needs were catered for apart from children with infectious diseases, who were rigorously excluded. They were not ignored, however, since they formed the majority of patients admitted to city fever hospitals. In the year ending June 1890, Monsall Fever Hospital, Manchester, admitted 1,564 cases of scarlet fever (representing 68 per cent of all patients admitted that year) of which 1,305, or 83 per cent, were children under 15 years of age.[8]

Thus, by the end of the century special institutions were perceived as the ideal means of restoring and maintaining the health of poorer working-class children. What seems to have evolved was enormous trust in the value of institutional care, rather than any furtherance of middle- and upper-class rejection of the home environment of needy children. For, during the same period of time, more affluent parents were sending their sons, and even their daughters, in ever increasing numbers to boarding school, often initially to preparatory schools at the early age of seven years. By the end of the Victorian era society seems to have decided that even very young children could manage quite well without their families for long periods of time and were often better off in a structured environment managed by adults more or less dedicated to their wellbeing. Thus the innocence of childhood could be protected (or so it was believed) and the young given a chance to develop moral character and physical fitness. What had begun as an ideal for upper-class boys spread to incorporate all children for, as Carolyn Steedman points out, 'despite the powerful restraints of class, we can witness an appropriation of the children of the labouring poor to the romantic ideal of childhood, from the middle years of the nineteenth century onwards'.[9]

Nowhere was the concept of childhood innocence more central than in the paediatric hospitals. Most of the original constitutions excluded patients over the age of ten or twelve years, so also excluding the risk of admitting children undergoing the physical and mental changes associated with puberty which, in the nineteenth century, usually happened appreciably later than in modern times. However, the medical staff, operating under a broader agenda, failed to co-operate in maintaining rules that so limited the spectrum of disorders to be investigated. Mrs. Anderson's wrath at the admission to the Edinburgh Hospital for Sick Children of a girl suffering from acquired venereal disease, discussed in a previous chapter, reflected revulsion against a patient who, superficially at least, so patently lacked the attributes of innocence. The established image of blameless suffering and impotence created an irresistible appeal to public benefactors. Furthermore,

[7] *Charities Register and Digest* (1890), p. ix.

[8] Cases under treatment in the Monsall Fever Hospital were tabulated in the *Report of the Manchester Royal Infirmary, June 25, 1889 to June 24, 1890*, pp. 119–23.

[9] Carolyn Steedman, 'Bodies, Figures and Physiology: Margaret McMillan and the late Nineteenth Century Remaking of Working Class Childhood', in Cooter (ed.), *In the Name of the Child*, pp. 19–44.

philanthropists would point out, almost ritually at hospital annual general meetings, that dealing with children and providing for their needs would bring out the finer qualities of human nature. The giver, or the active helper, would not only feel better but also improve as a person through service to sick children. The appeal was presumed most powerful when associated with institutions totally dedicated to the care of the young.

In Britain this dedication was mainly exhibited through the provision of specialized nursing services and of modernized physical surroundings. By the end of the century most of the children's hospitals had been relocated at least once since their inception. For the children of Manchester and Salford, Pendlebury Hospital, built on the most hygienic plan then available, opened in 1873 and remains in service to this day. Two years later, in 1875, a new building was opened at Great Ormond Street which remained viable until very recently. In 1895 the Edinburgh Children's Hospital moved to a specially constructed building on Sciennes Road which also continues to function. While hardly able to balance their annual budgets and while outcries of hospital abuse were rife, hospital directors confidently set about planning extensions to existing buildings or even entirely new structures which, they pointed out, were essential to allow for expansion in nursing services, in surgery, and in outpatient care. Usually they obtained the required capital through the expediency of setting up a building fund dedicated to the desired improvements. As was demonstrated in the 1980s by the incredible response to the 'Wishing Well Appeal' then launched for the rebuilding of Great Ormond Street, people of all ages and from all walks of life will contribute generously to a structure seen as essential for child care and survival.[10] Although in the late nineteenth century it had become almost impossible to obtain sufficient regular annual contributions to support the ever growing number of charitable institutions, the once-only special gift to a building fund was quite readily obtainable to children's hospitals.

As befitting to a charity, the senior hospital medical officers continued to volunteer their services while their income was derived from private practice which was rarely confined to children. Ostensibly because it was unnecessary, perhaps also because it was rarely likely to be remunerative, physicians and surgeons avoided specialization in paediatrics and even tended to regard such specialization as harmful rather than an ideal to be attained. Had they been salaried hospital attendants as on the Continent, or had paediatric private practice appeared more promising as in the United States, British doctors might have thought otherwise and placed more pressure on universities and medical schools to establish departments of paediatrics.[11] For lack of university backing, and because of their part-time status, they also undertook less laboratory based research than their French and German colleagues. Paul Weindling, using the development and testing of diphtheria anti-toxin as an example of this disparity, has shown that the influential British anti-vivisection movement also impeded medical research.[12] He suggests that finally the success of serum

[10] A vivid description of how the Wishing Well Appeal raised £42 million in two years may be found in Jules Kosky and Raymond J. Lunnon, *Great Ormond Street and the Story of Medicine* (London: Hospitals for Sick Children and Granta, 1991), pp. 52–3.

[11] The emergence of paediatrics as a speciality in the United States is discussed in Sydney A. Halpern, *American Pediatrics: The Social Dynamics of Professionalism, 1880–1980* (Berkeley: University of California Press, 1988).

[12] Paul Weindling, 'From Isolation to Therapy: Children's Hospitals and Diphtheria in *fin de siècle* Paris, London and Berlin', Cooter (ed.), *In the Name of the Child*, pp. 124–45. Stephen Paget, *Experiments on Animals* (London: James Nisbet, 1906), pp. 338–45, lists and discusses the anti-vivisectionist arguments against the use of diphtheria anti-toxin.

therapy in combating such a deadly disease as diphtheria 'reinforced the scientific approach to child health'. However, this phase belongs to the twentieth century. In the nineteenth, as we have seen, most of the research in British paediatric hospitals was of clinical and of pathological nature, consisting of investigations that did not require special equipment and extra funding. Although the advancement of medical science was one of the reasons given for founding children's hospitals, as stated in most annual reports, committees of management were then thinking in terms of research as it was prosecuted in the 1850s. They continued to do so for the rest of the century. As has been discussed, the management committee of Birmingham Children's Hospital originally rejected Drs. Ballard and Welch's project to investigate infantile diarrhoea because the plan involved mothers being admitted with their babies and maintained at the expense of the hospital.[13] Bacteriological examination of samples was to be carried out in London since the hospital had no facilities. A room for 'chemical and microscopical examination' was finally provided in 1904.[14]

The medical staff of paediatric hospitals were lax in insisting on the need for biochemical and microbiological laboratories, probably because they themselves had neither the time nor the training for such protracted investigations. The same was not true for radiological equipment, which was introduced into most paediatric hospitals within a few years of Roentgen's discovery of X-rays in 1895. The speed with which radiology emerged as a medical speciality forms an arresting contrast to the delays and false starts that afflicted paediatrics. A Roentgen Society was formed in London in 1897 and within two years it had over 150 members.[15] A journal of radiology had already been instituted with contributions from medical men firmly describing themselves as radiographers. To some extent specialization was forced upon the profession by outside circumstances beyond its control. For commercial outfits had appeared where patients could be X-rayed upon request and, in America at least, skiagraphs were being used to prove malpractice against orthopaedic surgeons.[16] Furthermore, before the end of the century, both French and American surgeons were being sued for skin lesions rather obviously caused by long exposure to Roentgen rays used diagnostically. For defensive purposes, quite apart from the challenge posed by the complex technology involved in both taking and interpreting X-ray films, the profession needed to produce its own specialists. No such imperatives existed for paediatrics.

Even surgery, although far more frequently undertaken in children's hospitals than originally anticipated, was rarely of an experimental nature, instead usually involving the application of methods developed elsewhere, either in general hospitals or abroad. Osteotomy to straighten deformed legs, although extensively practised in paediatric hospitals after about 1880, was originally undertaken by surgeons at the Glasgow and Edinburgh Royal Infirmaries. The general hospitals were the traditional repositories of patients requiring major surgery, including children, and continued to fulfil this role for the rest of the century. There was performed much of the acute abdominal surgery while

[13] Birmingham Children's Hospital Archives, Minutes of Committee of Management, 17 June, 1881.

[14] Rachel Waterhouse, *Children in Hospital: A Hundred Years of Child Care in Birmingham* (London: Hutchinson, 1962), p. 87.

[15] 'The Roentgen Society', *Lancet*, **ii** (1899): 390.

[16] C. H. Golding Bird, 'Remarks on Skiagraphy and Fractures: Especially in their Medico-Legal Relation', *British Medical Journal*, **i** (1901): 1390–4.

the children's hospitals mainly confined themselves to less dangerous operations such as tonsillectomies, osteotomies and the repair of hernias. Because they were latecomers to the surgical scene, these special hospitals were perhaps not yet fully trusted by general practitioners referring acute cases, or by surgeons who also had beds in the general hospitals. The higher mortality rates which would undoubtedly have accompanied the performance of major surgery were also best avoided by fledgling institutions. However, at the end of the century most of the children's hospitals were opening new operating theatres, acquiring X-ray equipment, and generally enlarging their surgical departments, so poising themselves for greater contributions to this branch of paediatrics. The cautious period of trial was coming to an end.

During the first decades the managers of children's hospitals had mainly sought to demonstrate that sick children would get better in their institutions, which would not be hotbeds of infection as had been predicted. Important requirements, therefore, were statistics showing high rates of cure accompanied by low rates of mortality and of outbreaks of infectious disease. In opposition to such desirable results were the patients themselves who presented with all kinds of diseases, including infectious ones, and the hospital doctors who preferred challenging cases to mildly ill children. Taken most seriously, according to hospital reports, was the avoidance of outbreaks of 'fevers'. Each unexpected case was investigated and rules for prevention became stricter including, as we have seen, the curtailing of family visiting rights. Also involved however was considerable expense, including isolation rooms and round the clock special nursing for infective patients. Furthermore, major outbreaks usually led to costly reassessments of sanitary and isolation facilities and sometimes to the entire rebuilding of parts of an hospital. In Manchester the decision to establish a new hospital in the country was made in part because of repeated outbreaks of typhus, or typhoid, fever in the original building in the late sixties.[17] These fevers could not then be distinguished but were associated with insalubrious air, dirt, and deficient drainage. The gradual establishment of publicly funded isolation hospitals during the last quarter of the nineteenth century served to liberate the paediatric hospitals from one of their most onerous and expensive liabilities. Thereafter they used the funds and space to enlarge, or even originate, facilities for surgery and for training nurses, but not yet for laboratories.

The plethora of small paediatric hospitals that were launched during the second half of the nineteenth century were not cost effective and coped with only a small proportion of sick children. More efficient and fairer services might have emerged had the state controlled the development of special hospitals (as it did that of fever hospitals), or had the general hospitals taken a greater interest in the care of sick children. On the other hand, the small and private nature of British paediatric institutions made possible an atmosphere of care and concern for patients that is not usually found in large institutions of any kind. Because the children spent weeks or months in the hospitals, and were relatively few in number, they were often well known not just to the medical and nursing staff on their wards, but to the rest of the hospital staff. Individual cases were discussed at meetings of management committees and regulations frequently relaxed under special circumstances.

[17] *Thirty-Seventh Annual Report of the General Hospital and Dispensary for Sick Children* (Manchester, 1866), pp. 8–9.

Disinterest in laboratory based research rendered unnecessary unpleasant and painful procedures such as the taking of blood. All in all, children's hospitals cultivated a more informal and unstructured atmosphere than that prevailing in general hospitals. To this day the difference persists and most paediatric hospitals are remarkable for their ability to implement the technical requirements of modern medicine while retaining a relaxed climate suitable for children and their anxious relatives.