

Medicalizing Childhood:  
Pediatrics, Public Health, and Children's Hospitals  
in Nineteenth-Century Paris and London  
by  
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## ABSTRACT

During the nineteenth century, children's physical health became a dominant theme in France and Great Britain, two of Europe's pediatric pioneers. This dissertation examines how British and French doctors, legislators, hospital administrators, and social reformers came to see the preservation of children's physical health as an object of national and international concern. Medical knowledge and practice shaped, and was shaped by, nineteenth-century child preservation activities in France and Great Britain, linking medicine, public health, and national public and private efforts to improve the health of nations, especially that of their future members. Children's hospitals played a significant role in this process by promoting child health; preventing and combating childhood diseases; fostering pediatric professionalization and specialization; and diffusing medical-based justifications for child welfare reforms in the second half of the century. This deeply contextualized tale of two hospitals, Great Ormond Street Hospital for Children in London (1852) and Sainte-Eugénie in Paris (1855), traces a crescendo in the interest, provision, and advocacy for children's medical care over time: from founding homes and dispensaries to specialized hospitals with convalescent branches and large outpatient clinics. As a comparative study of the medicalization of children's bodies between 1820 and 1890, this dissertation also investigates the transnational exchange of medical ideas, institutions, and practices pertaining to child health between France and Great Britain during a period of nation-building. Specialized pediatric institutions in Paris and London built upon and solidified local, national, and international interests in improving and preserving child health. Despite great differences in their hospital systems, French and British children's hospital administrators and doctors looked

to one another as partners, models, and competitors. Nineteenth-century French and British concerns for national public health, and child health in particular, had important distinctions and parallels, but medical, institutional, and legislative developments related to these concerns were not isolated activities, but rather, tied to transnational communication, cooperation, and competition.

## DEDICATION

For the patients of Great Ormond Street Hospital for Children and Sainte-Eugénie

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## CHAPTER 1

### INTRODUCTION

On January 6, 1859, a feverish seven-year-old child was admitted to an urban European children's hospital with chronic bronchitis. After fifty-three days in a children's ward, the young patient travelled to a convalescent hospital to recover in a wholesome setting located about seventy kilometers away. Across the English Channel, in a second hospitalization that year for the same condition, another four-year-old child who was prone to attacks of croup and inflammation of the larynx and lungs was admitted to another urban children's hospital on May 15, 1861, with an acute case of bronchitis. The patient remained in the hospital for thirty-six days, and upon improvement, was dispatched to a convalescent home located fourteen kilometers from the hospital. Both patients received care at their city's children's hospital free of charge because they came from poor families. Their ill health stemmed in part from dirty, disheveled city-living that offered little nourishment, overcrowded living spaces, poor sanitation, and little instruction or opportunity to practice good personal hygiene. Their medical practitioners prescribed sojourns at country convalescent homes in attempts to build up their fragile constitutions in healthy environments far away from their homes—sites of dirt, disease, and potentially death. Sainte-Eugénie, one of three children's hospitals in Paris, admitted the first child; the second child was a patient at Great Ormond Street Hospital, London's only children's hospital at the time. Despite their different locations, the circumstances of these child patients display remarkable similarities that cut across national boundaries

and underscore the intersection of childhood disease, public health, and children's hospitals during the nineteenth century.<sup>1</sup>

A careful social and cultural analysis of childhood health and disease through the lens of the medical institutions and practitioners that cared for sick children demonstrates connections between medicine, public health, and concerns about the strength and vigor of individuals and populations in nineteenth-century France and Great Britain. With a particular focus on two nineteenth-century children's hospitals in Paris and London, Sainte-Eugénie and Great Ormond Street Hospital (GOSH), this study examines how French and British doctors, legislators, and social activists came to see the protection of children's health as an object of national concern and the role of children's medical institutions in a dynamic process that I refer to as the early medicalization of children's bodies between 1820 and 1890. Arguing that medical knowledge and practice shaped, and was shaped by, nineteenth-century child welfare activities in Great Britain and France, this dissertation examines the role of the medical community in French and British child welfare efforts; the relationship between growing interests in infant and child health; the professionalization and specialization of pediatrics; and the diffusion of pediatric knowledge within wider social reform efforts in the second half of the nineteenth century.

A comparative and transnational approach demonstrates how a broad range of child health issues became subsumed in public health rhetoric within and across French and British national borders. Nineteenth-century French and British efforts to improve the

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<sup>1</sup> Archives de l'Assistance publique (AP/HP), Registre d'entrées, l'hôpital Sainte-Eugénie, patient #30, Emmanuel Normandin, admitted on January 6, 1859, and discharged to Roches Guyon on February 28, 1859. Historical Hospital Admission Records Project (HHARP) database, patient Edward Glover from Drury Lane, London, admitted on May 14, 1861, and sent to Mitcham on June 16, 1861.

health of the nation, including its youngest members, had international implications, and national leaders, public health officials, statisticians, doctors, and reformers looked to their European neighbors as models. Defining transnationalism as the movement of ideas and practices across national borders, this study explores the transnational dimensions of medicalizing childhood in France and Great Britain—the cross-cultural sharing, adopting, and adapting of medical ideas, institutions, and practices that pertained to child health. A transnational perspective on Franco-British exchanges in the fields of children's medicine and public health emphasizes how interrelated these topics were in the nineteenth century and how together they formed a crucial axis for internal projects of nation-building.

Since children's health and welfare is inextricably entwined with the health of their mothers, caregivers, and families, this study also explicitly addresses how class, gender, and familial issues accompanied this medicalized focus on children. In the nineteenth-century, the children's hospitals of Paris and London, like most hospitals, were welfare institutions, and they overwhelmingly served the children of poor and underprivileged families. In both countries, pediatrics, more than any other emerging medical specialty, needed the assistance of women, especially poor mothers and nurses, to prevent childhood diseases. These women cared for children on a daily basis; they, not doctors, inspectors, or public health officials, ultimately had the responsibility for implementing the proper feeding and hygiene practices preached by the experts. These circumstances created sites of collaboration and conflict among medical practitioners, hospital administrators, and family members seeking care for their sick children. The setting of the children's hospital highlights the contested terrains of children's medicine,

in which institutions, doctors, and family members challenged and negotiated their authority over young patients' medical care. Families sometimes followed doctor and hospital policies and recommendations; other times, they did not. Hospital administrators occasionally placed limits on doctor's powers, while doctors often disregarded or disputed institutional policies for the best interest of the patient or for professional ambitions. After the establishment of these children's hospitals in the 1850s, medical professionals and non-medical administrators and reformers—men and women alike—debated the role of the state, the medical community, and the family in providing for the physical health and welfare of children, a necessity that the wards of Sainte-Eugénie and GOSH made abundantly clear.

A study of the medicalization of children's bodies bridges two dominant theories on why the nineteenth century witnessed a rise in the attention and value placed on children. The notion of childhood is a social construction, and actions and attitudes surrounding children have been crafted and circulated differently according to specific times and cultures.<sup>2</sup> Similar to the notion of the innocent child, the sick child as an object to be protected and preserved by their own family is not a modern phenomenon, but the state impetus to assign joint responsibility of that task to public welfare institutions and regulatory bodies is a more recent development.<sup>3</sup> Michel Foucault and Jacques Donzelot argue that far from being privatized, childhood came under greater public scrutiny and surveillance during the nineteenth century, particularly through doctors and institutions

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<sup>2</sup> Philippe Ariès, *Centuries of Childhood: A Social History of Family Life* (New York: Vintage, 1962).

<sup>3</sup> Linda Pollock, *Forgotten Children: Parent-Child Relations from 1500 to 1900* (Cambridge: Cambridge University Press, 1983) uses numerous diaries and autobiographies to argue that the majority of early modern and modern parents maintained loving, protective relationships with their children and that parental discipline was and remains an integral, yet complex part of the parental role.

like the hospital. Foucault's insights on the "political economy of the body" and efforts to discipline and regulate bodies and populations through "scientific-juridical discourses," or bodies of knowledge that fused science and law, are a departure point for this study.<sup>4</sup> Doctors and medical institutions were integral components of this disciplinary process aimed to improve and control individual's physical health.

Similarly, Donzelot's study on the "policing" of French children and families by a "tutelary apparatus" of charities, social welfare agencies, schools, and hospitals also informs my perspectives on the nineteenth-century children's hospital, especially his insights on how class and gender infused cultural attitudes toward children and families, particularly mothers, and how efforts to police bourgeois and working class children and families took different forms.<sup>5</sup> In bourgeois families, doctors in particular formed alliances with mothers as domestic nurses and protectors, while for families of the *classes populaires*, doctors, along with social reformers, and legislators, sought to directly intervene into family affairs, even if it meant circumventing the mothers to reach the children. In addition to Donzelot's silence on public children's hospitals (except for foundling hospitals), my work departs from his in two significant ways: while the children's hospital was essentially a poor child's institution, childhood diseases placed all children on equal footing, and the hospitals were incubators for the study of a branch of medicine with the potential to help all children regardless of class. As a public welfare institution, the children's hospital might be considered a state instrument to "police" the health of poor children, but mothers were agents in their child's health care, not simply

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<sup>4</sup> Michel Foucault, *Discipline and Punish: the Birth of the Prison* (New York: Vintage, 1995), 25-28; and *A History of Sexuality, Vol. I: an Introduction* (New York: Vintage, 1990), 11-2, 25-6.

<sup>5</sup> Jacques Donzelot, *The Policing of Families* (Baltimore, MD: John Hopkins University Press, 1977), 16, 24, 31-2.

“state-approved nurses” or submissive subjects of direct surveillance. This study looks beyond the institutional powers to punish and police, focusing instead the children’s hospital as a site where the merger of medical knowledge and social reform performed the power to heal and protect sick children. While acknowledging that both sentimentalism and social control played a role in shifting attitudes about children and childhood, I propose that pediatric institutions and practitioners propelled and reinforced the need to preserve the health and welfare of all children, particularly poor children, but not without limits or constraints. Philanthropic and state organizations in both France and Great Britain increasingly devoted time and efforts into improving children’s health through the governance of poor families, but in the children’s hospitals, this governance was tempered by the actions and choices of mothers, fathers, and other family members, as well as by individual doctors and their own motivations.

The history of medicine, once construed as narratives of heroic progress, generalizations about the evolution of bedside, hospital, and laboratory medicine, or advancements made by great scientific minds, now encompasses a flourishing field of the history of social medicine that investigates the historical interplay between medicine and society.<sup>6</sup> This dissertation specifically highlights nineteenth-century medical and social developments, and as the following chapters show, the history of children’s medicine and medical institutions in Paris and London is messy and uneven, full of personal and professional decisions and actions that brought ground-breaking discoveries and successes as well as obstacles and devastating failures. Medical historian Michael

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<sup>6</sup>For critiques of medical histories as linear narratives of progress, see Andrew Wear, introduction to *Medicine in Society: Historical Essays*, ed. Andrew Wear (Cambridge University Press, 1992), 1. Also, Thomas Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1996), 16.

Worboys recently suggested that complex relations of different kinds of knowledge and practice in nineteenth-century medicine still need to be explored, particularly through studies of performance in the clinic, the laboratory, and the field in order to “understand how the performance of scientific work, both research and routine, was variously commingled with the “casework” of medical lives and what meanings different practices had for specific groups.”<sup>7</sup> This study takes up Worboys’ challenge and seeks to discover the interplay between medical theories, practices, and institutions within the milieu of nineteenth-century children’s hospitals, and how the performative work of hospital administrators, practitioners, promoters, and patients and families contributed to a growing national awareness and determination to conserve children’s physical health over time.

#### Child Health: An Interdisciplinary and Comparative Perspective

A study on the relationship between medicine, public health, and children brings together several distinct, yet overlapping historiographies: the history of medicine, the history of public health, and the history of social welfare. The history of child medicine (pediatrics) is a neglected field, and the few histories on the topic primarily focus on developments in nosology (categorization of childhood disease) and chronicle great medical thinkers and their advancements.<sup>8</sup> Most historical surveys of medicine touch on pediatric developments, but even those volumes dedicated to social medicine rarely

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<sup>7</sup>Michael Worboys, “Practice and the Science of Medicine in the Nineteenth Century,” *Isis* 102, 1 (March 2011): DOI: 10.1086/658660.

<sup>8</sup> The best example is Arthur Abt’s well-documented, but under-contextualized *Abt-Garrison History of Pediatrics* (Philadelphia: W. B. Saunders, 1965). An exception is *History of Pediatrics, 1850-1950*, edited by Buford Nichols, Angel Ballagriga, and Norman Kretchner, Nestle Nutrition Workshop Series, Volume 22 (New York: Raven Press, 1991), a volume which covers the development of pediatrics in specific national and topical contexts.



dedicate sections to childhood health, disease, or hospitals or draw links between pediatric knowledge and institutions and child welfare reform in industrialized countries.<sup>9</sup> As this study of nineteenth-century children's hospitals demonstrates, the emergence of pediatric knowledge and practice cannot be fully understood without taking into account national public health movements, including child welfare reforms, or transnational pressures to improve the health of the nation.

Throughout the nineteenth century, the concept of child health entailed physical as well as moral welfare, and concerns about childhood disease and mortality found expression in organized movements to promote public health, hygiene, and morality. Histories of Victorian public health and social reform offer engaging and informative social and cultural studies of the British sanitary movement and historicize concepts such as filth, purity, dirt, and slums, but these works only touch on the themes of child health, disease, and mortality.<sup>10</sup> When women and children enter these narratives, they are either sexualized or portrayed as the subjects of reform.<sup>11</sup> Similarly, French scholars note that public health reforms stemmed from the perception and reality of depopulation, high

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<sup>9</sup> For example, Keir Waddington, *An Introduction to the Social History of Medicine: Europe Since 1500* (London: Palgrave, 2011) discusses pediatric developments in chapters on hospitals, women's medicine, public health, and state health care. Earlier surveys include W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994) and Roy Porter, *Disease, Medicine, and Society in England, 1550-1860* (Cambridge: Cambridge University Press, 1995).

<sup>10</sup> William Cohen and Ryan Johnson, eds. *Filth: Dirt, Disgust, and Modern Life* (Minneapolis: University of Minnesota Press, 2005); Christopher Hamlin, *Public health and social justice in the age of Chadwick: Britain, 1800-1854* (Cambridge: Cambridge University Press, 1998); John M. Eyler, *Victorian Social Medicine: the Ideas and Methods of William Farr* (Baltimore, MD: The Johns Hopkins University Press, 1979); and Anthony Wohl, *Endangered Lives: Public Health in Victorian Britain* (Cambridge, MA: Harvard University Press, 1983).

<sup>11</sup> Seth Koven, *Slumming: Sexual and Social Politics in Victorian London* (Princeton, 2004) includes a chapter on poor, neglected street children assisted by Dr. Barnardo; Michelle Allen, *Cleansing the City: Sanitary Geographies in Victorian London* (Athens: Ohio University Press, 2008) traces middle-class attitudes about sanitation reform and its ability to physically and morally cleanse the working classes, particularly mothers and children.

infant mortality, and social constructions of death and disease in the early half of the century, but their impact on children's institutions and child welfare reforms is a brief side note rather than an explicit focus.<sup>12</sup> The "medical imperialism" and mission to "medicalize and moralize society" that Ann La Berge attributes to the Paris Health Council as a method to counteract the devastating effects of industrialization and urbanization on men, women and children, was equally evident in the activities at L'Assistance publique, the public body established in 1849 that administered all of the public hospitals of Paris.<sup>13</sup> Building on all these historical works, this study investigates how concerns about child health and welfare played out at the Paris and London children's hospitals and how the hospitals influenced, and were influenced by, French and British public health developments throughout the nineteenth century.

Focusing on the post-Napoleonic era to the 1890s, the periodization of this study offers new insights into the history of child welfare in France and Great Britain. For France in particular, this scope traverses the political regimes of republics and empires, which traditionally frame historical explanations of major shifts in nineteenth-century French politics, culture, and society. For example, many French scholars have identified the Third Republic as a time that crystallized a symbiotic relationship between the medical community, politics, and social reform. France's military defeat and regime change in 1870 marked a tradition of doctors serving in legislative positions until 1914, a time during which French physicians, reformers, and politicians increasingly linked

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<sup>12</sup>Sean Quinlin, *Great Nation in Decline: Sex, Modernity and Health Crises in Revolutionary France c. 1750-1850* (Aldershot: Ashgate, 2007); William Coleman, *Death is a Social Disease: Public Health and Political Economy in Early Industrial France* (Madison, WI: University of Wisconsin Press, 1982).

<sup>13</sup>Ann La Berge, *Mission and Method: The Early Nineteenth Century French Public Health Movement* (Cambridge: Cambridge University Press, 1992).

social and moral degeneration to medical deviance as a way to explain and “cure” a French culture that they perceived to be decadent, degenerate, and depopulated.<sup>14</sup> Interests in infant and child health were part of these legislative and medical developments, and outspoken advocates passed wet-nursing reforms, revised child labor laws, and acts to prevent child cruelty during the Third Republic (1870–1940).<sup>15</sup> The connection between Third Republic social reforms and the twentieth-century *puériculture* (infant welfare) is well-documented, as is the correlation between late nineteenth-century French social reforms and improved programs for women and children.<sup>16</sup> This work, however, indicates that efforts to protect the health and lives of children actually began well before the Third Republic. By the twentieth century, national concerns for child health and welfare contributed to the growth of eugenics movements in both countries, as the scientific discovery of genetics infiltrated discussions of natalism, population control, social hygiene, and racist and other biologically-based movements.<sup>17</sup> The periodization of this study precedes most of these Third Republic reforms, and with a focus on children’s hospitals, stresses the continuity of earlier ties between the medical public health communities that transcended political regimes.

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<sup>14</sup> Jack Ellis, *The physician-legislators of France: medicine and politics in the early Third Republic, 1870-191*. (Cambridge: Cambridge University Press, 1990); Robert A. Nye, *Crime, Madness and Politics in Modern France: The Medical Concept of National Decline* (Princeton: Princeton University Press, 1984).

<sup>15</sup>George D. Sussman, *Selling Mother’s Milk: The Wet-Nursing Business in France, 1715–1914* (Urbana: Illinois University Press, 1982); Lee Shai Weissbach, *Child Labor Reform in Nineteenth-Century France: Assuring the Future Harvest* (Baton Rouge: Louisiana State University Press, 1989); Sylvia Schafer, *Children in Moral Danger and the Problem of Government in Third Republic* (Princeton: Princeton University Press, 1997).

<sup>16</sup>Elinor A. Accampo., Rachel G. Fuchs, and Mary Lynn Stewart, eds. *Gender and the Politics of Social Reform in France, 1870–1914* (Baltimore: Johns Hopkins Press, 1995); and Rachel G. Fuchs, and *Poor and Pregnant in Paris: Strategies for Survival in the Nineteenth Century* (New Brunswick, NJ: Rutgers University Press, 1992).

<sup>17</sup> William Schneider, *Quality and Quantity: The Quest for Biological Regeneration in Twentieth-Century France* (Cambridge, Cambridge University Press, 2002), 69-70.

The establishments for children's medical care are essential guideposts for any study of nineteenth-century improvements in child health and welfare, yet the children's hospital is an understudied topic.<sup>18</sup> Nevertheless, British scholars have given more attention to the rise of the children's hospital, and Elizabeth Lomax's study on Victorian children's hospitals offers a full scholarly treatment of the expansion of children's hospitals in Britain after 1850 that also touches on parallel and intersecting medical and institutional developments on the Continent.<sup>19</sup> To show continuity and change in children's medical care from the eighteenth century to the mid- to late-nineteenth century, this dissertation links the histories of the London and Paris foundling hospitals and the London children's dispensaries to those of children's hospitals established after 1850; however, scholarly treatments on the two hospitals at the center of this study, Sainte-Eugénie in Paris and GOSH in London, are scarce.<sup>20</sup> Nineteenth-century children's hospitals are rarely mentioned with any specificity in French or British histories of the modern hospital, and no scholarly monograph of GOSH or Sainte-Eugénie exists.<sup>21</sup> Andrea Tanner's examination of GOSH and the interactions between

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<sup>18</sup> Eduard Seidler, "An historical survey of children's hospitals," in eds. Lindsay Grandshaw and Roy Porter, *The Hospital in History, 181-197* (London: Routledge, 1989) is the only broad study that I have found.

<sup>19</sup> Elizabeth Lomax, *Small and Special: the development of hospitals for children in Victorian Britain* (London: Wellcome Institute for the History of Medicine, 1996); also Rachel Waterhouse, *Children in Hospital: A hundred years of child care in Birmingham* (London: Hutchinson, 1962).

<sup>20</sup> For Paris, Rachel G. Fuchs, *Abandoned Children: Foundlings and Child Welfare in Nineteenth-Century France* (Albany: State University of New York Press, 1982); For London, Ruth K. McClure, *Coram's Children: The London Foundling Hospital in the Eighteenth Century* (New Haven, CT: Yale University Press, 1981), and Alysa Levene, *Childcare, Health and Mortality at the London Foundling Hospital, 1741–1800: "Left to the Mercy of the World"* (Manchester, UK: Manchester University Press, 2007). For the London Dispensary, Irvine Loudon, "John Bunnell Davis and the Universal Dispensary for Children," *British Medical Journal* (5 May 1979): 1191-1194.

<sup>21</sup> Luc Passion and Michel Sorin's brief chapter, "L'Invention du patient: l'hôpital et l'enfant à Paris au XIXe siècle," 191–200, in *Les Maux et les soins: médecins et maladies dans les hôpitaux parisiens au XIXe siècle*, eds. Francis Demier et Claire Barille (Paris: Action Artistique, 2007) is broad, top-down approach to

doctors, parents, and patients at this nineteenth-century children's hospital is one of the first to suggest that the development of the children's hospital and pediatric medicine might be seen as a consequence of changing western attitudes toward the preservation and protection of the working-class child."<sup>22</sup> Building on Tanner's work, this comparative dissertation affirms that pediatric developments were central to a growing concern for child health prior to the 1870s, yet also proposes that the Paris and London children's hospitals were an integral part of these changing attitudes, and transnational communication and competition helped to drive these attitudes forward. Furthermore, unlike any other study, this detailed analysis of the children's hospitals of Sainte-Eugénie and GOSH demonstrates how both were platforms from which pediatric knowledge disseminated into national and international conversations about pressing public health issues related to industrialization and urbanization, such as poverty, disease and epidemics, housing, and hygiene.

This examination of the "medicalization" of children's bodies at urban children's hospitals places the child patient front and center, along with medical practitioners, hospital administrators, and patient families. In both countries, national concerns about child health were linked to political, social and cultural anxieties about poor families and mothers. French and British historians have highlighted this relationship between poverty, public health, and government action, demonstrating how concerns for maternal and infant health spurred greater regulation of the commercial nursing and child care

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the Paris children's hospitals and patients. Seidler mentions *Enfants-Malades* in Paris and GOSH in London, but not Sainte-Eugénie.

<sup>22</sup> Andrea Tanner, "Choice and the children's hospital: Great Ormond Street Hospital patients and their families, 1855–1900," 135-161, in *Medicine Charity and Mutual Aid: the Consumption of Health in Britain, c. 1550–1950*, eds. Anne Borsay and Peter Shapely (London: Ashgate, 2007). Also see Janet Golden (ed.) *Infant Asylums and Children's Hospitals: Medical Dilemmas and Developments 1850-1920* (London: Garland, 1989).

industries and state-funded programs for poor mothers and children.<sup>23</sup> This study provides greater attention to children's hospitals that cared for unhealthy children during the nineteenth century and the medical ideas and practices that emanated from those institutions. Other studies on the medicalization of childhood overlook the children's hospital, attributing public concerns over child health with the advent of more stringent child labor reforms or school medical services within national education systems.<sup>24</sup> These works highlight how settings like the workplace and the school improved child health and welfare, but gloss over the medical institutions, theories, and doctors that influenced those reforms and address children as workers and students rather than sick patients. This study brings to light the long history of medical ideas, people, and places that made these reforms possible and highlights the significant role of children's hospitals—along with their practitioners, administrators, and patient populations—in shaping public action and attitudes toward children's medical care.

Finally, my approach is comparative and fully examines the interconnections between the British and French medical and public health communities.<sup>25</sup> Most histories

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<sup>23</sup>Commercial child care arrangements were typically referred to as wet-nursing in France and as foster care, or more notoriously, baby-farming, in Great Britain. Christine Adams, *Poverty, Charity, and Motherhood: Maternal Societies in Nineteenth-Century France* (Urbana, IL: University of Illinois Press, 2010). Works that highlight the gendered aspect of medical opinion on baby-farming practice include Ruth Ellen Homrighaus, "Baby Farming: The Care of Illegitimate Children in England, 1860–1943," Dissertation, University of North Carolina at Chapel Hill, 2003. Rev. ed., 2010, at Historytools, <http://www.historytools.org/babyfarming/baby-farming.html>; and George Behlmer, "Deadly Infanticide and Medical Opinion in Mid-Victorian England," *Journal of the History of Medicine* 34 (October 1979): 403-27.

<sup>24</sup>Bernard Harris, *The Health of the Schoolchild: A History of the School Medical Service in England and Wales* (Buckingham, 1995); Harry Hendrick, "Child labour, medical capital and the school medical service c. 1890-1918," in *Child Welfare, England 1872-1989*, ed. Roger Cooter (London, 1994). Colin Heywood *Childhood in Nineteenth-Century France: Work, Health and Education among the 'Classes Populaires'* (Cambridge, 2002).

<sup>25</sup> Ann La Berge, *Mission and Method: The Early Nineteenth-Century French Public Health Movement* (Cambridge: Cambridge University Press, 1992), 26, 73-5, 318.

of French or British medicine, hospitals, public health, or social reform note how other countries experienced similar movements at similar times and link these developments to “national interest” and concerns about the “health of the nation.” Rarely, however, do they investigate the international aspects of nineteenth-century activities to promote national health in general and child health in particular. In her conclusion to *Gender and the Politics of Social Reform in France, 1870-1914*, Rachel Fuchs offers tentative explanations for parallel nineteenth-century social welfare legislation in Europe and the United States: demographic concerns (depopulation or overpopulation), fears about the physical and moral degeneration of the nation’s population, altruistic and moral callings, and the politics of social control, but she does not consider the role of transnational, particularly Franco-British, communications in those parallels.<sup>26</sup> My comparative approach explores the roots of English and French parallels within pediatric knowledge and practice and highlights how child health concerns—so integral to national public health—also crossed national borders. On both sides of the English Channel, children’s doctors, hospital administrators, and medically-informed social reformers elevated child health as a national issue and their attempts to reduce child disease and mortality had important similarities and differences, as the following chapters show.

This comparative approach highlights the transnational nature of medical ideas and practice, building upon George Weisz’s work on nineteenth-century medical specialization in Europe and North America. He explicitly connects medical specialization to public attitudes and actions, demonstrating how rising public interest in specific health issues coincided with the emergence and consolidation of particular

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<sup>26</sup>Rachel G. Fuchs, “France in a Comparative Perspective,” 157-87, in *Gender and the Politics of Social Reform in France, 1870-1914*, eds. Elinor A. Accampo, Rachel G. Fuchs, and Mary Lynn Stewart (Baltimore: Johns Hopkins Press, 1995), 172-185.

medical specialties. For example, public concerns over infant mortality spurred the medical specialties of obstetrics and pediatrics, and once established as public “causes,” these concerns led to new institutions within which specialties could develop.<sup>27</sup> Weisz also notes how special medical interests crossed national boundaries through medical publications, societies, and congresses. Weisz examines Europe and North America broadly while this dissertation investigates how one specialty—pediatrics—expanded national interests in child health writ large across and between two geographic areas—France and Great Britain. Nineteenth-century French and British medical professionals and public health officials were at the forefront of advancing pediatric knowledge and practice within their own national milieus, and they also looked to one another for ideas and practices that would improve the health of their nation’s youngest citizens. Throughout the nineteenth-century, child health increasingly became a matter of national interest, yet French and British physicians, legislators, and social reformers engaged in international exchanges about how to effectively prevent or treat childhood sickness or remove obstacles to good health.

## Sources

The sources and methodology of this dissertation lend well to a transnational approach that compares and contrasts the structure, management, and activities of two nineteenth-century children’s hospitals and traces the flow of medical ideas and practices between these two institutions and their practitioners in Paris and London. Printed French and British primary sources such as medical treatises, manuals, journal articles, hospital

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<sup>27</sup> George Weisz. *Divide and Conquer: A Comparative History of Medical Specialization* (Oxford: Oxford University Press, 2005), 229.



guides, and conference and congress programs that refer to children's medicine or children's medical institutions demonstrate local, national, and international pediatric developments, specifically Franco-British communication and cooperation, in the early stages of pediatric medicine. While some of these sources were available online, many treatises and guides were only accessible through the rare book collections held at the Huntington Library in San Marino, CA, The Wellcome Library and Bishopsgate Institute in London, and the *Bibliothèque interuniversitaire de Santé* (BIUS) in Paris.

Investigations of the international scope of work of Paris hospital administrators like Armand Husson or London children's physician Charles West were possible through archival collections containing their personal papers, such as the Husson Collection at the Archives de Paris (AP), or professional papers, such as West's professional letters and personal library catalogue at the Great Ormond Street Hospital Archives (GOSH).

Augmented by the sources above, specific comparisons of the administrative and medical activities, patient populations, and family involvement at Sainte-Eugénie and GOSH were possible through archival hospital records at l'Assistance Publique—Hôpitaux de Paris (AP/HP) and GOSH and the online database of HHARP, the Historic Hospitals Archival Records Project. The magnitude of the admissions registers for Sainte-Eugénie required a random sampling of 35 patient entries per year, for every year, from the admission registers (*registres d'entrées*) between 1855 and 1876, while the fully searchable HHARP database allowed for particular searches of patients by year, institution, age, medical condition, and discharge information. Appendices A and B provide sample patient admission entries for both hospitals. For the London hospital, transcriptions of select physician case notes were available through the HHARP database,

while administrative reports, visitor logs, and promotional materials from the GOSH archives provided information on the establishment, administration, medical activities, and patient populations. The archives of AP/HP provided similar information for the Paris children's hospital, including a folio of forty letters of "exceptional admissions" at Sainte-Eugénie between 1855 and 1880.

### Nineteenth-Century Children's Hospitals of Paris and London

A comparison of two nineteenth-century children's hospitals in Paris and London offers a lens to investigate the "medicalizing of childhood" in urban spaces dedicated to receiving and treating poor, sick children. Established in 1852, Great Ormond Street Children's Hospital (GOSH) was the first pediatric hospital in London; the third children's hospital in Paris, Sainte-Eugénie was established just a few years later in 1855. On the surface, these hospitals could not have appeared more different. GOSH was a private charitable institution, envisioned by a passionate pioneering physician (Charles West) dedicated to understanding childhood sickness and disease and engineered through the philanthropic work of several influential and affluent British male sponsors. Sainte-Eugénie was a departmental, public welfare institution, part of a vast Paris hospital network under the supervision of a centralized public assistance administration, l'Assistance publique de Paris. Like most British voluntary institutions, GOSH was a small, cottage-type hospital with ten beds and one ward and served almost 150 children in its first year and eventually grew to several wards caring for about 14,000 over the course of its first twenty-five years. In contrast, Sainte-Eugénie was massive, containing ten wards that could hold over 250 children at one time. In its opening year, the hospital

serviced almost 3,000 children, and for the next twenty years maintained an average of 2,950 patients per year.<sup>28</sup>

Beyond these administrative and spatial differences, GOSH and Sainte-Eugénie were remarkably similar in their policies, organization, services, and most importantly, patient populations, justifying their comparison. At both these children's hospitals, child patients were viewed as distinctive medical subjects and their medical treatment was seen as a local and national responsibility. These two hospitals exemplify specialized institutions that advanced theories of childhood diseases and medical practices and fostered a new medical specialty—pediatrics—and a new medical practitioner—the pediatrician—during the second half of the nineteenth century in France and Great Britain. The persons and practices associated with these two institutions also illuminate the national and international aspects of their development and operation. GOSH and Sainte-Eugénie had similar hospital missions and objectives, organizing principles, ambitious and prolific doctors and surgeons, and a great deal of public support from the medical community, government leaders, including political rulers, and the public-at-large. Moreover, both hospitals were established within years of one another, placing them in the same international context at mid-century. The admissions registers, administrative documentation, and medical case studies generated at these two children's hospitals answer questions about how specialized institutions furthered pediatric knowledge and made child health concerns more visible, shaped medical and cultural ideas about child health in each country, and fostered Franco-British communication, cooperation, and competition on pediatric best practices.

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<sup>28</sup> For more on the size and capacity of these hospitals, see chapter four below.

## Chapter Highlights

The first two chapters investigate early children's medical institutions and the construction of a specific body of French and British pediatric practitioners, their ideas, and their practices from the late eighteenth century to the first half of the nineteenth century, and how these ideas and practices were transmitted and played out in both national capitals. Chapter one traces the precursors to GOSH and Sainte-Eugénie: the eighteenth-century Paris and London foundling hospitals, the London children's dispensary, and the first European children's hospital, Enfants-Malades in Paris. These institutions sowed the seeds of the nineteenth-century children's hospitals, equipping interested doctors with pools of children with medical needs to observe, examine, and dissect and providing evident reminders of the need for children's medicine. As the original children's hospital model, Enfants-Malades founded in 1802 attracted positive and negative attention, but its existence gradually gave way to a general acceptance of inpatient medical institutions for children. This chapter highlights how these early children's institutions collectively provided the building blocks for studying and teaching children's medicine, while also raising awareness of how the preservation of child health in the hospital depended as much on hygienic principles as medical skill.

Chapter two investigates pediatric practitioners in these early institutions, and their direct links to GOSH and Sainte-Eugénie. Analyzing and comparing physician's case notes and hospital training manuals, administrative reports and promotional materials, and as well as treatises and articles by key physicians in each of these institutions, in part through a prosopographical examination, I establish the physician's role in advancing pediatric knowledge, promoting child health as a specialized study, and

intensifying child health issues as topics of national concern. This chapter also highlights medical publishing as a conduit for greater pediatric specialization and the transmission of ideas between England and France. French and British medical journals established in the 1830s and 1840s published the work of world-wide medical authorities on a wide range of topics and nineteenth-century pediatric treatises, textbooks and translations disseminated medical theories and practices across the English Channel. These journals and treatises were the roots of an institutionalized cross-cultural sharing of pediatric knowledge that had the potential to spawn new adaptations of former institutions, like the medicalized crèche, or child care facility. While their published content reveals professional views of child health and disease in each country vis-à-vis the knowledge of similar concerns abroad, their publishing activities highlight doctors' roles in bringing these concerns to light for wider national and international audiences.

Chapters three through five describe how medical ideas and practices converged in new national and international efforts dedicated to treating sick children at mid-century. Case studies of children's hospitals—Great Ormond Street Hospital for Children in London and Sainte-Eugénie—investigate how these two new pediatric institutions built upon and expanded earlier approaches to child health reflected in the first two chapters. Emphasizing child health as a significant aspect of public health, chapter three examines national and transnational parallels between these two British and French pediatric institutions, particularly through medical statistics, children's hospital registers, and a broadened concept of public health that goes beyond sanitation, hygiene, and epidemics. This chapter examines the administrative efforts of Armand Husson, Director of L'Assistance publique in Paris, and his influence on the leaders and staff at the London

children's hospital, GOSH. This chapter also underscores how royal women patrons, Queen Victoria and Empress Eugénie, contributed to the success of children's hospitals differently within each national context, a topic that is overlooked in most histories of pediatrics.

Chapter four provides a side by side comparison of Sainte-Eugénie and GOSH in terms of patient populations, hospital policies, and organizing principles, gleaned from the archival records of each institution. Pointing out similarities and differences, this chapter demonstrates how the forces of industrialization, urbanization, and poverty created similar pools of poor, sick children in Paris and London, propelling similar initiatives to combat childhood disease and mortality at both hospitals in each capital, by means such as the expansion of inpatient and outpatient facilities and the creation of convalescent branches to accommodate larger numbers of patients. This chapter also discusses discrepancies between theory and practice in the children's hospitals, as administrators and doctors came into conflict over hospital policies and procedures.

Chapter five focuses on the poor, sick patients and their families to provide a window into the children's hospital experience. Administrators and doctors determined who would be admitted for medical care and how they would be treated; however, patients and their families also shaped hospital policy and experiences. Some parents advocated for their child's admission, requested particular doctors, and if payment was required, negotiated the costs of care; others denied the hospital access to their child altogether. Challenging the idea that poor families were the passive recipients of charity in either country, this chapter highlights how some patient family members and guardians were active participants in hospital decisions and in obtaining or refusing medical care.

Chapter six investigates how medical ideas about children's bodies dispersed in new directions outside the French and British children's hospitals from 1860 to 1890, a period that witnessed numerous protective measures for children and when child health became a central feature of an overarching concern for the "health of the nation." Using sources ranging from forensic treatises to organization bulletins to feminist tracts, this chapter traces currents of child protection rhetoric and activities on both sides of the English Channel circulated by forensic physicians, feminists and women reformers, and authors of hygiene manuals, all of whom "medicalized" childhood in various ways. Forensic physician Ambroise Tardieu wrote about the physical dangers of child abuse, medical and non-medical writers touted the benefits of maternal and child hygiene, and civic-minded feminists and other female reformers took up the banner of child health in their efforts to implement a wide range of social reforms and to push marginalized agendas, such as Annie Besant's advocacy of family limitation in Britain and Maria Deraismes's rhetoric on women's rights. The popularization of topics such as child abuse, child development, and child hygiene within circles engaging in legal medicine, social reform, and domestic hygiene circles intensified the "national interest" dimension of child health and further medicalized childhood as a matter of public health.

My conclusion proposes a reconceptualization of what constitutes "national interest" during the nineteenth century and considers the ways in which medical ideas, practices, and institutions concerning child health might be viewed as an international, as well as a national, phenomenon. From the perspective of child health as a significant aspect of public health, the concluding chapter touches on the flowering of pediatric programs in academia in the late 1870s and legislative acts to protect children's physical

and moral health in the late 1880s, such as the British Children's Charter and the French law on the divestiture of paternal authority, both passed in 1889. While national concerns for public health in general, and child health in particular, shared a similar pathway and time frame in France and Great Britain, the medical, institutional, and legislative developments related to these concerns were not isolated activities, but rather, tied to transnational currents that nineteenth-century children's hospitals helped to set into motion and to perpetuate into the next century.



## CHAPTER 2

### THE STATE OF CHILDREN'S MEDICAL CARE AND EARLY PEDIATRIC INSTITUTIONS, 1750–1850

Great Ormond Street Hospital for Children (GOSH) and Sainte-Eugénie, the two children's hospitals at the center of this study, did not spontaneously emerge from a sudden wellspring of new medical knowledge or international competition at mid-century. The establishment of these two children's hospitals in post-1850 London and Paris was a result of the culmination of long-term medical trends that accompanied increased medical, philanthropic, and state interest and capabilities in fostering public health from the eighteenth-century forward: a growing secularization of social welfare and the reconceptualization of the hospital from refuge to medical center, the rise of medical specialties, and the creation of institutions that could provide opportunities for focused study and treatment of these specialties. These developments were interlinked, as the recognition that childhood diseases and treatments were special and distinct from those of adults transformed existing charitable institutions for children into facilities better equipped to deal with medical issues and inspired entirely new institutions devoted to pediatrics. This chapter traces the development of institutions that provided varying degrees of medical care for French and British children from the 1750s to the advent of GOSH and Sainte-Eugénie: the Paris foundling hospital, Enfants-Trouvés, the London Foundling Hospital, the Universal Dispensary for Children (London), and the earliest children's hospital, Enfants-Malades. The life-course of these early institutions

demonstrates a gradual, but steady, evolution of public and private support for children's medical care and ultimately, hospitals devoted to that purpose.

The predecessors to the children's hospital, foundling hospitals and children's dispensaries, set the stage for the proliferation of children's medical institutions in European capitals during the second-half of the nineteenth century. The growth of specialized hospitals, clinics, and infirmaries to treat children's medical conditions corresponded to a general transition in the form and function of hospitals. In the eighteenth and early nineteenth centuries, the function of the hospital shifted from a hospice to a center for medical training, research, and the systematic care and treatment of individuals with a wide range of diseases and health conditions.<sup>29</sup> Since ancient and medieval times, "hospitals" were established for persons with a wide range of needs, such as travelers, the destitute, the infirm, the abandoned, or the incurable, and the concept of "hospital" meant a place of religious care and refuge.<sup>30</sup> Dating back to the fourteenth century, foundling hospitals across Europe offered refuge to abandoned and "found" infants and children, providing care to a special niche of abandoned, orphaned, and unwanted dependants.<sup>31</sup> In the eighteenth and nineteenth centuries, foundling hospitals operated in both Paris and London, providing temporary care for these children by lay or religious caregivers until they could be sent out to wet-nurse. In the mid-eighteenth century, the children's dispensary, an outpatient infirmary, appeared in Great Britain as a cost-effective way to medically treat poor children's without burdening the parish coffers

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<sup>29</sup> Eduard Seidler, "An historical survey of children's hospitals," in *The Hospital in History, 181-197*, eds. Lindsay Granshaw and Roy Porter (New York: Routledge, 1989), 181-82.

<sup>30</sup> S. Borsa and C.-R. Michel, *Des hôpitaux en France au XIXe siècle* (Paris: Hachette, 1985), 17-18.

<sup>31</sup> Isaac A. Abt, *Abt-Garrison History of Pediatrics*, reprinted from *Pediatrics*, Vol. I (Philadelphia: W. B. Saunders, 1965). A list of foundling hospitals from the Roman Empire to the nineteenth century can be found on pp. 118-119.

or infringing on domestic privacy. Both institutions offered practical experience for physicians interested in pediatric care, but neither had the vision, capacity, or funds to devote to a rigorous program of research and teaching. Despite their shortcomings, they inspired new, albeit divergent, models of institution-based medical care for children that ultimately convinced influential individuals in both countries that large-capacity inpatient hospitals for children made sense from a social and medical standpoint.

Foundling homes and children's dispensaries were also early forerunners of medical specialization, although this is often overlooked by medical historians. While scholars occasionally give a nod to *Enfants-Trouvés* (established in 1638) as one of the institutions that gave Paris the edge in early pediatric specialization, the medical function of the foundling home is overshadowed by the first official children's hospital, *Enfants-Malades*, founded much later in 1802.<sup>32</sup> Similarly, the London Foundling Hospital is rarely mentioned as a pediatric institution, and children's dispensaries, including the first, but short-lived, Dispensary for the Infant Poor, established in 1769 by George Armstrong, and the Universal Dispensary for Children, established in London by John Bunnell Davis in 1816, merits more attention.<sup>33</sup> Part of this historical oversight may be due to interpretations that draw a clear distinction between in-patient and outpatient institutions, where inpatient facilities are "true" hospitals and temporary settings like the foundling hospital and outpatient centers like the dispensary provided medical care as an

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<sup>32</sup>Erwin H. Ackerknecht, *Medicine at the Paris Hospital, 1794-1848* (Baltimore, MD: The Johns Hopkins Press, 1967), 172-173. Established within la Maison de la Couche by Vincent de Paul and the Dames de la Charité in 1638, *Enfants-Trouvés* was incorporated into the central organization of the Hôpital Général de Paris in 1670. See Rachel G. Fuchs, *Abandoned Children: Foundlings and Child Welfare in Nineteenth-Century France* (Albany: State University of New York Press, 1984), 7-9.

<sup>33</sup> One notable exception is Irvine Loudon's short, but useful article, "John Bunnell Davis and the Universal Dispensary for Children," *British Medical Journal* (5 May 1979): 1191-1194. Chapter two discusses George Armstrong and John Bunnell Davis's medical contributions in more depth.

auxiliary or circumscribed station. Furthermore, foundling homes and dispensaries were grounded in the philanthropic tradition of the hospice, but due to their mission to keep infants alive, they also constituted a hospital in the nineteenth-century sense. Crossing borders as hospice as well as hospital, these early children's medical institutions had highly specialized medical components that fostered the health and survival of abandoned newborns and children (foundling hospital) and of poor and needy urban children (dispensary).

Recognizing the eighteenth-century foundling hospital and dispensary as the building blocks for nineteenth-century pediatric institutions adds a new dimension to the history of medical specialization. Paris was the cradle of medical and surgical specialties at the turn of the nineteenth-century, when a new school of thought about the etiology of disease led to the addition of specialized hospitals for skin disorders, venereal diseases, mental illness, obstetrics, and children's diseases. This new concept identified diseases as localized pathologies that impacted specific bodily organs and areas, which could be studied and treated separately. This shift in understanding opened the door to the accumulation of specialized medical knowledge and the foundation of specialist hospitals.<sup>34</sup> As George Weisz points out, public perceptions of disease and medical specialization also went hand in hand. Over time, intensified public outcries about particular groups of unfortunates, such as the blind, sick children, or "cripples," gave rise to new institutions within which medical specialties could develop to better care for these

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<sup>34</sup> George Rosen, *The Specialization of Medicine* (New York: Froben Press, 1944), 16; Ackerknecht, 163-164.

groups of individuals.<sup>35</sup> High rates of child abandonment and mortality, along with swarms of poor children on the streets of Paris and London, led some reformers, government officials, and members of the medical community to unite in efforts to carve out distinct spaces to better understand, treat, and prevent infantile and childhood diseases. To combat these problems, the medicalization of children's bodies began in the infirmaries of foundling hospitals and children's dispensaries and flowered in the wards of nineteenth-century children's hospitals. In addition, cross-cultural communication about childhood diseases and medical conditions emanating from the doctors associated with foundling homes, the dispensaries, and Enfants-Malades between the 1750s and 1850s helped to encourage children's medicine as a mainstream medical specialty worthy of expansion in both countries.

Although they both ended up with world-class children's hospitals, uneven developments in French and British hospital infrastructure led Paris and London down two separate paths towards children's medical care. Under the direction of the French state, Paris pursued comprehensive inpatient medical services in general and specialized hospitals scattered throughout the capital, while London contained a mix of independent private and public or "free" hospitals subsidized by the crown, supplemented by local outpatient infirmaries and dispensaries. Children's medical care mirrored these trends, with the founding of Enfants-Malades in the French capital and a revitalized Universal Dispensary for Children in London. These choices had international consequences, turning Paris into the epicenter for the study of medical specialties in the first half of the century. Dozens of hospital guidebooks promoted the supremacy of the Paris hospitals to

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<sup>35</sup> George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization* (Oxford: Oxford University Press, 2005), 229.

foreign students and advertised a wide menu of medical specialties like skin disorders, venereal diseases, and pediatrics. The inclusion of Enfants-Malades in the metropolitan hospital network allowed practitioners to study childhood diseases, surgeries, and therapies in a large hospital setting. Until 1826, Enfants-Malades offered an exclusive opportunity for doctors across Europe and North America to partake in the most comprehensive training on pediatrics available at the time. The realization that hospitals like Enfants-Malades were the most effective place to study pediatrics spurred other nations to propagate children's medical facilities, and Enfants-Malades became the institutional mold for numerous children's hospitals and clinics that emerged during the 1830s and 1840s in cities like Vienna, Berlin, Prague, Budapest, Moscow, Stockholm, Copenhagen, and Constantinople.<sup>36</sup> London clung to its dispensary model until the first children's hospital opened in 1852, but as this chapter demonstrates, Enfants-Malades and the vision of the children's hospital had an inescapable influence on British medical visitors on the Continent throughout the first half of the century.

### The Paris and London Foundling Hospitals: An Overview

The eighteenth century roots of nineteenth-century French and British children's hospitals such as Sainte-Eugénie and GOSH were foundling hospitals. While the histories of the foundling hospitals in Paris and London are well documented, their role in the evolution of children's hospitals, which I emphasize here, is not.<sup>37</sup> The life course of the

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<sup>36</sup> Abt, 119.

<sup>37</sup>For the London foundling home, see Ruth K. McClure, *Coram's Children: The London Foundling Hospital in the Eighteenth Century* (New Haven, CT: Yale University Press, 1981), and Alys Levene, *Childcare, Health and Mortality at the London Foundling Hospital, 1741–1800: "Left to the Mercy of the World"* (Manchester, UK: Manchester University Press, 2007). For the Paris foundling home, see Rachel G. Fuchs, *Abandoned Children*.

Paris and London foundling hospitals underscores how civic leaders in these nations had divergent and fluctuating notions about needy children and the duties of the state and private philanthropy in meeting their needs, including their medical needs.<sup>38</sup> The circumstances of these two foundling hospitals correspond to the two dominant European systems for institutional care, the Catholic system (France, Italy, Spain), characterized by a combination of religiously and publicly supported hospitals, foundling homes, and orphanages, and the Protestant system (Germany and Great Britain), with a wide range of local organizations such as work houses, dispensaries, and highly selective children's institutions, of which the London foundling hospital represented a singular break from the Protestant system of care.<sup>39</sup> These same attitudes and systems of care influenced the evolution of children's medical institutions in these two countries, as the Paris foundling hospital was subsumed into the city's hospital network and privately-funded dispensaries operated in London and other British cities. The Paris foundling hospital became a precursor to children's hospitals in France; the London foundling hospital potentially delayed the growth of children's hospitals in Great Britain.

By the middle of the eighteenth century, foundling hospitals operated in both Paris and London to prevent infanticide and to receive legitimate and illegitimate unwanted children. Rooted in a long tradition of Catholic charity, the Paris institution had a more complex history. Similar French hospices can be traced back to the twelfth century, but the Paris foundling home, *Enfants-Trouvés*, was established in 1638 by

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<sup>38</sup> Brian Pullan. *Poverty and Charity: Europe, Italy, Venice, 1400–1700* (Aldershot, UK: Variorum, 1994.)

<sup>39</sup> Rachel G. Fuchs and Stephanie McBride-Schreiner, "Foundlings and Abandoned Children," in *Oxford Bibliographies Online: Childhood Studies*, <http://www.oxfordbibliographies.com/view/document/obo-9780199791231/obo-9780199791231-0075.xml>, accessed October 14, 2014.

Vincent de Paul and the Dames de la Charité, a group of pious, affluent lay women involved in various charitable projects.<sup>40</sup> Within decades, increasing numbers of foundlings and decreasing charitable donations led to the incorporation of Enfants-Trouvés into the Hôpital Général of Paris in 1670, effectively subsidizing the institution with funds from the Crown and “elevating the foundling home to the status of a public utility similar to the hospitals for the sick and poor.”<sup>41</sup> The foundling hospital was nationalized with the Decree of 1811, which gave the Ministry of the Interior and local departments a mandate to provide for all aspects of child welfare, including abandoned children, although the various means by which this would be accomplished continued to be debated and modified over the course of the nineteenth century. Despite fluctuations, religious charity still played a vital role in the institution, as members of Catholic sisterhoods consistently performed most of the day-to-day caregiver work.

The London foundling hospital, or the Hospital for the Maintenance and Education of Exposed and Deserted Young Children, opened its doors in 1739. Its founder, Thomas Coram, was well aware of the foundling institutions of Paris, Rome, Madrid, and Lisbon, all models that inspired him and other like-minded philanthropists to pursue a similar project to preserve the lives of foundlings at home. He recognized through years of inquiries, preparations, and roadblocks, however, that for the institution to succeed in London, it needed to be independent from royal or church support, or both, unlike the hospitals in Paris and other Catholic cities. As a result, Coram masterminded a

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<sup>40</sup> Albert Dupoux, *Sur les pas de Monsieur Vincent: Trois cents ans d'histoire parisienne de l'enfance abandonnée* (Paris : Revue de l'Assistance publique a Paris, 1958), Chapter V, “St. Vincent de Paul,” 29-45. Dupoux’s book provides a detailed, comprehensive institutional history of Enfants-Trouvés, and while outdated, it provides a straightforward and reliable account based upon the archives.

<sup>41</sup>Fuchs, *Abandoned Children*, 7-8.



novel form of charitable institution, the voluntary corporate association, much like the modern-day non-profit organizations of Great Britain and North America. While it needed a royal charter to exist, the London foundling hospital became the first corporate body supported by member subscriptions and legally entitled to manage the care of foundlings and to solicit donations and legacies to support that effort.<sup>42</sup> Coram and his advisors were also aware of the involvement of the Dames de la Charité with the creation of Enfants-Trouvés, and they also worked to attract the support of British women of wealth and influence. A group of twenty-one women of noble standing signed their name to a King's petition; as petitioners, they helped to secure the royal charter, and their visibility in the project provided an example of affluent benevolence that would allow the foundling hospital to become one of London's most fashionable charities.<sup>43</sup> In the end, however, their participation was fleeting and did not extend to the same level of involvement and responsibility of daily operations as the Dames de la Charité, who acted as a board of directors, or the Sisters of Charity, who actually oversaw the care of the children in the wards and infirmaries of Enfants-Trouvés.<sup>44</sup>

Enfants-Trouvés and the official concern for foundlings in France more than inspired British attempts to establish a foundling home; its founder, early supporters, and governing members looked to the institution as a source of foreknowledge and experience for their project. Investigations on the regulations and practices of the Paris foundling home informed them what to do and what not to do in a British version. As early as the 1730s, British Queen Caroline ordered the assemblage of a "very circumstantial Account

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<sup>42</sup> McClure, 19-20.

<sup>43</sup> Ibid., 21-22, 34-35. A list of the Ladies Petitioners may be found in Appendix I, chart 1.

<sup>44</sup> Fuchs, *Abandoned Children*, 119. McClure, 44.

of the Management of the Hospital for Foundlings at *Paris*, from its Establishment to the present Time” (italics in original).<sup>45</sup> Once the London foundling hospital was established, the governing General Committee almost immediately contacted British ministers in Paris, Florence, Venice, Turin, and Amsterdam and requested them to gather data about foreign foundling hospitals; *Enfants-Trouvés* was one of the first to respond.<sup>46</sup> In the hospital’s first few years, its governors borrowed some aspects of various Continental practices and discarded others.<sup>47</sup> The most notable replication concerned foundling placement. The governors closely followed the Paris plan and placed the infants with wet-nurses or dry nurses in the countryside as soon after admission as possible and required the nurses to care for them for three years before returning them to London.<sup>48</sup> This quick turnaround policy was viewed by both institutions as the most economical approach as well as the best chance for foundlings’ survival.

The greatest difference between the French and British foundling hospitals was size and capacity. Throughout the eighteenth and nineteenth centuries *Enfants-Trouvés*

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<sup>45</sup>*An account of the foundation and government of the Hospital for Foundlings in Paris. Drawn up at the command of her late Majesty Queen Caroline, and now published for the Information of those who may be concern’d in carrying on a like Design in this City.* London, [1739]. Preface, 1. Eighteenth Century Collections Online. Gale. Arizona State University AULC. accessed August 9, 2014. The object of the tract was informative as well as comparative:” Those Particulars which may be of Service in the Execution of a like Design in this Kingdom, may be retain’d, and perhaps, improv’d; and those which shall be thought to be otherwise, may be laid aside.”

<sup>46</sup> McClure, 37-8. The foundling hospital’s royal charter was signed on August 14, 1739, and the first meeting of the corporation, when the charter was formally presented and General Committee members were elected was held on November 20, 1739. By February 23, 1740, reports had arrived from Amsterdam and Paris.

<sup>47</sup> The revision of British Poor Law institutions after the 1834 created local welfare institutions like the parish workhouse, which for children served a similar function to that of French institutions like *Enfants Trouvés*. They both provided for indigent children, but the differences were great. See Lynn Hollen Lees, *The Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth-Century London*,” 68-91, in *The Uses of Charity, The Poor on Relief in the Nineteenth-Century Metropolis*, ed. Peter Mandler (Philadelphia: University of Pennsylvania Press, 1990), 74-77.

<sup>48</sup> McClure, 47.

took in thousands annually, and in 1740, the year the London foundling hospital was established, Enfants-Trouvés received 3,150 children.<sup>49</sup> In 1795, Enfants-Trouvés moved to a confiscated monastery on the Rue d'Enfer, and it still admitted over two thousand children that year.<sup>50</sup> For much of the eighteenth century, the average number of children at the foundling hospital on a given day was around three hundred.<sup>51</sup> In stark contrast, London foundling hospital started small with room for sixty beds and caring for between 20 and 200 children in any given year during most of the eighteenth century.<sup>52</sup> During one exceptional five-year period of unrestricted admissions between 1757 and 1762 called the "Great Reception," the London foundling hospital received up to 4,000 children annually, which prompted the opening of four satellite branch hospitals during this period. By the nineteenth century, admissions leveled out to four or five hundred yearly admissions.<sup>53</sup> The Great Reception confirmed that London needed at least a dozen more foundling hospitals, but replications never appeared. Regardless of the size differential, the foundling hospitals pooled together poor children under one roof to be physically cared for by extra-familial caretakers, religious or secular, or both. In the process, the foundling home generated a model for the institutionalization of poor

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<sup>49</sup> For admission numbers at Enfants-Trouvés between 1815 and 1900, see Fuchs, *Abandoned Children*, 143-144, Table 4.3; the number of Enfants-Trouvés admissions in 1740 was from London foundling hospital reports cited in McClure, 43.

<sup>50</sup> Ackerknecht, 173.

<sup>51</sup> Fuchs, *Abandoned Children*, 128.

<sup>52</sup> Levene, 7-8.

<sup>53</sup> McClure, 250. Fuchs notes that these mortality rates are not equal comparisons because the average age of the London foundling was older, which statistically gave children a better chance of survival. However, if the average length of stay at the London foundling hospital was longer, this factor would decrease children's chance for survival.

children and provided the opportunity to observe and treat numerous diseases and medical conditions specific to their youthful populations.

### Foundling Hospitals as Medical Institutions

Enfants-Trouvés and the London foundling hospital provided medical care as an auxiliary function in their infirmaries, but neither was considered a bastion of medical care. One British medical student visited the Paris foundling home during some free time and noted it was “an exceedingly curious institution—its seems so strange to see cradles arranged around long wards in double rows. . .”<sup>54</sup> The student did not study there, for Enfants-Trouvés did not offer “cliniques” for visitors. His shock at seeing so many institutionalized infants in one place reflects the underlying differences between French and British efforts to care for foundlings. Transnational comparisons of these two institutions were common, and at least one British account of the London institution found its way into French translation.<sup>55</sup> While most nineteenth-century French- and English-language guides to the Paris hospitals did not include *Enfant-Trouvés* in their table of contents, at least one American guidebook did. The exclusion of the foundling hospital in the French and British hospital guides confirms the reticence to officially recognize these places as medical institutions. The American example suggests that

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<sup>54</sup> Diana Manuel, ed. *Walking the Paris Hospitals: Diary of an Edinburgh Medical Student, 1834-1835* (London: The Wellcome Trust, 2004), 182.

<sup>55</sup> For example, the following English-language history of the London foundling hospital published in London, 1825, found its way into a French translation in 1827: AP/HP, Fosseyeux Collection, 706/66. *Notice historique sur l'hospice des Enfants-Trouvés de la ville de Londres suivie des reglements en usage pour la direction des enfants admis dans cet établissement*. The Fosseyeux Collection (thereafter, FOSS) contains folios of archival documentation and manuscripts collected by archivist Marcel Fosseyeux between 1902 and 1913. Note the translated title identifies the London foundling hospital as *Enfants-Trouvés*. As already mentioned, British supporters of a foundling hospital in London sought out accounts of *Enfant-Trouvés* prior to and after its foundation.

regardless of British and French attitudes, Enfants-Trouvés had value for medical science as well as for its humanitarian mission. In 1843, New York doctor F. Campbell Stewart offered a somewhat balanced perspective on *Enfant-Trouvés* to his readers. His description of the foundling hospital focused on the hospital's staff and structure, including the various accommodations for sick children, and the most common diseases and health disorders affecting patients. While noting the hospital's high infant deaths, he also praised the institution for reducing those mortality rates in recent years (a result of sending children out to wet-nurses) and for helping to maintain low numbers of infanticides in France.<sup>56</sup>

As primarily a drop-off point for abandoned newborns on their way to wet-nurses in the countryside, the time spent at the Paris foundling hospital was a temporary, but critical, moment in the lives of children. A typical foundling stay was only a few days, until the child was either transported to a country wet-nurse or died.<sup>57</sup> Their mortality rates during the first half of the nineteenth century were appalling to critics and supporters alike; between 1800 and 1850, an estimated one-quarter of *Enfants-Trouvés* children died during their few days in the hospital, and twenty-six percent of the London foundlings died during the same period.<sup>58</sup> Both foundling hospitals hospital attracted critics at home and abroad, and some overenthusiastic critics emphasized the high infant mortality numbers (not rates or averages) per annum at *Enfants-Trouvés* compared to the low numbers of deaths at the London counterpart. Judging an eighteenth or nineteenth-

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<sup>56</sup> F. Stewart Campbell, *The Hospitals and Surgeons of Paris. An Historical and Statistical Account of the Civil Hospitals of Paris; with miscellaneous information and biographical notices of some of the most eminent of the living Parisian surgeons* (New York: Langley, 1843), 73-78.

<sup>57</sup> Fuchs, *Abandoned Children*, 126.

<sup>58</sup> McClure, 250.

century foundling hospital by its mortality rate was not entirely fair, since infant deaths was one of the stark realities of child abandonment and the poverty and illegitimacy that so often accompanied it.<sup>59</sup> Mortality was exponentially greater among foundlings; due to the desperate circumstances of their young lives and the mothers who gave birth to them, the newborns that passed through the Paris and London foundling hospitals were typically malnourished, unhygienic, highly vulnerable to disease, and some suffered from congenital defects or chronic conditions. Some children entered the foundling hospitals in a morbid state, dying almost immediately after reception. For many outside observers, the high death rates, largely unavoidable due to unsanitary infant feeding methods, limited knowledge of infant diseases, institutional neglect and inadequate numbers of nursing attendants, and the poor condition of the foundlings at admission tarnished the medical reputation of the foundling hospital.<sup>60</sup> Only the very compassionate or very pragmatic could fully grasp and grapple with the range of obstacles to health faced in these children's institutions.

The already compromised state of health of the foundling, combined with the added propensity for infection, poor hygiene, sanitation, and ventilation with hundreds of children living together meant that doctors, surgeons, and infirmaries were a necessary mainstay at the foundling hospitals. For much of their existence, *Enfants-Trouvés* and the

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<sup>59</sup> For example, one French critic remarked that in the five years between 1819 and 1834 in London, 151 children were abandoned and another 4,668 children were sent to workhouses in London, while in the same timeframe, 25,277 foundlings of Paris were cared for by the state. The numbers here reflected actual numbers of children admitted to institutions, of which London was sorely lacking, not the actual numbers of abandoned, homeless, or orphaned children in London, including those not living in any type of charitable institution. See Archives de l'Assistance publique (AP/HP), FOSS 706/7, Papiers de M. Jourdan, diverses lettres et manuscrites.

<sup>60</sup> Evaluations of poor infant feeding practices and the state of children's health at the Paris and London foundling hospitals and with wet-nurses may be found in Fuchs, *Abandoned Children*, Chapters 4 and 6 (France), and Levene, *Childcare, Health, and Mortality at the London Foundling Hospital*, Chapters 3, 4, and 7.

London Foundling hospitals were filled to capacity, and due to the limited number of beds at the London institution, hundreds of children were turned away each year. Overcrowded conditions and difficulties maintaining proper sanitation, ventilation, and a basic level of cleanliness contributed to the ill-health of the young residents, earning the hospitals names like nurseries of contagion or death.<sup>61</sup> The Paris hospital primarily housed infants and the London hospital had a much older population, yet general preventative measures were a constant task at both institutions: separating the ill from the healthy; fumigating wards and common areas; making sure the charges received baths; sufficient nutrition; inoculations and later, vaccinations, for smallpox; and routine examinations. Fortunately, the London and Paris foundling hospitals drew in some of the leading pediatric pioneers of the time who attempted to improve pediatric knowledge and practice. In London, William Cadogan, Hans Sloane, William Watson, and Richard Mead, among others, collectively furthered medical understanding of topics such as wet-nursing, epidemics, inoculation, and medication. In Paris, early nineteenth-century physicians like François Valleix and Charles Michel Billard performed some of the first large-scale case studies on newborn foundlings, and in the process, created new classifications for children's diseases, updated diagnostic practices, and validated the value of autopsies in investigations of children's diseases.<sup>62</sup> While some practices would later appear controversial, such as Mead's recommendation for nurses to give fretful children opiates to calm them down, their trials and errors were part of a large learning

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<sup>61</sup> For Paris, Dupoux, 287 and Fuchs, *Abandoned Children*, 126-133; For London, McClure, 206-207, Levene, 163.

<sup>62</sup> Abt, 87.

curve to comprehend the health and mortality of infants and children between 1750 and 1850.

Paris and London foundling hospitals advanced children's medical care in at least three important ways. First, the separation of the ill from the healthy required the creation of special infirmary wards. Between 1859 and the 1870s, the London hospital developed special infirmaries to house children suffering from infectious diseases, scabies ("the itch"), scrofulous and eye conditions, and even a convalescent center for children recovering from the ravages of various diseases.<sup>63</sup> The Paris foundling hospital also created three infirmaries on the second floor of the central building, including a general medical infirmary, a surgical infirmary, and an eye disease ward (*salle d'ophtalmie*) that had up to fifty patients at one time.<sup>64</sup> The practice of isolating specific diseases and disorders within their own distinctive space had the practical purpose of quarantining children to prevent further infection and pooling patients with similar conditions for doctors to observe and treat together. With the space and resources to implement separation policies, which institutions like workhouses could not, these hospitals were in "the vanguard of new medical ideas and practice."<sup>65</sup> This early pattern of separation by disease—although rudimentary—was replicated and advanced by nineteenth-century children's hospitals. By the 1880s, momentous changes in medical understanding and treatment of disease, such as Louis Pasteur's discovery of the germ theory, Robert Koch's isolation of bacilli, and the discovery of new vaccines, led most Paris and London

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<sup>63</sup> McClure, 206.

<sup>64</sup> Fuchs, *Abandoned Children*, 128. Stewart, "The Hospitals and Surgeons of Paris," 75-76.

<sup>65</sup> Levene, 157.



children's hospitals, including the foundling hospitals, to created separate isolation wards for diphtheria, measles, and scarlet fever, at the very minimum.

The Paris and London foundling hospitals were also vigilant in the prevention of smallpox. As a disease that thrived in dense populations and needed healthy hosts to remain endemic, smallpox was a deadly threat within the foundling hospitals, which had both prerequisites. While challenged in the realm of density and overall cleanliness, London foundling hospital governors and doctors overcame criticism and debate and approved a general policy of inoculation for the disease soon after the institution opened, with the first inoculation performed in 1744.<sup>66</sup> Prior to 1800, smallpox remained a killer and took up to one fifth of the children between the ages of one and five years old; however, mandated inoculations of children upon their return from their nurses prevented a worse death toll.<sup>67</sup> In the early nineteenth century, the London hospital replaced inoculation with vaccination, a lower-risk alternative in smallpox prevention developed by British doctor William Jenner in 1798. France was an early supporter of vaccination, and under the Consulat and the Empire, a special vaccine committee directed efforts to spread the practice.<sup>68</sup> During the 1800s, foundlings at Enfants-Trouvés either received vaccination upon admission or by doctor-inspectors in the country, as state regulations required foundlings to be vaccinated within their first three months. While the administration of the vaccine saved lives from the smallpox virus, a deadly side effect was that it prolonged a child's stay at the foundling hospital. As noted in 1861, "the

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<sup>66</sup> McClure, 207.

<sup>67</sup> Levene, 163.

<sup>68</sup> A. Renault, *Collection of historical notes and extracts on smallpox, inoculation, and vaccination*, Wellcome Library, Rare Books Collection, MS 4193, 142.

custom that all children stay in the Hospice until the scab forms around their smallpox vaccination” contributed to the hospital’s high mortality rates.<sup>69</sup>

Another pediatric contribution of the foundling hospital that should not be underestimated was the concentrated effort to improve the health of its temporary residents. However controversial, even brutal, their methods might seem, such as artificial feeding experiments with goat’s, ass’s, and cow’s milk performed at Enfants-Trouvés, for the most part, the willingness to explore every possible medical avenue to improve a child’s condition set the medical staff at the Paris and London foundling’s hospital apart. At the London hospital, they sent children to the healing baths at other convalescent hospitals, purchased trusses, leg braces, eye glasses, and orthopedic shoes for children that needed special devices, and supported children with incurable conditions, such as blindness, epilepsy, and mental illness<sup>70</sup> As Alyssa Levene points out, due to the orphaned or abandoned status of these children, any form of medical experimentation might appear to be exploitative and suspect, yet the hospital’s willingness to try different methods and treatments had two significant silver linings: they incontrovertibly saved or improved the lives of children that otherwise might not have survived were they not in the institution, and the hospital’s medical efforts opened up the possibilities for the clinical investigation of children’s health and disease.

The Paris and London foundling homes arose out of a concentrated desire to save the lives of children who might otherwise perish due to neglect, abandonment, or death.

Foundling hospital supporters likened them to other hospitals for sick and disabled

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<sup>69</sup> Fuchs, *Abandoned Children*, 147. Fuchs also notes that doctor-inspectors appear negligent in their vaccination of foundlings at the homes of nurses, either due to actual failure of their duties or incomplete reporting, 226.

<sup>70</sup> McClure, 216.

persons but stressed that their design was of even greater importance because children were involved. While genuine humanitarianism fueled much of fervor to protect abandoned children, religious belief, civic duty, and state interests also played significant roles in the establishment these institutions. Pious and civic-minded individuals circulated arguments about the great necessity for establishments such as *Enfants-Trouvés*. One mid-eighteenth century French author wrote: “as Children of the State, it is necessary to conserve them, it is the [State’s] force and glory; Humanity commands it, Religion requires it, and Society benefits from it.”<sup>71</sup> London foundling hospital supporters also emphasized this dual impetus: “In a religious View, the prevention of Murder is a thing which Morality and the Principles of the Christian Religion ought to induce us to lay to Heart; and as the Strength of a Country depends very much on the Number of Hands which it has to support it, in a civil view such Hospitals must be of great Advantage to a Nation. . .”<sup>72</sup> Saving poor, abandoned children from certain death was a sacred and national responsibility for reform-minded French and British alike, and this same set of values impressed British supporters of another type of institution: the children’s dispensary.

### The Children’s Dispensary

Along with the London foundling hospital, two significant London dispensaries have also been identified as the forerunners of the infant welfare movement: George

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<sup>71</sup>AP/HP, FOSS 13/6 *Abrège historique de l’établissement de l’hôpital des enfans trouvés* (Paris: Thiboust, imprimeur du Roi), 1758. My translations throughout unless otherwise noted.

<sup>72</sup>*An account of the foundation and government of the Hospital for Foundlings in Paris. Drawn up at the command of her late Majesty Queen Caroline, and now published for the Information of those who may be concern’d in carrying on a like Design in this City.* London, [1739], Eighteenth Century Collections Online, Gale. Arizona State University AULC, accessed 9 Aug. 2014, preface, 1

Armstrong's Dispensary for the Relief of the Infant Poor established in 1769 and John Bunnell Davis's Universal Dispensary for Children, founded in 1816.<sup>73</sup> The British alternative to children's hospitals, these two institutions played the only, however circumscribed, role in the prevention and treatment of children's diseases and other health conditions prior to 1850. Considered the "embryos of children's hospitals" in Great Britain, the children's dispensary was the first institution solely dedicated to provide medical care to poor children. Even with a low intensity level of care, the children's dispensary impressed upon the medical community and the general public the notion that sick children needed a special institution to provide medical care that was distinct from adults.<sup>74</sup>

The establishment of the Armstrong Dispensary and the Universal Dispensary coincided with a larger dispensary movement that spread across Great Britain. According to historian Irvine Loudon, the period between 1770 and 1850 was the "golden age" of the free dispensaries in Great Britain, a movement that brought a completely new level of medical care to the urban and provincial poor.<sup>75</sup> The first dispensary supposedly originated at the Hôtel-Dieu, the largest general hospital in Paris, France, during the middle of the seventeenth century. As an "innovation" that provided some support to "sufferers who would not have come into the hospital wards," the Royal College of Physicians imported the French concept to Great Britain and opened its own dispensary in 1696, followed by the Westminster Dispensary in 1715 and the Aldersgate Dispensary

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<sup>73</sup> John Davis, "British Pediatrics," 31-37, in Buford Nichols, Angel Ballagriga, and Norman Kretchner, *History of Pediatrics, 1850-1950* (New York: Raven Press, 1991), 31.

<sup>74</sup> Seidler, 184.

<sup>75</sup> Irvine Loudon, "The Origins and Growth of the Dispensary Movement," *Bulletin of the History of Medicine* (Fall 1981), 342.

in 1770.<sup>76</sup> Eventually, the utility and availability of outpatient care made dispensaries popular, and in the arrested development of large hospitals to meet the medical needs of a growing British population, dispensaries multiplied quickly. By 1800, London had sixteen general dispensaries and another twenty-two existed in the provinces.<sup>77</sup>

In the mid-eighteenth century, dispensaries were a primary source of medical care for poor British families and children. The typical dispensary was a small, local voluntary institution that resembled a modern walk-in clinic where individuals could consult with an attending doctor and receive medical advice and medications free of charge. Many of the visitors were “casualties,” or casual attendees who drifted in and out and not always at the prescribed times of operation.<sup>78</sup> Dispensaries and their cousins, outpatient facilities within general hospitals, provided outpatient care and home visits for individuals too sick to travel. Without wards or inpatient services such as surgeries and special therapies, the cost of maintaining these institutions was much more economical than a fully-equipped hospital.<sup>79</sup> As a site where medicine and philanthropy intersected, the dispensary sometimes landed more on the side of philanthropy, especially at hospital outpatient departments, where a short visit with the doctor was more of a “token charitable gesture” rather than an attempt to provide quality medical care.<sup>80</sup> In contrast to outpatient wards at general hospitals, the British children’s dispensaries were special projects of strong-minded and capable physicians who devoted much of their time and resources to their

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<sup>76</sup> Irvine Loudon, “Historical Importance of Outpatients,” *British Medical Journal* (15 April 1978): 974.

<sup>77</sup> Loudon, “Dispensary Movement,” 324.

<sup>78</sup> Loudon, “Outpatients,” 974.

<sup>79</sup> Loudon, “Dispensary Movement,” 324.

<sup>80</sup> Loudon, “Outpatients,” 974.

dispensaries. This extremely personal connection between founder and institution was a double-edged sword: Armstrong and Davis were the lifeblood of their dispensaries, and when the lives of their founders expired, the dispensaries struggled or closed their doors.<sup>81</sup>

The first institution of its kind, Armstrong's Children's Dispensary at 7 Red Lion Square in London had a simple mission: "to administer advice and medicines gratis to the children of the Industrious Poor, from the birth to the age of 10 or 12 years."<sup>82</sup> The key word was industrious, as Armstrong sought to forge a respectable charity that would elevate the health and conditions of children of the deserving, hardworking poor. Although his charity only lasted a dozen years, it treated almost 35,000 children, an average of eight outpatients a day.<sup>83</sup> Although Armstrong was a physician, his philosophy behind the children's dispensary was more social than medical, and he had strong opinions about what children's medical care should entail and what it should not. His goal was to save children's lives, but he was not in favor of special children's hospitals or admitting children as inpatients in general hospitals because he did not believe that children should be separated from their mothers.<sup>84</sup> Armstrong was also a strong proponent of increasing medical knowledge and wrote a treatise on children's diseases

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<sup>81</sup> Seidler, 184. Also Loudon, "Dispensary Movement," 323. Different accounts give different dates, but Armstrong's Dispensary lost its financial support due to the founder's financial issues and a loss of public support sometime between 1782 and 1783. According to Loudon, after Davis died in 1824, the Universal Dispensary struggled with debts and lack of direction until 1856 when the dispensary became the Royal Infirmary for Women and Children. See Irvine Loudon, "John Bunnell Davis and the Universal Dispensary for Children," *British Medical Journal* (5 May 1979): 1193.

<sup>82</sup> George Armstrong, "A general account of the dispensary for the relief of the infant poor," in *An Account of the Diseases Most Incident to Children, from the Birth till the Age of Puberty, with a Successful Method of Treating Them* (London, 1783).

<sup>83</sup> Seidler, 184-85.

<sup>84</sup> Jules Kosky, *Mutual Friends: Charles Dickens and Great Ormond Street Children's Hospital* (London: Weidenfeld and Nicolson, 1995), 59.

based on his work in the dispensary. As much as Armstrong desired to devote every moment to preserving “a great many lives very useful to the Public,” he did not see inpatient medical facilities as an appropriate conduit for an increase in pediatric knowledge. Armstrong was obviously not the only opponent of children’s hospitals, and similar attitudes impeded any attempt to open an institution of that type for decades.

### The Universal Dispensary’s Medical Mission

John Bunnell Davis’s Universal Dispensary for Children had not only greater longevity, but it took London’s medical and charitable circles one step closer to an inpatient children’s hospital. The Universal Dispensary expanded the rules of charitable medical care through more inclusive (as opposed to selective) admission policies, a more comprehensive approach to child health, disease, and mortality, and the vision to promote medical training in the field of pediatrics on site. Established in 1816 at St. Andrew’s Hill, Doctor’s Common, London, the Universal Dispensary lived up to its name by accepting patients from any district in or outside of London and admitting all urgent cases without a letter of recommendation.<sup>85</sup> This policy was a departure from most voluntary medical institutions—hospitals and dispensaries alike—and was starkly different from the selectivity of Armstrong’s dispensary. At a time when most children were turned away from general or specialized hospital wards in London, the Universal Dispensary opened its doors to any child in need of medical care.

The Universal Dispensary disseminated ideas for comprehensive childhood health commiserate with Davis’s socio-medical philosophies, some of which were ahead of his time. The title of his 1817 treatise on child mortality in London indicates his medical

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<sup>85</sup> Loudon, “Universal Dispensary,” 1192.

ambitions fused with social and philanthropic interests: *A cursory inquiry into some of the principal Causes of Mortality among Children with a view to assist in ameliorating the State of the Rising Generation in Health, Morals, and Happiness, to which is added and account of the Universal Dispensary for Sick Indigent Children.* Considering childhood health and disease “a separate branch of public medicine,” the dispensary used its contact with families to instill more healthy and hygienic habits at home.<sup>86</sup> The physicians at the dispensary encouraged breast-feeding and health visiting, distributed special dietary guides for children by age group, and proposed a separate baby clinic with advisory leaflets and a corps of health visitors that was somewhat reminiscent of modern childhood health and wellness programs.<sup>87</sup> Judging by numbers, the Universal Dispensary for Children’s approach to child health was welcomed by London’s poor and the dispensary filled a great need in the metropolis. In its first year, the dispensary admitted almost 2,000 children, and with each child returning for consultation or treatment between three to four times per year, the facility logged a total attendance of between seven and eight thousand. Eight years later, both admissions and total attendance had nearly tripled.<sup>88</sup>

Training mothers and children on the prevention of disease was not the only educational agenda: the Universal Dispensary was also interested in promoting and professionalizing its medical specialty. Although its governors never used the term “pediatrics,” the dispensary was committed to advancing pediatric knowledge through a

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<sup>86</sup> John Bunnell Davis, *Annals, Historical and Medical, during the first four years, of the Universal Dispensary for Children, St. Andrew’s Hill, Doctors’ Commons* (London: W. Simpkin and R. Marshall, 1821), 68.

<sup>87</sup>G. F. McCleary, *The Early History of the Infant Welfare Movement* (London: H. K. Lewis, 1933), 20.

<sup>88</sup> Loudon, “Universal Dispensary,” 1192-93. As a comparison, in 1824 the Universal Dispensary attended to 20,000 children, just shy of sixty-percent of Armstrong’s total attendance for twelve years.



medical training program. Similar to training opportunities at an inpatient hospital, its governing leaders urged young general practitioners to attend lectures based on medical observations and case studies of admitted patients. The Universal Dispensary and its Southwark Station branch offered lecture topics like the “theory and practice of medicine in relation to the diseases of infancy” particularly to students studying to be general practitioners because they were likely to meet child patients in private practice.<sup>89</sup> Since most British hospitals followed a strict no-children policy, this type of opportunity was unique within London. By promoting the dispensary as a center for specialized medical study, the governors and physicians of the Universal Dispensary for Children directed the attention of the medical field to the value of pediatric study while also emphasizing its distinctiveness as a specialty.

The medical writings of John Bunnell Davis illustrate the beginning of strategic comparisons between French and British systems of care to promote and justify new dispensaries and hospitals dedicated to serving the medical needs of children in a particular locality. For example, in his *Annals of the Universal Dispensary for Children*, Davis partially justified the London dispensary through a comparison of the state of child health in Paris and London. Alluding to an unnamed French authority, he emphasized that although overall deaths in Paris exceeded those in London, the mortality rates of children under two years of age were higher in the London metropolis.<sup>90</sup> Davis viewed the situation as endemic, affecting not only infants; he was appalled to find out that in 1815, of 19,650 children under the age of five in London, 7,116 died in that age group.<sup>91</sup>

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<sup>89</sup>Loudon, “Universal Dispensary,” 1192.

<sup>90</sup> John Bunnell Davis, 16-17.

To further make his point, Davis made another international comparison, noting that this proportion exceeded that of any other large capital in Europe, including Paris, Berlin, and Vienna. Alluding to the benefit of Enfants-Malades, the Parisian children's hospital, without even mentioning its name, Davis blamed London's high child mortality rate above all on "the inadequacy of medical establishments, from the impossibility of directing their assistance exclusively to the infant branch of society."<sup>92</sup> Davis's argument implied that if London had more medical institutions serving children, fewer children would be lost to disease.

This same logic, reiterated by later British pediatricians, eventually generated some outcomes that would have pleased Davis. As the first British children's dispensary, the Universal Dispensary was the first training ground on British soil for general practitioners with an interest in childhood health, hygiene, and disease. The lineage of children's dispensaries and hospitals established in Great Britain later in the century can be traced to the Universal Dispensary. Physician founders like Dr. Samuel Malins, who founded the Liverpool children's infirmary in 1851, and Dr. Charles West, who founded the Great Ormond Street Hospital for Children (GOSH) in London in 1852, both worked in the Universal Dispensary in London.<sup>93</sup> Their dispensary experiences shaped the future endeavors of these physicians, and although they both created even grander, more sophisticated children's medical centers, three pillars of the Universal Dispensary's

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<sup>91</sup> Loudon, "Universal Dispensary," 1192.

<sup>92</sup> Davis, *Annals*, 67.

<sup>93</sup> Conor Ward, "The Liverpool Infirmary for Children, 1851-1920" *Medical Historian* (The Bulletin of the Liverpool Medical History Society, vol. 18 (2006-2007): 11-23. Obstetrician Dr. Samuel Malins proposed a children's dispensary in Liverpool in 1832 after working at the Universal Dispensary in London because one-third of Liverpool's children died before age two and one-half died before age ten. The Liverpool Infirmary for Children opened in 1851, and eventually became a children's inpatient hospital, 11-12.

mission remained guiding principles for later British establishments: (a) to provide medical treatment for poor children; (b) to advance the study of the diseases of infancy and childhood; and (c) to educate poor mothers on domestic health and hygiene so as to prevent childhood disease and illness. Later establishments, like GOSH and the hospitals for sick children in Liverpool (1856), Manchester (1855), and Birmingham (1862), had similar mission statements, but with one important difference. These inpatient hospitals substituted the objective of the training of poor mothers with “the training of nurses for children,” fitting with the more clinical mission of the medical institutions at that time.<sup>94</sup>

#### Pioneering Pediatrics at *Enfant-Malades*: Diagnoses, Textbooks, and Autopsies

Generally accepted as the first children’s hospital in the world, l’Hôpital des Enfants-Malades holds great social, political, and medical significance as the premier model of a children’s medical institution. Opening its doors in 1802 on the site of a former orphan asylum, Les Orphelins, this hospital was born out of several pre-Revolutionary hospital reforms that came to fruition in the decades surrounding the French Revolution.<sup>95</sup> These reforms overhauled the Paris hospital system on a grand scale and facilitated a host of changes: the improvement and aggrandizement of the existing general hospitals; the erection of new, smaller hospitals; the confiscation of church properties for use as state hospitals; and state takeover of the ownership and administration of hospitals.<sup>96</sup> Between 1775 and 1785, the state constructed six new

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<sup>94</sup> For Liverpool, Ward, 13; for GOSH, GOS/1/2/1, Minutes of the Provisional Committee of the Hospital for Sick Children; for Birmingham and Manchester, Rachel Waterhouse, *Children in Hospital: A hundred years of child care in Birmingham* (London: Hutchinson), 20.

<sup>95</sup> M. Pastoret, *Rapport sur l’état des hôpitaux, des hospices et des secours à domicile à Paris, depuis le 1<sup>er</sup> janvier 1804 jusqu’au 1<sup>er</sup> janvier 1814* (Paris: Huzard, 1816).

<sup>96</sup> Ackerknecht, 17.

hospitals (Cliniques, Necker, Cochin, Beaujon, Veneriennes, and Maison de Santé), and in the next few decades, new hospitals found life in old monasteries and asylums. As one of these new hospitals, *Enfant-Malades* was the only one that specialized in pediatric care. What began as a three-hundred-bed facility in 1802 eventually grew to hold over six-hundred beds, a covered gymnasium, a chapel, an autopsy examination room (*l'amphithéâtre des morts*), an operations and lecture theatre (*l'amphithéâtre des opérations and des cours*), and an outpatient department complete with baths.<sup>97</sup> As the first attempt to institutionalize poor children in dire need of medical care, the Paris establishment treaded a rocky slope as both a model to emulate and a model to avoid. Without significant advancement in the knowledge of childhood health and disease, *Enfant-Malades* forged a specific place and set of practices to further this knowledge, but at a high cost in human life.

As an object of emulation, *Enfants-Malades* benefited from being a part of a centralized, state-funded Parisian hospital network that allowed for the porous flow of medical advancements between hospitals. Paris physicians not necessarily tied to *Enfants-Malades* pioneered diagnoses and surgical techniques that became indispensable tools at the children's hospital. Pierre Bretonneau first identified diphtheria, croup, and typhoid fever, and Armand Trousseau, a student of Bretonneau, practiced the surgical technique of the tracheotomy, also invented by his mentor.<sup>98</sup> The only children's hospital in Europe for over twenty-five years, *Enfant-Malades* catered to a growing group of

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<sup>97</sup> AP/HP, FOSS 21/1. F. S. Ratier, *Medical Guide to Paris: A Description of the principal hospitals of Paris with some account of the practice of the most eminent physicians and surgeons attached to the different hospitals*, trans. J. Rutherford Alcock (London: Burgess and Hill, 1828), 109.

<sup>98</sup> Luc Passion and Michel Sorin, "L'Invention du patient: l'hôpital and l'enfant à Paris au XIXe siècle," in *Les maux et les soins: médecins et maladies dans les hôpitaux parisiens au XIXe siècle*, 191-200, eds. Francis Demier and Claire Barille (Paris: Action Artistique), 197.

physicians and surgeons exclusively interested in children's medicine, and as a result, the Paris children's hospital became a key mover and shaker in pediatric specialization and professionalization in the first half of the nineteenth-century. As early as the 1815, its medical staff provided lectures on a range of children's diseases at the hospital, and some doctors and interns delivered private lectures for a small fee.<sup>99</sup> At Enfants-Malades, students and visitors could make the rounds in the morning with physicians and surgeons to observe individual cases.<sup>100</sup> In 1863, Henri Roger, physician at Enfants-Malades, helped to facilitate the official recognition of pediatrics as a specialty in France when he delivered the first clinic on childhood diseases to the Paris Faculty of Medicine.<sup>101</sup>

Enfant-Malades was the destination par excellence for medical students interested in studying childhood disease on a grand scale. The children's hospital was listed in every medical guide to the Paris Hospitals printed after 1802. As one French medical guide promised, "it is only here, in Paris, that the diseases of children may be studied to the greatest advantage."<sup>102</sup> Some of the pioneering pediatrics techniques were more effective than others. The children's hospital setting permitted the standardization of medications and dosages for children suffering from specific conditions, which were added to formularies, or published compilations of medicines and treatments.<sup>103</sup> In an era

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<sup>99</sup> Stewart, 140.

<sup>100</sup> John Cross, *Sketches of the Medical Schools of Paris, including remarks on the hospital practice, lectures, anatomical schools, and museums; and exhibiting the actual state of medical instruction in the French metropolis*. (London: J. Callow, 1815), 177.

<sup>101</sup> This lecture was published in 1864. Henri-Louis Roger, *Clinique de l'Hôpital des Enfants. Séméiotique des maladies des enfants; leçons professées en 1863* (Paris: P. Asselin, 1864).

<sup>102</sup> Ratier, "Medical Guide to Paris," 111.

<sup>103</sup> F. S. Ratier, *A Practical Formulary of the Parisian Hospitals*. Transl. by R. D. McLellan (New York: Clayton and Van Norden, 1831).

before radiology or the perfection of laboratory science, the doctors at Enfants-Malades faced the greatest difficulty in the field of diagnoses. Children, if they could articulate their pain or symptoms at all, were often vague or uncertain. In the absence of information from patients, early pediatric doctors had to rely on their powers of observation to form a diagnosis. Pioneered by Dr. Jadelot, *semiologie*, or *physiognomie*, the observation of minute changes in the physical appearance of the patient, such as the color of the skin and facial expressions, became a common diagnostic tool practiced at Enfants-Malades.<sup>104</sup> The semiological drive led Henri Roger to discover one of the simplest, yet most useful, diagnostic tools used today, the measurement of body temperature by thermometer.<sup>105</sup> Although *semiologie* was one of the least effective approaches, the practice was part of a trial and error process by which doctors used the instruments available at the time to forward their understanding of children's ailments.

A more morbid, but necessary and successful technique practiced at the Paris children's hospitals was the clinical observation of diseased corpses: the autopsy. At the foundling hospital, Billard made great strides with his autopsy examinations; Enfants-Malades physicians and surgeons also seized on the value of the autopsy for children's medicine. Paris-trained physicians Frédéric Rilliet and Antoine-Charles-Ernest Barthez conducted numerous clinical examinations of childhood affections in the vast wards, operating theatres, and autopsy rooms at Enfants-Malades.<sup>106</sup> Observations of large numbers of children laboring from similar diseases and conditions were helpful, but the

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<sup>104</sup> Roger's *Clinique de l'Hôpital des Enfants. Séméiotique des maladies des enfants; leçons professées en 1863* is an example of how this practice continued well into the nineteenth century. Also see Ratier, 114-115.

<sup>105</sup> Robert Laplane, "French Pediatrics," in Buford Nichols, Angel Ballagrifa, and Norman Kretchner, *History of Pediatrics, 1850-1950* (New York: Raven Press, 1991), 42.

<sup>106</sup> Abt, 89.

key to understanding disease and specific causes of death came from the autopsy, or post-mortem examination. In the Enfants-Malades post-mortem examination room (*l'amphithéâtre des morts*), doctors would probe and dissect cadavers for pathological lesions that indicated the cause of death, or in the operations and lecture theatre (*l'amphithéâtre des operations and des cours*), the cadaver and its pathological lessons would be investigated and presented to groups of students and observers.<sup>107</sup>

Billard, Valleix, Rilliet and Barthez could not have accomplished what they did without a steady stream of newborn patients. The Paris children's hospitals provided them with thousands of patients and tiny bodies to carefully observe and examine, and using the tool of the medical autopsy, they were able to record, analyze, and further understand the causes of infant mortality on an unprecedented scale. Billard's treatise on newborn infants involved eighty-seven case histories of separate child patients, but he likely drew his general findings from a much greater number of observations and autopsies. During the term of his internship, the foundling hospital admitted 16,335 children, and approximately 4,344 children died.<sup>108</sup> Valleix's treatise included 112 Enfants-Trouvés patient observations from the year 1834, during which time 4,941 children were admitted to the foundling hospital and 1230 died in the institution.<sup>109</sup> While a handful of Billard's and Valleix's treatise examples survived their hospital stay and found their way to a wet-nurse in a rural department, the majority of abandoned babies perished. At Enfants-Trouvés high mortality rates, combined with little or no resistance to

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<sup>107</sup> Russell Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (Cambridge: Cambridge University Press, 1987), 138.

<sup>108</sup> Fuchs, *Abandoned Children*, 143, Table 4.3, "Mortality of Abandoned Children at the Hospice."

<sup>109</sup> *Ibid.*

the performance of autopsies on the cadavers of abandoned infants and children, unfortunately aided these physicians' research capacities and made possible their pediatric advancements.

### Critiques of the Paris Hospitals: Infant Mortality and Poor Hygienic Principles

Not everything at Enfants-Malades was worthy of imitation, and with a primarily clinical-anatomical focus, the comfort and well-being of the afflicted young patients was of secondary importance. For the most part, the children received what was perceived as good nutritional care at the time, receiving the prescribed diet of liquid, partial-solid, or solid foods corresponding to the patient's condition.<sup>110</sup> The hospital generously provided children with portions of roast meat and wine, which prior to the pasteurization of milk and sterilization of water, were universally considered the best foods and drinks to build up a child's strength.<sup>111</sup> Due to large numbers of children, however, basic public health considerations, such as clean, dry, well-ventilated wards and proper sanitation, were not managed well at Enfants-Malades. In the 1830s, a campaign to improve the hygiene and contagion deficiencies at the children's hospital began, with medical commissions dispatched to observe hospital regimes in 1833, 1835, 1838, and 1839.<sup>112</sup> Each study revealed severe problems. In 1833, a Conseil des hôpitaux report complained that "the

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<sup>110</sup> Cross, 172.

<sup>111</sup>Michael Ryan, *A new practical formulary of hospitals of England, Scotland, Ireland, France, Germany, Italy, Spain, Portugal, Sweden, Russia, and America, or a conspectus of prescriptions in medicine, surgery and obstetrics*, Trans. from the French edition by Milne Edwards and P. Vavasseur (London: Henderson, 1835), 345.

<sup>112</sup> These commission inquiries are not surprising, since they followed in the aftermath of the first devastating cholera epidemic to impact Paris, as well as other major European cities, in 1832. For a study of cultural responses to the 1832 epidemic (and the later epidemic in 1849), see Catherine Kudlick, *Cholera in Post-Revolutionary Paris: A Cultural History* (Berkeley: University of California Press, 1996).



doctors of Enfants-Malades are pleased with themselves for admitting children into the hospital wards where they may provide compassionate care and rescue the patients from the misery of their parents, but the large numbers of children result in insidious clutter and contagious sicknesses.”<sup>113</sup>

Many of the deficiencies of Enfants-Malades could be traced to insufficient public health practices and poor organization and maintenance of the hospital structures. While the acute medical and surgical wards appeared clean and airy, the ringworm (*teigne*) and scabies wards were damp and unhealthy due to the noxious sulfur potassium baths and ointments used to treat the hair and skin of the patients.<sup>114</sup> In 1835, the commission echoed numerous complaints about insalubrious areas of the hospital, the crowding of certain wards and the potential effect of projected increases on space, the defects of the heating system (*chauffage*), the construction and the policing of the bathrooms, the placement of the latrines and the autopsy rooms too close to the sick wards, and the urgency of certain sanitation and building repairs.<sup>115</sup> Intimately connected to these concerns, fears about contagion within the wards were a concern since the hospital’s inception, but in the 1830s and 1840s, it became a pressing topic that spurred hospital reorganization and the addition of new wards.<sup>116</sup> According to one French hospital commission report:

“At a later age, contagious diseases are not as frequent as in childhood, yet there does not exist at the children’s hospital any system of isolation for the patients

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<sup>113</sup> Armand Husson, *Etude sur les hôpitaux* (Paris: Paul Dupont, 1862), 128.

<sup>114</sup> Cross, 175-176.

<sup>115</sup> Husson, 128.

<sup>116</sup> For a complete study of the far-reaching concept of contagion in French medical and public health circles, see Andrew Aisenberg, *Contagion: Disease, Government, and the “Social Question” in 19<sup>th</sup> Century France* (Stanford, CA: Stanford University Press, 1999).

such as for smallpox (*variole*). The same rooms receive all the sick patients, despite the nature of their malady. Also smallpox, measles, and scarlet fever are endemic in this hospital. An observer there is continually afflicted by the view of children who, after having been admitted for very grave sicknesses, contract one or another of these endemic diseases, to which many finally succumb.”<sup>117</sup>

Similar concerns were echoed across the English Channel in the works of public health officials William Farr and Edwin Chadwick.<sup>118</sup> Chadwick in particular warned against the potential for contagion from children’s exposure to corpses of family members interred in homes, a tradition among London immigrants that was dangerous to an individual’s health.<sup>119</sup> The public health challenges of maintaining a large-capacity facility for hundreds of sick children at one time was a constant concern for French hospital administrators which would not abate until Listerian antisepsis practices and isolation wards were finally implemented in the 1880s. Regardless of these obstacles, the great desire and need for children’s hospitals only increased in the metropolis as Enfants-Malades’ capacity proved grossly inadequate for the numbers of children seeking admission each year.<sup>120</sup> By 1854, this situation eventually propelled the state’s decision to establish another large children’s hospital, Sainte-Eugénie, which opened its doors in 1855 to relieve the swelling wards of Enfants-Malades and to offer a newer, more hygiene-focused children’s hospital to the laboring classes of Paris.

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<sup>117</sup> Husson, 129.

<sup>118</sup> John M. Eyler, *Victorian Social Medicine: The Ideas and Methods of William Farr* (Baltimore, MD: The Johns Hopkins University Press, 1979); Christopher Hamlin, *Public health and social justice in the age of Chadwick: Britain, 1800–1854* (Cambridge: Cambridge University Press, 1998).

<sup>119</sup> Edwin Chadwick, *Report on the sanitary condition of the labouring population of Great Britain. A supplementary report on the results of a special inquiry into the practice of interment in towns* (London: Clowes and Sons, 1843).

<sup>120</sup> AP/HP, FOSS 21/1, *Notices sur les hôpitaux* (1878). Enfants-Malades maintained 440 patient beds from 1802 to 1843. In 1843, and that year two pavilions containing 160 beds were added, and another 78 beds were added in 1859. This situation would eventually precipitate the state’s decision to establish another large children’s hospital, Sainte-Eugénie, in 1854.

The high human costs that furthered medical science at the Paris children's hospitals became a topic of concern in British medical journals. Despite copious amounts of praise and admiration for these doctor's observations and discoveries, the connection between poor care, nutrition, and hygiene and high mortality rates at the children's hospital and foundling hospital were apparent. In his guide to the Paris hospitals, F. Campbell Stewart made special notice that for the year 1840, Enfants-Malades had the highest rate of mortality for both medical and surgical patients (1 out of 4.02 medical patients and 1 out of 7.88 surgical patients died).<sup>121</sup> In a 1839 *British and Foreign Medical Review* article noted almost all of Valleix's cases were complicated with serious afflictions, and nearly every patient, regardless of the disease, died at Enfants-Trouvés due to "utter neglect of all hygienic care under which its victims suffer," such as lack of cleanliness, proper nutrition (breast-milk), or fresh air.<sup>122</sup> British articles also noted how prejudice and fear about contagion led Parisian hospitals to incorrect diagnoses and unjustifiable infant deaths. For example, some medical and non-medical staff at Enfants-Trouvés, convinced that all infantile diseases of the skin were associated with syphilis, promptly removed from the wet-nurse and sent to the infirmary numerous otherwise healthy and robust infants displaying a rash or *pustules*. One instance of this occurred in July and August of 1835, when according to Valleix, twenty-six out of thirty-one infants were admitted to the Enfants-Trouvés infirmary with skin disorders soon after died of a disease caught in the infirmary.<sup>123</sup> Life in the foundling infirmary could be a death

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<sup>121</sup>Campbell, 100. Campbell provided separate tables of mortalities of medical and surgical patients in the principal hospitals of Paris for the year 1840.

<sup>122</sup> *British and Foreign Medical Review*, vol. 7, no 13 (Jan. 1839), 81.

<sup>123</sup> F. L. I. Valleix, *Clinique des maladies des enfans nouveau-nés* (Paris, 1838), 665.

sentence: if a foundling did not die from an infectious disease, he or she might have died from unsanitary artificial feeding methods. Similarly, a hospital stay at Enfants-Malades could be precarious due to overcrowding, poor isolation techniques, and still rudimentary medical knowledge of childhood diseases.

These well-advertised aspects of the Paris children's hospitals invariably had mixed responses, depending on the audience. Not surprisingly, the infant mortality led many British physicians and social reformers to frown on the prospect of a children's hospital in London. The French teaching methods of bed-side observation and the teaching autopsy also drew criticism, as for some, they infringed on British sensibilities of personal privacy and human decency. During this period, closed autopsies were tolerated in Great Britain, but the teaching autopsy was not, due to its connection to illicit activities associated with anatomical dissections such as the atrocities of body-snatching and grave robbers.<sup>124</sup> This British disdain for dissection was not shared by most members of the medical community, and the ability to observe and participate in autopsies only added to Enfants-Malades real and perceived value as a pediatric research and teaching institution for British students interested in children's diseases. Autopsies, teaching amphitheaters, and pediatric textbooks all became the hallmarks of French children's hospitals. For most pediatric practitioners across the English Channel and in other European countries, all of these elements would be essential features of new children's hospitals developed later in the century.

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<sup>124</sup> Even when children's hospitals opened in Great Britain in the 1850s and 1860s, they only contained "dead houses," physician-only areas for post-mortem examinations that were not open to the public.

## Summary

Eighteenth-century foundling hospitals in Paris and London, the Universal Dispensary for Children in London, and the Paris children's hospital, Enfants-Malades, paved the way for later nineteenth-century children's hospitals. These institutions provided the building blocks for Sainte-Eugénie and GOSH by providing spaces dedicated to caring for children's medical needs, places to adopt the most current medical techniques and procedures or discover new ones for the benefit of their charges. These specialized medical spaces also provided doctors with pools of poor, sick children with diverse medical needs, through which medical professionals could better understand and advance pediatric knowledge. As the first model for a children's hospital, Enfants-Malades was in the international spotlight, inspiring praise and critiques from a variety of professional and general sectors. Collectively, the foundling hospitals, children's dispensary, and Enfants-Malades reinforced the great necessity and value of children's medical institutions as places to study and teach children's medicine so as to learn how to better relieve poor children's physical suffering. These institutions also accentuated certain medical and hygienic principles that would continue to plague practitioners as the century progressed: the intimate link between infant and maternal health and the inadequacies of artificial feeding methods, and the supreme importance of implementing the most advanced sanitary principles in hospitals that were available at the time.

With limited opportunities to study children's diseases at general hospitals and dispensaries, physicians and surgeons interested in children's medicine in the early nineteenth-century traveled to Enfants-Malades and Enfants-Trouvés in Paris. Despite their insufficient and insalubrious conditions and high mortality rates, especially at the

foundling hospital, these hospitals were incubators for a new kind of practitioner, the pediatrician, and a new medical specialty, pediatrics, terms that would not officially come of age until later in the century. At the children's hospitals in Paris and the children's dispensary in London, these medical men pursued their training and practice in children's medicine, and in the process, carved out a special niche for themselves. The following chapter explores this particular set of French and British medical practitioners in more detail, exploring their individual accomplishments within an international context and tracing the methods and impact of their transnational communication and cooperation in the years leading up to and following the establishments of GOSH and Sainte-Eugénie.

## CHAPTER 3

### DOCTORS AND CHILDREN'S MEDICAL INSTITUTIONS: EDUCATION, PUBLICATIONS, AND PROFESSIONAL NETWORKS

Foundling hospitals, dispensaries, and the first European children's hospital, *Enfants-Malades*, were the earliest institutional spaces that addressed children's medical needs in London and Paris. Through them, a corps of medical practitioners began to further pediatric knowledge, ply and hone their medical and surgical skills, and advance the study of childhood medicine and disease nationally and internationally. This process of professionalization was historically specific, and as Keir Waddington explains, shaped by local and national contexts and tied to questions of identity, medical knowledge and practice, status and authority, competition and medical training.<sup>125</sup> In the field of children's medicine, the children's hospital provided a unique laboratory for doctors to explore and perfect their specialty as well as foster a group of pediatricians and a pediatric identity—the sense of belonging to a particular group of fellow children's doctors and surgeons that studied children's medicine, well before the terms “pediatrics” or “pediatricians” were common vocabulary.<sup>126</sup> As a place to congregate, teach and learn from one another and their patients, and produce specialized knowledge, the children's hospital separated these medical men from other general and specialist practitioners,

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<sup>125</sup> Keir Waddington, *An Introduction to the Social History of Medicine* (London: Palgrave Macmillan, 2011), 168. For accounts of medical professionalization in nineteenth-century France and Great Britain, see Matthew Ramsey, *Professional and Popular Medicine in France, 1770-1830* (Cambridge: Cambridge University Press, 1988) for France; Ann Digby, *Making a Medical Living: Doctors and Their Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1992), for Britain, which also includes a section on the practice of women's and children's medicine.

<sup>126</sup> The term pediatrics first appeared as references to academic departments and chairs in the 1870s (but as early as 1845 in Germany) and to professional societies and their accompanying journals and society transactions devoted exclusively to children's medicine in the 1880s. See Abt, 122-27.

while simultaneously requiring pediatricians to cast a wide net for professional connections abroad. As this chapter demonstrates, even before children's medicine became an officially recognized medical specialty, the world of French and British pediatricians during the nineteenth century was intertwined in complex and changing ways, and professionalization and specialization were key components of Franco-British medical interchanges.

In the early nineteenth-century two medical developments augmented transnational communication in every branch of medicine, connecting European and North American medical practitioners in unprecedented ways: the changes in Paris medical education that gave open access to foreign students and practitioners at the Paris hospitals, and the rise of commercial medical publishing that created an unprecedented increase in the production of medical treatises, reports, and journals.<sup>127</sup> The expansion of knowledge about children's medicine throughout the nineteenth century was aided by these two interrelated processes. For example, throughout the eighteenth and nineteenth centuries, intermittent streams of pediatric knowledge crossed national boundaries

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<sup>127</sup>Literature on nineteenth-century Paris medicine is immense. Ackerknecht's account of the primacy of early nineteenth-century Paris medicine and hospitals is the most influential. See Erwin H. Ackerknecht, *Medicine at the Paris Hospital, 1794-1848* (Baltimore, MD: The Johns Hopkins Press, 1967). However, others challenge his argument for a one-way transfer of knowledge from Paris outwards until 1850, such as John Harley Warner, "Paradigm Lost or Paradise Declining": American Physicians and the 'Dead End' of the Paris Clinical School, 337-383, in Caroline Hannaway and Ann La Berge, eds. *Constructing Paris Medicine* (Amsterdam: Editions Rodopi, 1994). Others stress more complex patterns of cross-cultural exchange and the role in morbid anatomy in those exchanges; see Russell Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (Cambridge: Cambridge University Press, 1987). For Franco-British relations in the area of medical education, see Thomas N. Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1996). For pediatrics, Elizabeth Lomax, *Small and Special: The development of hospitals for children in Victorian Britain* (London: Wellcome Institute for the History of Medicine, 1996) highlights Franco-British transfers of knowledge about children's diseases as well as shaping British opinions on the Paris children's hospitals, 8-9, 22-24. The impact of medical journalism on shaping specific medical fields and the making of specific medical communities is meager except for an edited volume by W. F. Bynum, Stephen Lock, and Roy Porter, *Medical Journals and Medical Knowledge: Historical Essays* (London: Routledge, 1992).



through published medical treatises, but after 1820, medical periodicals offered an easier, more rapid process to share information.<sup>128</sup> In Paris, hands-on training in large teaching hospitals gave doctors and students unprecedented access to living and non-living anatomical research subjects, while medical publishers turned out treatises, reports, and journals that allowed practitioners—not just in Paris—to print, read, and share up-to-date studies and reports on every medical topic conceivable. The relationship between medical publishing, the generation and dispersal of knowledge about childhood medicine, and the consolidation of pediatric practice was significant, as treatises and journal articles not only shaped and extended the pediatric knowledge base but helped to cement the credentials and reputations of pediatricians at home and abroad. According to Joy Harvey, “periodical fever” struck most physicians in the Paris clinics between 1820 and 1860, as contributing authors, young and veteran physicians alike, used journal publications as a method of self-advancement.<sup>129</sup>

In the field of children’s medicine, these developments led to specific patterns of Franco-British exchange in the first half of the nineteenth century, and in some ways, all roads did lead to Paris. Ample research and training opportunities allowed Parisian doctors to produce some of the first major pediatric textbooks of the age. British students seeking firsthand experience in childhood diseases travelled to children’s hospitals in

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<sup>128</sup> Roy Porter has demonstrated that an extensive medical press, including medical journals and medical society transactions, existed in France and Great Britain prior to 1800, but these journalistic attempts were fleeting and short-lived. See Roy Porter, “Medical Journalism in Britain to 1800,” in *Medical Journals and Medical Knowledge: Historical Essays*, 6-28, eds. W. F. Bynum, Stephen Lock, and Roy Porter, (London: Routledge, 1992): 8-9. The rest of the book essays discuss various facets of established nineteenth-century British medical journals, including their transnational effects in the United States. For France, Joy Harvey’s “‘Faithful to its old traditions’? Paris Clinical Medicine from the Second Empire to the Third Republic (1848-1872), 313-335, in *Constructing Paris Medicine* eds. Caroline Hannaway and Ann le Berge (Amsterdam: Editions Rodopi, 1994), 313-319, provides a discussion of French medical journals and gazettes.

<sup>129</sup> Harvey, 314.

Paris, Berlin, or Vienna or made due with observations in fever wards or dispensaries, generating medical reports based on limited samples. However, the road did not end or stay in Paris, as British pediatricians took home new ideas, models, and methods to practice and modify at home. Paris provided the original examples for what pediatric hospitals and pediatricians could achieve, and professionally driven doctors borrowed from that example. Early pediatricians, their published works, and their professional contacts across the English Channel are part of a shared legacy between l'hôpital Sainte-Eugénie and Great Ormond Street Hospital for Children (GOSH). This chapter traces the development of this system of communication, comparison, and competition that linked Paris and London pediatricians, demonstrating how these transcontinental relationships particularly influenced the establishment of GOSH in London by the middle of the nineteenth-century. In short, the transmission of pediatric knowledge between France and Great Britain was a two-way street with a long history.

### Eighteenth Century Pediatric Knowledge and Exchanges

Prior to the nineteenth-century, most pediatric knowledge developed sporadically and disseminated between Great Britain and the Continent at a snail's pace in treatises on children's diseases, health, and hygiene. The limited medical function of the foundling hospitals and dispensaries did not readily support rapid advances in children's medicine, and the medical press prior to 1820 was inconsistent and not internationally widespread. The physicians at European foundling hospitals performed their charitable duties with the scant knowledge available and produced very little literature on any pediatric advances made at their institutions. At the London foundling hospital, William Cadogan and Sir

William Watson were two exceptions who made early contributions through published sources. Watson was interested in measles and published his observations on two epidemic outbreaks at the hospital.<sup>130</sup> Cadogan was a strong advocate of maternal suckling, or wet-nursing if the former was not possible, and used his experience at the hospital as the basis for his 1748 treatise on nursing and the management of infants. George Armstrong, founder-physician of the short-lived Armstrong Dispensary for Children in London turned his compilation of the common diseases observed at the dispensary into his 1777 *Essay on the Diseases most Incident to Children*. Armstrong's and Cadogan's work influenced an obstetrician at the London Lying-in Hospital named Michael Underwood who wrote a three-volume treatise on the diseases of children in 1784 that would serve as the leading pediatric text until the late 1840s. Underwood's treatise on the diseases of children was based on his hospital experience and reviews of works by previous authors, including Armstrong.<sup>131</sup>

Pediatric publications in France and Great Britain began to develop into two categories in the late-eighteenth century: general works that focused on child health and hygiene and medical works that identified and classified children's diseases, medical treatments, and later, surgical procedures. Books on child health and hygiene, or *puèriculture* in French, typically addressed the needs of children under the age of three

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<sup>130</sup>This book titled, "An account of the putrid measles, as they were observed at London in the years 1763 and 1768," is described in Alysa Levene, *Childcare, Health, and Mortality at the London Foundling Hospital, 1741-1800: "Left to the Mercy of the World,"* (Manchester, UK: Manchester University Press, 2007), 157-159.

<sup>131</sup> Abt, 78. Michael Underwood, *A treatise on the diseases of children, with general directions for the management of infants from the birth* (London: Mathews, 1784.) Underwood also mentioned the work of Walter Harris his Latin text, *De morbis acutis infantum, (A Treatise of Acute Diseases of Infants)*, one of the earliest pediatric works from the seventeenth-century.

and had a particular social purpose, to prevent infant mortality.<sup>132</sup> A short work primarily focused on infant care and feeding, Cadogan's work illustrated this type of child health hybrid that covered a range of topics from nutrition to baths and exercise to illness. A combination of an essential manual for general practitioners on children's health topics and a self-help book for wet-nurses and mothers, this type of medical work was popular in eighteenth-century Great Britain. Written for use by an educated reading public, these books tapped into Enlightenment principles of learning, self-improvement, and personal responsibility.<sup>133</sup> Cadogan's work inspired other works on children's diseases, feeding, and hygiene, such as William Buchan's 1803 *Advice to mothers on the subject of their own health and on the means of promoting the health, strength and beauty of their offspring*, which also made its way to France. Judged to be a work of 'utility' and in a similar vein to a French work on "maternal medicine" by Alphonse Le Roy, Buchan's translator included an appendix with Cadogan's treatise.<sup>134</sup> In France and Great Britain, this type of manual became a popular channel for doctors to impart their knowledge of child health and hygiene to one another—and to a wider public, especially women caregivers—throughout the nineteenth century

In their emphasis on infant feeding, mothers, and domestic hygiene, the works by Cadogan, Le Roy, and Buchan all highlighted the intimate connection between a child's health and its mother's health, a reality that pediatricians—whatever their focus—could

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<sup>132</sup>Robert Laplane, "French Pediatrics," in Buford Nichols, Angel Ballagriga, and Norman Kretchner, *History of Pediatrics, 1850-1950* (New York: Raven Press, 1991), 39.

<sup>133</sup>Roy Porter, "The Patient in England, c. 1660-1800," in Andrew Wear (ed.) *Medicine in History: Historical Essays*, 91-118 (Cambridge: Cambridge University Press, 1992), 106-107.

<sup>134</sup>William Buchan, *Le Conservateur de la Santé des mères et des enfants*, trans. Thomas Duverne de Praïle (Paris: Mètier, 1804). The translations also included a review and augmented notes by Docteur Mallet, from l'Hôtel-Dieu in Paris.

not deny. Interest in children's diseases developed in the maternity hospitals as well as in the children's hospitals, as doctors in maternity hospitals recognized other important mother-newborn links such as congenital defects and mother's passing on disease to their infants. Even the early, more "scientific" works by Underwood and Armstrong included sections on infant feeding and proper care and hygiene in their lengthy medical treatises.<sup>135</sup> At the children's dispensaries in London, both Armstrong and John Bunnell Davis tried to educate families on the importance of personal and household cleanliness, proper nutrition, and supervision for a child's good health. Armstrong admonished parents for bringing their children to the dispensary in filthy clothes, and Davis provided weekly dinner recommendations for mothers, including what to serve children under and above the age of four years.<sup>136</sup> With digestive disorders such as enteritis, gastritis, and diarrhea as the most common issues facing his young patients, Davis also encouraged mothers to suckle their infants, if they could, as long as possible.<sup>137</sup>

In contrast to more general health manuals, medical works like Armstrong's and Underwood's addressed a different audience and had a different purpose. Written for medical professionals, their treatises focused on identifying, observing and treating diseases and medical conditions specific to childhood. While pioneering works for the time, these early works consisted of descriptive nosologies, or classifications of disease,

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<sup>135</sup> George Armstrong, *An Account of the diseases most incident to children, from the birth till the age of puberty* (London: Cadell, 1783). Armstrong's treatise included a lengthy essay titled, "Rules to be observed in the Nursing of Children, With a particular view to those who are brought up *by Hand*," p. 148-177. Underwood's 1784 edition included a very detailed section on infant care and feeding, pp. 213-287.

<sup>136</sup> John Bunnell Davis, *Annals of the University Dispensary for Children* (London, Simpkin and Marshall, 1821), 637. A sample dinner menu for Tuesday Dinner: Two ounces of boiled leg of mutton, three ounces of bread, and one potato well boiled, for each child above four years—Barley broth, or soup only for each child under four years.

<sup>137</sup> Davis, "A concise essay on the bodily management of children," in *ibid*, 578. Of 376 cases admitted to the dispensary between August and October 1820, digestive disorders were most common (54), followed by pneumonia, measles, and ascarides (parasites).

that corresponded to a condition's visible symptoms, such as "watery grippe" for diarrhea, or "scald head" for ringworm, or reproduced entries for little understood conditions like scrofula, swollen lymph glands caused by tuberculosis, which they called the "king's evil." Even with outdated terminology, these works were the backbones of early pediatrics in Great Britain and France, and they were recycled, reprinted, translated and modified for decades.<sup>138</sup> Armstrong's book had at least five editions, Underwood's had nine editions, and both were translated into French. Underwood's treatise in particular influenced British and French pediatricians well into the nineteenth-century, and his original ideas were frequently cited and recognized in French medical treatises and dictionaries.

#### Nineteenth-Century Pediatricians and the Paris Children's Hospitals

Greater opportunities for transnational exchange between French and British medical communities opened up after the post-Revolutionary reorganization of the Paris hospital system and continued well into the second half of the nineteenth century. After the French Revolution, medical students and practitioners increasingly looked overseas for opportunities to enhance their training, to learn specialized techniques, and to compare and contrast hospital systems, surgical methods, and treatments. At least two dozen guidebooks for medical study were published in France, Germany, and Great Britain between 1794 and 1817, and this genre continued well into the 1840s.<sup>139</sup> By 1815, following the end of the Napoleonic hostilities, Paris stood at the center of the medical world with the largest and most varied hospital system in Europe and a widely sought

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<sup>138</sup> Lomax, 169.

<sup>139</sup> Bonner, 71.

after formal medical education at the French medical school, the *Faculté de médecine de Paris*, and hospital *cliniques* run by notable clinicians and surgeons.

Several factors made Paris a popular destination for medical study apart from London, Edinburgh, Berlin, and even Vienna. The easy access to hospitals for foreigners, the unfamiliar disregard for patients' privacy, the almost limitless supply of dead bodies for surgical training as well as routine dissection, the gratuitous or low fees for medical classes, and the open reception to students by noted clinicians and surgeons made a positive impression on visitors from all countries.<sup>140</sup> Foreign students might also take advantage of private tutelage in specialties by some of the most renowned practitioners in obstetrics, pediatrics, venereal disease, and skin diseases.<sup>141</sup> British students were encouraged, if not expected, to “cross the Channel” and take a grand tour of the Paris hospitals to augment their medical training.<sup>142</sup> A distance away from the concentrated corridor of Paris hospitals in the city center, the smaller hospitals like Enfants-Malades attracted fewer students and provided better opportunities for viewing case details and treatments.<sup>143</sup> As one commentator noted, “Morbidity anatomy is a branch of study by no means neglected in the French schools; much care is given to improve the opportunities of teaching it to students. Nothing is more useful than the histories of and comments upon cases, and demonstrations of morbid parts.”<sup>144</sup> Students of pediatrics could greatly benefit

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<sup>140</sup> Ibid., 149.

<sup>141</sup> Diana Manuel (ed.), *Walking the Paris Hospitals: Diary of an Edinburgh Medical Student, 1834-1835* (London: Wellcome Trust, 2004), 15.

<sup>142</sup> Maulitz, 147.

<sup>143</sup> Bonner, 124; Manuel, 41.

<sup>144</sup> John Cross, *Sketches of the Medical Schools of Paris* (London: J. Callow, 1815), 43.

from the more intimate, and morbid, learning environment of the Paris children's hospital.

In the first half of the nineteenth-century, pediatric knowledge emerged in full force at Enfants-Trouvés and Enfant-Malades. The foundling hospital, Enfants-Trouvés, under the directorship of Dr. Jean-Francois Baron, led the field in the area of infancy, or birth to age two (*petite enfance, première enfance*), and the children's hospital, Enfants-Malades, came to dominate the field for the years between infancy and puberty, or age two to twelve or later (*deuxième enfance*).<sup>145</sup> At home and abroad, the most esteemed foundling hospital and children's hospital clinicians were those with the greatest contributions to pediatric literature. Two such productive individuals, François Louis Isidore Valleix and Charles Michel Billard (both mentioned in chapter 1) began their careers in children's medicine at the Paris foundling hospital. Valleix found his interest in pediatrics as an extern at Enfants-Trouvés in 1829, and after he earned his doctorate, he returned to complete his fourth year as an intern at the foundling hospital in 1834.<sup>146</sup> During that year, Valleix collected the observations and data to complete his first publication, *Cliniques de maladies des nouveau-nés*, in 1838. Later, as a physician for the Central Bureau, he continued to work with children at Paris hospitals and published on pediatric topics. The Paris foundling hospital's claim to fame, however, was Charles Michel Billard, a young intern whose work from 1826-1828 at Enfants-Trouvés

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<sup>145</sup> Albert Dupoux, *Sur les pas de Monsieur Vincent: Trois cents ans d'histoire parisienne de l'enfance abandonnée* (Paris: Revue de l'Assistance publique a Paris, 1958), 285-6. Dupoux's historical account names both Baron and Valleix two significant physicians at Enfants-Trouvés. Catherine Rollet-Echalier, *La politique à l'égard de la petite enfance sous la IIIe République* (Paris: Institut National d'Etudes Démographiques, 1990), 11, provides a discussion of various French medical terms and ranges for childhood. An infant, or child under the age of two was also called *petit enfant, enfant du premier âge, nourrisson*, or *bébé* (baby), and a newborn (nouveau-né) was also called *enfant de naissance*.

<sup>146</sup> P. Lorain, (ed.) *Guide du médecin praticien: résumé général de pathologie interne et de thérapeutique appliquées*, 5 ed. (Paris: Baillière, 1866), xviii.



transformed the classification of childhood disease. Medical historians credit him as the first to apply anatomical and clinical practices pioneered by medical leaders such as Jean-Nicolas Corvisart, Xavier Bichat, and René Laennec to the study of children's diseases, and they recognize his 1828 treatise on the illnesses of newborns, "*Traité des maladies des enfants nouveau-nés et à la mamelle*," as the first nosology of children's diseases from a pathological, rather than descriptive, perspective.<sup>147</sup>

Groundbreaking works published by Billard and Valleix provided a confident base for a network of other professionals that studied childhood diseases in Paris and beyond. Billard studied the causes and effects of prevalent childhood conditions, such as sclerema and other skin diseases, eye diseases, digestive problems, pneumonia, typhoid, scrofula, and tuberculosis, already noted by pediatric pioneers, but his voluminous clinical observations led to specific breakthroughs. He was the first, for example, to abandon the idea of dentition diseases (diseases brought on by teething), and his use of techniques like percussion and auscultation and scholarly tools such as medical statistics were ahead of his time.<sup>148</sup> Valleix built on Billard's work, but following the work of another Enfants-Trouvés doctor, Jean-François-Nicolas Jadelot, also paid keen attention to facial features and symptoms as an equally important diagnostic tool. Valleix was said

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<sup>147</sup>Robert LaPlane, "French Pediatrics," in *History of Pediatrics, 1850-1950* (eds.) Buford Nichols, Angel Ballariga, and Norman Kretchner (New York: Raven Press, 1991), 42. Also see Abt, 87. Billard classified childhood diseases according to the localized site of the illness. Categories included skin; digestive apparatus, viscera, air passages, circulation, cerebra-spinal system, locomotive system, generative organs, lymphatic, eye, infantile jaundice, alterations of the blood, and abnormalities and congenital diseases.

<sup>148</sup> Charles-Michel Billard, *A Treatise on the Diseases of Infants, founded on recent clinical observations and investigation in pathological anatomy made at the Hospice des Enfants-Trouvés with a dissertation on the viability of the child*, 2<sup>nd</sup> American ed., trans. from the 3<sup>rd</sup> French ed. (New York: J. and H. G. Langley, 1840).

to request two separate observations of each newborn patient, once while the child was calm, and once while the child was agitated.<sup>149</sup>

At *Enfant-Malades* a team of Paris-trained physicians, Frédéric Rilliet and Antoine-Charles-Ernest Barthez, gathered material for the first widespread pediatric textbook, *Traité clinique et pratique des maladies des enfants*, a three-volume work that and passed through three editions. Based on numerous clinical observations at the hospital and Rilliet's previous detailed observations of children's epidemics of typhoid fever (1840), measles (1848), mumps (1850), and cholera (1856), the text was voluminous and in the French-style, containing numerous case studies of childhood affections such as measles, mumps, gastro-intestinal disorders, pneumonia, bronchitis, meningitis, and many other conditions.<sup>150</sup> This co-authored work superseded all the prior outdated works by British physicians as well as by Billard and Valleix. To British medical students like Charles West, Rilliet's studies on tubercular meningitis, paralysis, polio, and encephalitis were particularly valuable, as were Barthez's ideas on respiratory diseases like pneumonia, bronchitis, and pleurisy, which were common in London's damp, cool climate.<sup>151</sup> According to pediatricians writing decades after the publication of Rilliet's and Barthez's grand treatise, these two *Enfants-Malades* physicians threw "the most light on the anatomy and pathology of cerebral hemorrhages" and other inflammatory diseases of the brain and chest than any of their predecessors years later.<sup>152</sup>

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<sup>149</sup>Lorain, xix.

<sup>150</sup> Abt, 89.

<sup>151</sup> West's comments on Barthez's conservative approach to treating mild cases of pneumonia without purgatives or bleeding reflects the still antiquated methods of treatment. Charles West, *Diseases of Infancy and Childhood* (London: Longman, Green, Longman, and Green, 1865), 340-41.

<sup>152</sup> *Ibid.*, 62.

The opportunities that the French children's hospitals afforded clinicians like Billard, Valleix, and Rilliet and Barthez were simply not available to medical students in British institutions, a situation that drove some of Great Britain's brightest and most ambitious pediatric students to study in Paris.

Further expanding the children's hospital as a base for the production of pediatric knowledge, these early pediatricians instilled confidence and provided a network for rising practitioners and students seeking to make their own mark in the medical specialty. Students interested in studying any aspect of childhood disease gravitated to the Paris children's hospitals of Enfants-Trouvés, Enfants-Malades, and after its establishment in 1855, Sainte-Eugénie, where they could explore pediatric topics for their Faculté de Médecin de Paris theses. J. L. Emile Molland from Dijon based his thesis on observations of 164 children affected by an epidemic of typhoid fever at Sainte-Eugénie in 1857, which looked at the cases in terms of age, gender, the duration, severity, and progress of the sickness, complications, and treatments.<sup>153</sup> Other young scholars finishing their *interne* requirement at Sainte-Eugénie like A. J. C. Garnier published their observations on diseases of great interest as a stepping stone for their medical careers. Written decades before serum therapy was developed to combat the disease, Garnier's report on diphtheria at Sainte-Eugénie identified ten different manifestations of the disease in 141 cases over the course of one year.<sup>154</sup>

Other clinicians, seeking to further specialize within their pediatric specialty, like H. Bouvier, conducted lectures on specific medical conditions observed at the children's

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<sup>153</sup> J. L. Emile Molland, *Épidémie typhoïde observée à l'hôpital Sainte-Eugénie*, Thèse pour le doctorat en médecin (Paris: Rignoux, 1859), 14, 63-67.

<sup>154</sup> A. J. C. Garnier, *Compte rendu des faits de diphthérie observées à l'hôpital Sainte-Eugénie pendant l'année 1859* (Paris: Delahaye, 1860), 8-9.

hospital of Enfants-Malades and later published them in treatise form to be read by a larger medical audience. Bouvier's clinical lessons addressed chronic afflictions that limited children's motor functions, particularly Potts disease (spinal tuberculosis) and rickets, conditions that occasionally appeared at all the Paris children's hospitals.<sup>155</sup> Bouvier's attention to rickets (*rachitisme*) is particularly important since the disease was so prevalent and had always been considered an "English disease."<sup>156</sup> The hard lives, unbalanced diets, and crowded, unhealthy living conditions of patients and their families often left marks on children's bodies such as undeveloped and diseased bones like rickets or predisposed children to bouts of infectious diseases like typhoid and diphtheria, and at the nineteenth-century Paris children's hospitals, doctors and students were there to observe, record, and publish on those medical conditions.

In addition to furthering the specialization of children's medicine as a whole, the Paris children's hospitals were also incubators for greater professionalization within the nascent field of pediatrics. Two Sainte-Eugénie practitioners, Eugène Bouchut and René Marjolin, exemplify this dual purpose, highlighting how the Paris children's hospitals furthered pediatric knowledge as well as pediatric careers. Both medical men were well-known and respected in their own right. Bouchut, a physician, pioneered the use of the ophthalmoscope to diagnose nervous system diseases in children, such as meningitis, and he also developed intubation, or the insertion of tubes in the trachea, a nonsurgical alternative technique to assist the breathing of children with croup and diphtheria.<sup>157</sup>

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<sup>155</sup> H. Bouvier, *Leçons cliniques sur les maladies chroniques de l'appareil locomoteur professées à l'hôpital des Enfants-Malades* (Paris : Baillière, 1858).

<sup>156</sup> Sir William Jenner, *The Practical Medicine of Today: Two addresses delivered before the British Medical Association and the Epidemiological Society* (London: H. K. Lewis, 1869), 41.

Bouchut lectured and wrote about the diseases of children and the laws of infant mortality, and his textbook treatise on childhood diseases went through six editions. Unlike other practitioners who passed through the children's hospitals, Bouchut emphasized a holistic notion of child health and well being, in which nutrition and hygiene—not just pathology—factored into child and infant health. In reflection of these ideas, Bouchut's pediatric treatise included chapters on infant feeding, bathing, and physical activity as well as a wide range of diseases and clinical case studies.<sup>158</sup>

Bouchut's long-standing recognition in pediatric expertise is exemplified in his listing in the bibliographical catalog of Paris physicians and surgeons compiled for the Universal Exposition of 1878. Bouchut's entry included forty-eight works and publications between 1848 and 1878, eleven of which were featured in the exhibition.<sup>159</sup>

René Marjolin, however, illustrates how productivity in the publishing department was not necessarily a requirement to be a pediatric leader. Marjolin, unlike some of the doctors and interns who rotated in and out of several Paris hospitals over time, was a long-time veteran of Sainte-Eugénie and served as the primary surgeon at the children's hospital throughout the 1860s and during the chaotic years of the Franco-Prussian War and Paris Commune. The son of Jean-Nicolas Marjolin, respected anatomist and surgeon to Louis-Philippe, Marjolin the younger did not have any great publications to his credit,

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<sup>157</sup>Isaac Abt, ed. *Abt-Garrison History of Pediatrics*, (Philadelphia and London: W. B. Saunders, 1965), 88. Buford Nichols, Angel Ballagrifa, and Norman Kretchner, *History of Pediatrics, 1850-1950*. Nestle Nutrition Workshop Series, Vol. 22 (New York: Raven Press, 1990), 44. Bouchet's intubation was less invasive and more successful than the surgical opening of the trachea favored by his colleague Armand Trousseau.

<sup>158</sup> Eugene Bouchet, *Traité pratique des maladies des nouveau-nés, des enfants à la mamelle et de la seconde enfance* (Paris, Baillière, 1845). Also, Abt, 89.

<sup>159</sup> Administration Générale de l'Assistance Publique, *Index bibliographique des ouvrages, mémoires et publication diverses de MM. les médecins et chirurgiens des hôpitaux et hospices et Catalogue des volumes et brochures exposés* (Paris: Grandremy and Henon, 1878), 16-18.

but he was adept in medical and administrative politics. One of the founders of the Société de Chirurgie in 1843, Marjolin was one of the most vociferous staff members at Sainte-Eugénie when it came to improving the quality and quantity of the hospital's medical and surgical capacities.<sup>160</sup> Marjolin and Bouchut were sufficiently respected in the Paris hospital network to earn appointments in 1860 on the first medical commission of l'Assistance publique, charged with collecting, analyzing and distributing medical statistics of all the Paris hospitals.<sup>161</sup> Sainte-Eugénie was one of only two hospitals represented in the commission by both a physician (Bouchut) and a surgeon (Marjolin), and some Paris hospitals had no representatives, including Enfants-Trouvés. Their appointments to this medical commission helped to advance Bouchut's and Marjolin's own careers and reputation as capable medical practitioners as well as their medical specialty—children's medicine.

#### British Pediatricians in Paris

French medical training and hospitals had a significant cross-cultural impact on British pediatric students during the first half of the nineteenth century.<sup>162</sup> Those who observed and studied at Enfants-Malades in Paris in the 1820s, 30s, and 40s were struck by the absence of a similar institution in the British capital, especially when child and infant mortality rates were similarly high in Paris and London. In the absence of larger children's hospitals at home, influential British pediatricians like John Bunnell Davis and

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<sup>160</sup> Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP), 9L154/5 Administration et Reglementation de Sainte-Eugénie.

<sup>161</sup> AP/HP, AP IJ2, Circulaire du service des statistiques médicales (15 decembre 1860): 396-397.

<sup>162</sup> Elizabeth Lomax has noted how British physicians were also exposed to writings by Continental pediatricians based in hospital settings. See Lomax, 8.

Charles West took advantage of learning from the Paris hospital scene. Their examples are notable for several reasons. First, they both studied in Paris and adopted some key aspects of French medical training. Secondly, their French experience directly influenced their decisions to open children's medical institutions in London, and they both succeeded in opening voluntary children's medical institutions in London: Davis's Universal dispensary in 1816 and West's children's hospital on Great Ormond Street in 1852. At the center of an emerging transnational pediatric network, these two individuals exemplify significant cross-cultural Franco-British exchanges on pediatric ideas, practices, and institutions that continued throughout the rest of the nineteenth century.

Davis conceived the idea of a British children's medical center while detained in France during the Napoleonic wars.<sup>163</sup> Prior to the wars, he earned medical degrees at universities in Montpellier and Edinburgh, both internationally acclaimed centers of university-based medical study at the turn of the nineteenth-century, but also studied under prominent physicians in Paris.<sup>164</sup> Davis dedicated his written account of the dispensary to his mentor, Edward Rigby, who suggested that he study in Paris, and in his preface, he expressed his gratitude to "Messieurs Pinel, Dupuytren, Roux, Orfila, Edwards, Magendie, Beclard, Breschet, Serres, and Desportes, without whose assistance I could never have gained sufficient information respecting the Parisian Schools. . ."<sup>165</sup> No doubt dazzled by *Enfants-Malades* and its promise to cure the poor, sick children of Paris,

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<sup>163</sup> Loudon, "Universal Dispensary for Children," 1191.

<sup>164</sup> Abt, 86; Manuel, 9; Guenther Risse, "Medicine in the Age of the Enlightenment," in Andrew Wear (ed) *Medicine in Society*, 149-195 (Cambridge: Cambridge University Press, 1992), 156.

<sup>165</sup> Davis, *Annals of the Universal Dispensary*, 1821.

Davis established in 1816 a medical institution in London that he hoped would evolve into a children's hospital with many outpatient branches.<sup>166</sup>

Davis and the Universal Dispensary ultimately played a role in establishing London's first children's hospital, but a different physician made it happen with a different institution. Charles West, a physician who worked at the Universal Dispensary in the 1840s (then called the Royal Universal Infirmary), had similar ideas about serving the medical needs of poor children in London. Like Davis, he had travelled to the Continent, where he earned his MD in obstetrics, but his true passion was children's medicine.<sup>167</sup> West took every opportunity available to learn medical skills in various settings at home and abroad. Unable to study at the Royal College of Medicine in London because of his religious denomination (he was the son of a Baptist minister), he traveled to Bonn, Berlin and Paris to obtain his medical training. In Paris he took classes at the large clinical hospitals like Hôtel-Dieu and took advantage of more hands-on training at the maternity hospital, Maternité, and the children's hospital, Enfants-Malades. He too had been impressed by Enfants-Malades and its medical attention to sick children. In 1842 he took the position as chief physician at the Infirmary, but also spent considerable time working with poor children in other London institutions, such as the poor dispensary in Finsbury and the Asylum for Infant Orphans.<sup>168</sup> Unsatisfied with providing outpatient care, West spent several years attempting to convince the Royal Universal Infirmary to accept inpatients, and with no success, he branched off on his own and campaigned for

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<sup>166</sup> Loudon, "Universal Dispensary," 1191-92.

<sup>167</sup> Abt, 89.

<sup>168</sup> Jules Kosky, *Mutual Friends*, 82.



the funds and supporters that would help him establish Great Ormond Street Hospital for Children (GOSH).<sup>169</sup>

### Cross-Cultural Currents of Pediatric Knowledge

In addition to providing models for future children's medical institutions in their own country, the French hospital system and its pediatric clinicians provided these British individuals with other resources. French medical science provided fresh ways of thinking about and investigating pathology, and thanks to an explosion of medical publishing and the establishment of new medical journals in France and Great Britain after 1820, those ideas could be communicated and evaluated on a much wider scale. John Bunnell Davis and Charles West utilized the knowledge they gained in Paris to become better at their skill, and by providing lectures on children's diseases, they taught and inspired others to practice what was at the time a neglected branch of medicine. As their examples show, the world of children's medicine became more accessible, international, and defined as the nineteenth-century progressed.

One example of this transfer of pediatric knowledge can be found in the medical writings of Davis, who published his works in the early 1820s prior to the rise of medical journals. Davis understood a Paris-learned anatomical conception of disease, where pathology derives from particular bodily systems and organs, as evidenced in his *An Outline of Nosological Arrangement of Diseases in Children, Acute and Chronic* (see Appendix C). Davis compiled the classification system for his teaching experiment, *Lectures on that branch of the Practice of Medicine which relates to the Diseases, and Medicinal Management of Children and Young Persons*, which he delivered at the

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<sup>169</sup> Loudon, "Universal Dispensary," 1193.

Universal Dispensary and its second branch near Guy's hospital, Southwark Station.<sup>170</sup> In this sophisticated chart for the time, Davis divided children's diseases into thirteen different types, eleven of which were identified based on where they were "seated in" the body, and the other two belonging to fevers, with or without skin eruptions. Davis then further divided the eleven anatomical types of diseases into two groups, acute and chronic. An acute disease appeared with great rapidity and force, while chronic diseases were more gradual, long-lasting, or recurring conditions. This chart clearly antedates the type of nosology that Billard was credited with pioneering in 1829. Due to the marginalized, independent nature of his London children's dispensary, Davis's work remained outside the canon of classic pediatric works, which during the early half of the century emanated from the Paris medical circles.

Almost thirty years later, in the early 1840s, Charles West's professional career looked a great deal different on paper than Davis's, in a large part due to a more far-reaching world of medical publishing. West benefited from the accessibility to European and American medical journals and the ability to publish his own work in those same medical publications. While French and British periodicals devoted to pediatrics would not take off until the 1890s, doctors interested in publishing on children's diseases could submit their work to the major medical journals. When West was starting out as Universal Dispensary physician in the early 1840s, Paris was home to at least thirty-four scientific journals, with almost twenty devoted to medical science.<sup>171</sup> The longest-running

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<sup>170</sup> Davis, "An Outline of a Nosological Arrangement of Diseases in Children, Acute and Chronic," in *Annals of the Universal Dispensary*.

<sup>171</sup> A complete list of French medical and scientific journals and their descriptions as of 1843 can be found in F. Campbell Stewart, *The Hospitals and Surgeons of Paris* (Philadelphia and New York: Langley, 1843), 164-69.

journals for physicians and surgeons were the *Archives Générales de Médecine* (1823), *Gazette Médicale de Paris* (1830), *Gazette des Hôpitaux* (1828), and *Annales d'Hygiène Publique et de Médecine Légale* (1829). The purported “father of the medical periodical” was the popular *Gazette Médicale*, edited by Jules Guerin, and covering a range of articles on medicine and surgery.<sup>172</sup> The *Archives* attracted clinical readers, while *Gazette des Hôpitaux* and *Annales* reached wider audiences with interests in military medicine and hospitals in the former and public health and forensic science in the latter. The *Gazette des Hôpitaux* was the best source for medical news, summarizing and reporting developments in the Paris hospitals as well as in the medical academies.<sup>173</sup> By the 1840s, the British had several prominent medical journals, including the *British Medical Journal* (*BMJ*, 1840) and *Lancet* (1823), along with the *British and Foreign Medical Review* (1836) that provided studies and reports from home and abroad, as did the foreign literature reviews and select articles in the *BMJ* and *Lancet*. While medical journals developed within the same time frame, the discussion of children’s medical issues within these journals overwhelmingly radiated from the Paris hospitals.

Due to the presence of large children’s hospitals in the French capital, French medical journals published many more articles on infant’s and children’s diseases than their British counterparts prior to 1850. In addition, Paris hospital gazettes surveyed the entire range of Paris hospitals, while British hospitals published their own gazettes, such as *Guy’s Hospital Reports* in London.<sup>174</sup> As a result, articles on children’s medicine were

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<sup>172</sup> Joy Harvey, 315. Harvey notes that when Thomas Wakely, editor of the *Lancet*, began his feature “Mirror of the Practice of Medicine and Surgery in the Hospitals of London” in the journal in the late 1840s, he followed the clinical reporting style of the *Gazette Médicale*.

<sup>173</sup> Stewart, 167.

<sup>174</sup> Harvey, 317.

a mainstay in the French journals, while in the absence of children’s inpatient hospitals and paucity of child patients in the British general hospitals, the topic only appeared sporadically in British publications. Some notable exceptions existed, such as Dr. P. Hennis Green’s weekly or bi-weekly reports on various “pathologies of children” that appeared in the *BMJ* in the early 1840s. Green, a lecturer on diseases of children at the Hunterian School of Medicine, likely drew his case studies from the small children’s ward located at Guy’s Hospital, but his series was short-lived.<sup>175</sup> Prior to the 1850s, other doctors occasionally reported on children’s medical conditions in the *BMJ*, the *London Medical Gazette*, and the *British and Foreign Medical Review*, including cases from the London Fever Hospital, another hospital where limited numbers of children could gain admittance.<sup>176</sup> GOSH founder Charles West also sought out journals in which to publish his reports in the 1840s, landing several pediatric articles in the *British and Foreign Medical Review* and *London Medical Gazette* based on case studies of his work as physician-accoucheur at the Finsbury Infirmary and physician at the Royal Infirmary for Children between 1839 and 1843.<sup>177</sup> A direct link existed between institutions and publications, and considering somewhat parallel developments in the area of medical publishing and journals in France and Great Britain, the accessibility to more child

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<sup>175</sup> “Dr. Green on Diseases of Children,” *BMJ* 1841; s1-1:259, doi: <http://dx.doi.org/10.1136/bmj.s1-1.16.259> (accessed on September 10, 2014.) The series lasted from December 1840 to March 1841.

<sup>176</sup> For example, Sir William Jenner, one of the first physicians at GOSH, published a series of lectures and essays on fevers that included cases of child patients suffering from typhus fever and typhoid fever at the London Fever Hospital and in the care of a Dr. Tweedie between the years 1847-1850. William Jenner, *Lectures and Essays on Fevers and Diphtheria, 1849-1879* (London: Rivington and Percival, 1893): 194-206 (typhus), 325-329 (typhoid).

<sup>177</sup> Archives of the Great Ormond Street Hospital for Children (GOS), “Works by Dr. Charles West, *The West Library Catalogue*, The Hospital for Sick Children, Great Ormond Street, London, 22-23.

patients in children's hospitals gave Paris doctors a prominent edge in acquiring and disseminating pediatric knowledge.

Early pediatric works written by Charles West provide a glimpse of this discrepancy between British and Continental, particularly French, pediatric output. West's professional writings are an excellent indicator of where the major seats of children's medicine lay in Europe because he was educated in France and Germany, earned his MD in Berlin, yet lived and worked at several institutions across London. Given these credentials, one might expect that he would rely more heavily on German or English sources, but this was not the case in the 1840s or for the rest of his career. In his early articles he predominantly cited French and German sources. One article, a report on children's pneumonia, shows a clear preference for French works on the subject. His citations range from dissertations to journal articles to full treatises, demonstrating that West was proficient in other languages and well-read in the various publishing mediums for the medical field. One sample page of West's article included references to Valleix's *Clinique des Maladies des Enfants* and Rilliet and Barthez's *Traité Clinique*, a German dissertation, and German and American journal articles, with the remaining references from the *Gazette des Hôpitaux*, the *Archives Générales de Médecine*, and other French works.<sup>178</sup> West's own major pediatric treatise, *Diseases of Infancy and Childhood*, published first in 1848, provided copious references to French, German, and American

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<sup>178</sup> Charles West, "Clinical and Pathological Report on the Pneumonia of Children as It Prevails Among the Poor in London," *British and Foreign Medical Review*, no. 30 (1843), 4, and *Report on the Progress of Practical Medicine in the Departments of Midwifery and the Diseases of Women and Children, during the years 1842-43* (London: C. and J. Adlard, 1844). In his *Diseases of Women and Children*, he made a notable reference to a St. Petersburg doctor on scrofula and a lengthy comment on a questionable finding about rickets from a German doctor.

authors in the text and in the notes, but West's clinical heritage shines through in specific references to certain French masters like Trousseau, Rilliet, and Barthez.<sup>179</sup>

West's use of foreign pediatric works illustrates the many layers of international exchange in the field of pediatrics at mid-century. He did much more than reference international sources; he evaluated and compared the work of foreign authors with his own clinical findings, integrated new theories and practices as he saw fit, and provided his own translation skills in the service of disseminating important pediatric information across borders. He published a translation of a treatise on cancer by German author J. Muller in 1840 as well as an English-language review of Rilliet and Barthez's pediatric treatise in 1843.<sup>180</sup> On more than one occasion, he became an advocate for French institutions and hospital practices under international fire, such as foundling hospitals and religious nursing orders. For example, in 1842, the *British and Foreign Medical Review* published West's in-depth commentary, "The Foundling Hospitals of France," which included reviews of books by four French authors on the topic. West's article took a supportive stance on foundling hospitals in general, which were at the time under attack by traditionalists in both Protestant and Catholic countries due to their horrifyingly high mortality rates and their association with affronts to contemporary social mores, such as illegitimacy and child abandonment. West, unlike many British medical men and philanthropists, argued for their social value, stating that foundling institutions "have

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<sup>179</sup> Abt, 90. Charles West's *Diseases of Children*, based on nearly two hundred case studies and six hundred port-mortem examinations, was the culmination of lectures that he gave at Middlesex Hospital in London in 1847, and he published his lectures in 1848. The book had seven editions and was translated into most European languages and Arabic.

<sup>180</sup> *The West Library Catalogue*, 23. J. Muller. *On the nature and structural characteristics of cancer and of those morbid growths which may be confounded with it*, trans. Charles West (London, 1840), and Charles West, "Review of Rilliet and Barthez: *Traité clinique et pratique des maladies des enfants*," 1843.

done great good, and are likely to bring about much more” with greater attention to and improvement in care provided to the children.<sup>181</sup>

West’s engagement with foreign authors was not a one-way street. West’s work was recognized by French physicians as early as 1842, when his and other British and American physicians’ ideas about remittent fever made its way into debates within the Paris Académie de Médecine over the nature of typhus and typhoid fever and whether or not they were two different affections or manifestations of the same condition.<sup>182</sup> West’s name appeared as a medical authority in French medical and surgical dictionary entries on measles, scarlet fever, and smallpox.<sup>183</sup> West was also recognized by French, German, Italian, Danish, and American pediatric communities through book translations. By the mid-1860s, his work on children’s diseases appeared in German, Danish, and French versions, and his treatises on women’s diseases and children’s diseases had American and German editions in the 1850s and Italian editions in the 1860s.<sup>184</sup> One of the prominent physicians at Enfants-Malades, Dr. Eugène Raymond Archambault, was an admirer of West and published a French translation of West’s textbook on the diseases of infants and children in 1876.<sup>185</sup> Archambault had a high regard for West’s style and manner of practice as much as for his clinical knowledge and techniques. In the preface of his

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<sup>181</sup> Charles West, “The Foundling Hospitals in France,” *British and Foreign Medical Review*, vol. 13 (January–April 1842), 311.

<sup>182</sup> H. Landouzy, *Mémoire sur l’épidémie de typhus carcéral* (Reims and Paris: Baillière, 1842), 116.

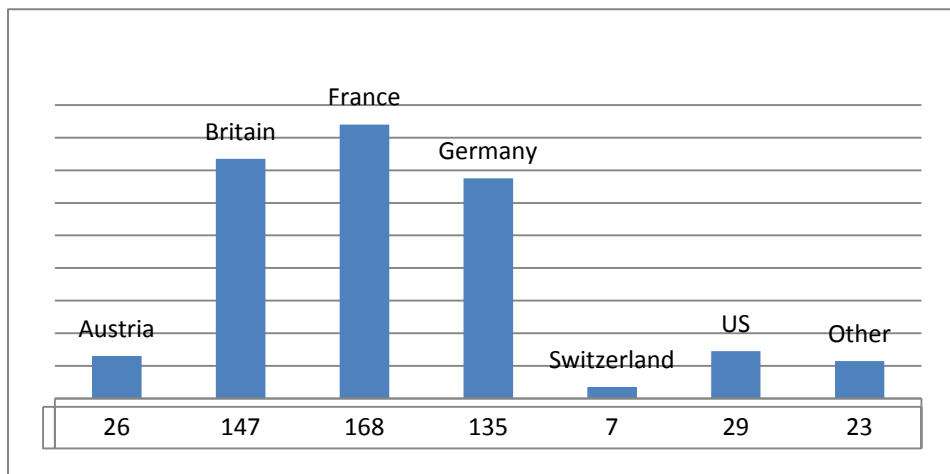
<sup>183</sup> Benjamin Anger et al. (eds) *Nouveau dictionnaire de médecin et de chirurgie pratique* (Paris: Baillière, 1871), 24.

<sup>184</sup> *The West Library Catalogue*, 22. For example, his *Lectures on the Diseases of Infancy and Childhood* appeared in Philadelphia in 1850, in Tiel in 1854, in Berlin in 1865, in Milan in 1869.

<sup>185</sup> Administration Générale de l’Assistance Publique, *Index bibliographique*, 1. Archambault’s work was titled, *Traduction avec notes de l’ouvrage du Dr. Charles West sur les maladies de la première et de la seconde enfance* (1876).

translation, he wrote, “in West, one will find a children’s doctor who is caring, conscientious, and neglectful of nothing that might aid the poor young patients; he brings us to the conclusion that to do children’s medicine, one often finds the greatest success with sound understanding and the application of good hygiene, by small cares and respecting nature to take its course towards a cure rather than with the aid of forceful medicine.”<sup>186</sup>

Figure 2.1 Works in Charles West Medical Library, by Country of Publication



Source: Great Ormond Street Hospital Archives, *The West Library Catalogue*.

A survey of Charles West’s personal medical library also reveals his abundant use of French pediatric sources well into his career. (See Fig. 2.1) Compiled for the duration of West’s professional career lasting from the 1830s to the 1890s, the library contents include works from European countries and the United States, with the greatest numbers of French, British, and German works, respectively.<sup>187</sup> American and Austrian authors

<sup>186</sup> Nécrologie, “Eugène Raymond Archambault,” *Le Progrès Médical*, vol. 11 (1884), 577.

<sup>187</sup> In a similar study using late-nineteenth century American texts, Elizabeth Lomax also found these three countries to be leaders in pediatric literature, but with German papers as the most frequently quoted.



constituted a smaller portion of the library because those countries were slower to develop a strong pediatric specialty.<sup>188</sup> A closer look at the numbers of national works by topic in West's library collection (see Table 2.1) suggest that certain nationalities excelled in the sub-specialties developing within the emerging pediatric field. While German authors published slightly more works in the areas of general pediatric and neonatal studies during the nineteenth century, West's library contained the seminal works of British and French authors in this category, including Armstrong, Underwood, Billard, Rilliet and Barthez, and Bouchut. French authors were stronger in more categories, including paralysis, mental illness, public health, hygiene, and infant mortality, while British studies appeared prominent in the areas of respiratory diseases and infectious diseases. The greatest numbers of works representative of single authors in West's collection belonged to three French authors: Frederic Rilliet, Henri Roger, and Ernest Bouchut, all mentioned earlier. Rilliet's and Roger's work also spanned numerous categories, indicating their broad pediatric interests; for Bouchut, West found his treatise on general pediatrics so useful that West accumulated four out of six of the French editions and one English translation, as well as Bouchut's practical manual on the health of newborns and sucklings.<sup>189</sup>

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However, in response to J. A. Davis's suggestion that "Britain may have led the world in the art of pediatric medicine," she states, "in my opinion, France posed a strong challenge to that title." See Lomax, 156, 168.

<sup>188</sup> Abt, 119, 120, 121. The first US children's hospital opened in 1855 in Philadelphia, which helps to explain this delay. In contrast, Vienna had two children's hospitals by 1850, one in 1826 and the other in 1842. The paucity of Austrian works is outside the scope of this study, but clearly the existence of urban children's hospitals does not unilaterally result in a wellspring of pediatric scholarship. Under-recognized specialties within particular medical communities and underdeveloped medical publishing outlets may have also played a role in the American and Austrian situation.

<sup>189</sup> *The West Library Catalogue*, 8-9.

Table 2.1 Charles West Medical Library, by Topic and Country

Medical Topic	Austria	Britain	France	Germany	Switz	US	Other
Anatomy	2	4	2	3			1
General medicine		6	2	5		1	
Diagnosis		3	3				
Temperature		5	1				
Therapy	1	4	1	2		3	
General Pediatrics	6	16	20	28		3	7
Meningitis			3				
Newborn	1	3	9	17		2	2
Nervous System	2	9	9	9		4	1
Hydrocephalus	2	7	3	5			2
Paralysis		5	8	4	1		1
Disorders of Mind	1	4	10	6	2	2	
Convulsions	1	5	5	1		2	
Diphtheria, Croup							
Respiratory Diseases	1	7	5		1	1	1
Whooping Cough	1	4	2	2		1	
Bronchitis/Asthma/ Pneumonia		11	15	8			1
Heart		3	2	4			
Malnutrition		3	5	5		1	
Infections		13	8	6			2
Tumors and Cancer		1	1	4			
Vaccinations		4	4	3		1	
Skin		4	4	1			
Ear		2					
Parasites			1	1			
Public Health/Infant Mortality	1	3	7		1		2
Growth/Development	1	4	2	3		2	1
Hygiene/Physical Education			3		1		
Child Care	3	5	6	3			1
Biography/History	1	1		1			

Source: Great Ormond Street Hospital Archives, *The West Library Catalogue*.  
 Cross-Cultural Transfer: GOSH's Adaptation and Medicalization of the French *Crèche*

The Franco-British exchanges found within the volumes of Charles West's private medical library confirm both the internationalism of medical publishing in general and

the significance of cross-cultural exchanges in nurturing the pediatric specialty within and across national borders. The benefits of these transnational exchanges are not particularly surprising, considering three most-recognized pediatric text books of the mid-nineteenth century were those of Rilliet and Barthez, Bouchut, and Charles West.<sup>190</sup> Early Franco-British pediatric exchanges involved British physicians seeking French models for children's medical facilities and adapting French missions and methods to suit the demands of British medical culture and society. Charles West and John Bunnell Davis never attempted to copy or imitate French institutions; they tried to transform them. One example of a French transplant on British soil was Charles West's creation of a Parisian-style *crèche* at the Great Ormond Street Hospital for Children. The *crèche*, or infant nursery, only lasted for five years, but considering the history of the concept, its adoption at GOSH testifies to the overlapping nature of nineteenth-century designs for child health and hygiene, early care and education, and child welfare, as well as the British proclivity for French institutions for children and strong interests in piloting versions of those projects in London that had any chance of improving the health of poor children. Simply put, the instillation of the hospital *crèche* at GOSH adds another layer of the transnational exchange of ideas, practices and institutions concerning children's health and welfare during this period.

*Crèche*-like institutions that provided care and education to the children of the working poor under the age of six grew in prominence in the early nineteenth-century, as reformers and leaders in large urban communities like Paris and London worried about negligent working-class parenting and what happened to poor infants and children under

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<sup>190</sup> Abt-Garrison, 89.

the age of five years while their parents worked.<sup>191</sup> Efforts to provide early care and education came in many different forms. In Great Britain, infant schools developed as early as the late 1700s in conjunction with charitable “ragged” schools in local parishes and tended to the physical, educational, and moral needs of young children. The British infant school and its social utility attracted the attention of Jean-Marie de Gérando, the secretary of the *Société pour l’instruction elementaire*, who proposed to the Conseil des hospices that it found similar institutions in Paris in the mid-1820s.<sup>192</sup> The results of de Gérando’s efforts led to the creation of multiple *salles d’asiles*, literally rooms of refuge that sheltered young persons from harm and immorality found in their neighborhood and at home. British infant nurseries and French *salles d’asiles* served a primarily moralizing mission: to instill middle-class values to poor children through education and shape them into productive, law-abiding members of society. By the 1850s, another model of early child care developed in Paris that built upon the charitable, moralizing qualities of the infant nurseries and *asiles*, but with a concerted health and hygiene focus: the *crèche*.

The founder and advocate of the *crèche* concept, Firmin Marbeau, claimed “the essential elements of a *crèche*, a true *crèche*, are hygiene, morality, and spirit of charity. Hygiene, or, the precautions taken to conserve and better health; morality, or, moral practice, charitable spirit, or that which has the most purity, the most benefit here below, the love of pure men sanctified by the love of God.”<sup>193</sup> Marbeau’s concentrated focus on hygiene and the physical as well as the moral and intellectual health of the child set his

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<sup>191</sup> Jean-Noël Luc, *L’invention du jeune enfant au XIXe siècle: De la salle l’asile à l’école maternelle* (Paris: Belin, 1997), 7. 16.

<sup>192</sup> *Ibid.*, 26.

<sup>193</sup> Firmin Marbeau, “Le Crèche,” *Annals de la Charité*, no. 11. (Paris: Adrien Le Clerc, 1855), 133.

*crèche* apart from other children's institutions of care. Marbeau's ideal *crèche* had a high sanitary standard—clean and tidy with fresh air and good ventilation—and was under strict medical surveillance, with doctor visits each day and a temporary suspension of attendance if a child came down with a sickness.<sup>194</sup> In his concern for children's comprehensive wellness and his dedication to provide medical services to children and families in need, West was drawn to Marbeau's institution and worked to expand the scope of GOSH's work in London to include such a facility in its list of services.

West modeled the Great Ormond Street Hospital infant nursery on the *crèches* that he observed while in Paris. The infant nursery took mostly, but not only, legitimate newborns and children up to age five and provided child care from morning to night for working-class parents. For as many as fourteen hours per day, nurses tended to these children, whom they bathed, fed, amused, and put down to nap for a "trifling charge."<sup>195</sup> To many outside observers, the infant nursery setting was an excellent value for the money, since it provided safety, nutrition, and amusement for only 2 pence per day: "here baby was able to lie, or crawl, or waddle, or walk, according to his powers without fear of getting bruised or hurt; he had the nicest toys to amuse him, and four meals of proper food to satisfy him and make him comfortable, at the ... bare cost of the milk diet."<sup>196</sup> In its five years of operation, it took in a total of 458 children.<sup>197</sup> Despite its popularity with many families and subscribers, this GOSH appendage closed its doors in 1864 to make room for a convalescent ward. The choice was made of out medical necessity; the

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<sup>194</sup> Ibid, 136.

<sup>195</sup> Archives of the Great Ormond Street Hospital for Children (GOS), GOS/1/1, 1861 Annual Report, 5.

<sup>196</sup> GOS/11/1/13, GOSH Press Clippings, *The Sunday Reader*, no. XVI (Saturday 29, 1866).

<sup>197</sup> GOS/1/1, 1864 Annual Report, 6. For some perspective, the GOSH inpatient wards admitted an average of 490 patients per year; the *crèche* attendees constituted an additional eighty to one-hundred children.

hospital had limited room, and with admission numbers on the rise, space needed to be carved out to separate patients suffering from acute conditions from those on the mend.

The *crèche* concept did not end at GOSH; the short-lived model there found new life at home and abroad. After the closing of the GOSH *crèche*, a noticeable rise in *crèche*-style infant nurseries sprung up across London in the 1860s and 1870s, as shown in figure 2.2. In North and Central London alone, after an initial peak in the 1850s, which included GOSH, the numbers of infant schools, or *crèches*, doubled in the next two decades (see Appendix D for a complete list of the infant school establishments by area from 1820-1890). Like the infant nursery, the *crèche* found approval in Great Britain because it was charitable institution that promoted several hallmarks of British values: self-sufficiency, regularity, and a strong work ethic for parents, as well as structure, education, and hygiene for their young children. The health and hygiene focus of the GOSH *crèche* corresponded to other developments in the 1850s and 1860s, such as the increase in British public health initiatives following the 1848 public health act and the creation of Metropolitan Boards of Health and the push for national systems of education.<sup>198</sup> During its years of operation, the GOSH infant nursery attracted local visitors, including notable reformers and administrators. Most visitors praised the establishment and “were much struck with the order and cheerfulness in the nursery and felt [ ] the children were judiciously attended to.”<sup>199</sup> Its visitor list included individuals who had already founded or who were starting up similar establishments in lay and

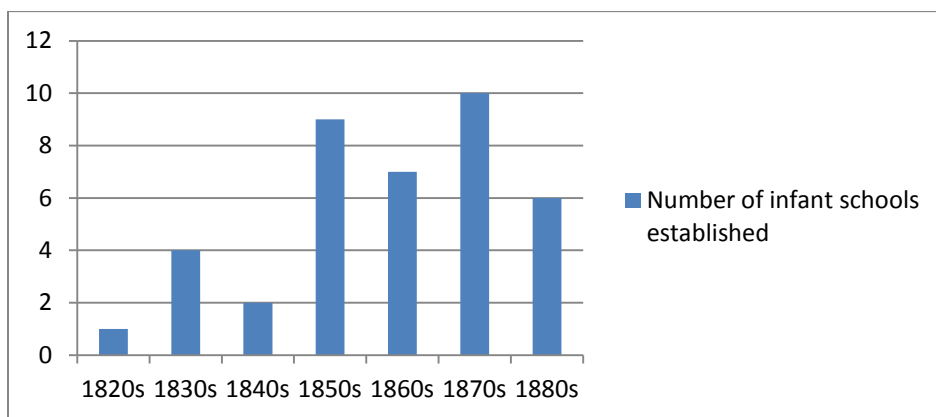
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<sup>198</sup> Dorothy Porter, *Health, Civilization and the State: A history of public health from ancient to modern times* (London: Routledge, 1999), 127. Porter notes that from 1848 to 1872, the British Parliament passed 23 acts of public health legislation, addressing issues of sanitation, disease prevention, and public health administration.

<sup>199</sup> GOS/7/1/2 Visitor’s Books, Vol. 2, entry on August 17, 1860, by B.G. Barlee and Murdoch Bayswater.

parochial settings within the slums of Marylebone, Paddington, and Whitechapel, including Octavia Hill, who would pilot her lodging-house system for poor tenants just a few years later.<sup>200</sup> Since the infant nursery was attached to the only children’s hospital in London at the time, these visitors witnessed the nursery’s unparalleled model of medical supervision and expertise.<sup>201</sup>

Figure 2.2 Infant Schools Established in North London, 1820-1890, by Decade



Source: Westminster City Council, *Historical Notes on Westminster Schools*, Local History Resource, North Westminster Community School, 1960.

The GOSH infant nursery concept built on the health and hygiene aspects of Marbeau’s *crèche* by installing it directly in a children’s medical institution. The idea of combining health care and educational care in the children’s hospital did not take, but the emphasis on maintaining children’s physical health in educational institutions did, as medical services and physical education programs became prominent within the national

<sup>200</sup> GOS/7/1/2, Visitor’s Books, Vol. 2, on December 14, 1860, Miss Octavia Hill, Superintendent of the All Saints Infant Nursery; on June 6, 1862, Miriam Harris, Jews Infant School, Whitechapel; on November 27, 1862, Reverence G. F. Prescott, St. John’s Paddington Infant Nursery.

<sup>201</sup> The Victorian Hospital for Children in Chelsea opened in 1866, followed shortly by the Alexandra Hospital for Hip Disease in 1867 (opened by former GOSH nurses) and Evelina in 1869.

public schools in both France and Great Britain after 1880.<sup>202</sup> The *crèche* concept came full circle in the 1860s when a significant French visitor came to observe the GOSH infant nursery as private French *crèches* were struggling. On his visit in summer of 1862, J. B. Desplaie, member of the Société générale des crèches de Paris (the *crèche* society of Paris) “found the *crèche* to be well installed and properly run” and he remarked that certain aspects of the GOSH infant nursery were worthy of imitation in the French institutions.<sup>203</sup> Although he did not explicitly say so, Desplaie may have been impressed with the more secular focus on health that the GOSH *crèche* exemplified, which eventually characterized the municipal *crèches* established in Paris during the 1870s.

## Summary

Prior to and during the nineteenth-century, French and British medical practitioners crossed the English Channel in search of the most up-to-date ideas and practices pertaining to children’s medicine. Some traveled in person and studied in Paris, the early nineteenth-century capital of medicine; others benefited from treatises, journal articles, and manuals published by key physicians in the Paris and London’s children’s hospitals and dispensaries and available through a burgeoning medical press. While the hands-on training opportunities at the Paris children’s hospital were essential to grasp the magnitude and possibilities for the study and practice of children’s medicine, medical publishing was also an important conduit for greater pediatric professionalization and

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<sup>202</sup> For the British school medical service, see Bernard Harris, *The Health of the Schoolchild: a History of the School Medical Service in England and Wales* (Buckingham: Open University Press, 1995). For physical education in French schools, see Maurice Crubellier, *L’enfance et la jeunesse dans la société française, 1800-1950* (Paris : Armand-Colin, 1979), Chapter 9, on l’éducation du corps, 187-206.

<sup>203</sup> GOS/7/1/2, Visitor’s Books, Vol. 2: entry on August 27, 1862.



specialization in the first half of the nineteenth century. Medical publishers and journals such as the *British Medical Journal*, *British and Foreign Medical Review*, *Annales d'hygiène publique et de médecine légale*, and *Gazette Médicale de Paris* permitted doctors like Charles West in London and François Valleix in Paris to share their case studies, theories, and questions with national and international audiences. Together, early pediatric institutions and publications provided discursive spaces for this group of doctors to produce ground-breaking pediatric knowledge, promote pediatrics as a specialized study, and intensify issues of child health and disease as topics of local and national concern.

The example of the GOSH *crèche* exemplifies another outgrowth of this transnational exchange: adoption and adaption. When Charles West opened his *crèche* at the children's hospital, he accentuated the medical features of Marbeau's French institution in Paris, just as Marbeau had transformed the British model of the British infant school to realize his vision for a children's refuge that promoted physical health as well as moral well being for every child that it harbored. The adaption and readaptation of the *crèche* concept across London and Paris communities highlights the complex nature of the transmission of ideas across time and cultures, especially when it involved children's health and hygiene. More than any doctor's case notes or treatise could possibly convey, the various manifestations of the British and French *crèche* demonstrate the social dimensions of pediatrics, a medical specialty in which patient health care is also enmeshed with the needs and desires of the family and the community at large.

## CHAPTER 4

### CHILDREN'S HEALTH AS PUBLIC HEALTH: CHILDREN'S HOSPITAL REGISTERS, MEDICAL STATISTICS, AND ROYAL PATRONS

The first systematic efforts to gather numeric calculations of national populations and resources coincided with the rise of the modern state in the seventeenth and eighteenth centuries, yet statistics emerged as a widespread practice in France, Great Britain, and other European nations between 1820 and 1850.<sup>204</sup> As Silvana Patriarca notes, “statistical investigations and descriptions were predicated on an idea of the nation as an object to be known, measured, compared, and governed.”<sup>205</sup> As a significant feature of nation-building, this infatuation with numbers led to the establishment of statistical societies, specialized journals, and state bureaus and departments for the collection, categorization, and examination of diverse social phenomena that politicians, social reformers, and government administrators deemed necessary to shape policy and to govern society. The statistical impulse within modern states and the formation of bureaucratic entities that collected and studied statistics grew out of increased concerns about the harmful effects of urbanization, industrialization, and population growth on public health and welfare, including infant and child mortality.<sup>206</sup> Despite these common

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<sup>204</sup> Theodore M. Porter, *The Rise of Statistical Thinking, 1820-1900* (Princeton: Princeton University Press, 1986).

<sup>205</sup> See Silvana Patriarca, *Numbers and Nationhood: Writing Statistics in Nineteenth-Century Italy* (New York: Cambridge University Press, 1996), 1–2, 7. Like Patriarca, this chapter refers to nineteenth-century statistics as both a science and a genre of writing that employed numbers to describe territorial entities and collectivities,” 5.

<sup>206</sup> Joshua Cole, *The Power of Large Numbers: Population and Politics in Nineteenth-Century France* (Ithaca: Cornell University Press, 2000); Simon Szreter, “The Population Health Approach in Historical Perspective,” *American Journal of Public Health* 93, 3 (March 2003): 421–431.

denominators, few works explicitly examine local repositories of medical statistics and their relationship to national statistics collections, and even fewer focus on statistics related to child health.<sup>207</sup> This chapter emphasizes the rising role of children's hospitals in concentrated efforts to improve the health and well being of the youngest members of French and British society, and children's hospitals' contributions to national and international discussions about statistics, public health, and hospital administration. An important sidebar to national interests in public health institutions, concurrent royal patronage of the London and Paris children's hospitals by British and French female sovereigns in the 1850s and 1860s illustrates how visible political support for children's hospitals elevated children's medical needs as an issue of national public health.

While the French and British both took care to collect national statistics, the use of those statistics in these two countries took distinctive paths between 1850 and 1880. British vital statistics promoters straddled politics and public health through the medical branch of the public health movement, the British Medical Association and individual doctor-reformers, and so vital statistics came to play an instrumental role in local and national social reforms. In contrast, the world of French statistics operated across several separate disciplines—the economists, the medical elite, and the positivist social scientists and reformers and quasi-scientific municipal administrators. Especially during the Second Empire (1850-1870), the political and medical elite confined official statistical inquiry to a more descriptive and advisory role, and with the more science-oriented

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<sup>207</sup> Some edited volumes dedicated to the subject of medical statistics include Gerard Jorland, Annick Opinel, and George Weisz, eds., *Body Counts: Medical Quantification in Historical and Sociological Perspective* (Montreal: McGill-Queen's University Press, 2005); for British medical statistics see, Eileen Magnello and Anne Hardy, eds., *The Road to Medical Statistics* (Amsterdam: Rodopi, 2002); for a comparative study that links eighteenth-century British and French medical statistics, infant mortality, and public health measures, see Andrea Rusnock, "Quantifying Infant Mortality in England and France, 1750-1800," in Jorland, Opinel, and Weisz, eds., *Body Counts: Medical Quantification in Historical and Sociological Perspective* (Montreal: McGill-Queen's University Press, 2005), 65-86.

positivists on the fringes of centralized power during the Second Empire, national population and medical statistics had a less substantive function until the Third Republic.<sup>208</sup> This examination of French and British children's hospital records and the medical statistics that they generated highlights how both institutions informed and influenced the provision of public health vis-à-vis children's medical services. Through the stringent documentation required by l'Assistance publique, French children's hospitals like Sainte-Eugénie used hospital statistics to evaluate their institutions, institute new hospital policies, and govern their client populations as much as its London counterpart, which was not overseen by a central administrative unit. Moreover, the statistics produced by GOSH and Sainte-Eugénie crossed borders and enlightened one another in productive ways, reflecting the international character of medical and hospital statistics, public health, and hospital development after 1850.

In nineteenth-century France and Great Britain, official attempts to quantify social problems such as poverty, crime, mortality and disease, began with establishment of national statistical bureaus, the General Registrar's Office (GRO) in Britain in 1834, and the Statistique Générale de la France (SGF) in France in 1836. While these bureaus performed the same function, the British organization was more efficient and detailed, dispatching professionals to collect individual-level weekly reports, while often untrained French functionaries collected summary information that might not be available to public assistance administrators or statisticians for a year or more.<sup>209</sup> Great Britain also surged ahead in the race for statistics with the creation of municipal statistical societies

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<sup>208</sup> Libby Schweber, *Disciplining Statistics: Demography and Vital Statistics in France and England, 1830-1885* (Durham, NC: Duke University Press, 2006): 26-29.

<sup>209</sup> Schweber, 106.

across the country, including the Royal Statistical Society of London in 1834. The Société de Statistique de Paris (1861) and the institutionalization of the discipline of demography at the School of Anthropology in the Paris Faculty of Medicine (1876) came much later. However, centralized public health institutions and statistical societies eventually followed in both countries with the establishment of L'Assistance publique (1849) in Paris. Throughout Britain a series of public health acts established local boards of health (1848) and a Metropolitan Sanitary Association to monitor public health provisions in London (1849). In the midst of these national campaigns to investigate and regulate public health and systematize statistical collection, statistics appeared on the international stage in 1853 at the first International Congress of Statistics, where statisticians and administrators met nine times between 1853 and 1878 to discuss best practices for compiling national population statistics. At mid-century, both France and Great Britain wrestled with the problem of poor, sick or diseased children, and as new institutions with the capacity to furnish raw data on this particular population group, GOSH (1852) and Sainte-Eugénie (1855) would each play a role in fueling statistics-driven changes in hospital care and public health services.

#### Medical Statistics and the Children's Hospital

Hospital admission registers are an essential part of the record-keeping for any medical institution, and children's hospitals were no exception. At the most basic level, registers provided the essential annual statistics on numbers of patients admitted and numbers of children who died at the institution. Sainte-Eugénie sent its annual statistics to the director of the Administration générale de l'Assistance publique in Paris, the

central clearinghouse for medical statistics of all hospitals in the department of the Seine.<sup>210</sup> London hospitals, including GOSH, contributed their yearly statistics to the General Registrar Office, which also ended up in various publications, such as the Bills of Mortality. As an independent, voluntary institution, GOSH also needed its hospital registers to furnish the content for published annual reports, for promotional materials to raise funds for the hospital, and for internal meetings of the hospital's management and medical committees. For both children's hospitals, admissions registers were the standard tool to measure their institution's successes, failures, and areas for improvement.

A detailed breakdown of the types of information collected by Sainte-Eugénie and GOSH registers reveals both similarities and differences, indicating that while certain statistical information was common, culturally specific medical philosophies and attitudes about children and the working poor also shaped data collection in diverse ways. Paris children's hospitals were part of a large, multi-faceted public assistance network, and patient statistics gathered through the admissions registers helped network administrators to regulate the delivery of medical care and the quality and quantity of service. As one of many hospitals within Paris, Sainte-Eugénie was funded by the French state and therefore not reliant on private funds. The number of admissions and deaths still mattered, however, as the state bureaucracy required methodical record-keeping by all its hospitals to efficiently manage the use of public coffers while also ensuring medical care for those who were eligible. Hospital directors meticulously documented the flow of children in and out of the hospital wards and convalescent homes and sent the statistics to the Administration générale de l'Assistance publique, where officials studied them and

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<sup>210</sup> Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP), AP1J1, *Recueil des arrêtes, instructions et circulaires réglementaires concernant l'Administration générale de l'Assistance publique à Paris, 1849-1855*, Tome 1. (Paris: Paul Dupont, 1855).

strategized ways to simultaneously maximize the numbers of children and retain a high standard of care without overspending. Admission registers played a key role in this endeavor, especially when it came to questions of a patient's residence. L'Assistance publique worked hard to ensure that the children's hospital in Paris served primarily children from the department of the Seine (Paris, and after 1860, its outlying areas newly incorporated into the city), and admissions registers were a key component in regulating that obligation. The administration required Sainte-Eugénie to record the place of residence (*domicile*) of all their patients, distinguishing between children from the department of the Seine, including Paris and its suburbs (*banlieues*), and from those departments outside of the Seine.<sup>211</sup>

For the children's hospital on Great Ormond Street, admissions statistics were essential to prove it was a viable charitable institution and demonstrate the "good work" accomplished by the hospital, a key factor in raising funds for day-to-day hospital operations and special projects such as building improvements or expansions. In the fledgling years of the hospital, statistics proved the institution's social utility by showing the rising numbers of patient admissions. Greater numbers of sick children justified the existence of a specialized hospital for sick children along three important lines. The rise in admissions showed that the hospital filled a definite need in the city. The hospital offered some degree of relief, or the promise of relief, from suffering to the children and

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<sup>211</sup> AP/HP, 9L154, Règlement et instruction; instruction pour l'admission des malades payants. Letter no. 16, from the Administration de l'Assistance publique to the Director of Sainte-Eugénie, September 4, 1854. After restructuring in 1860, the former Paris suburbs were incorporated into the Department of the Seine, creating new suburbs.

their families. Finally, by treating more patients over time, the hospital would contribute in some measure to the advancement and diffusion of medical knowledge.<sup>212</sup>

A rising numbers of patient admissions at GOSH also fueled the need for larger or more updated hospital facilities over time, and annual statistics provided the fodder for these changes in and outside administrative board meetings. In the mid-1860s, when GOSH admissions began to exceed the number of available beds, due in part to a spike in the number of patients arriving from counties outside of London, hard facts on overcrowding in the hospital wards spurred plans for expansion.<sup>213</sup> In 1866, strategic discussions began about how to alleviate the problem, prompting plans to raise funds to support three construction projects to make more room for inpatients. Plans to extend the benefits of the hospital included: opening a country branch for convalescents on the outskirts of London; purchasing premises adjoining the existing hospital to house resident staff, so that their quarters might be converted to in-patient accommodation; and a grand future project involving the construction of an entirely new hospital.<sup>214</sup> The first of these visions, the opening a country branch, materialized just a few years later when GOSH leased Cromwell House, a spacious old mansion in Highgate on the outskirts of London, in 1867, and opened for business. Cromwell House initially took in twenty convalescent patients on July 29, 1868, with a stated goal of “not merely improved chances of restoration to health to the children at Highgate, but increased space at GOSH from where the children are drafted.”<sup>215</sup> After years of building fundraisers that stressed the

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<sup>212</sup> Archives of Great Ormond Street Hospital for Children (GOS), GOS/1/1, First Annual Report of the Hospital for Sick Children, 49 Great Ormond Street (1853), 8.

<sup>213</sup> GOS/1/1, 16<sup>th</sup> Annual Report (1857), 6.

<sup>214</sup> *Ibid.*, 8.



rising numbers of inpatients and outpatients crowding the Great Ormond Street doors, the new hospital erected on properties adjacent to the existing structure opened later in 1875.

### Hospital Registers: Vital Information

Hospital admission registers for Sainte-Eugénie and GOSH performed two key functions. Medically, the register was a mechanism to track the medical trajectory of child patients, and administratively, the register was a tool that collectively tracked the health of hospital operations. Considering this dual function, the children's hospital registers reveal as much in the data collected as in their omissions. Register designs were functional, based on the needs of each institution. Sainte-Eugénie shared a similar register design as those of other Paris hospitals, conforming to a standardized data collection process that was subject to change by order of l'Assistance publique. GOSH founders created their own registers, based upon examples from other hospitals and the anticipated uses for information collected about each patient.<sup>216</sup> Through a cursory comparison of both sets of records, three distinctive categories of data emerge: vital information, supplementary or non-essential information, and information unique to the mission and operation of each hospital. Taken together, these data sets indicates each hospital's particular management style, but equally as important, they provide a clear picture of patient populations that passed through the hospital doors.

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<sup>215</sup> GOS/1/1, GOSH 18<sup>th</sup> Annual Report, (1871). 6.

<sup>216</sup> GOSH kept several registers: in addition to the in-patient register, the hospital maintained a register of all rejected cases, a separate book of fever admissions, and an infant nursery register for its operational years (1858 to 1864). Very little information is available about outpatients at Sainte-Eugénie or GOSH beyond hours of operation, construction problems and repairs, and annual numbers. Outpatient registers do not exist for the years studied here, but each annual report stated the numbers of children served in the outpatient department. Per annum, the outpatient departments served between ten and twenty times more children than the inpatient wards between 1852 and 1879, so therefore those records would have been too voluminous to store indefinitely.

Certain types of patient information formed an essential core of knowledge for any general or children's hospital. The vital information collected by Sainte-Eugénie and GOSH included patient number, name, age, residence, disease, admission, and discharge date (see Table 3.1, Section 1). In both hospitals, most important in terms of statistics and accounting, all admitted patients received an identification number that also served as a tally for the hospitals' total annual admissions for that year. Even if the patient was nameless or without a proper diagnosis, this identification field was always completed as a marker of service, as even anonymous patients had value in terms of the hospital's bottom line. The next category of vital information constituted personal and family details, including the patient's first and last name, family member's names, age, and current residence. Family names and residential locations were necessary in case a family member needed to be contacted for any reason, and for some GOSH patients, for follow-up home visitations.

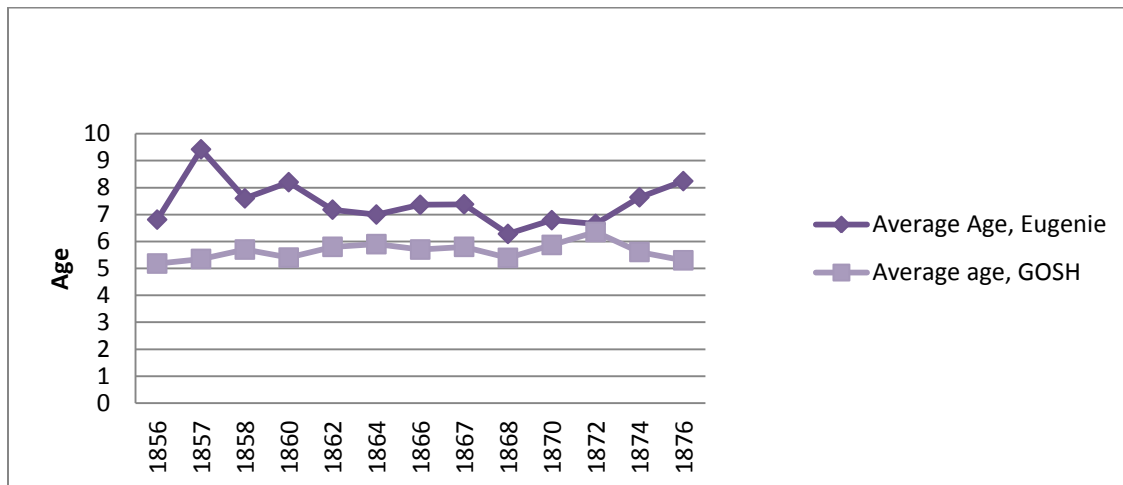
Age mattered when it came to the hospitalization of children in mid-century Paris and London, and in theory age was a key determinant for whether or not a child would be admitted. A family seeking to place their child in either Sainte-Eugénie or GOSH during the 1850s, 1860s, and 1870s could be turned away if the child was either too young or too old for care. Both institutions had policies that placed age limits for all new admissions. Sainte-Eugénie, following the same policy as Enfants-Malades, had the more liberal policy, and received inpatients and outpatients between the ages of two and fifteen.<sup>217</sup> At GOSH, where financial constraints and spatial limitations were much greater, the policy on age was more conservative. The London hospital limited inpatient service to children between the ages of two and ten and raised the upper limit to age twelve for outpatient

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<sup>217</sup> AP/HP, Fosseyeux (FOSS) 13/1, Notice historique sur l'hôpital Sainte-Eugénie, 1867.

services. To avoid any confusion about eligibility, GOSH and Sainte-Eugénie highlighted the regulations pertaining to age on their daily schedule of inpatient, outpatient, and for GOSH only, dental services.<sup>218</sup> One consequence of the hospitals different age policies was that the patient population at Sainte-Eugénie was generally older, and the GOSH wards contained a younger group of patients. The average age of Sainte-Eugénie patients was seven and one-half years (7.46), while the average age of new admits at GOSH was just over five and one-half years old (5.64).<sup>219</sup> (See Fig. 3.1) Despite slight variations each year, these averages remained relatively stable over twenty years. According to these numbers, both hospitals served their intended age group.

Fig. 3.1 Average Age of Sainte-Eugénie and GOSH Patients, 1856–1876



Source: *HHARP*, Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University; AP/HP, Sainte-Eugénie, Registres d’entrées, 1856-1876.

<sup>218</sup>GOS/1/1, “Regulations in Reference to the Attendance and Admission of Patients,” printed in GOSH Annual Reports for 1863, 1867. The Paris children’s hospitals of Enfants-Malades and Enfants-Trouvés had a long history of employing dentists to provide needs-based services for patient since 1816s, and Sainte-Eugénie likely had this service. AP/HP, AP1J1, Arrête du 10 avril 1850 (no. 6181), Dispositions concernant le service des dentistes dans l’hospice Enfants-Trouvés et l’hôpital des Enfants-Malades.

<sup>219</sup> GOSH data based on total admissions found on HHARP database, Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University; Sainte Eugénie data from AP/HP, Sainte Eugénie, Registres d’entrées, sample from 1856-1876.

Another category of vital information related to a patient's medical condition: the child's disease or complaint, admission date, discharge date, and cumulative length of stay. From a physician's standpoint, this documentation was essential for understanding and treating the individual patients. For French and British doctors (and interns completing their requirements) working at Sainte-Eugénie and GOSH, this information became extremely useful years later while writing their treatises, manuals, and dissertations on childhood diseases. GOSH doctors, following the example of physician Dr. Charles West, were also interested in the long-term provenance of a disease, which often related to the patient's and family's medical history. GOSH admission registers, unlike those at Sainte-Eugénie, had a separate column for the "date of attack," or the initial onset of the disease, and notes about a patient's previous diseases and conditions—as well as those of the father, mother, and siblings—were common. From an administrative perspective, this complete data set provided a comprehensive view of the most prevalent medical conditions in each institution, which, when taken into consideration along with the length of patient stays, provided an idea of the relative costs of service for certain patients and conditions.

The length of a patient's stay was another crucial aspect for the operations of both hospitals, particularly since extremely lengthy hospital stays became a budgetary strain on the institutions. During the two decades from 1856 to 1876 the amount of time that a patient remained at Sainte-Eugénie and GOSH was remarkably similar. Most children stayed between 25 and 50 days at Sainte-Eugénie and between 27 and 44 days at GOSH.<sup>220</sup> Some child patients, however, stayed for exorbitant lengths of time at each

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<sup>220</sup>GOSH data from HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University; Sainte Eugénie data from AP/HP, Sainte Eugénie, Registres d'entrées, 1856-1876.

hospital. Prior to the regular use of seaside and countryside convalescent hospitals, patients with chronic conditions might remain in hospital for several months to a year. At Sainte-Eugénie, it was not uncommon for a patient to stay for a year or more, and in rare cases, children might remain at Sainte-Eugénie for as long as three or four years. These patients were typically children with chronic conditions such as severe cases of ringworm (*teigne*), scrofula or some tubercular condition.<sup>221</sup> Ringworm and scrofula were often related diagnoses, and sample cases indicate that while the initial diagnosis was *teigne*, official diagnosis was scrofula, and vice versa. The three longest hospital stays in the Sainte Eugénie sample included these kinds of diagnoses: one patient admitted with scrofula on May 9, 1871 and discharged on October 29, 1874 (1,270 days); one patient admitted with scrofula on July 29, 1865 and discharged on January 25, 1869 (1,278 days); and one patient admitted with ringworm on August 10, 1864 and discharged on April 8, 1869 (1,357 days). Long hospital stays of several months were costly to the institution and did not go unnoticed by l'Assistance publique. In the 1860s, the administration attempted to better understand and monitor those cases by requiring follow-up documentation on all patients hospitalized at Sainte-Eugénie for one year or longer.<sup>222</sup>

As a private institution reliant on donor contributions and an extremely limited number of beds, GOSH openly discouraged excessive patient stays. One way that the children's hospital prevented extremely long patient sojourns was through its policy of

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<sup>221</sup> AP/HP, Sainte Eugénie, Registres d'entrées, 1856-1876.

<sup>222</sup> AP/HP, AP1J3, *Recueil des arrêtes, instructions et circulaires réglementaires concernant l'Administration générale de l'Assistance publique à Paris* (1861-1865), Tome 3. Circulaire du 15 décembre 1864 aux directeurs des hôpitaux et hospices sur le contrôle des malades ayant plus d'une année de séjour à l'hôpital.

refusing to treat chronic illnesses. To some extent, this policy constrained high numbers of lengthy residential stays in the children's hospital, and from GOSH's establishment in 1852 to the end of the nineteenth-century, only eight children remained in the hospital for one year or more.<sup>223</sup> Not surprisingly, all of these cases were chronic: four of these patients suffered from a tubercular condition affecting their bones and joints, while three had severe respiratory diseases. The longest hospital stay at GOSH, however, highlights how despite their best efforts, circumstances of a nineteenth-century children's hospital also created lengthy stays. In September 1880, GOSH admitted a one-year-old patient named William Powley who suffered from diphtheria and due to a series of complex circumstances, the hospital had little choice but to keep the child in hospital for a total of 583 days. The young patient survived a successful tracheotomy, but in recovery, he caught scarlet fever in the boys' ward.<sup>224</sup> Additional details provided in the register stated that William was later transferred to Cromwell House, the GOSH convalescent home in Highgate on April 28, 1882. This patient's physical fragility due to his young age, his severe medical condition, intensive operation, and subsequent acquisition of another contagious disease, combined with ample time for recoveries in between, all played a role in his lengthy hospital stay.

#### Hospital Registers: Supplemental Information

In contrast, supplemental information collected about Sainte-Eugénie and GOSH patients varied by institution (see Table 3.2, Section II). This variance corresponded to

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<sup>223</sup>HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University.

<sup>224</sup>HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University. Register information provided for William Powley, admitted September 22, 1880.

the overarching governing principles of each institution's admission policies, as well as the size of the institution. Overall, the Paris hospital was the more rigorous and bureaucratic of the two in its data collection concerning patients and their families. As a state institution that provided medical care to the most needy of Parisian children, details about family circumstances—such as parent's or parents' occupation(s) and place of residence—was crucial to determine if a patient qualified for free or subsidized care or if he or she entered as a paying patient, or *malade payante*. *Payants/payantes* appeared sporadically, but consistently, and these patients were always clearly identified in the admissions register. Their steady appearance in the register suggests that each ward could accommodate a certain number of paying patients, although no correlation exists between paying patients and specific bed numbers in any of the hospital wards. By contrast, in GOSH, as a voluntary institution, the subscription process drove hospital admissions, and families and friends of patients needed a letter from a governor, donor, or subscriber, along with the attending medical officer's approval in order to be entered as an inpatient. This subscription process, or letter system, assumed that those who distributed the letters carefully chose the patients and families with the greatest need.

The spatial capacity of the institution also shaped the contours of the admissions register, and so supplemental information such as a patient's sex or their location according to ward and bed varied by institution. Due to the sheer size and volume of Sainte-Eugénie, a patient's ward and bed assignment was a practical issue and provided facile tracking of a particular child's movement through the hospital. At Sainte-Eugénie, the hospital saved space in the register by noting a patient's sex via his or her placement in a male ward or female ward: a young girl in *Salle Marguerite* and a young boy in *Salle*

*Josèphe*. At GOSH, a patient’s sex was recorded in the register, but the ward and bed assignment was not an issue until much later in the 1870s when the hospital numbers began to swell and a new building with several wards was constructed.

Table 3.1. Line Item Entries in Sainte-Eugénie and GOSH Admissions Records

Register Line Item		Sainte-Eugénie Register	GOSH Register
<b>I. Vital Information</b>			
Patient Number		X	X
Name		X	X
Age at Admission		X	X
Current Residence		X	X
Official Diagnosis		X	X
Medical Outcome	Admission Date	X	X
	Discharge Date	X	X
	Length of Stay	X	X
<b>II. Supplemental Information</b>			
Patient Sex		--	X
Birth Date		Post-1860, inconsistent	--
Parent’s Names		X	Infant nursery only
Occupation		X	Infant nursery only
Patient’s Birthplace		X	--
Ward		X	ca. 1868 and later
Bed Number		X	--
Admitting Doctor		X	ca. 1864 and later
Additional comments		X	X
<b>III. Institution-Specific</b>			
Date of Death, if applicable		X	Only in notes
Detailed Result of Treatment		Only in notes	X
Vaccination		--	X
Name of Subscriber		n/a	X
Date of Parent’s Marriage		n/a	Infant nursery only

Source: *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University; AP/HP, Sainte-Eugénie, Registres d’entrées, 1855-1876.



Despite their different capacities, both hospitals recognized that each patient was unique and every case had the potential to require additional explanation or specific details that could not be included anywhere else on the form. Therefore, a “comments” or “remarks” section was an essential aspect of both Paris and London registers, particularly with regards to a patient’s discharge—where or to whom the child was sent, if the discharge was against hospital advice, or if the patient was readmitted. Sainte-Eugénie administrators used this space to record additional personal information about patients, such as their religious affiliation if they were not Catholic or if a child was admitted with an injury that required police intervention. In cases of accidents or suspected intentional harm, the register alluded to a police report of the event.

#### Institution-Specific Information

Medical outcomes—whether patients survived or died as a result of their hospital stay—were one of the most significant aspects of a hospital register (see Table 3.1, Sections I and III). For both GOSH and Sainte-Eugénie, these outcomes provided key measurements of the health of poor, urban youth populations in each capital and the effectiveness of each children’s hospital in fostering the health of its patients to the best of its ability. Despite similar aims, the documentation of medical outcomes took very different forms in the Paris and London records, in part due to institutional differences. A state institution, Sainte-Eugénie’s records served a primarily administrative function, to monitor and govern state services, and its entries tended to be frank and abbreviated, with the record simply stating the date of patient discharge (survival) or decease (death). GOSH, on the other hand, depended on its medical success rate for continued private

support and public approval registries. To demonstrate its achievements, however minor or short-lived, the London hospital registry offered more qualitative and descriptive results, with distinctive categories that qualified a patient's discharge into varying degrees of health and illness.

The striking difference between the methods for recording medical outcomes at the Paris and London children's hospitals also reflects wider variations in French and British approaches to statistical reasoning. French statistical knowledge was certain knowledge, whose scientific value was based on a 1:1 correlation between observation and numbers.<sup>225</sup> Sainte-Eugénie, and the Paris hospitals registers in general, focused on life or death, black or white, as opposed to various shades of recovery. The Paris hospitals, schooled in positivism, focused on observed empirical outcomes: whether a patient survived or not. Sainte-Eugénie clearly recorded deaths in a *décès* column and noted if the child died later in a convalescent home, but gave few details on the state of the patient when they left the hospital (full, partial, or no recovery). Due to high volumes of patients and a generalized French bureaucratic focus on numbers and underlying empirical attitude towards medical care, the Paris children's hospital registers paid little attention to the grey areas.

In contrast, GOSH hospital registers offered a greater extrapolation of the medical results for each individual patient (see Table 3.1, Section III). While by no means absolute or accurate, the GOSH registers reflected the various shades of wellness and morbidity of its young charges: capitulation to disease (death), full recovery (cured) and partial recovery (relieved), or no change (not relieved). The notes section might serve as shorthand for the doctor's case notes, offering some brief explanation for the course of

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<sup>225</sup> Schweber, 213-214.

the disease, such as if and when a patient contracted an infectious disease during their stay and what happened to the patient, or if a complication arose due to a previous medical condition.<sup>226</sup> The range of medical outcomes downplayed the most unfortunate outcome—death—and emphasized the environmental and hereditary aspects of the patients' diseases, ultimately affirming GOSH's roles as refuge for the city's poor, sick children.<sup>227</sup>

Both Sainte-Eugénie and GOSH frequently admitted the same child more than once for the same condition, indicating that some patients may have been well enough for discharge but were not completely “cured.” Only rarely did Sainte-Eugénie admissions registers record a patient's re-admittance, but with high volumes of patients and high rates of turnover or rotation of duties, admitting officers perhaps overlooked or omitted previous admission data during the readmission process.<sup>228</sup> Occasionally notes appeared about patients who died in the convalescent branches after discharge, but these infrequent examples might be equally attributable to the short-term successes of the convalescent hospitals as well as to a lack of attention to detail by hospital employees. The numerous GOSH patients readmitted with the same condition suggest an overall optimism when it came to recording medical outcomes at the London children's hospital. Particularly for

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<sup>226</sup> For GOSH, select doctor case notes were accessible through some patient entries on the HHARP database as a transcription or a digital copy of the original. For Sainte-Eugénie, I could not locate doctor case notes, but occasionally details about a patient's medical outcome were included in the hospital register comment section.

<sup>227</sup> Later in the century, eugenic movements in both countries linked poverty, disease, and heredity with national degeneration and decline. William Schneider, *Quality and Quantity: The Quest for Biological Regeneration in Twentieth-Century France* (Cambridge: Cambridge University Press, 2002) and Robert A Nye, *Crime, Madness and Politics in Modern France: The Medical Concept of National Decline* (Princeton University Press, 1984) examine the role of the medical and public health community in the development of this movement in France. The idea that physical and “moral” diseases were inherited was also explored in literature, such as Emile Zola's series on the Rougon-Macquart family.

<sup>228</sup> The hand-written registers at Sainte-Eugénie display constant and marked change in handwriting several times throughout the year, suggesting that new people took admissions duties every couple of months.

patients with complicated or little understood chronic conditions, administrators or physicians were more likely to tick the “relieved” and “cured” boxes if the patient demonstrated varying levels of improvement, even if the patient was not fully recovered.

Despite these differences in administrative statistical reportage, medical publishing offered an outlet for both French and British doctors to discuss fully the wide range of outcomes for children’s medical, surgical, and therapeutic treatment.

Throughout this period, GOSH physicians like Charles West, William Cheadle, and Robert Gee published detailed case studies from the children’s hospital in their treatises on childhood diseases. The hallmark of a French medical treatise or thesis was its detailed case studies of individual patients, and similarly, children were the focus in several of these types of publications by Paris hospital physicians and students who based their studies on observations in the Sainte-Eugénie wards. Their studies present in-depth details of patients who were cured (*guérisons*), who died (*morts*), whose results were unknown (*inconnues*), as well as cases where a patient operation or placement of a special apparatus provided some degree of improvement (club foot or curvature of the spine).<sup>229</sup> At greater liberty to elaborate in their own writings, Paris physicians and surgeons described diseases, with thick medical details, to audiences that were as equally interested in the modes of observation and treatment as well as the objective outcomes.

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<sup>229</sup>For an example of this type of reporting on specific cases at Sainte Eugénie, see A. J. C. Garnier, *Compte Rendu des faits de diphtérie observés à l’hôpital Sainte-Eugénie dans le service de M. Barthez* (Paris: Delahaye, 1860); for operations and apparatuses, see H. Bouvier, *Leçons cliniques sur les maladies chroniques de l’appareil locomoteur* (Paris: Baillière, 1858).

## Vaccination: Public Health and the Children's Hospitals

Some registry items factored into statistics collection at nineteenth-century children's hospitals, but not as prominently as one might imagine. For example, policies surrounding smallpox vaccination, the biological injection of the weakened pathogen to create its immunity within an individual, appeared as a significant topic of discussion in random records at both GOSH and Sainte-Eugénie, but are surprisingly silent in the admissions registers of both institutions. At mid-century, despite the availability of the smallpox vaccine in both France and Great Britain (discovered by British physician Edward Jenner in 1796), smallpox continued to be a deadly disease for young children. Due to differences in national legislation during the nineteenth-century, a notice of a patient's vaccination took on greater importance at GOSH than Sainte-Eugénie. Compulsory smallpox vaccination in the first year of life was not required for French children until 1902, but Great Britain passed a vaccination law in 1853, just one year after GOSH's establishment.<sup>230</sup> Revised again in 1867 with reinforced provisions, the Vaccination Act of 1853 mandated that every infant be vaccinated for smallpox within the first three months of life. When a parent or guardian registered the birth of a child, the registrar informed them of the measure, directed them to the public vaccinator in their district who, upon the child's vaccination, would send a certificate to the registrar. Vaccination was free, provided by parish Poor-Law funds and noncompliance with the Act—failure to vaccinate the child or refusal to have the child inspected as confirmation of the vaccination—incurred a penalty.<sup>231</sup>

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<sup>230</sup> S. L. Kotar, and J. E. Gessler, *Smallpox: A History* (Jefferson, NC: McFarland, 2013): 176.

Despite stiff British requirements, the status of a patient's vaccination did not appear prominently in GOSH admission registers. The hospital did not turn children away because they did not have a record of vaccination for the disease, but the general hospital policy was "No Child suffering under Small-Pox was received into the House."<sup>232</sup> The philosophy behind this medical decision may have been that vaccination would not be an issue if smallpox patients were not admitted. However, GOSH bent the rules with regards to this policy at least three times, admitting three children between 1858 and 1863 with a diagnosis of smallpox.<sup>233</sup> Sainte- Eugénie did not have a policy that excluded young patients affected with smallpox, but this disease appeared infrequently as a diagnosis, with only thirteen instances in the 1855-1876 sample.<sup>234</sup> French physicians also distinguished between *variole* and *varioloïde*—a mild recurrence of smallpox in individuals previously infected with or vaccinated for the virus—another indication that smallpox in all its variations was not excluded from treatment at the French children's hospital. However, cultural and geographic differences also played a role in whether a child had been vaccinated or not. The majority of first-time smallpox patients in the Sainte-Eugénie registers were foreign-born or born in a rural French department; *varioloïde* patients all were Paris-born. These indicators suggest that most poor children

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<sup>231</sup> Ibid., 172. According to the 1867 Act, "Within 7 days of a registered birth, the registrar was to deliver a notice of vaccination. If the infant was not vaccinated within three months or brought for confirmation of its success, the parents or guardians were liable to a summary conviction and fined 20 shillings.

<sup>232</sup> GOS/1/1, "Regulations in Reference to the Attendance and Admission of Patients," printed in GOSH Annual Reports for 1863, 1867.

<sup>233</sup> HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University. Register information for James Andrews, admitted May 1858; Henry Macmahon, admitted September 1860; and George Gibbs, admitted March 1863. Another 98 patient records included mention of "smallpox" in the case notes.

<sup>234</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, 1855-1876. Nine smallpox diagnoses were recorded in 1855 (2), 1856 (2), 1858 (1), 1859 (1), 1861 (1), 1864 (1); four *varioloïde* diagnoses were recorded in 1861 (1); 1866 (1); 1870 (1); and 1871 (1).

born in Paris were exposed to smallpox through vaccination, while those patients born in rural departments were not. These findings are not surprising, since families in the capital city had more doctors per capita and more vaccination resources at their disposal.

While vaccination information does appear in the medical history sections of almost one hundred other GOSH patient case files, the matter of whether a child was vaccinated or not was more important at the GOSH infant nursery than at in the inpatient wards at the hospital. Since the nursery was attached to the “House” and the child attendees were only daytime residents, GOSH required proof of smallpox vaccination at admission, which was then recorded in the register. Similarly, French *crèches* were more vigilant about smallpox vaccination than the children’s hospitals like Sainte Eugénie. From their conception in the 1840s, the first French *crèches* employed physicians to regulate the health and hygiene at the institutions, and one of the physician’s roles was to examine babies prior to their admission and to determine if they needed vaccination.<sup>235</sup> About half of all children admitted to the Paris *crèches* were already vaccinated, but if not, the family members needed to agree to vaccinate the child right away.<sup>236</sup> In the absence of a national vaccination law, vaccination policies, dependant on the physician or the *crèche directrice*, likely varied from *crèche* to *crèche* and from year to year in Paris.

Despite their different policies concerning hospital admissions and vaccination, smallpox (*variole*), was not one of the most prominent categories of disease in the inpatient wards of GOSH or Sainte-Eugénie. Maintaining vaccination records for

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<sup>235</sup> Firmin Marbeau, *Des crèches, moyen de diminuer la misère en augmentant la population*, 3<sup>rd</sup> ed. (Paris, 1846): 70-80.

<sup>236</sup> Ann F. La Berge, “Medicalization and Moralization: The Crèches of Nineteenth-Century Paris,” *Journal of Social History* 25, 1 (Autumn, 1991), 65-77. La Berge’s findings are based on the records of the St.-Ambroise crèche and the St.-Gervaise crèche in Paris. Her discussion of the primary role of the physician in the medicalization program of the crèches can be found on pages 70-75.

inpatients also does not appear to have been a top priority for these children's hospitals, suggesting that vaccination was not a mandatory prerequisite for inpatient admission at either institution. These factors, combined with evidence for vaccination in the French *crèches* and British infant nurseries, indicate that a majority of the children in the working-class districts of Paris and London were already vaccinated for smallpox when they entered the doors of the hospital, whether this vaccination was compulsory or not.

#### Statistics as Link between the Local, the National, and the International

The hospitals of London and Paris were locally managed, but they were a common vortex for transnational exchanges about a variety of statistics-based inquiries, discussions, and debates. Building upon a long history of French and British medical men and publications crossing the English Channel, the connections between physicians, public health officials, and hospital administrators in Paris and London grew more prevalent and diffuse during the second half of the nineteenth-century. Just as doctors travelled from London to Paris to observe the premier hospitals in the world earlier in the century, hospital administrators like Armand Husson, Director of l'Assistance publique from 1859 to 1871, traveled to London for first-hand observations of the capital's hospitals, and Sir John Simon, Chief Medical Officer of Health for London (1848 - 1855) and for the Crown (1856-1876) toured the Parisian hospitals.<sup>237</sup> British nurse and hospital reformer Florence Nightingale, trained in the Paris hospital herself in 1853, corresponded with Husson about hospital construction and design. She and Husson both advocated the "pavilion-style" hospital, large buildings with light, airy spaces that separated the sick

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<sup>237</sup> Armand Husson, *Etudes sur des hôpitaux*, and Royston Lambert, *Sir John Simon (1816-1904) and English Social Administration* (London: MacGibbon and Kee, 1963).



from operational and administrative facilities. She included several French and British hospital designs in her own work, *Notes on Hospitals*, which also reappeared in Husson's own *Etude sur des hôpitaux*.<sup>238</sup>

Statistics of all kinds—vital statistics, medical statistics, mortality statistics, and hospital statistics—played a role in these exchanges, and the advent of an era comprised of world expositions and international congresses of every denomination fueled the desire for statistical internationalism as well as national exhibitionism. In the years following the First World Exposition at the Crystal Palace in London in 1851, international congresses on sanitation, statistics, medicine, and charity brought French and British leaders and thinkers together in the major European capitals to address a wide range of public health concerns and administrative deficiencies, as well as to showcase their success in the areas of technology, science, education, culture, and charity. National and international gatherings co-mingled, as in 1862, when the Third International Philanthropic Congress (*Congrès international de bienfaisance*) convened alongside the Sixth Annual Meeting of the National Association for the Promotion of Social Science (NAPSS) in London.<sup>239</sup> Regular attendees at national gatherings of the NAPSS, Simon and Nightingale spoke at this meeting, and Nightingale also presented her work on hospital reform at International Statistical Congresses during the 1860s.<sup>240</sup>

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<sup>238</sup> Lynn McDonald, ed. *Florence Nightingale and Hospital Reform*. Vol. 16 of the Collected Works of Florence Nightingale (Wilfreid Laurier University Press, 81-2).

<sup>239</sup> Program of the 6<sup>th</sup> Annual National Association for the Promotion of Social Science Annual Meeting, 1862.

<sup>240</sup> *Ibid.*, page 2, presentation on army sanitary reform on July 12 ; Other papers she presented at the NAPSS include, "Hospital Statistics and Hospital Plans: in *Transactions of the NAPSS*, 1861; Sanitary Statistics of native schools and hospitals, *Transactions of the NAPSS*, 1863.

The professional relationship between Armand Husson and various British administrators, reformers, and physicians is significant in terms of the collection, compilation, and distribution of medical statistics at the local and international level. Despite his limited access to official discussions about national population in the elite academy circles, Husson took a transnational approach to hospital statistics, gathering data from all the large European hospitals and studying statistical ideas and methods proposed by foreigners like Belgian statistician Adolphe Quetelet and British physician William Farr, as well as by French demographers like Louis Adolphe Bertillon. His personal papers contain works ranging from disinfection products to the London Bills of Mortality to French reports on depopulation. A self-styled statistician, Husson's work illustrates how municipal-level French administration was divorced from national statistical developments at home or abroad. His fixation with statistics led to several projects that integrated local, national, and international aspects of medical statistics, public health, and hospital administration, and the fruits of Husson's work during the 1860s attracted the attention of the administration of the London children's hospital on Great Ormond Street and its longstanding physician, Charles West.

#### French Hospitals, l'Assistance Publique, and *Statistiques Médicales*

The transnational ties that Armand Husson forged in his professional role exemplify the productive force of Franco-British statistical comparisons within nineteenth-century medical and public health circles. Under Armand Husson, Director of l'Assistance publique from 1859 to 1871, medical statistics in Paris became more standardized and regulated. Husson laid the administrative groundwork for a more

efficient, accurate collection and analysis of information gathered from the Paris hospitals and hospices. Soon after his appointment in 1860, Husson surveyed the current system and found it “insufficient and incomplete,” and to remedy the situation, he nominated a special committee on medical statistics.<sup>241</sup> For Husson, this committee would achieve the twin goals of a successful public administrative body: reliable data collection and reliable records. Husson believed that the Paris hospital system was worthy of emulation and study, and the establishment of a mechanism to quantify its effectiveness would promote its value both inside and outside France. The medical statistics commission, Husson hoped, would propel l’Assistance publique into a worldwide leader in statistical collection in the future. Believing “our example will follow,” he envisioned that the medical commission’s “instructive results” would prompt all the hospitals of London, Brussels, Berlin, and Vienna to follow down “the road that we have opened.”<sup>242</sup>

To reach these lofty goals, Husson needed a solid, committed group to spearhead this Administration-wide project, so he drew from the ranks of the “eminent” physicians and surgeons installed at the Paris hospitals.<sup>243</sup> The first commission consisted of eleven prominent doctors and surgeons representing a range of hospitals, including the two general hospitals, Hôtel-Dieu and Necker, specialty hospitals, and the Bureau Central (See Table 3.2). These appointed committee members shared Husson’s enthusiasm for the project, accepted their charge, and expressed their eagerness to obtain the project’s

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<sup>241</sup> AP/HP, APIJ2, Recueils des arrêtes, instructions, et circulaires de l’Assistance publique: Arrête de 2 octobre 1860.

<sup>242</sup> AP/HP, APIJ2, Circulaire sur le service des statistiques médicale (15 décembre 1860), 418.

<sup>243</sup> Ibid, 396-97. Article I of the order stated that the commission’s work would commence on January 1, 1861. Article II presented the list of commission members, presented in figure X.

first results.<sup>244</sup> The president of the commission was Dr. Grisolle, physician at the largest general hospital in Paris, Hôtel-Dieu, and like many of his colleagues, a professor at the Faculté de médecine. Two hospitals enjoyed the distinction of having not one but two representatives sit on the medical statistics commission: the Paris maternity hospital, Lariboisière, and the children's hospital, Sainte-Eugénie. These hospitals had a medical and surgical voice in the project: Ambroise Tardieu and Édouard Chassaignac from Lariboisière, and Eugène Bouchut and René Marjolin from Sainte-Eugénie. Their combined appointments reflect l'Assistance publique's recognition that women's and children's diseases were important, and statistical collection and interpretation of these topics deserved special attention by experts in those hospital settings. The inclusion of both doctor and surgeon from Sainte-Eugénie attests to its prominent place within the Paris hospital network after its establishment in 1855 and the skill and reputation of its medical staff, especially Eugène Bouchut and René Marjolin.

Table 3.2 First Medical Statistics Commission of the Paris Hospitals, 1860

Name of Physician/Surgeon	Position, Hospital
Grisolle (President)	Physician, Hôtel-Dieu
Guillot	Physician, Necker
Beau	Physician, Charité
Chassaignac	Surgeon, Lariboisière
Hardy	Physician, Saint-Louis
Gueneau de Mussy	Physician, Pitié
Behier	Physician, Beaujon
Tardieu	Physician, Lariboisière
Bouchut	Physician, Sainte-Eugénie
Marjolin	Surgeon, Sainte-Eugénie
Depaul	Doctor, Bureau Central
Broca	Surgeon, Bureau Central

Source: AP/HP, AP1J2, Recueils des arrêtes, instructions, et circulaires de l'Assistance publique, Article II, Circular on the Service of Medical Statistics, December 15, 1860.

<sup>244</sup> AP/HP, APIJA, Report of November 16, 1860 to Husson, the Director of l'Assistance publique, signed by all the members of the committee, 399.

The commission members respected Husson's vision and his international aspirations for the Paris administration and its network of hospitals and hospices. Husson encouraged members to investigate hospitals across Europe and use that information to devise the "model" best practice for the collection of medical statistics. Even prior to the official start of the commission, members followed Husson's recommendation and embarked on an early fact-finding mission about data collection techniques by a foreign hospital, notably Guy's Hospital in London. According to J. O. Steele, Guy's superintendent, the commission reported, a simple clinical card containing the name of the patient, the date of entrée and departure, the nature of the disease and result, and the type of institution (private or public), provided a yearly statistic that furnished information of great interest to medicine, surgery, and the art of *accouchements*.<sup>245</sup>

Another outcome of the medical statistics commission—whether it was the brainchild of committee members or of Husson himself—was the creation of *Bulletin des statistiques médicales*. This publication complemented the larger data collection project by offering a forum to interpret, discuss, and debate the medical statistics provided by specific hospitals. The *Bulletin*'s mission was to collect, analyze, and publicize statistics about the most pressing medical issues at the time, including medical services (diagnosis and description of diseases), surgery (techniques and apparatuses), childbirth, and services for venereal diseases.<sup>246</sup> For example, statistics collected at the maternities would inform the section on childbirth, while Saint Louis data would inform the section on venereal disease. Despite the presence of two medical men specializing in children's

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<sup>245</sup> AP/HP, APIJA, Report of November 16, 1860 to Husson, the Director of l'Assistance publique, signed by all the members of the committee, 412.

<sup>246</sup> *Ibid.*, 402.

diseases on the commission, children's diseases were not included as a primary topic for the *Bulletin*, possibly since infants and infantile diseases comprised a major part of the childbirth section and specific children's medical, surgical, and venereal cases fell under the larger umbrella categories. Ultimately, the *Bulletin* set a framework for understanding medical statistics, by setting forth divisions that limited the immense scope of such an undertaking and setting priorities for the larger project.

#### Cross Cultural Impact of Husson's *Etude* on British Hospitals and Doctors

The compilation of children's hospital statistics in France and Great Britain were not only confined to municipal and national interests, but were a part of a larger transnational conversation about medical care, public health, and charity that began in the first half of the nineteenth century and exploded in the second half.<sup>247</sup> All three levels were intertwined, as statistics provided important indicators about the health of both a locale and of the nation, and hospital statistics was one comparative tool that informed key players involved in public health and hospital reform of where their nation stood in terms of other countries.

Published in 1862, Armand Husson's, *Etude sur les hôpitaux*, exemplifies this interconnectedness between the local, the national, and the international. As Director of l'Assistance publique of Paris and founder of the journal, *Statistique médicale des hôpitaux de Paris*, Husson had access to vast amounts of records for every hospital in the

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<sup>247</sup> All across Europe, administrators and health officials, doctors, and social reformers in each nation kept a watchful eye on how other governments and charitable institutions dealt with harsh realities and human toll associated with urbanization and industrialization. The Transactions of the National Association for the Promotion of Social Science from 1861-1880 reflects this explosion, as numerous British presentations and papers, particularly those on infant mortality, juvenile delinquents, and poor relief, referenced French examples, and French attendees presented on their country's initiatives as models in these areas of concern.

department of the Seine. Combining French data with information gathered from hospital administrators from a wide range of foreign countries, Husson presented a detailed catalogue of Paris hospitals in international context, one that focused on the hospitals over which he had direct oversight while offering assessments of European and North American hospitals. While children's hospitals comprise just a small section of this voluminous work, Husson took care to include histories, maps, and statistical information of all the hospitals serving Paris children at the time—Enfants-Malades, Enfants-Assistés, and Sainte-Eugénie—and two convalescent hospitals outside of Paris, Berck-sur-Mer and Forges-des-Bains.<sup>248</sup> Aside from their own merits and their value added to the entire l'Assistance publique administration, Husson also included children's hospitals to emphasize the long tradition of French specialty institutions and the benefits that they offered to the poor of Paris.

While it only mentioned the children's hospital on Great Ormond Street in footnotes, Husson's work had an immediate effect on GOSH administrators. Just a year after its publication, GOSH's annual report for 1863 summarized Husson's *Etude* and suggested that subscribers read the full work. The GOSH summary emphasized the annual admissions and numbers of beds, further broken down to include the number of beds for particular types of medical conditions (acute disease, surgeries, or scrofulous cases) for all the Paris children's hospitals outlined by Husson, except for *Enfant*

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<sup>248</sup> Enfants-Assistés, formerly Enfants-Trouvés, the Paris foundling home, was a technically a hospice serving abandoned children. Children at Enfants-Assistés were wards of the state, unlike most patients at Enfants-malades or Sainte Eugénie. All three institutions, despite their different populations, belonged under the larger umbrella of the Conseil générale des hôpitaux, coordinated by the Administration de l'Assistance publique. For a useful discussion of the differences between French hospices and hospitals, see Alain Lellouch, "Mortalité : Espérance de vie et morbidité dans les hospices parisiens du XIXe siècle," Communication présentée à la séance du 28 janvier 1989 de la Société française d'Histoire de la Médecine. PDF available at Bibliothèque interuniversitaire de Santé, <http://www.biusante.parisdescartes.fr>. For a detailed history of this institution, see Fuchs, *Abandoned Children*.

Assistés. Combined, these hospitals provided 943 beds in the city and 372 beds in the country (for scrofulous cases exclusively for poor children living in the Department of the Seine). In light of these statistics, GOSH administrators seized on these data and used them for their own aggrandizing purposes. The 1863 Annual Report lamented the state of children's hospital provision in London, especially "when it is borne in mind that the population of the Department of the Seine is far below that of London, the disproportion in the extent of the relief furnished to the same classes in the two capitals is very startling."<sup>249</sup> While publically acknowledging the quantitative superiority of the Paris children's hospitals and avoiding issues of quality, the GOSH annual report used Husson's work to stir a sense of guilt among supporters and affiliates, decrying "none will deny that the meager and insufficient provision which is at present made for the sick children of the destitute classes in London is a defect in our social economy, for which a speedy remedy ought to be provided."<sup>250</sup> Beyond its reproachful tone, the report's underlying message was clear: if GOSH wanted to gain recognition as a preeminent children's medical facility and compete on an international level, the hospital needed to expand its scope of care and service.

In addition to spurring a competitive spirit, Husson's work also gave GOSH leaders the opportunity to reflect on other similarities and differences between French and British children's hospitals. For example, the 1863 GOSH annual report did not overlook the difference between a private voluntary and a public state institution, noting "that hospitals abroad are not, as in England, dependent for the maintenance and support upon private munificence alone, but receive endowments and contributions out of the public

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<sup>249</sup> GOS/1/1, GOSH 13<sup>th</sup> Annual Report, 1866, 6.

<sup>250</sup> Ibid.



treasury.”<sup>251</sup> The writer of the report alluded to this aspect of French statism as an “advantage” for the children’s hospitals in Paris, but Sainte-Eugénie had its own set of challenges in managing such a large institution with fixed public funds that were certainly not limitless.

Years later, Husson’s *Etude* continued to influence GOSH physician Dr. Charles West and served as a primary source for West’s book *On Hospital Organisation*. Written in 1877, this slim volume was the first work to systematically and comparatively discuss the specific nature of children’s hospitals and the unique organizational considerations required to best treat young patients. Throughout the book West used information provided by Husson’s *Etude* to compare British and French children’s hospitals on topics ranging from administrative structure and costs of service to a full discussion on the pros and cons of lay nurses or nursing sisterhoods, as well as more mundane topics like bedding and laundry services. In addition to his references to Husson’s *Etude*, West drew information about the French children’s hospitals from official reports and circulars distributed by l’Assistance publique. Even the most commonplace subjects could be useful fodder for comparison. For example, West spent several pages listing the various types of patient diets in the French children’s hospital. He concluded that the French provided far superior hospital dietary regimes and claimed “it would be well worth the while of the managers of any English hospital to obtain for three or six months the help of some sister who had been in the Paris hospitals, and who could make some suggestions on how to make the diets less costly and more varied.”<sup>252</sup> With its predominantly French-

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<sup>251</sup> Ibid.

<sup>252</sup> Charles West, *On Hospital Organisation, with special reference to the Organisation of Hospitals for Children* (London: Macmillan, 1877), 79.

British assessments and numerous French footnotes, West's little book on children's hospitals suggests that in the 1870s, the Paris and London institutions were indeed leaders in children's medical care, but despite their individual achievements, they should still take care to learn from one another.

#### Royal Patronage and the Children's Hospitals: Empress Eugénie and Queen Victoria

As doctors and hospital administrators exchanged information and data about how to best measure and build up the health of children and the health of the nation, French and British political leaders were involved in another form of nation-building: the consolidation of a Franco-British military alliance. While Franco-British foreign relations did not necessarily reap direct rewards for the Paris and London's children's hospitals, their visible connections to royal patronesses mutually benefited both children's institutions and their royal patrons in different ways. During the nineteenth-century, royal patronage of European charitable institutions was common, and to some degree expected, whether the charity was public or private. Since the seventeenth-century, French and British royalty and nobility erected and patronized large-scale urban hospitals to demonstrate political power, military prowess, and elite benevolence. Imposing hospital structures like the military hospital of *Les Invalides* in Paris and the Chelsea Royal Hospital in London changed the topography of these capitals.<sup>253</sup> At mid-century in France and Great Britain, a mutual association between crown and charity enhanced the standing of both parties: the royal patrons appeared as generous and engaged sovereigns, while the charities received direct and indirect rewards through state support, public visibility,

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<sup>253</sup> For a discussion of the significance of hospitals as agents of change in eighteenth-century London, see Dana Arnold, *The Spaces of the Hospital: Spatiality and Urban Change in London 1680-1820* (New York: Routledge, 2013).

and access to potentially lucrative donors within royal circles. The children's hospitals of Sainte-Eugénie in Paris and Great Ormond Street in London both enjoyed the patronage of royal female heads-of-state: Sainte-Eugénie's royal patroness and name sake was the Empress Eugénie, consort to Napoléon III, while GOSH's most illustrious patron was Queen Victoria.<sup>254</sup> Both royal patrons offered the children's hospitals financial support from state coffers, but perhaps more importantly, their association with these early pediatric institutions had a national and international symbolic significance.

The involvement of Empress Eugénie and Queen Victoria with children's hospitals in Paris and London coincided with international political developments at mid-century. These crowned rulers became allies in a global conflict, the Crimean War, when on April, 19, 1854, France and England signed a defensive and offensive treaty against Russia. While French and British armies fought in the Crimean region, their leaders cemented their strategic military pact through royal visits and diplomatic receptions in both countries.<sup>255</sup> The 1850s also witnessed the first World Exposition in London in 1851, setting off a series of global gatherings in European and North American capitals throughout the rest of the century centered on national advancements in science, technology, and culture. In conjunction with these opportunities for Franco-British cooperation, the first meeting between Empress Eugénie and Queen Victoria occurred April 1855 in London, later followed by a British entourage to Paris for the first World Exposition in Paris.<sup>256</sup> During these official excursions, the showcasing of national

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<sup>254</sup> AP/HP, FOSS 13/1. Notice historique sur l'hôpital Sainte-Eugénie, Fête de l'hôpital, novembre 1867.

<sup>255</sup> Jacques Debussy, *L'Impératrice Eugénie* (Paris: Pierre Lafitte, 1914), 79-80. Some contemporary sources also viewed this alliance as an effective method for the two countries to police and maintain order in Europe and the world. See *Petit Journal*, "Madame Napoléon," sixième édition revue (1871), 38.

<sup>256</sup> Henri Bouchut, *Les Élégances du Second Empire* (Paris: Librairie Illustrée, 1896), 32. The inaugural World Exposition was held in 1851 at the Crystal Palace in London, so the timing of the British envoy to

treasures and innovations provided opportunities for mutual admiration in the midst of ambassadorial meetings and military planning sessions. These international visits also accentuated the Queen's and Empress's roles as feminine figureheads and mothers.<sup>257</sup>

Victoria was the mother of nine children, five girls and four boys, and many of her children and grandchildren eventually sat on the thrones of Great Britain, Prussia, Greece, Romania, Russia, Norway, Sweden and Spain. The Empress Eugénie was supposedly fond of children, but she and Napoléon only had one son, Napoléon Eugène Louis Jean Joseph Bonaparte, known as the Prince Impérial.<sup>258</sup>

As mothers to future leaders and figurative mothers of the nation, Empress Eugénie's and Queen Victoria's involvement with the children's hospitals built upon on a long tradition of feminine philanthropy within royal circles, especially with regards to women's and children's institutions.<sup>259</sup> French consort Anne of Austria offered financial support to the Paris foundling home, Enfants-Trouvés, in the seventeenth-century, and English Queen Caroline championed the idea of a London Foundling Hospital in the early eighteenth century.<sup>260</sup> Queen Victoria's and Empress Eugénie's connection to

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Paris for the premier Paris exposition was politically advantageous for France, as an affirmation of French prowess and "progress" and in science, technology, and culture.

<sup>257</sup> Pierre de Lano, *L'Impératrice Eugénie* (Paris: Victoire-Havard, 1893), 92.

<sup>258</sup> Octave Aubrey, *L'Impératrice Eugénie*, Paris: Fayard, 1931), 131. After his father was dethroned in 1870, the Prince Impérial moved with his family to England and was killed in 1879 fighting for the British in the Anglo-Zulu war.

<sup>259</sup> For a range of patronage activities for British women sovereigns, see Clarissa Campbell Orr, ed. *Queenship in Britain, 1660-1837: Royal Patronage, Court Culture, and Dynastic Politics* (Manchester University Press, 2002). For royal motherhood as a maternal icon, see 38-39.

<sup>260</sup> Fuchs, *Abandoned Children*, 8; Also, *An account of the foundation and government of the Hospital for Foundlings in Paris. Drawn up at the command of her late Majesty Queen Caroline, and now published for the Information of those who may be concern'd in carrying on a like Design in this City*. London, [1739]. Eighteenth Century Collections Online. Gale. Arizona State University AULC. accessed August 9, 2014. Preface. Queen Caroline was posthumously viewed as the hospital's "Protectrix and Benefactrix," but the

GOSH and Sainte-Eugénie accentuated their natural maternal roles, while cementing their sovereign interests in promoting the health of their nation's future population. Royal patronage for these stately ladies, however, played out quite differently within their own unique national contexts. Due to the statist nature of the Paris hospital network, Empress Eugénie's relationship to the children's hospital of Sainte-Eugénie was direct from the start and her imprint on the hospital's structures and activities evident from the hospital's establishment in 1854.<sup>261</sup> In addition to her imperial patronage and the bestowal of her name on the hospital, one of the girl's wards for chronic conditions, *Salle de Eugénie*, also possessed her name. A pious Catholic, the Empress also exerted an influence on the hospital's religious instruction by her requisition for several religious tableaux to be placed in the chapel on the hospital grounds.<sup>262</sup> The Empress directly intervened on the behalf of a patient in at least one instance; she specifically requested the gratuitous admission of a patient at Sainte-Eugénie, a young girl by the name of Marie Agnès Martin, in 1858.<sup>263</sup>

The Empress had a penchant for supporting charities serving women, children, and the infirm, thus her involvement with Sainte-Eugénie was fitting. Although all of her charitable works were paid through state coffers, she helped to channel substantial municipal funds to maternal societies, women's and children's hospitals, asylums and

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author foretold that royal support would continue through the king's deeds: "there is no Reason to fear but it will receive from his *Majesty's* Protection and all proper Encouragement."

<sup>261</sup> L'hôpital Sainte-Eugénie was established just two years after the 1853 marriage of Napoleon III and his consort, Eugénie, comtesse de Montijo.

<sup>262</sup> AP/HP, 9L 154, Letters dated on 15 juin 1855 and 29 septembre 1855 referred to the Empress's authorization for specific works to be displayed in the hospital chapel. A portrait of the emperor was also prominently displayed in the entrance of the children's hospital (letter of 11 janvier 1866).

<sup>263</sup> AP/HP, 9L 155, Letter from l'Assistance Publique to le Directeur de Sainte-Eugénie, 12 novembre 1858.

places of refuge (*asiles*), and youth apprenticeship programs.<sup>264</sup> At her imperial debut, the Empress used the state's marriage gift to create a home for young female apprentices in the faubourg Sainte-Antoine, and after the birth of her son, she established an apprenticeship program for orphan boys, the Orphelinat du Prince Imperial, in his name.<sup>265</sup> Her interest in protecting vulnerable children also extended to foundlings, and she donated money towards efforts to reunite abandoned babies with their biological mothers.<sup>266</sup> She visited numerous Paris hospitals and poor quarters of Paris, and following in the legendary (or notorious) footsteps of other French queens, she reportedly made incognito visits to institutions serving the poor and sick, accompanied by only one maidservant.<sup>267</sup> Her most publicized visits were official tours of several hospitals in Paris in 1855 and Amiens in 1856 during cholera epidemics, in which she supposedly visited every patient's bed to offer encouragement and comfort.<sup>268</sup>

While the Empress Eugénie's consistent shows of charity and compassion were no doubt well-intentioned, her hospital visits and other *oeuvres de bienfaisance* were also deliberate acts to fashion a particular public persona and to enhance the perception of the emperor and the imperial regime. The Empress was a foreigner, born to a well-to-do

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<sup>264</sup> Critics of the imperial crown highlight this facet of royal patronage to charities, such as the *Petit Journal*, "Madame Napoleon," 1871. According to Debussy, the state allocated a sum of 600,000 francs per year to the Empress to spend on charitable works. See Debussy, 69, fn 1.

<sup>265</sup> Debussy, 102-103. The Orphelinat du Prince Imperial was officially under the patronage of the prince, and the program provided annual subventions for honest workers and their families who were willing and able to take the orphan boys into their homes, provide for their care, and train them in a skill. For a discussion of these orphan's experiences, see Lenard R. Berlanstein, "Growing up as Workers in Nineteenth-Century Paris: The Case of the Orphans of the Prince Imperial," *French Historical Studies*, Vol. 11, No. 4 (Autumn, 1980), pp. 553-576.

<sup>266</sup> Fuchs, *Abandoned Children*, 48.

<sup>267</sup> Thomas Evans, *Le Second Empire. Memoires du Dr. Thomas W. Evans*. 3<sup>rd</sup> ed. (Paris: Plon Nourrit, 1910), 85; Debussy 64-65.

<sup>268</sup> Debussy, 67-68. Evans, 86-87.

Spanish family, and her acts of kindness toward poor women, children, sick patients, and the incurables—the most vulnerable groups in France—were an essential component to her self-representation as a noble, yet generous and kindly consort worthy of the love and esteem of the French people.<sup>269</sup> Her attention to worthy causes also played into the imperial aims to create a national and international perception of the Second Empire as liberal and “progressive” and Napoléon III as an enlightened monarch. Yearly announcements of the total contributions and numbers of maternal societies and poor mothers served through the largesse of the Empress’s official acts appeared in publications like the *Annales de la Charité*.<sup>270</sup> An illustration of her visit to Sainte-Antoine portrayed the Empress as a soothing, benevolent angel in the midst of want, misery, and illness, an image that also favored her husband, Napoléon III, and the Second Empire. Imperial charity, separate from but integrated with public and private charity, shaped the Parisian systems of care and assistance during the Second Empire, and Sainte-Eugénie’s name on one of the Paris children’s hospital was a conspicuous reminder of that endeavor.

In contrast, Queen Victoria’s patronage of the children’s hospital on Great Ormond Street resembled a fashionable connection more than a gesture of ardent support, although the royal connection to GOSH strengthened over time. Initially, the Queen’s

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<sup>269</sup> de Lano, 94. Rachel Fuchs explains how imperial interests in protecting children impacted abandoned children after 1850. She notes that while Second Empire officials took repressive measures to keep admissions to hospices low, they also attempted to take better care of the children who were admitted. These measures, according to Fuchs and others, were tied to an imperial attitude that foundlings were socially and economically useful to the state as workers and soldiers. See Fuchs, *Abandoned Children*, 46-48. For a detailed examination of imperial attitudes on mid-century child labor reforms, see Lee Shai Weissbach, *Child Labor Reform in Nineteenth-Century France: Assuring the Future Harvest* (Baton Rouge: Louisiana State University Press, 1989).

<sup>270</sup> AP/HP, APIJ2, Actes officielles. Rapport à sa Majesté L’impératrice sur les sociétés de charité maternelle. *Annales de la Charité*, no. 11 (1855), 120-123.

patronage was as much pretense as fact, and royal support was more of a legitimizing force than a financial asset in GOSH's early years. In the hospital's first annual report, the Committee of Management proclaimed "the utmost gratification in announcing that her majesty has graciously conceded to become the patron of the hospital and has given a munificent donation of £100."<sup>271</sup> From the early 1860s onwards, the hospital publicized gifts sent to the hospital patients from the royal family, such as toys, books, and even socks sewed by the Princess Helena.<sup>272</sup> While Queen Victoria never visited the hospital, the "gifts of our good queen," her yearly Christmas package consisting of boxes of German-made toys, were especially newsworthy in the annual reports and even made the news in publications like the *Englishwoman's Domestic Magazine* or the *Daily Telegraph*.<sup>273</sup> While highly praised, these gifts were out of touch with the genuine needs of GOSH's sick patients—medical supplies, corrective apparatus, medicines, or even good nutrition, suggesting that while despite good intentions and a genuine concern for sick children, British royal patronage also publicity-driven.

Royal patronage at GOSH changed dramatically in the late 1860s when Queen Victoria's children became GOSH patrons and took on more visible roles with hospital fundraisers, visitations, and special events. In 1867, the Prince of Wales, later Edward VII, and Princess Helena (also known by her married title, Princess Christian of Schleswig-Holstein) became vice-patrons of the children's hospital, and in the following years, other daughters of the Queen—Princesses Victoria, Alice, and Louise—and the

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<sup>271</sup> GOS/1/1, 1852 Annual Report. Subsequent annual reports listed the Queen as first hospital patron and her royal donation as first in the long list of donors, subscribers, and bequests, although the actual distribution of her yearly contribution is questionable.

<sup>272</sup> GOS/1/1, 1861 Annual Report, 5; 1863 Annual Report, 11.

<sup>273</sup> GOS/11/1/13, Press Cuttings, *Daily Telegraph*, Wednesday, December 2, 1863; "Spinnings in Town," *Englishwoman's Domestic Magazine*, January 1869.



Princess of Wales, Alexandra of Denmark, honored the hospital with royal visits and some funds.<sup>274</sup> The Prince of Wales was a prominent figure at GOSH ceremonies in the 1870s related to the fundraising and dedication of the new hospital building. In 1870, the Prince presided at the Anniversary Festival, at which the building fund gained an additional £5,000, and the Prince and Princess of Wales laid the first foundation stone for the new hospital building, a pompous occasion reported on by all the major news carriers of the day.<sup>275</sup> These formal acts of patronage boldly proclaimed the goodwill of the British ruling family, while at the same time presenting a royal stamp of approval on the children's hospital and its work. According to one GOSH annual report, "these visits were not passing compliments, but each royal visitor made a most minute inspection of the wards, and showed the [sic] tenderest sympathy for the little inmates."<sup>276</sup> In 1875, the new and enlarged GOSH hospital building contained five distinct wards, and in a nod to the hospital's royal patronesses, the governing board named each ward after Queen Victoria's four eldest daughters and daughter-in-law: Victoria, Helena, Alice, Louise, and Alexandra.<sup>277</sup> Thus, the royal names were stamped on the hospital building for the rest of the nineteenth century.<sup>278</sup>

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<sup>274</sup> GOS/1/1 1867 Annual Report, 6. The Prince of Wales did not overstep Her Majesty's yearly contribution. In the annual donor list, the Queen still gave £100, while the Prince contributed £50 per annum.

<sup>275</sup> GOS/1/1. 1872 Annual Report. 6. GOS/11/1/13, Press Cuttings; papers that reported the foundation stone ceremony included the *Daily Telegraph*, the *Daily News*, the *Morning Post*, the *London Times*, the *London Mirror*, the *Christian World*, and the *Illustrated London News*.

<sup>276</sup> GOS/1/1, 1868 Annual Report, 8.

<sup>277</sup> *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University: "The Ward Names at Great Ormond Street Hospital, 1852-1914."

<sup>278</sup> The redevelopment of Great Ormond Street Hospital in 2012 introduced new nature-based wards names, such as the Butterfly and Rainforest Wards. See Great Ormond Street Hospital for Children website, <http://www.gosh.nhs.uk/parents-and-visitors/coming-to-hospital/ward-and-admissions-information/>

According to nineteenth-century gender prescriptions and royal expectations, Empress Eugénie’s and Queen Victoria’s real and perceived support of children’s hospitals was a seemingly natural fit. Press reports of the sovereigns’ magnanimous gifts to Sainte-Eugénie and GOSH emphasized their “motherly concern” for the disadvantaged children and youth in their nations. While advantageous for both, the link to the children’s hospital proved more so for Empress Eugénie—a foreigner who aspired to win the hearts of the French people. Queen Victoria preferred to pass her patroness duties to other members of the royal family, who took the reins with enthusiasm and eventually set the stage for a long legacy of royal support for GOSH and other British children’s institutions. Ultimately, the Empress needed the children’s hospital to help boost her reputation, but her imprint did not survive long after the overthrow of the Second Empire. Enacted by the Préfecture de la Seine on December 28, 1880, l’hôpital Sainte-Eugénie became l’hôpital Trousseau, and in this sweeping act, the Empress was virtually wiped from the history of the children’s hospital.<sup>279</sup> Across the channel, GOSH and its royal patrons maintained a symbiotic relationship: the children’s hospital banked on royal support while it fostered an optimistic perception of its royal patrons.

## Summary

After 1850, important parallels existed between French and British concepts of public health and their employment of population statistics and medical statistics to know and measure the health of the nation. The children’s hospitals of Paris and London—

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<sup>279</sup> AP/HP, 9L 154, *Patrimoine de Sainte-Eugénie*. The name was changed to l’hôpital Armand-Trousseau in memory of Armand Trousseau, “the eminent Paris physician who was devoted to understanding childhood diseases.”

Sainte-Eugénie and Great Ormond Street—contributed to local and national public health efforts by collecting vital personal and medical information in their admission registers, pinpointing particular characteristics of poor, urban children whose health was at the greatest risk. In an era of world congresses that fostered international comparison, cooperation, and competition, national initiatives to improve public health, such as the best way to collect and use medical statistics or the best architectural layout for hospitals, had transnational dimensions as well. As the professional works of Armand Husson, Director of l'Assistance publique in Paris, and Charles West, GOSH physician in London, demonstrate, topics such as medical statistics and hospital organizations spurred transnational exchanges as French and British leaders compared and analyzed each other's hospital systems, attempting to discover the best practices to improve the health of their urban poor. Royal patrons like Queen Victoria and Empress Eugénie played their own small, yet significant role in promoting the children's hospitals of the British and French capitals. In the process, royal patrons accentuated poor, sick children's health as a national concern, while at the same time, their connection with GOSH and Sainte-Eugénie enhanced their own political persona.

The connections between children's hospital registers, medical statistics, and royal patronage of children's hospitals in the 1850s and 1860s confirms that childhood health, disease, and mortality were matters of local, national, and international interest at mid-century. Child health was a significant aspect of public health, and the information that hospitals gathered about the diseases and medical conditions that afflicted children, the diseases most fatal to children, and mortality rates at each institution had national and international implications. The reputations of the Paris and London hospitals depended in

no small degree on their medical outcomes; those same outcomes were points of transnational analysis, comparison, and competition between France and Great Britain, specifically in studies about hospital construction, organization, and administration during the 1860s and 1870s. Ultimately, these transnational exchanges brought to light how, despite their different administrative structures, children's hospitals like Sainte-Eugénie and GOSH developed comparable organizing principles and policies to manage similar patient populations.

## CHAPTER 5

### OPERATING THE CHILDREN'S HOSPITAL: PATIENT POPULATIONS, ORGANIZING PRINCIPLES, AND HOSPITAL POLICIES

At the Paris and London children's hospitals, the institutional mission provided the basic charge for each establishment, however, the implementation of the task, or hospital organization, was a much more complex and fluctuating operation. Hospital organization had many facets ranging from day-to-day administration to rules and regulations to the arrangement of space and patients. At first glance, GOSH and Sainte-Eugénie appear to be completely different in terms of dimension and oversight, yet parallel social forces at work in populous cities like Paris and London bestowed upon Sainte-Eugénie and GOSH similar patient populations that required similar organizational structures and configurations. The instability and misfortunes associated with urbanization, migration and immigration, and industrialization touched the lives of most of the patients and families who walked into the children's hospitals. Both children's hospitals drew similar pools of local, needy children with similar diseases, frequently caused by the unsanitary conditions of urban life, poverty and insufficient nutrition, parental lack of care or know-how, or a combination of those factors.

As places that brought poor, sick children and their families under the care, guidance, and instruction of expert doctors and administrators of charitable or municipal charity, French and British children's hospitals were sites for both the medicalization of children's bodies as well as a place for the moralization of the working classes. In both France and Great Britain, mid-century bourgeois, or middle-class, ideals extolled

traditional virtues of property, family, and Christian morality, valuing legitimacy in marriage and birth, nuclear households, financial self-sufficiency, and physical and spiritual purity and cleanliness.<sup>280</sup> Living in poverty, sickness, and want, most of the poor families whose children inhabited the wards of the children's hospitals like Sainte-Eugénie and GOSH already fell short of those ideals and inspired fears about the degeneration of French and British society through destitution, infirmity, promiscuity, illegitimacy, alcoholism, domestic violence, and other so-called threats to middle-class stability. To some middle-class reformers, poverty itself was an endemic, contagious moral "disease" infecting society.<sup>281</sup> In a sense, both private and public children's hospitals took poor children under their wing, and by sanitizing, delousing, feeding, and treating the sick or diseased patient's body, the hospital staff purportedly also impressed middle-class moral virtues of self-respect, self-care, and self-sufficiency on the child, and by extension, the family.

As a space where explicit medicalization and implicit moralization converged, the hospital was a place of multiple practices, or in de Certeau's phrase, a "practiced place."<sup>282</sup> As this chapter demonstrates, the character and force of patient populations also shaped the organizational and spatial contours of GOSH and Sainte-Eugénie. Each hospital established policies and practices to ensure the smooth operation of the facility

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<sup>280</sup> For an overview of the middle-class moral values in relation to urban centers like Paris and London in the second half of the nineteenth century, see Rachel G. Fuchs, "Preserving the Future of France: Aid to the Poor and Pregnant in Nineteenth-Century Paris," 92-123, in *The Uses of Charity: The Poor on Relief in the Nineteenth-Century Metropolis*, ed. Peter Mandler (Philadelphia: University of Pennsylvania Press, 1990), 92-93; Lynn Hollen Lees, "The Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth-Century London," 68-91, in *The Uses of Charity: The Poor on Relief in the Nineteenth-Century Metropolis*, ed. Peter Mandler (Philadelphia: University of Pennsylvania Press, 1990)

<sup>281</sup> Lees, 81.

<sup>282</sup> Michel de Certeau, *The Practice of Everyday Life* (Berkeley, CA: University of California Press, 1984), 117.

and set necessary parameters to protect the institution and assist its staff as much as to guide patients, families, and friends through the hospital experience. Administrators at the children's hospital arranged patient wards consistent with similar practical requirements and moral codes, partitioning spaces according to medical condition and gender, establishing age policies, and expanding into new spaces attached to or outside of the original locations. While the hospital rules and regulations appeared rigid and immutable, external factors, such as greater demands for more room and services, and human dynamics, such as a certain doctor's inclination, might shift the rules of operation.

### Urban Locales and Local Populations

Despite administrative differences in French and British systems of care, the geographical placement of Sainte-Eugénie and Great Ormond Street Hospital shaped the nature of their patient populations. Between the 1850s and 1880s, Paris and London experienced major urban growth and change, from large-scale public health projects and district restructuring to local revitalization efforts.<sup>283</sup> These dynamic urban forces contributed to the development of an east-west axis in both cities, dividing a more privileged west from a less privileged east, which predated the 1850s. Situated near some of the poorest sections in east Paris and northeast London, each hospital was in close proximity to the urban peripheries where numbers of working poor families struggled to survive and some of the most destitute children resided. For many patients, the hospitals

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<sup>283</sup> Peter Mandler, ed., *The Uses of Charity, The Poor on Relief in the Nineteenth-Century Metropolis* (Philadelphia: University of Pennsylvania Press, 1990). Mandler's introduction provides an overview of the social challenges of urban growth and change in major European cities like Paris and London. Also, David Harvey, *Paris, Capital of Modernity* (New York and London: Routledge, 2006), introduction, and Andrew Lees and Lynn Hollen Lees, *Cities and the Making of Modern Europe, 1750-1914* (Cambridge: Cambridge University Press, 2007), 63-65.

were within walking distance, and in an era before transport by train or motorized vehicles was widespread, reliable, and affordable, these locations offered a significant advantage that saved already-strapped families much time and money.

Sainte-Eugénie sat squarely in the ancient faubourg of Saint Antoine (Fig. 4.1). This neighborhood formed part of the eighth arrondissement in *ancien Paris*, the term for the city in the years prior to 1860 and Baron Georges-Eugène von Haussmann's urban reconstruction efforts. In 1860, Haussmann expanded the city limits to create a *nouveau Paris*, by annexing several new arrondissements, restructuring existing arrondissements, increasing the number of the arrondissements from twelve to twenty.<sup>284</sup> (See Fig.4.2) In this *nouveau Paris*, Sainte-Eugénie found itself situated in the northwest corner of the twelfth arrondissement, straddled between the Seine and the thirteenth arrondissement to the south and the eleventh and fourth arrondissements to the north and east. Once outlying towns, areas where the *classes populaires* resided like Belleville, Bercy, Charonne, Ivry, Chapelle, and Villette became integrated parts of the urban whole, rounding out the new arrondissements that surrounded the capital.

Regardless of its shifting geographic borders, the hospital's environ in the eastern part of the city remained home to some of the poorest members of the Parisian urban working class. Located near the site of the Bastille, the faubourg Saint Antoine was infamous for working-class revolutionary activity since the time of the French Revolution. Once the home to Enfants-Trouvés, the hospital stood on grounds originally intended to receive and maintain abandoned children, relegated far from public view.

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<sup>284</sup> Archives de Paris (AP), Husson Collection, D6Z/3 Note relative a l'annexion des nouveaux arrondissements. Localities surrounding Paris that were added to new city arrondissements after 1860 included Bercy (12<sup>th</sup>); Maison Blanche (13<sup>th</sup>); Plaisance (14<sup>th</sup>); Vaugirard and Grenelle (15<sup>th</sup>); Auteuil and Passy (16<sup>th</sup>); Batignolles, Montrouge, des Thermes (17<sup>th</sup>); Montmartre and la Chapelle (18<sup>th</sup>); La Villette (19<sup>th</sup>); and Belleville and Charonne (20<sup>th</sup>).



Situated between the rue de Charenton and rue de Faubourg Saint-Antoine, the hospital's main gate was at the north entrance, and the entry to the outpatient department's was on the rue de Charenton at the opposite end of the property. At the westernmost tip of the faubourg, the area surrounding Sainte-Eugénie was a gateway between the established sections of the city center and the crowded working-class outskirts that grew up around it. In nineteenth century urban landscapes, the densest neighborhoods were the poorest, but with urban reconstruction efforts, the poorest and densest areas gradually shifted from the center city outward to the north, east, and south.<sup>285</sup>

L'Assistance publique statistics gathered during the 1860s provide a glimpse of the children's hospital's proximity to Parisian poverty. Between the years 1861 and 1869, two of the three arrondissements containing the highest numbers of indigent households (*ménages*) in Paris were located close to the children's hospital: the 5<sup>th</sup> (to the southwest) and the 11<sup>th</sup> (to the north). The third poorest district, the 20<sup>th</sup> arrondissement in the far north, was not as geographically close, but the children's hospital still drew a large number of patients from the area.<sup>286</sup> Other arrondissements relatively close to the hospital's faubourg—the 5<sup>th</sup>, the 10<sup>th</sup>, and the 13<sup>th</sup>—also consistently returned the highest counts of individual indigence from 1861 to 1869.<sup>287</sup> Taken together, these statistics indicate that a veritable circle of domestic and personal poverty encompassed the children's institution during this period in the 5<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, and 13<sup>th</sup> arrondissements, and

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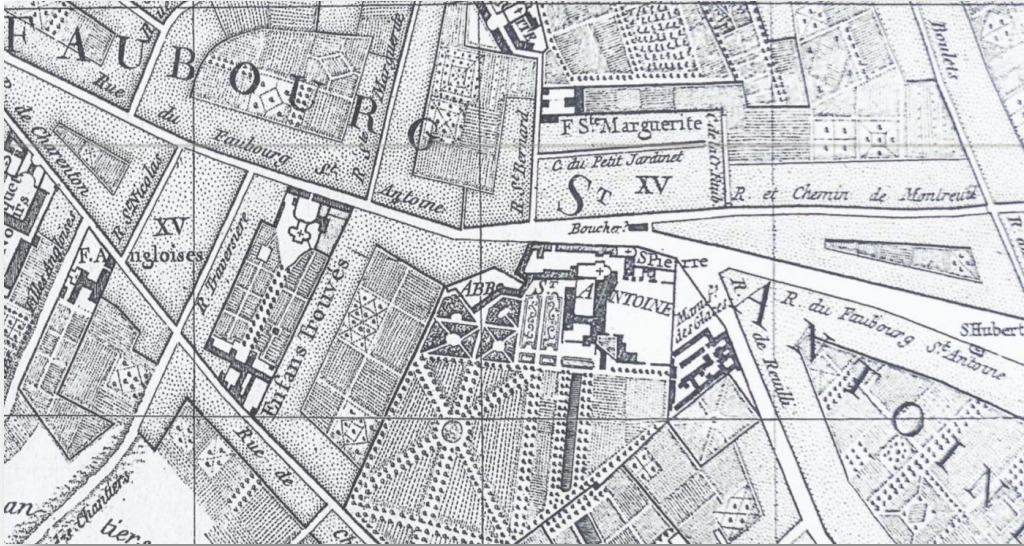
<sup>285</sup> AP, Collection Husson, D6Z/4, Administration générale de l'Assistance publique, Renseignements statistiques sur la population indigente de Paris d'après le recensement opéré en 1869 (Paris: Paul Dupont, 1871), 10.

<sup>286</sup> *Ibid.*, table on pages 8-9.

<sup>287</sup> *Ibid.*, 6. These three arrondissements recorded between 3,000 and 4,000 indigent families for the years 1861, 1863, 1866, and 1869.

later as the city expanded its geographical boundaries and poor families moved to the northern and eastern suburbs (*banlieues*) the 18<sup>th</sup> and 20<sup>th</sup> arrondissements.

Figure 4.1 Location of Sainte Eugénie on former site of Enfants-Trouvés, (pictured middle left).

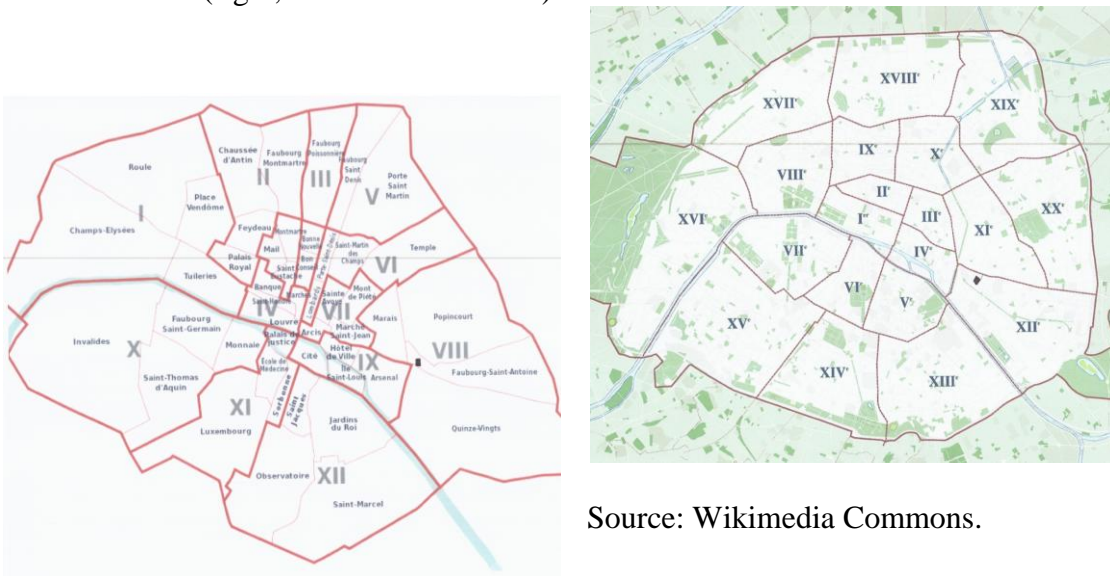


Source: Carte de Paris Vaugondy (1760) Saint-Antoine faubourg, Wikimedia Commons.

Sainte-Eugénie's registers confirm that indeed the most indigent children of Paris resided in these districts surrounding the hospital. The majority of Sainte-Eugénie's patients came from homes of the skilled and unskilled working poor that resided in the arrondissements adjacent to the hospital, particularly 7<sup>th</sup>, 8<sup>th</sup>, and 9<sup>th</sup> arrondissements in *ancien* Paris and the 11<sup>th</sup> and 12 arrondissements in *nouveau* Paris. For example, fourteen out of 35 (40 percent) patients in 1855 were residents of the old 8<sup>th</sup> arrondissement, and between one-third and one-half of patients after 1860 were residents of the 11<sup>th</sup> or 12<sup>th</sup>

arrondissements (former 8<sup>th</sup> arrondissement).<sup>288</sup> Mirroring l'Assistance publique's findings about indigence on the rise in the city's north and eastern peripheries, the numbers of children admitted from the 18<sup>th</sup>, 19<sup>th</sup>, and 20<sup>th</sup> arrondissements steadily grew after 1860, especially in the years 1865 and 1866.<sup>289</sup> This spike in admissions from these districts was likely related to a cholera epidemic in the fall of 1865 and the fall of 1866. However, my sample shows cholera cases were equally dispersed throughout the arrondissements and not necessarily concentrated in these northern and eastern districts.

Figure 4.2 Location of Sainte-Eugénie in *Ancien Paris* (left, 8<sup>th</sup> arrondissement) and in *Nouveau Paris* (right, 12<sup>th</sup> arrondissement).



Source: Wikimedia Commons.

The poor circumstances of some hospital patients stemmed from their social position as the children of migrants or immigrants. Originating from outside the city, they belonged to recently immigrated families from other rural departments across France or from neighboring countries such as Belgium, Germany, Italy, and Switzerland. The

<sup>288</sup> Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP), Sainte-Eugénie, Registres d'entrées, sample for 1855, 1860-1876.

<sup>289</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, sample for 1865-1866.

hospital registers show numerous admissions of the sons and daughters born to wood workers (*ébenistes*) from the Moselle or Brussels, cobblers (*cordonniers*) and tailors (*tailleurs*) from Savoie and Nord, or workers and handymen from all over France and Europe. Some of these recent implants may have practiced a skilled trade; but when a skilled worker could not find steady work, he or she resorted to temporary labor positions to make ends meet. The most common entry for a parent's occupation in the Sainte-Eugénie registers was general worker (*journalier/journalière*), indicating an unskilled worker. Another common entry was handyman (*homme de peine*), a position that likely involved temporary day work, possible transiency, and little to no job security.

Similarly, the location of the children's hospital on Great Ormond Street was ideally situated to attract and serve London's most needy children and families. When considering locations for the children's hospital, GOSH's Provisional Committee, consisting of twelve governing members, agreed that the children's hospital—which would function as both a hospital and as a dispensary, or out-patient facility—must be accessible to the poor and therefore located within the London metropolis. Initially the Provisional Committee sought several other locations to adapt for the children's hospital, such as the existing children's dispensary, the “Infirmery for Children” on Waterloo Road, a private home in Marylebone near Regents Park, and the “old consumptive hospital” in Chelsea, then a northwestern section of London about three miles northwest of Charing Cross.<sup>290</sup> The first mention of Great Ormond Street as a possible location came in the meeting of April 1, 1851, when the subcommittee reported that they “looked over a house and premises in Great Ormond, St Russell Square, at the corner of Powis

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<sup>290</sup> Archives of Great Ormond Street Hospital (GOS), GOS/1/2/1 Minutes of the Proceedings of the Provisional Committee, Vol. 1. Meeting on April 5, 1850 (Waterloo Infirmery); November 5, 1850 (Gloucester Street, Marylebone); March 13, 1851 (Consumptive Hospital).

Place.”<sup>291</sup> Located in Holborn (then part of the parish of St. George the Martyr) in the central part of the city, the 49 Great Ormond Street home already had substantial medical roots as the former residence of eighteenth-century royal physician and London foundling hospital doctor, Dr. Richard Mead. The conversion of Mead’s home into the first London children’s hospital is fitting, considering Mead influenced the decisions to add medical and therapeutic facilities to the foundling home, such as a sick room, a pharmacy, and a garden for exercise.<sup>292</sup>

Like Sainte-Eugénie, GOSH was in the midst of a changing urban landscape. Once part of a posh Queen Anne-era neighborhood on the outskirts of London one hundred and fifty years earlier, the dilapidated mansion and its surroundings became neglected due to the exodus of affluent families to the capital’s northern and western suburbs.<sup>293</sup> The hospital site was a short distance from the London foundling hospital, somewhat of a pariah English institution, another indicator that the location was not choice real estate. The parishes surrounding GOSH harbored some of the most disreputable slums in London such as Saffron Hill, Gray’s Inn, and St. Giles, which only grew worse as surrounding once-respectable abodes fell into disuse and disrepair. From the time of Hogarth’s depiction of St. Giles’ Gin Lane in the eighteenth-century until Charles Dicken’s description of the “filthy and miserable appearance” of the rookery, the St. Giles and Seven Dials area just to the west of the hospital was especially notorious.<sup>294</sup>

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<sup>291</sup> GOS/1/2/1 Minutes of the Proceedings of the Provisional Committee, Vol.1. Meeting of April 1, 1851.

<sup>292</sup>Ruth McClure, *Coram’s Children: The London Foundling Hospital in the Eighteenth Century* (New Haven, NH: Yale University Press, 1981), 212.

<sup>293</sup> This population movement also had an impact on hospital fundraising and finances. See Keir Waddington, *Charity and the London Hospitals, 1850-1898* (London: Boydell & Brewer, 2000), 117-120.

Poor individuals and families sought cheap lodging in this section of the city, and poor, sick children were prevalent in the area. In the fifth annual report, the hospital claimed “its usefulness in the immediate neighborhood” since according to the most recent census, 6,100 children under the age of ten lived in the hospital parish and the four surrounding parishes.<sup>295</sup> These parishes of St. George the Martyr, Holborn, Bloomsbury, St. Pancras, and Clerkenwell generated the majority of GOSH’s patients over the course of the hospital’s first twenty years.

During the 1850s, the central district where GOSH found its home was in the most densely populated area in the city.<sup>296</sup> The combined central districts of St. Giles, St. George the Martyr, Bloomsbury, Strand, Holborn, Clerkenwell, St. Luke, East London, West London, and London City sheltered almost 40,000 people within 2.9 square miles.<sup>297</sup> In comparison, the western districts, including Kensington, Chelsea, St. James, Westminster, St. Martin-in-the-Fields, and Hanover Square covered just less than seventeen square miles and housed two thousand less individuals. Furthermore, the hospital was not far from the growing working class districts of East London such as

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<sup>294</sup> Jules Kosky, *Mutual Friends: Charles Dickens and Great Ormond Street Children’s Hospital* (London: Weidenfeld and Nicolson, 1989), 23.

<sup>295</sup> GOS/1 GOSH Fifth Annual Report, 1856, 7.

<sup>296</sup> Archives de Paris (AP), Husson Collection, D5Z/5, A Summary of Births, Deaths, and Causes of Deaths in London; with meteorological observations for the 1841-1855. (London, 1856), vii. This report, found in Armand Husson’s personal collection, contained tables compiled from the weekly returns, published by the London Registrar General. The following statistics are taken from the table, Annual Mortality in London, in Five Divisions. Husson’s possession of this data on London affirms the international nature of the study and the focus of Husson’s work.

<sup>297</sup>The registration district of Holborn, created in 1837, was abolished and subsumed into the Pancreas registration district in 1865. During this period, nearly all Holborn’s subdistricts encompassed the parishes adjacent to the hospital, including: City Road, Clerkenwell, Finsbury, Goswell Street, Holborn, Holborn & Clerkenwell, North Clerkenwell, Old Street, Pentonville, Saffron Hill, St. Andrew & St. George the Martyr, St. Andrew Eastern, St. Andrew Holborn, St. George the Martyr, St. Giles & Bloomsbury, St. James Clerkenwell, St. Luke, South Clerkenwell, Whitecross Street.

Shoreditch, Bethnal Green, and Whitechapel, which collectively housed 48,522 souls in only 9.7 square miles in 1851. GOSH's location straddled the East and West Ends of London, an environment characterized by a fateful trio of overcrowding, poverty, and youth. Contemporary observers remarked on an East-West disparity, in which the "wretched East only contained two or three hospitals but the more respectable West had ten times that amount."<sup>298</sup> Complicating this "East-end distress," the eastern parishes collectively housed at least a quarter of a million children by the late 1860s.<sup>299</sup> In the city center, GOSH was well-placed to receive the capital's most poor, sick children.

Like Sainte-Eugénie, the majority of GOSH patients came from the poor, crowded neighborhoods adjacent to the children's hospital during its first twenty years: 21 percent from the home parish of Holborn; 18 percent from St. Pancras to the northwest, and six percent each from St. Giles to the west and from Islington to the north.<sup>300</sup> (See Fig. 4.3) Families that lived in parishes further away from the hospital were less likely to have a child admitted at GOSH: fewer than two percent of all patients travelled from Lambeth, south of the Thames River, or Hackney in the far northeastern corner of the city. For another seven percent of patients, no residence was recorded, perhaps because the child's family was transient or homeless or family members refused to provide the information. Approximately ten percent of GOSH's patients travelled from areas outside London, including counties immediately surrounding the city like Middlesex, Surrey, Kent, Essex, and Hertfordshire that are now considered part of

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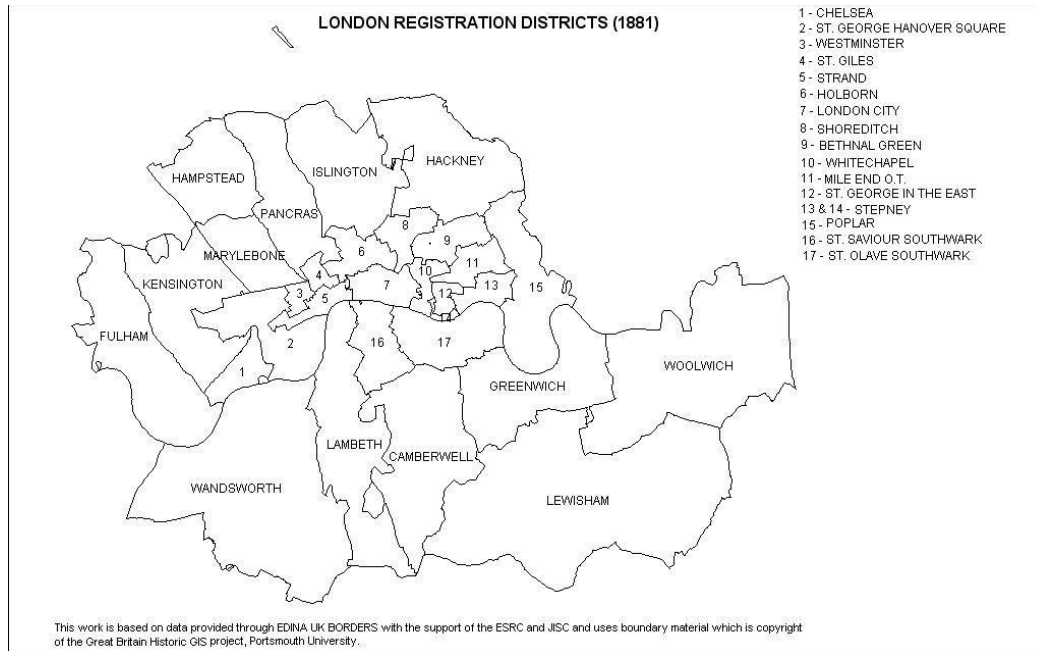
<sup>298</sup> Thomas Archer, *The Terrible Sights of London and labours of love in the midst of them* (London: Stanley Rivers, 1870), 73.

<sup>299</sup> *Ibid.*, 72.

<sup>300</sup> Sue Hawkins, "Origins of GOSH Patients, 1852-1870" table, The Historic Hospital Admission Registers Project (HHARP), [www.HHARP.org](http://www.HHARP.org).

Greater London. The GOSH administration congratulated itself on admitting patients from places as far away as Devon, Gloucester, Lincoln, and Stafford, but the children’s hospital remained a local institution for the rest of the nineteenth century.<sup>301</sup>

Figure 4.3 London Registration Districts (1881), with GOSH in Holborn District (6)



GOSH is located in the Holborn district (6), top center.

Source: Great Britain Historic GIS Project, Portsmouth University, [www.HHARP.org](http://www.HHARP.org)

### Space and Place: Buildings, Wards, and Beds

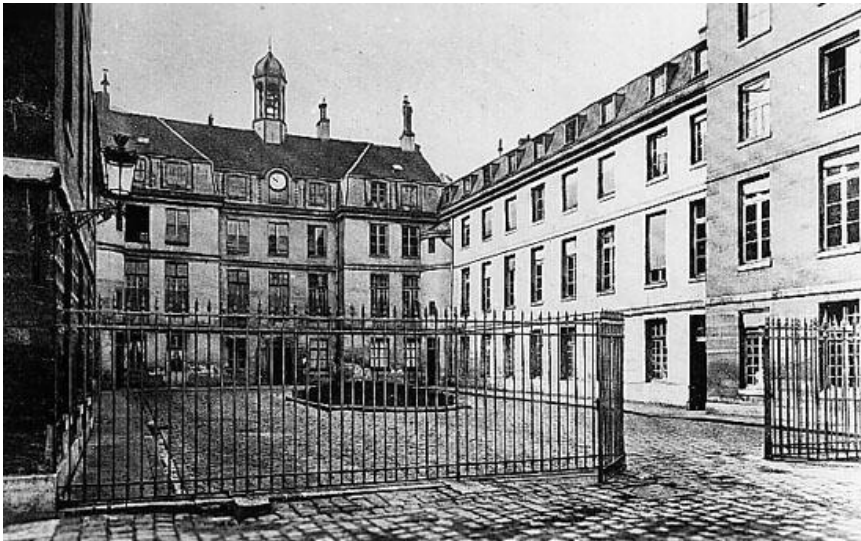
Although the hospitals resided in similar urban environments and served similar family populations, in terms of their physical structures, Sainte-Eugénie and Great Ormond Street were very different. The Paris hospital was in a word, monumental (see

<sup>301</sup> GOS/1/1. Sixteenth Annual Report, 1867, 6. According to the report, the hospital admitted patients from the following counties: Berkshire, Buckinghamshire, Cambridgeshire, Devonshire, Dorset, Essex, Gloucestershire, Herefordshire, Hertfordshire, Kent, Leicestershire, Lincolnshire, Somerset, Staffordshire, Suffolk, Surrey, and Sussex. In the twentieth century, GOSH admitted greater numbers of non-Londoners, as much as 45 percent. See Sue Hawkins, “Facts on the Children’s Hospitals” PowerPoint, table on the origins of GOSH Patients, 1902-1914, Historic Hospital Admissions Records Project, [www.HHARP.org](http://www.HHARP.org).



Fig. 4.4). Established in 1854 on the former site of Enfants-Trouvés, until 1836 the Paris foundling hospital, the converted institution was an impressive structure that exuded a commanding presence, taking up an entire city block. The hospital was large enough to house separate sections for different types of patient conditions and treatments, a large operating theatre, and a two-story outpatient department. The property also contained areas for various household services (laundry, kitchen, and lavatories) and personnel housing, a library for both patients and staff, a museum, covered and uncovered gymnasiums, a chapel, and a large garden. The hospital of Sainte-Eugénie was almost a self-contained, walled city.

Fig. 4.4 Court of Honor, Sainte-Eugénie (*ancien* Hôpital Trousseau)



Source: Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP)

The main hospital building was immense and four stories high, with each floor dedicated to a particular health condition, with acute medical treatment and surgery taking the lion's share of the hospital's inpatients. The ground floor served surgical

patients; the first floor, patients with acute medical illnesses, such as severe respiratory diseases and infectious fevers, the second floor, chronic conditions such as scrofula, rickets, and tubercular conditions; the third was devoted to ringworm and other hygiene problems.<sup>302</sup> A two-story outpatient department was accessible at the back of the hospital property. Outpatients and their families entered through separate entrance off the rue de Charenton, where a waiting room, exam room, and baths filled the ground floor and the pharmacy and dispensary were on the first floor. The bed capacities for each ward ranged from thirty to sixty beds each, allowing Sainte-Eugénie to serve hundreds of children on any given day. With a total of 400 beds, Sainte-Eugénie admitted an average of 2,949 children per year between 1855 and 1871 (Table 4.1). As one unit of a centralized, high-capacity system covering all of the Paris hospitals, Sainte-Eugénie was structured to receive, treat, and move through great numbers of children with efficiency and economy.

Table 4.1 Sainte-Eugénie Total Admissions per Year, 1855-1871

<b>Year</b>	<b>Total Admissions</b>	<b>Year</b>	<b>Total Admissions</b>
<b>1855</b>	2786	<b>1864</b>	2752
<b>1856</b>	2878	<b>1865</b>	2829
<b>1857</b>	2860	<b>1866</b>	2960
<b>1858</b>	2682	<b>1867</b>	2995
<b>1859</b>	2986	<b>1868</b>	3256
<b>1860</b>	2834	<b>1869</b>	3234
<b>1861</b>	2829	<b>1870</b>	3726
<b>1862</b>	2930	<b>1871</b>	2983
<b>1863</b>	2784		
			<b>Total: 50,138</b>

Source: AP/HP, Sainte-Eugénie, Registres d'entrées, 1855-1871.

<sup>302</sup> AP/HP, FOSS 793/ 56–7, Chirurgie: plan du rez-de-chaussée; médecin: plan du 1er étage; scrofuloux: plan du 2e étage; teigneux: plan du 3e étage.

In relation to the vastness of Sainte-Eugénie, GOSH was a small-scale production with a distinctively English “cottage” hospital size and feel. Established in a large Queen Anne-style gentleman’s home, the wards looked like a home more than a hospital, and in its early years, doctors and nurses did not wear uniforms. The hospital strived to supply all the comforts of a well-to-do home within a sanitary, orderly environment. One description of the convalescent ward evoked an ideal domestic scene: “a large, comfortable nursery, where about eight children play contentedly, and indeed, they well may for toys and games are placed before them in quantities... There is a large and well furnished doll’s house, a large aquarium, and a fern case...”<sup>303</sup> Similarly, the sick wards were “tidy,” “fresh and clean,” and the patients rested in cribs and cots with movable trays that slid up and down to bear food at mealtime or hold toys during the day.<sup>304</sup> Clean, tidy, and fresh (or healthy-smelling) were the most common compliments given to the GOSH wards by the visiting governors, lady visitors, and other hospital visitors. After going about his observations on his weekly round, one governor’s report described the hospital as if were a warm and nurturing family scene: “children look comfortable, wards clean and tidy and nurses giving attention to duties in a kindly motherly way.”<sup>305</sup>

In one pictorial rendition of the GOSH general ward (see Fig. 4.5) portrays an aura of warm domesticity, with each child patient in its own cot and attentively cared to by nurses, lady visitors or visiting governors, and visiting family members. In the middle of the room, idle hands and minds are kept busy, productive, and engaged with some

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<sup>303</sup> GOS/11/1/13, Description of the GOSH convalescent ward in “Spinnings in Town,” *Englishwoman’s Domestic Magazine* (January 1869).

<sup>302</sup> *Ibid.*

<sup>305</sup> GOS/7/2/1, Visiting Governor Report, May 1856.

organized activity, under the watchful eye and gentle instruction of a nurse or teacher. the authorities in the room are clearly the male doctors located front and center of the image: Dr. Charles West examines a child's leg (center), while Dr. Jenner dictates instructions to a woman holding a child (far left).

Figure 4. 5 GOSH General Ward



Source: Archives of Great Ormond Street Hospital (GOS), London.

In contrast to Sainte-Eugénie, GOSH's patient capacity was considerably limited, and the numbers of admissions between 1852 and 1876 reflect its much smaller patient population. The hospital continued to grow over the first twenty-five years, with some ebbs and flows due to building renovations and the construction of a new building between 1872 and 1875 (see Table 4.2). With 143 patients in the first year, the children's hospital initially comprised one main general with ten beds, and a small fever room. In

the second year a rise in admissions prompted the addition of ten more beds, the creation of separate wards for boys and girls, and an outpatient department on the ground floor. For the first two decades, the children’s hospital made due, but space was always an issue. With its beds constantly occupied, the children’s hospital placed patients on waiting lists or turn them away.<sup>306</sup> The building needed rooms “for special cases that need absolute quiet and seclusion and more ample space to separate convalescents from the sick all day long.”<sup>307</sup> In 1875 the erection of a new hospital building allowed the hospital to expand beyond its former walls and add five more inpatient wards. In the next two years, the new hospital accommodated 869 and 926 patients, respectively, well over one hundred more patients than previously served in the older building (see Fig. 4.6).

Table 4.2 GOSH Total Admissions per Year, 1852-1877

<b>Year</b>	<b>Total Admissions</b>	<b>Year</b>	<b>Total Admissions</b>
<b>1852</b>	143	<b>1865</b>	658
<b>1853</b>	190	<b>1866</b>	758
<b>1854</b>	256	<b>1867</b>	620
<b>1855</b>	281	<b>1868</b>	719
<b>1856</b>	341	<b>1869</b>	711
<b>1857</b>	332	<b>1870</b>	680
<b>1858</b>	380	<b>1871</b>	678
<b>1859</b>	410	<b>1872</b>	558
<b>1860</b>	366	<b>1873</b>	578
<b>1861</b>	578	<b>1874</b>	530
<b>1862</b>	544	<b>1875</b>	519
<b>1863</b>	548	<b>1876</b>	869
<b>1864</b>	583	<b>1877</b>	926
			<b>Total: 13,756</b>

Source: *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University.

<sup>306</sup> GOS/1/1 Second Annual Report, 1853, 5, 10.

<sup>307</sup> GOS/1/1 First Annual Report, 1852, 10.

## Separation Principles: Efficiency, Gender, and Disease

In spite of their differences in dimension and feel, Sainte-Eugénie and GOSH shared similar organizing principles. Categorizing and compartmentalizing places and spaces was an everyday task at both hospitals, and several layers of separation occurred as patients made their way through each hospital system. Both Sainte-Eugénie and GOSH dispersed their child patient populations into specific locations on the hospital grounds according to most efficient space to treat the patient—outpatient or inpatient department, the patient’s gender, and the type and intensity of the patient’s medical issue. While hospital administrators and medical staff drew up the rules and therefore made the majority of these decisions, parents and other family members had prerogatives as well. In seeking out medical attention for their children, families took the first steps toward health care when they brought young patients to the doors of the hospital’s inpatient and outpatient departments.

At both hospitals, an initial level of selection occurred at intake when potential patients were designated as inpatients or outpatients. At GOSH and Sainte-Eugénie, inpatient wards were separate from outpatient wards, and while sharing the same premises and connected by the same hospital administrations, these departments and their patients were very different. Frequently, French and British families first sought medical attention at the outpatient departments, where hospital staff would serve their child’s medical needs, or if the case was severe, make a recommendation for placement in the inpatient wards. The majority of outpatients at Sainte-Eugénie and GOSH were children with mild to chronic medical conditions similar to what we would consider today as “walk-ins.” At the time of admission, a patient might be sent to the outpatient department

because they were either too young for inpatient care or their medical condition was not considered severe enough to warrant inpatient placement. During its early years, GOSH in particular did not have the space or funds to accommodate everyone, and in these rare cases, patients were reportedly placed on a waiting list and serviced as an outpatient until a bed opened up.<sup>308</sup>

Similar to mini-health clinics, the outpatient departments of Sainte-Eugénie and GOSH catered to the local population surrounding each hospital. The concept of the outpatient department—a cross between an infirmary and a dispensary—already had a long and fruitful history in Great Britain, which the Paris children’s hospital of Enfants-Malades adapted when l’Assistance publique authorized a “fifth medical service” to receive outpatients in the early 1850s.<sup>309</sup> Open every day except for Sundays and public holidays, these departments provided a range of non-emergency (*legère*) much-needed services for poor, local children and families, such as medical consultations, a limited menu of treatments, medication prescriptions and dispensations. The larger and better equipped facility of Sainte-Eugénie offered hygienic procedures such as baths and applications to de-louse or treat other parasitic conditions, such as ringworm and scabies. At Sainte-Eugénie and its sister institution, Enfants-Malades, ringworm was such a

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<sup>308</sup> GOS/1/1 Annual Report, 1853, 9. The report states that “mothers now often seek admission for their children, whom want of room, or rather want of funds, and compels the medical officers to refuse.” GOSH Annual Report, 1854, 5, notes that “the full number of beds has been constantly occupied and many parents have anxiously waited for vacant beds for their sick children.”

<sup>309</sup> For more on the history of the dispensary, see chapter 2 of this dissertation. The implementation of external services at Enfants-Malades appears to have been related to excessive demands for non-emergency services, such as ringworm cases, in the inpatient wards. To free up doctors for more serious cases and to provide more efficient service, the children’s hospital established an outpatient (*externe*) department in early 1853. AP/HP, AP1J1, Circulaire no. 201, Création du traitement externe a l’hôpital des Enfants-Malades (17 janvier 1853).

problem that special outpatient clinics were set up to deal with the malady on a permanent basis for two mornings a week at each location.<sup>310</sup>

Due to their high degree of accessibility, no or little costs, and for some parents, their non-invasive character, Sainte-Eugénie and GOSH outpatient departments were extremely popular with families. Outpatient registers are nonexistent, but other hospital records illustrate their popularity. Each hospital established an outpatient department during their first year of operation; between the mid-1850s and mid-1870s, these departments consistently served more outpatients than inpatients per annum. During its first twenty years, GOSH outpatients numbered between ten and twenty times more than its inpatients each year. For example, in its second annual report, GOSH reported its inpatients numbered 143 in 1852 and 290 in 1853, while its outpatients numbered 1,250 in 1852 and 4,251 in 1853.<sup>311</sup> By the late 1860s, GOSH was serving between twelve and fifteen thousand outpatients per year.

The total number of Sainte-Eugénie's outpatient numbers is unknown, but some clues of the large numbers of children served through its outpatient department remain. In the 1880s, an Assistance publique commission on hospital hygiene included appendices with lists of children treated in Paris children's hospital outpatient services according to medical condition.<sup>312</sup> According to these appendices, Enfants-Malades' outpatient

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<sup>310</sup> Henri Bergeron, *Rapport sur les résultats obtenus dans le traitement des enfants scrofuleux à l'hôpital de Berck-sur-Mer* (Paris: Dupont, 1866) 334. This report listed the various treatments offered at the Paris hospitals for scrofulous children, the majority of whom were ultimately transferred to the convalescent hospital at Berck. Ringworm was treated at Enfants-Malades on Wednesdays and Saturdays between 10 am and noon and at Sainte-Eugénie on Tuesdays and Fridays between 11 am to 1 pm.

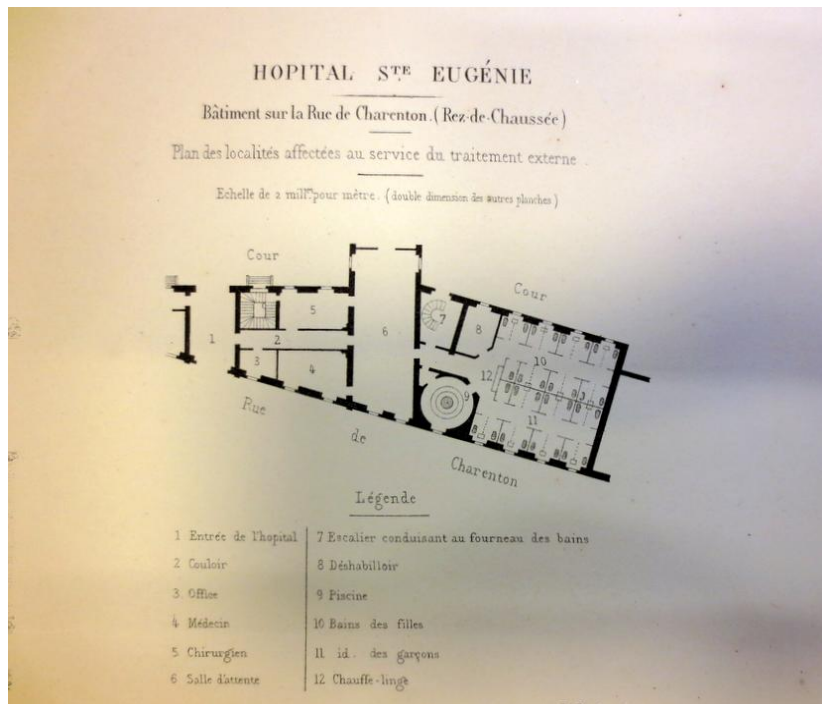
<sup>311</sup> GOS/1/1, Annual Report, 1854, 5. Due to such numerous outpatients at both hospitals, the records were too voluminous to keep indefinitely, hence their absence at either the London or Paris archives.

<sup>312</sup> AP/HP, Commission d'hygiène hospitalière, *Rapport présenté par M. Grandjacquet, architecte, sur les services d'isolement à construire à l'hôpital Trousseau*, 1887, Annexe A and B, 29-30.



department treated 4,249 boys and girls with scrofula between 1854 and 1865, and Sainte-Eugénie’s outpatient department treated 4,119 of the same. Both outpatient departments recorded intake numbers for another common condition involving bone deformities, Pott’s disease (*mal de Pott*), with Enfants-Malades receiving 177 cases and Sainte-Eugénie receiving 253 cases between 1854 and 1864.<sup>313</sup> If these hospitals served approximately 400 children per year suffering from scrofula and Pott’s disease, they likely served hundreds of other children with other conditions and mild complaints. If the Paris hospitals served fewer children in their outpatient departments than GOSH, they more than made up for the discrepancy with their enormous inpatient counts.

Figure 4.6 Floor Plan of Outpatient Department at Sainte-Eugénie



Source: Armand Husson, *Étude sur les Hôpitaux* (Paris: Paul Dupont, 1862), plate 4.

<sup>313</sup> Ibid., Annexe C and D, 32-33.

An unceasing utilization of outpatient services at GOSH in particular prompted the children's hospital to enhance and streamline their programs. Visiting governors repeatedly voiced concerns over the inadequate number of outpatient medical staff, and how the delay in service was an inconvenience to patients and the mothers and friends attending with them as well as a stain on the reputation of the hospital.<sup>314</sup> A sustained surge in outpatients throughout the late 1850s led GOSH administrators to add a more spacious waiting room for outpatients and their families and to enlarge the dispensary for more rapid delivery of medications in 1859. Eventually the hospital hired an assistant for the only dispenser on staff in 1862.<sup>315</sup> The popularity of the London outpatient departments also brought greater scrutiny, as medical officers and hospital administrators strove to prevent abuses of the system. On the one hand, large numbers of outpatients led to difficulties in giving priority to the weakest or most afflicted patients over those with trifling concerns, or even worse, people of means who could well afford to pay for competent medical care taking advantage of the free services for themselves and their children.<sup>316</sup> One visiting governor noted his suspicions of the later occurring the GOSH outpatient department, stating "some of the outpatients appeared to be above the class for whom the hospital is intended."<sup>317</sup> In its first decades, GOSH indiscriminately treated outpatients until their number became so considerable that the overworked medical officers could not attend to them properly. By the early 1870s, the GOSH outpatient

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<sup>314</sup> GOS/7/2/1, Report by Eyre, October 9, 1860; Report by Plumer, July 9, 1863; Report by Veuker, August 24, 1863; Report by Rothery, May 12, 1865; report by Dukinfield, May 20, 1866; Report by Plumer July 30, 1866.

<sup>315</sup> GOS/1 Annual Report, 1859, 6 (space modifications); GOSH Annual Report, 1863, 10 (new hire).

<sup>316</sup> Archer, 471.

<sup>317</sup> GOS/7/2/2, Report by Plumer, December 24, 1868

department admitted all patients without question on their first visit, but on following visits, the patient's family needed to provide information on their occupation, wages, and family size, which was then countersigned by the inspector of the Charity Organization Society (COS) responsible for one of the 83 districts in which the family lived.<sup>318</sup> Once verified as a child from a family deserving of the hospital's charity, the patient was admitted. According to physician Charles West, the plan worked well, reducing the number of GOSH outpatients from 13,000 in 1873 to 9,000 in 1876.<sup>319</sup>

### Separation by Gender and Disease

The organization of space and placement of patients in the children's hospital was governed by both moral and medical concerns. Separation of patients by gender is a prime example of the moralistic underpinnings of hospital classification and organization. Nineteenth-century children's hospitals were gendered spaces, with a clear differentiation between the sexes of young patients and the construction of distinctive girls' and boys' wards, or *salles* at both hospitals. At mid-century the improvement of children's physical and moral health was a twin goal of French and British children's hospitals; middle-class ideals of order, propriety, and salubrity demanded partition between young, impressionable males and female patients. In the Paris hospitals that routinely admitted patients as old as fifteen, the separation of the sexes helped to maintain hygienic standards and limit seemingly vulgar or unrespectable behaviors and situations. For example, boys and girls wards had separate bathrooms, so as to limit sexual knowledge of

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<sup>318</sup> Charles West, *The Profession of Medicine; Its Study and practice; Its Duties and Rewards* (London: Kegan, Paul, Trench, Trubner and Co., 1896), 82-83.

<sup>319</sup> *Ibid.*, 84.

innocent children. The French separated boys and girls since the early days of Enfants-Malades, and despite some isolated ripples of opposition, l'Assistance publique enforced the principle.<sup>320</sup> In the 1860s, l'Assistance publique Director Armand Husson noted that historically France and Great Britain were kindred spirits on the matter, and (unnamed) French children's hospital pioneers apparently borrowed some ideas for its defense of the principle from Great Britain. At Sainte-Eugénie, gender separation even extended to the names of the hospital wards. Girl patients were housed in wards with female names like Marguerite, Mathilde, Geneviève, Eugénie, and Rosalie, and boys resided in the Josèphe, Benjamin, Napoléon, Augustine, and Vincent wards.

Another layer of separation involved the classification and treatment of diseases. Children with severely acute cases of disease, surgical cases, and cases deemed worthy of medical intervention or observation were admitted as inpatients. A further opportunity for differentiation presented itself when an inpatient improved to a non-critical stage of health, and a choice needed to be made concerning whether the patient would enter a convalescent ward in the hospital, move to a convalescent home outside the hospital, or continue recovery at home. During the first couple of decades at GOSH and Sainte-Eugénie, patients with acute conditions such as fevers or respiratory infections found themselves separated from wards for chronic cases or non-life-threatening diseases. Separate "fever" wards emerged that quarantined patients suffering from a variety of contagious fevers. GOSH initially placed contagious patients in a "fever house," a small detached shed-like structure off the back of the main structure. By the end of the 1870s, Sainte-Eugénie had distinct wards for patients with whooping cough, measles, diphtheria,

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<sup>320</sup> Armand Husson, *Etude sur les Hôpitaux*, 130.

ringworm, and scarlet fever, as well as an isolation structure located far from the general wards.

Despite these attempts to prevent contagion from sweeping through the rest of the wards, cases of children catching infectious diseases in hospital was all too frequent. During GOSH's first year of operation, a visiting governor report on the spread of a contagious disease within the hospital stressed the need for the proper placement and careful supervision of the young patients: "Two children caught whooping cough in the girls' ward from the boy there recovering from [w.c.]—concerned that this boy is still there—even though his bed was kept apart from the others and could not come in contact—concerned that girls are playing with other children in the outpatient room (convalescent) and this needs to be changed."<sup>321</sup> This particular example of the dreaded mixing of boys and girls and patients with fevers and patients without fevers demonstrated how inadequate space prevented the hospital from achieving its organizing principles according to separation by gender and medical condition. The culprit in this situation was lack of space: GOSH did not have enough room for spacious boys and girls wards or for separate convalescent wards for each gender. Overflow in the boy's ward demanded a young male patient convalesce in the girls wards, while his premature convalescence and movement into the girls ward endangered not only two young female patients, but outpatients as well.

Other attempts at separation due to medical condition were more successful. During epidemics, new wards sprung up out of necessity. During the cholera epidemic of 1865-66, new wards opened to accommodate Sainte-Eugénie's cholera cases: an Armand

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<sup>321</sup> GOS/7/2/1, Visiting Governor Report, February 10, 1853.

ward for boys and a Ferdinand ward for girls.<sup>322</sup> Similarly at GOSH, when cholera broke out in 1865, hospital administrators “made arrangements for the reception of children who might be suffering from the disease, in a ward properly isolated.”<sup>323</sup> Considering the acute conditions of isolated patients who were bed-ridden, feverish, and possibly dying, separation by gender was not an issue. In an era where contagion was a controversial issue and germ theory still unknown, the decision to designate separate spaces for different diseases at GOSH and Sainte- Eugénie is noteworthy. Informed by commonsense and experience more than medical understanding, separation according to medical condition prior to knowledge and acceptance of the germ theory was a practical, life-saving choice at both hospitals.

### Patient Spaces

Patient wards and bed assignments conveyed a patient’s place within the larger structure and composition of each hospital. The children’s hospital must have appeared to be a strange new world for many young patients. The separation of boys and girls would have seemed foreign to poor children for whom the mixing of the sexes in tight quarters was a part of everyday life. For other children who faced hunger on a daily or weekly basis, the hospital food appeared as a bountiful gift. Occasionally, the doctor’s case notes highlighted a correlation between the patient’s ill health and domestic hardship. The notes for four-year-old William Bunce, admitted to GOSH in May 1864, illustrates how rickets, malnutrition, and family poverty could be a deadly combination for children.

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<sup>322</sup> AP/HP, Sainte-Eugénie, Registres d’entrées, 1865-66. These *salles* emerged in the Sainte Eugénie admissions record for the first time in the fall of 1865. In this case, the use of a feminine name for a girl’s ward was not applied.

<sup>323</sup> GOS/1/1, Fifteenth Annual Report, 6.

Described as “very weak,” “anaemic,” and “rickety,” William had five other siblings who all showed signs of rickets. Poor nutrition was the primary culprit, as the doctor noted that William’s “father has been sometimes out of work—child has had bread and butter for food. Now seldom sick.”<sup>324</sup> Unfortunately for William, he had broken his thigh bone a year earlier, and a lack of appropriate bed rest and care for his injury, combined with poor nutrition and lack of sunlight and vitamin D, set him on a fatal course. The hospital could re-admit patients like William, but attending physicians and nurses could do little to reverse the physical damage that life had already doled out to them.

A rudimentary aspect of the modern hospital experience—the bed assignment—was a departure from the routine of many poor nineteenth-century hospital patients. Some patients likely shared a room or bed with siblings and for the poorest of the poor, entire families may have shared the only bed in the living quarters. Patients were assigned their own bed or *lit* (Sainte-Eugénie) or cot (GOSH), which for some children may have seemed like an extravagant space all to themselves, or for other children, was a lonely and miserable space apart from their loved ones. At a large institution like Sainte-Eugénie, sisters or brothers admitted with the same fever could more easily be separated from one another in different wards (and required anyway if one had an infectious fever and the other did not). While traumatic at the time, in many cases, it saved a young child from watching their sibling rapidly decline in health and slip away forever.

The hospital experience differed greatly from child to child. At least one GOSH patient may have enjoyed her stay so much that she feigned a condition to remain in the ward. Rebecca Norvis, a nine-year-old patient was admitted to the hospital for

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<sup>324</sup>HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University, Case notes for William Bunce, admitted May 23, 1864.

intermittently refusing to eat, speak, or walk for months, and two weeks prior to entering the hospital, she closed her eyes and would not open them.<sup>325</sup> Doctors never really understood her condition, but they were fascinated with her case enough to keep her for observations as an inpatient for six weeks. Rebecca may have had rare, fleeting nervous disorder, or she may have liked the care and attention that she received at the children's hospital. In contrast, the hospital experience could be so intense as to hinder further treatment, especially for young patients upset by the separation from their mothers for days or weeks at a time. For example, after only five days in the boy's ward for treatment of pleurisy (a respiratory condition), two-year-old William Brown was discharged to his parents for "fretting too much."<sup>326</sup> Patients who remained in the hospital for several weeks or months may have eventually found some small comfort in their own little corner of the ward as they played with some of the hospital's cache of toys, listened to a lady visitor read a story, or made friends with a ward mate.

### From Hospital Ward to Convalescent Home

Patients' spatial movements come into view in the admission registers that tracked children moving from ward to ward, depending on their medical conditions, or from hospital wards to convalescent home, depending on their recovery needs. These divisions had practical value for smooth operations of each institution. For example, separating children with extreme medical needs (inpatients) from those with minor or less

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<sup>325</sup> HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University, Rebecca Novis of Islington, age nine, admitted on April 17, 1871, discharged end of May, and readmitted on July 3 for ten days before sent to the convalescent home at Highgate, where she stayed for three weeks, discharged with a "cured" result on August 3, 1871.

<sup>326</sup> HHARP: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University, Case notes for William Brown, admitted July 3, 1866.



critical medical complaints allowed these hospitals to allocate the greatest resources and space to the neediest patients. The movement of patients through various hospital wards and convalescent options maintained a steady balance of admissions and discharges, keeping waiting lists low and available beds to a maximum capacity.

Large numbers of Sainte-Eugénie and GOSH patients moved on to convalescent homes, institutions that increasingly became essential appendages to the children's hospitals. Sainte-Eugénie utilized several *maisons de convalescence* over the years. Opened in 1850 and expanded in 1854, La Roche Guyon had a dozen spots for young boys from the Paris children's hospitals with non-contagious conditions.<sup>327</sup> Opened in 1859 near healthy mineral waters located about 40 kilometers from Paris, Forges-des-Bains (see Fig. 4.7) contained over 110 beds for anemic and scrofulous Paris patients of both sexes.<sup>328</sup> Constructed in 1861 as a pilot sea-side hospital for children, Berck-sur-Mer accommodated between fifty and one-hundred anemic, scrofulous, and rickety children. In 1869, the pilot hospital was enlarged to hold 500 beds solely for Paris patients and was renamed l'hôpital Napoléon for a short time.<sup>329</sup> Over time, hospital registers revealed distinct trends in patient medical conditions that warranted operational changes, also driven by economization. Between 1855 and 1867, between ten and thirty percent of the patients in the Sainte-Eugénie sample (between 3 and 13 patients) went to another *maison* or hospital, and all of these patients were identified as having scrofula.<sup>330</sup> Since convalescent hospitals like Berck-sur-Mer and Forges-des-Bains received greater

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<sup>327</sup> AP/HP, FOSS 21/1, *Notes sur la fondation, la destination et le fonctionnement de l'hôpital*, 36-37.

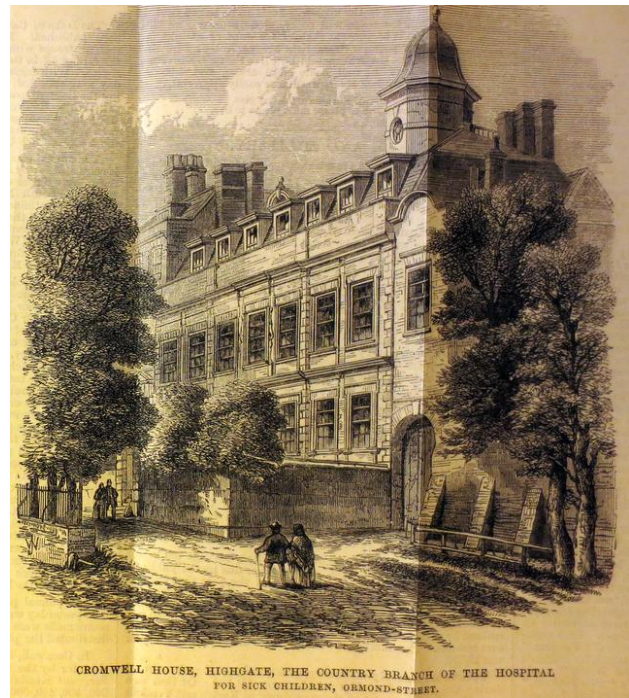
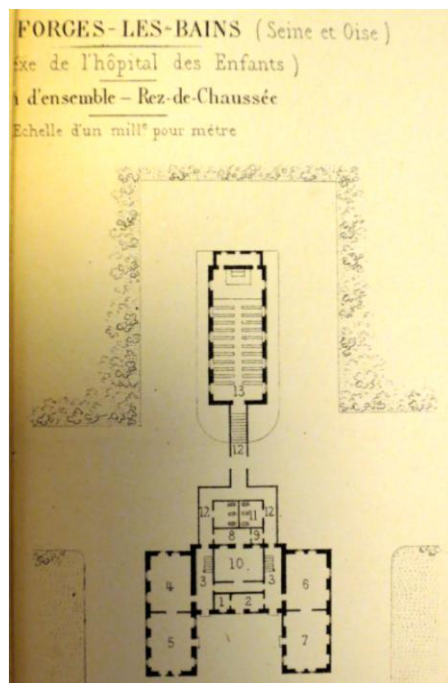
<sup>328</sup> Armand Husson, *Etudes sur les hôpitaux*, 130.

<sup>329</sup> Henry Paul, *Henri de Rothschild, 1872: Medicine and Theater* (Farnham: Ashgate, 2011), 32-33. This book provides a contextualized account of this hospital's most avid supporters, Dr. Henri de Rothschild.

<sup>330</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, 1Q2/1-6.

numbers of patients from the wards of Sainte-Eugénie in the late 1860s, the hospital began sending groups of patients to these locations and set up a monthly schedule to maximize the economy of transportation.<sup>331</sup> In April 1868, the first mass transport to Roche Guyon carried seven scrofulous children, and in September 1869, sixteen children admitted to Sainte-Eugénie were sent to Berck-sur-Mer the same day.<sup>332</sup> Between the months of March and October, caravans of patients traveled to convalescent centers outside the city, sometimes twice a month with up to forty children in a single trip.<sup>333</sup>

Figure 4.7 French and British Convalescent Homes: Forges-des-Bains (left) and Cromwell House (right)



Source: Armand Husson, *Étude sur les Hôpitaux* (Paris: Paul Dupont, 1862), plate 4; Archives of Great Ormond Street Hospital for Children (GOS), Press Clippings (right)

<sup>331</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, 1Q2/9-12, 1872-1880. Sainte-Eugénie patients also traveled to convalescent homes with transports from Enfants-Malades and Enfants-Assistés.

<sup>332</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, 1Q2/7-8, patients left for Roche Guyon on April 6, 1868; Berck patients left for Berck-sur-Mer on September 4, 1869.

<sup>333</sup> AP/HP, Sainte-Eugénie, Registres d'entrées, 1Q2/10. On November 17, 1875, 39 patients at Sainte-Eugénie sent to Berck-sur-Mer.

GOSH utilized several convalescent cottage hospitals, including a seaside home at Brighton, a country home at Mitcham, the Margate Infirmary, and numerous other homes all located outside of London.<sup>334</sup> Collectively, the transport of recovering GOSH patients to these convalescent homes increased “the utility of the hospital by relieving its ward of those patients who only require good air and good food, and that special medical treatment which the hospital provides.”<sup>335</sup> The first mention of a convalescent home was in the hospital’s annual report for 1855, which mentioned that Samaritan Funds defrayed patient transportation costs to “Brighton, where several convalescent children under the gratuitous care of a benevolent and munificent lady have enjoyed the benefit of sea air.”<sup>336</sup> Another home that GOSH frequently utilized was Rumbold’s Farm near Mitcham, noted for its “pure air,” and ability to ensure a recovery for those obliged to leave the children’s hospitals to make room for others, whose “recovery would be retarded, not to say rendered impossible, by a return to the close, unwholesome atmosphere of their own homes.”<sup>337</sup> Throughout the late 1850s and 1860s, increasing numbers of convalescing patients were shipped off for the dual goal of making more inpatient beds available and giving patients the chance for a more rapid and complete recovery. By 1866, GOSH subscribers purchased two beds at the Margate Infirmary for patients recovering from surgery, and during that year, twelve patients went to Margate, 25 to Brighton, 68 to Mitcham, 3 to Torquay, 3 to St. Andrew’s Home at Clewer, 2 to Rugely, and 5 to

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<sup>334</sup> GOS/1/1, GOSH annual reports between 1855 and 1867.

<sup>335</sup> GOS/1/1/13, *The Christian Times*, “Visits to Benevolent Institutions. No. IV. Hospital for Sick Children,” 44.

<sup>336</sup> GOS/1/1, GOSH 1855 Annual Report, 8.

<sup>337</sup> GOS/1/1/13, *The Christian Times*, “Visits to Benevolent Institutions,” No. IV. Hospital for Sick Children, 44.

Shepherd's Bush.<sup>338</sup> Ultimately, the value of the convalescent homes was so evident as to propel the hospital administrators to install their own convalescent hospital at Cromwell House in Highgate, just outside London in 1868 (see Fig. 4.7) A permanent branch of GOSH thereafter, Cromwell House served as convalescent home and sanatorium for patients that needed "fresh air more than medical skill to perfect their recovery."<sup>339</sup>

Although space at the children's hospital was at a premium, medical opinion, however, superseded all other considerations about the transport of patients from hospital ward to convalescent home. Doctors at Sainte-Eugénie and GOSH ultimately made the final determination. At the children's hospitals of Paris, the process of selecting patients for convalescent centers was state-mandated, but dependent on the decision of the attending physicians.<sup>340</sup> In theory, convalescent homes were useful appendages that facilitated greater quantity and quality of patient recoveries; in practice, the use of convalescent homes certainly allowed more numbers of child patients to enter both hospitals, but the success of these "recoveries" was likely overrated. Some GOSH and Sainte-Eugénie patients moved in and out of the main hospitals and their convalescent branches repeated numbers of times, suggesting that even if the patient achieved a "perfect" recovery, their success was soon marred again by another attack of the same chronic condition that led them to the hospital in the first place.

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<sup>338</sup> GOSH/1/1, GOSH 1866 Annual Report, 6.

<sup>339</sup> GOS/1/1, GOSH 1868 Annual Report, 6.

<sup>340</sup> AP/HP, APIJ1, Recueils des arrêtes, instructions, et circulaires de l'Assistance publique, Arrête No. 252, *Dispositions relative to the transport of patients to Forges-des-Bains* (April 8, 1854). This order stated that patient transfers to convalescent centers outside of Paris required parental consent and doctor authorization, whereby the doctor would designate which patients were eligible for transfer and provide documentation of the nature and degree of the patient's conditions at the time of departure to, and if applicable, return from, the convalescent home.

## Age Policies

Even before a patient was admitted to the children's hospital, his or her age was an important and pre-determining factor in whether or not the patient would be admitted for care. Since both Sainte-Eugénie and GOSH limited their patients to children within a specific age range, admissions of "underage" and "over-age" inpatients was a concern at both Paris and London children's hospitals. According to the official admission policies at both Sainte-Eugénie and GOSH, underage children, or children under the age of two years, and over-age children, over the age of fifteen at Sainte-Eugénie and over the age of ten (and later, twelve) at GOSH, were not permitted for treatment in the wards. As the hospital registers demonstrate, however, exceptions abounded, and especially in the case of underage applicants great discrepancies existed between recommended and real admissions by age category.

Concerns about underage and overage admissions appear more prominently in the London hospital records, suggesting that GOSH had more to lose if the hospital admitted too many infants. GOSH, reliant on charitable donors and subscribers, walked a fine line as it tried to balance its mission goals while satisfying the expectations of its watchful supporters. Saint -Eugénie did not face this consternation, although l'Assistance publique desired and praised "positive" medical statistics generated by each hospital in its network. Excessive numbers of infant deaths at Sainte-Eugénie would have reflected poorly on the Paris hospital administration, and pressure to generate medical successes was constant. Although funding was not dependant on certain percentages of survival rates, medical success was just as important as the economy of care for the reputation of

the children's hospital, particularly since the Paris children's hospitals were the European standard for comparison.

In his publication, *On Hospital Organization*, GOSH physician Charles West clearly laid out the stakes involved for children's hospitals if they admitted patients under the age of two (infants) and over the age of ten, with an emphasis on the problem with receiving infant patients.<sup>341</sup> In West's view, the limited understanding of infantile diseases was a key concern but more so was the risk involved in courting high infant mortality rates. Infants—here, meaning children below the age of two—were too young and demanded too much attention, and the nature of infantile diseases was either so acute or so chronic that in both cases, death was the likely result. West recognized that all these issues affected the reputation of the institution, leading him to conclude that for GOSH, “the good accomplished by their reception would be small, the cost immense, the scandal of the high death rate of which the public would not understand the reason, would be immense, too.”<sup>342</sup> For most of the nineteenth century, admitting too many “under twos” as inpatients was too great a gamble for this British hospital that relied on charitable gifts and support. In the 1880s, a noticeable shift in this line of thinking occurred, primarily due to a new generation of doctors and new advancements in the study of infant feeding methods. While some GOSH physicians continued to believe that the safest place to study infantile diseases without repercussions to the institution was in the out-patient

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<sup>341</sup> In this context, “infant” is defined as any children under the age of two. In other contexts, medical and non-medical alike, “infant” could designate children under the age of five, or in the style of some nineteenth century social reform writings, “infant” could serve as a very general term encompassing all children of school age.

<sup>342</sup> West, *On Hospital Organization*, 49.

department, others embraced the opportunities to study, observe, and treat infantile disorders in both inpatient and out-patient settings.<sup>343</sup>

In spite of, and in light of, all the concerns over infant mortality, the elusiveness of infantile diseases, and the inability to properly attend to their needs, the actual numbers of children that GOSH admitted who were under the age of two are striking. During its first twenty-five years (1852-1877), Great Ormond Street admitted a total of 2,291 patients just under the age of three (36 months or less), 555 of which were under the age of two (24 months or less). In the context of all hospital admissions during this period, these numbers provide insight into the actual breakdown of GOSH's relatively young patient population (see Fig. 4.8). One explanation for the relative abundance of one-year-old patients can be traced back to GOSH's tripartite mission, specifically its objective "to study the diseases of childhood," including those of infancy. As Charles West also noted in his manual on children's hospitals, "exceptional cases" of infants could be received "for medical or surgical reasons."<sup>344</sup> It would be tempting to conclude that all the "under two" admissions were exceptional cases, but upon closer consideration, GOSH physicians were adept at finding extraordinary value in almost any underage patient.

GOSH had other practical reasons to admit children who fell below the official age limit. Each year, the hospital accepted children under the age of two, but some unusual patterns provide clues about why the hospital bent the rules more during particular times. Certain years brought greater underage admissions, particularly during

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<sup>343</sup>Robert J. Lee, *Lectures Delivered at the Hospital for Sick Children, Great Ormond Street*. 2nd ed. (London: Baillière, Tindall, and Cox, 1885), 11; W. B. Cheadle, *On the Principles and Exact Conditions to be observed in the Artificial Feeding of Infants; the Properties of Artificial Foods; and the Diseases Which Arise From Faults of Diet in Early Life*. (London: Smith, Elder and Co, 1892).

<sup>344</sup>West, *On Hospital Organization*, 49.

the first ten years of the hospital when this category of patients comprised between five and ten percent of the total admissions (1852, 1854, 1857, and 1860) (see Fig 4.8). In the early years when the hospital was just getting off the ground, most governing members and doctors were more interested in garnering public support and local confidence in the institution than strict enforcement of the age limits. Complaints over small numbers of subscribing patients in the minutes of early GOSH Committee of Management suggest that low inpatient attendance was one reason for this subtle acquiescence. Without a de facto statement on relaxing the age requirements, exceptional admissions were made at the discretion of the medical staff, and “no child applying for admission to the hospital be rejected, until a reference has been made to some medical officer.”<sup>345</sup> With the decision left to the doctors, infants found their way into the GOSH wards; the physician’s commitment to saving lives and the promise of knowledge about infantile diseases made it difficult to turn away a sick infant. Some governors openly approved of the physicians’ choices and made positive notes about infant admissions in their inspection reports. Governor Owen noted that two infants admitted with very “sad cases of disease” appeared to be “nurtured and skillfully attended to by our medical officer.”<sup>346</sup> Other governors were less enthusiastic, such as Governor Bathurst, who complained that the hospital was in order except for “the admission within the last few days of three children under the age of two, and two of them eight months old and requiring very constant attention.”<sup>347</sup> Despite this ambivalence over the minimum age requirements, the pressure

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<sup>345</sup> GOS/1/2/4, Committee of Management Meeting minutes, January 26, 1854, 113.

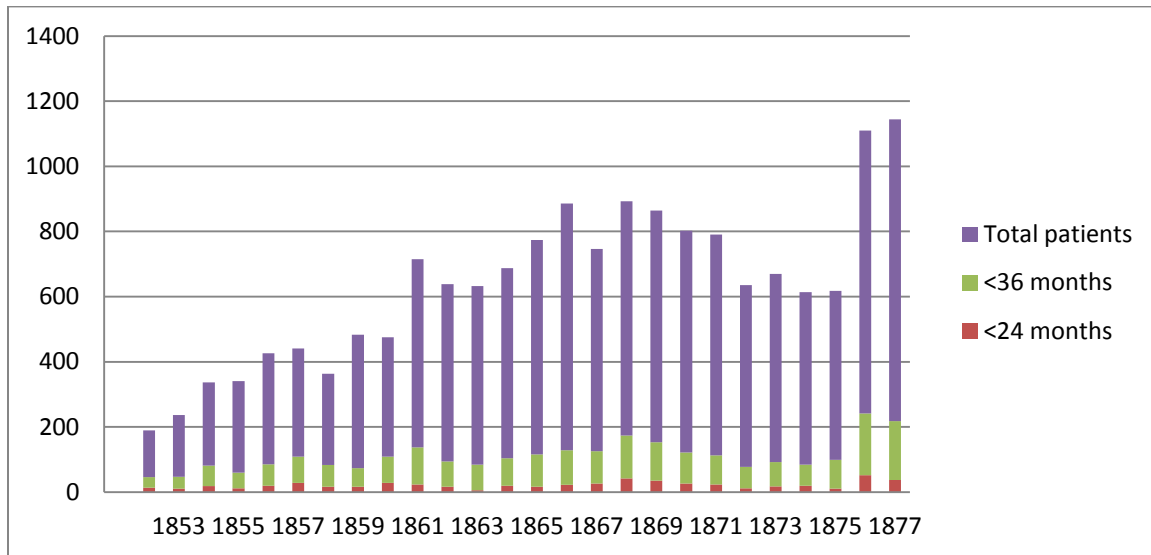
<sup>346</sup> GOS/7/2/1 Visiting Governor Report, July 4, 1856 (Owen).

<sup>347</sup> GOS/7/1/2 Visiting Governor Report, September 12, 1860 (Bathurst).



to have abundant numbers of patients to prove the institution's usefulness took precedence and led to GOSH's more forgiving approach to infant admissions.

Figure 4.8 Underage Patients at GOSH, by Age, 1852-1877



Source: Data collected from the Historic Hospital Admission Records Project (HHARP) database, (<http://www.hharp.org>), Kingston University.

Other factors stemming from events both inside and outside the hospital contributed to fewer or greater infant admissions at GOSH for particular years. In 1859, the steep decline in underage patients likely coincided with the opening of the adjoining infant nursery. Since the hospital frequently drew ranks from repeat outpatients, medical officers could channel borderline cases under the age of two from the GOSH outpatient department into the new infant nursery with less scrutiny than into the inpatient wards. Some children received at the infant nursery may have been in extremely poor health, as at least sixteen nursery attendees died during the service's operation, fourteen of which

were between the ages of one month to one year.<sup>348</sup> While the cause of death for these children are unknown, over half had their smallpox vaccinations and only two had a history of previous childhood diseases like measles or whooping cough, so the probability of them succumbing to a debilitating infantile medical condition such as diarrhea, convulsions, or failure to thrive is highly likely.

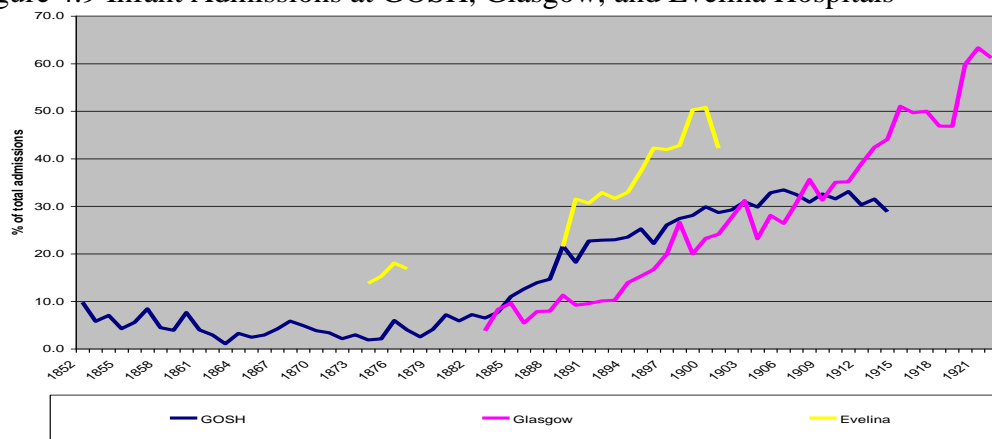
The years 1868 and 1869 also witnessed higher numbers of infant admissions, which may find some explanation in the national drama and rhetoric that unfolded during these years about infant mortality and the abuses of baby-farming (sending out pauper infants to commercial dry nurses). In these two years leading up to the 1870 Infant Protection Act regulating the commercial nursing industry, GOSH doctors, governor, and philanthropic subscribers undoubtedly felt some pressure to do their part in “saving” infants. If they perceived some of the youngest patients coming through GOSH’s outpatient and inpatient departments may end up in some baby-farming scheme, better to have the child in hospital than at risk of dying under the poor care of a baby-farmer. The national furor over baby-farming and its fatal consequences for the very young during the late 1860s and early 1870s influenced opinions about infant admissions at British children’s hospitals as the century progressed. As figure 4.9 shows, GOSH infant admissions steadily increased after 1879, reaching up to thirty percent or more of all patient admissions at the end of the century. Other children’s hospitals like Evelina in London and in Glasgow, Scotland, followed a similar trend shortly after their establishments in the 1880s. This burgeoning attention to infant mortality, combined with the opening of an improved and enlarged facility on November 19, 1875, permitted a

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<sup>348</sup> GOSH Infant Nursery Register, March 1859-June 1861. *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University.

sharp rise in infant admissions at GOSH during 1876 and 1877. The new edifice allowed for greater numbers of patients across every age group, so not surprisingly, GOSH received more children under the age of two to fill up the multiple wards. The annual report for 1875 reflects this new attitude in its praise for the new hospital building, “furnished with every modern appliance, for the alleviation of infantile diseases and suffering.”<sup>349</sup> In 1878, GOSH began to publish a series of medical statistics in each annual report, and the total number of infant admissions was a distinct category of yearly comparison, along with total numbers of inpatients, breakdowns of surgical and infectious cases, and a list of operations performed during each year.<sup>350</sup> This transparency regarding underage patients confirms a decisive break with the pre-existing prohibitions and signaled changing attitudes about infant admissions at the London children’s hospital, a shift that involved a combination of factors, including professional research desires, humanitarianism, and concentrated national concerns over infant mortality.

Figure 4.9 Infant Admissions at GOSH, Glasgow, and Evelina Hospitals



Source: [www. HHARP.org](http://www.HHARP.org), accessed September 30, 2014.

<sup>349</sup> GOS/1 Annual Report, 1875, 5.

<sup>350</sup> GOS/1 Annual Report, 1888, 19. This first medical report stated a comparison between the years 1877 and 1878.

Sainte-Eugénie's pool of underage children tells a different story. The Paris children's hospital admitted children under the age of two years old very sparingly, and the scarcity of infants in its wards remained consistent throughout this period. Out of a sample of 770 total patients, only fifteen children were under two years of age, and all but one of these patients was at least one year old.<sup>351</sup> Fourteen out of the twenty-two years included in the sample contained no underage admissions at all, and the fifteen examples were spread out over eight separate years. Its infrequent underage admissions suggests that the Paris children's hospital adhered to the age policy more closely than its London counterpart, but like GOSH, Sainte-Eugénie occasionally relaxed the rule when a medical or surgical emergency or an interesting case study presented itself. For example, about one-third of these patients had an urgent medical condition: two had diarrhea and dehydration, one had cholera, one had pneumonia, and one had a severe burn. Another three cases required an emergency surgery (tracheotomy) associated with the croup, which from a clinician's standpoint, was also an excellent opportunity to practice surgical techniques. The rest had non-life-threatening issues that posed some interest for clinical research, such as impetigo, eye infections, bone deformities, dentition problems, swelling, and general aches and pains.<sup>352</sup>

One of the clues to understanding Sainte-Eugénie's underage admissions can be found in the patient outcome ratio. Eleven out of fifteen patients under the age of two survived, while four patients died (the three croup patients, and the pneumonia patient).

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<sup>351</sup> AP/HP, Sainte-Eugénie registre d'entrées (1859). The hospital admitted one four-month-old patient named Paul Bouleroy from Belleville (#325) on February 7, 1859, with a diagnosis of *kératite* (inflammation of the eye, typically the cornea).

<sup>352</sup> AP/HP, Sainte-Eugénie registre d'entrées, 1858 (diarrhea); 1859 (croup operation, *kératite*, rickets); 1861 (teething problems, burn); 1863 (edema); 1864 (edema); 1865 (conjunctivitis, cholera); 1866 (pneumonia); 1868 (impetigo, curvature of the spine); 1873 (2 croup operations).

From a twenty-first century perspective, this survival rate is extremely low, even if one considers that oftentimes young children were brought to the hospital in a moribund state. In the middle of the nineteenth century, however, eleven successes out of fifteen was not a poor rate for this age category, especially in France where infant mortality rates for all children who were wet-nursed ran as high as fifty percent for some years due to the prevalence of the wet-nursing industry.<sup>353</sup> Sainte-Eugénie achieved a higher than average survival rate for its underage patients because it applied a strategy that balanced higher admissions with a low risk of death (eye and skin diseases, chronic conditions) and fewer admissions with a high risk of death (croup operations, severe acute conditions). This approach to underage age admissions permitted doctors to study infantile conditions, obtain clinical and surgical experience, and publish medical treatises on their patient cases without compromising the children's hospital's success rates.

### Over Age Patients

Adolescent children, or children between the ages of twelve and sixteen years, posed a different set of issues to children's hospitals, and Sainte-Eugénie and GOSH approached the issue with slightly different philosophies and policies. For both hospitals, considerations about upper age limits conflated medical knowledge with moral anxieties, in which ideas about the best methods to promote health and wellness were imbued with apprehensions about sexual morality, surveillance, and order. Although similar underlying principles guided the Paris and London children's hospitals in setting

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<sup>353</sup> George Sussman, *Selling Mother's Milk: The Wet-Nursing Business in France, 1715-1914* (Urbana: Illinois University Press, 1982).

maximum age limits for patients, these ideas translated into very different hospital policies.

Upper age limits emerged out of rational and ideological considerations during the hospital reforms of the French Revolution. As early as 1786, reformers Jacques-René Tenon and François de La Rochefoucauld-Liancourt surveyed the Paris hospitals and were horrified at the *mélange* of the ages and sexes in the same sick wards, or even worse, the same beds at Hôtel-Dieu, the main general hospital in Paris at the time, and at Pitié and Salpêtrière—two hospitals that accommodated youth of both sexes between the ages of six and eighteen. On a practical level, the indiscriminate mixing of children and adults in hospital wards was counterproductive to the healing process as children and adults passed contagious diseases ranging from smallpox to scabies among one another. Mixed wards also stimulated moralistic arguments, as reformers worried that too little supervision in the wards would taint the innocence of child patients. For them, a poorly monitored amalgamation of children and adults was dangerous, allowing “disorderly mores, characters, and behaviors to triumph over all paths of discipline and transforms a house of charity into a place of scandal.”<sup>354</sup> These separation principles have survived into the modern age, as adults and children continue to have separate wards in modern US and European hospitals. The solution to both quandaries, as determined by the Conseil Générale des Hôpitaux in 1802, was to create *Enfants-Malades*, a special institution reserved for sick children, defined as encompassing youth between the ages of two and fifteen years.

The two- to-fifteen-years-old age policy at *Enfants-Malades* extended to *Sainte-Eugénie* when the hospital was established in 1855. While occasionally the hospital

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<sup>354</sup> Husson, 125.

received patients over the age of fifteen, the liberal policy provoked little need to bend the rules. The Sainte-Eugénie sample from 1856-1876 contained only five cases of patients over the age of fifteen, and three of these cases did not involve an acute illness: one young man was diagnosed with arthritis of the hand, one young woman with amenorrhea (cease of menstrual cycle), and another young woman with hysteria.<sup>355</sup> These patients suffered from medical conditions that likely generated a greater sense of curiosity than urgency to an admitting physician, especially the young women's conditions, and their admissions justified by the need for an advancement of specific medical knowledge.

In contrast, GOSH's maximum age for patients was far more circumscribed and less static over time. At the time of the hospital's establishment, GOSH's governing board set the maximum age limit at ten years old. Similar to Sainte-Eugénie's example, the justifications for this age limit encompassed medical and moral positions. From a strictly medical view, GOSH founding physician Charles West firmly believed that diseases experienced by children over the age of ten or twelve resembled the nature of adult diseases more so than childhood diseases, therefore they belonged in the wards of the general hospitals.<sup>356</sup> Other arguments revolved around moral anxieties and a fear of working-class children's promiscuity. Admitting children who were just entering or had already entered puberty ran the risk of contaminating the younger, supposedly more innocent children and making it difficult to maintain "the purity of the moral

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<sup>355</sup> AP/HP, Sainte-Eugénie registre d'entrées, 1857 (Marie Vignet, 16, amenorrhea); 1859 (Eugene Noel, age 16, arthritis); 1860 (Maria Vienne, 16, hysteria). Sainte-Eugénie also admitted two other 16-year-olds: Louise Loppe on August 4, 1855, with hydroarthrose, and Clemence Voisenat on January 19, 1863, with bronchitis.

<sup>356</sup> West, *On Hospital Organization*, 49.

atmosphere.”<sup>357</sup> Older patients who allegedly masturbated were a nightmare for hospital staff, as this “peculiarity of habit” rendered it necessary that “Strict Watch should be kept on them.”<sup>358</sup> At GOSH, one fifteen-year-old patient would leave his bed to complete his ritual in the ward, until he was detected and secured to the bed.<sup>359</sup> Although rarely stated in the sources, older children such as apprentices who were on their own, children who were used to fending for themselves or caring for siblings, and child laborers might resent authority and present behavior issues.

In 1877 GOSH raised the maximum age to twelve years of age, by recommendation of the medical committee.<sup>360</sup> However, servicing twelve-year-olds was not entirely new to the children’s hospital. Since its beginning, the outpatient department saw children up to twelve years old on a routine basis. After twenty-five years in existence, this alteration of the age rule for inpatient services indicates the London hospital’s willingness to re-evaluate previous policies and make changes in accordance with lessons learned through of years of experience and observation about the nature of children’s diseases. More than simply a medical epiphany, an expansion of the upper age threshold was a dynamic, but delayed response to the real needs of London’s sick, poor children who, considering the chronic nature of many of their medical conditions, endured the same ills at age ten as at age twelve. Perhaps hospitals governors and

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<sup>357</sup> Ibid., 50.

<sup>358</sup> Ibid.

<sup>359</sup> *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University, Case Notes, Harry Harries, admitted April 28, 1861. This is the only record of this practice that I have found any children’s hospital.

<sup>360</sup> GOS/1/1, GOSH Annual Report 1877, 6.



physicians needed over two decades of direct day-to-day experience to relinquish some of their fears about the depravity of working-class children.

Despite clear cut rules about age and admission, Sainte-Eugénie and GOSH both admitted under-age and over-age patients, and not sparingly. Nineteenth-century children's hospitals had good reason to set age parameters, particularly when it came to infants. At mid-century, physician's inadequate understanding of infantile diseases limited their field of action in treating them, leading many to simply send any child under the age of two to outpatient care or the dispensaries. As late as 1885, GOSH physician Robert Lee wrote, "At this hospital, for good reasons, children less than two years of age are not generally admitted, so that the diseases of infancy proper must be studied in the out-patient department."<sup>361</sup> Doctors were ill-equipped to deal with medical conditions that commonly attacked children in the first years of life such as severe diarrhea or congenital defects. Losing such high numbers of patients would severely compromise the effectiveness of a children's hospital and high infant mortality rates would associate the institution with highly criticized aspects of the foundling homes of Paris and London.<sup>362</sup>

#### Medical Authority and Its Limits: Doctors at Saint-Eugénie and GOSH

The desires and demands of the medical personnel and hospital administration were not always in harmony at the children's hospital. Sometimes medical staff desires were eclipsed by the administrative powers; other times, doctors and surgeons willfully

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<sup>361</sup> Robert J. Lee, *Lectures Delivered at the Hospital for Sick Children, Great Ormond Street*, 2<sup>nd</sup> ed. (London: Baillière, Tinnall, and Cox, 1885), 11.

<sup>362</sup> Elizabeth Lomax, *Small and Special: The development of hospitals for children in Victorian Britain* (London: Wellcome Institute for the History of Medicine, 1996), 21. Enfants-Malades also came under attack for high mortality rates prior to improvements made after 1850.

disregarded administrative policies. In the French system, special committees created by l'Assistance publique determined the types and quantities of medical instruments provided to the general and specialized hospitals and handled applications for additions or replacements.<sup>363</sup> Sainte-Eugénie's requests were occasionally turned down because the equipment was deemed too expensive or unnecessary. For example, at least three requests by their physicians for *sphygmographes de Marey* were routinely denied between 1868 and 1873. The sphygmograph, designed and patented in 1860 by Etienne-Jules Marey, was the first portable device that recorded blood pressure. In 1868, when Dr. Barthez and Dr. Bergeron demanded one medical instrument for each doctor's professional use, their appeal was denied with a statement that they could borrow the device from l'hôpital Saint-Antoine. Apparently the administration did not fully grasp the utility of the sphygmograph because a few years later in 1873, another application for the same device was denied because the cost was too prohibitive at 130 francs.<sup>364</sup> Continued requests from doctors and surgeons for better tools could lead to investigations on the practicality of requested items. For example in 1874, l'Assistance publique formed a special commission to review new instruments and remedies and offer recommendations. While the summons of a new commission suggests the administration's recognition of the value of new technological advancements, chances are that budgetary considerations were the greatest priority.<sup>365</sup>

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<sup>363</sup> AP/HP, 9L154/5 Administration and Reglementation, 9 novembre 1864, a letter from the Director of l'Assistance publique to the Director of Sainte-Eugénie authorized a standardized list of materials to be included in the kits for general surgeries (*vitrines*) and autopsies (*boites aux autopsies*) provided to the children's hospitals.

<sup>364</sup> AP/HP, 9L154/5. Letters from l'Assistance publique to the Director of Sainte-Eugénie on March 23, 1868, pertaining to Barthez's and Bergeron's requests and January 27, 1873, pertaining to Dr. See's request.

At the Paris children's hospital, doctors and surgeons had little to do with the admissions process, which was in the hands of the hospital administrators under the purview of l'Assistance publique de Paris. When they did step outside the boundaries, they might be chastised. For example, when four-year-old Adele Girard was admitted from outside the department of the Seine with a diagnosis of scrofula, and her family was unable to continue with the payments, l'Assistance publique asked why the patient was given a place "*on the recommendation of a doctor when the child does not have an acute disease?*" (Source emphasis).<sup>366</sup> This question was pertinent because her admission doubly breached the children's hospital policies. As an *étrangère*, she needed the consent of the director of l'Assistance publique prior to her admission. Furthermore, the young patient had a chronic, non-life-threatening condition; if her medical situation was urgent or involved an emergency surgery to save the young girl's life, circumstances would have allowed for an exceptional admission without question. L'Assistance publique's emphasis on the doctor's involvement in this admissions fiasco represents the administration's attempt to draw clear boundaries between the responsibilities of l'Assistance publique and the hospital's medical staff and to rein medical staff from overstepping their bounds.

At GOSH, the medical staff had an equal say in the children's hospital's administration, due to the joint committee structure of governance that divided power

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<sup>365</sup> AP/HP, 9L154/5. Circulaire de 15 July 1874. L'Assistance publique to Paris hospital directors announced the formation of a new "commission de médicaments and remèdes nouveau."

<sup>366</sup> AP/HP, 9L 155, n. d. Letter between l'Assistance publique to director of Sainte-Eugénie mentioned a date of admission, September 10, 1856, and cross-referencing this letter to the admissions register for 1856, this patient appeared to be Adele Girard, the daughter of Pierre and Eugénie Girard from Bercy. The father was a painter. The young patient was admitted with a skin disorder (*dartres*, likely a glandular swelling on the side of her neck due to tuberculosis) and placed in Ward Rosalie, bed 26, as a paying patient on September 10, 1856, and stayed for 39 days, released on October 19.

between a Medical Committee and a Management Committee. Comprised mostly of individuals without a medical background, the Management Committee was the more pragmatic and budget-minded arm of the organization, while the Medical Committee was more idealistic and pushed the envelope for more equipment and space. As a voluntary hospital, budgetary concerns were always an issue, especially in the first few years of the establishment, personal investments on behalf of certain committee members helped ease the divide. With the correct assumption that the Management would not approve certain “luxury” articles, Charles West personally purchased several items for the children’s hospital out of his own pocket, including a go-cart and a hot air bath.<sup>367</sup> When it came to hospital maintenance or the addition of space, the Management Committee often had to reel in the medical staff’s requests. At a joint committee meeting in 1854, several logistical barriers to medical services demanded attention, and when the medical committee urged a larger outpatient ward and the construction of a separate fever ward, the Management Committee committed to doing the least expensive option and tabled the fever ward.<sup>368</sup>

In theory, GOSH doctors also had an equal say with the administration in admissions to the hospital, and their level of authority in this realm appears to have exceeded other non-medical colleagues. In questionable admission cases the attending physician or surgeon had the final say, even if a patient could not provide a subscriber letter. Numerous entries in the GOSH register between 1852 and 1877 confirm that attending doctors were quite liberal in admitting patients. If the hospital had a bed, children were not likely to be turned away if a member of the medical staff had a say.

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<sup>367</sup> GOS/1/2/1 Minutes of the Committee of Management, Vol. 1. October 28, 1852, 198.

<sup>368</sup> GOS/1/2/1 Minutes of the Committee of Management, Vol. 2. December 1, 1854, 216.

Even if the diagnosis was not an acute condition or if the patient was under the hospital's age limit, doctors would admit the child and deal with the consequences, which usually was a disgruntled or concerned comment from a visiting governor about too many infants on the ward or suspicious fever cases.<sup>369</sup> Other doctor-initiated admissions occurred in the GOSH outpatient department, when the attending doctors identified patients in need of pressing medical care or surgery. If the parent or guardian conceded, which was not always the case, the child was immediately placed in the appropriate inpatient ward. Conversely, if a family or friend came to the hospital seeking inpatient care for a child who did not have an acute medical condition, the medical staff might direct them to the outpatient department instead.<sup>370</sup> With or without a subscriber's letter, the doctors had the right to reserve hospital beds for the patients that, from a medical perspective, needed them the most.

## Summary

At mid-century, children's hospitals of Paris and London served similar patient populations within comparable, changing urban landscapes. To address the varying, often chronic medical conditions of their patients, GOSH and Sainte-Eugénie operations required multiple layers of categorization and organization, and in establishing policies and procedures to meet those needs, more similarities between the two institutions exist

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<sup>369</sup> GOS/2/7/2 Visiting Governor's Reports, November 2, 1854 (children admitted with fever); September 12, 1860, and December 9, 1867 (infant admissions).

<sup>370</sup> GOSH kept a separate register of those refused admission to the hospital. No information is available for the years of this study, but the register from 1881 to 1892 survives. Out of a sample of 200 refusals, 84 children (42%) were referred to the outpatient ward. Another 76 children (38%) were listed as unsuitable, but with no reason given; some of these children may have also been referred as an outpatient. *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University, data sample available at: <http://hharp.org/library/gosh/general/refused-admissions.html>, accessed September 5, 2014.

than differences. Their separation principles based on gender and medical condition were pragmatic and scientifically justified, and while they contributed to the efficient and successful operation of each hospital, these principles also involved moralistic ideological underpinnings. As the numbers of patients increased over time, both hospitals took similar measures to increase space, efficiency, and medical success. To administrators, sending children to special institutions to convalesce was necessary to make room for other patients, but equally as important, discharge to a convalescent home was medically expedient for the health of the patient. Many physicians and hospital administrators knew that the longer a child was allowed to convalesce in a healthy environment with clean air, rest, and proper nutrition, the better chance of recovery.

GOSH and Sainte-Eugénie hospital policies, however, were never written in stone. Doctors and administrators sometimes came into conflict, the former privileging decisions based on professional growth, medical knowledge, and the best medical options for the patient, while administrators often prioritized the health of hospital operations and the future success of the children's hospital over other considerations. In both settings, hospital policies were dynamic and changed over time, as the flow of new patients into these institutions required administrators and doctors to create new or revise former practices and policies. As the next chapter demonstrates, patient families also shaped the London and Paris children's hospitals in significant ways.

## CHAPTER 6

### PATIENTS, FAMILIES, AND CHILDREN'S HOSPITALS: AUTHORITY, CHOICE, AND NEGOTIATION

During the 1850s, the emergence of two new children's hospitals in France and Great Britain constituted one attempt to address the rising concerns of childhood health, ill-health, and mortality. While the drive to construct new children's hospitals like Sainte-Eugénie and GOSH was led by doctors, social reformers, and government figures, no story of this process would be complete without also intimately examining the patients and families served by these institutions and their interactions with the children's hospital administrators, doctors and other medical staff, and volunteers. While French and British children's hospitals invariably impacted the lives of their patients—for better or worse—patients and their families also shaped the life course of the nineteenth-century children's hospital in terms of policy and administration, the accrual of medical knowledge, and a greater understanding of and ability to meet the needs of its clientele. As this chapter demonstrates, some patients and family members were not passive recipients of charitable aid at either the Paris or London children's hospitals, but rather, active agents in the evolving systems of specialized children's health care in both countries.

A common critique of the history of childhood is that children's experiences are only refracted through the lens of adult observers; however, it would be a mistake to overlook or underestimate the value of children's hospital records and their ability to provide a glimpse into the lived experiences of patients and their families.<sup>371</sup> In recent

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<sup>371</sup> Hugh Cunningham, *Children and Childhood in Western Society since 1550*, 2nd ed. (New York: Longman, 1995). 2-4.

decades, histories on European and American foundling homes and orphanages show the wealth of information available through institutional records about children and families.<sup>372</sup> The complex interactions between children's hospitals, patients, and their families have received less attention, except for Andrea Tanner's work on family authority and choice at Great Ormond Street hospital between 1855 and 1900.<sup>373</sup> Reading between the lines of admission records, doctor case notes, administrative reports, and communiqués reveals a great deal about patients and their families that goes beyond vital statistics, and nuggets of information within GOSH'S and Sainte-Eugénie's hospital records document how mothers, fathers, and patients, hospital staff, and government public health officials interacted with one another. A comparison of patient and family experiences at these children's hospitals display how family members on both sides of the English Channel figured out their available options, made their own choices, and exercised authority in the face of stern yet still malleable policies and regulations.

According to their general missions, the children's hospitals in Paris and London aimed to improve the health of the capital's poorest, ailing children. A close examination

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<sup>372</sup> The historical and demographic literature on foundling homes, orphanages, and other charitable institutions for poor or abandoned children is immense. A few works stand out in their attention to the experiences of foundlings, orphans and abandoned children and their families and their interactions with the welfare institutions that provided care for children. For the early modern Europe, see Thomas Max Safley, *Children of the Laboring Poor: Expectation and Experience among the Orphans of Early Modern Augsburg* (Boston: Brill, 2005). For eighteenth and nineteenth century Europe, see Rachel G. Fuchs, *Abandoned Children: Foundlings and Child Welfare in Nineteenth-Century France* (Albany: State University of New York Press, 1984); David I. Kertzer, Heather Koball, and Michael J. White. "Growing Up as an Abandoned Child in Nineteenth-Century Italy." *Journal of Family History* 2, 3 (1997): 211 – 29; Alysa Levene, *Childcare, health and mortality at the London Foundling Hospital, 1741–1800: 'Left to the mercy of the world,'* (Manchester: Manchester University Press, 2007); Lydia Murdoch, *Imagined Orphans: Poor Families, Child Welfare, and Contested Citizenship in London*, (New Brunswick, NJ: Rutgers University Press, 2006); and Joan Sherwood, *Poverty in Eighteenth-Century Spain: The Women and Children of the Inclusa* (Toronto: University of Toronto Press, 1988).

<sup>373</sup> Andrea Tanner, "Choice and the children's hospital: Great Ormond Street Hospital patients and their families, 1855-1900," in *Medicine, Charity and Mutual Aid: the Consumption of Health in Britain, c. 1550-1950*, 135-161. Anne Borsay and Peter Shapely, eds. (London: Ashgate, 2007). Some of my work overlaps with Tanner's, but her examination was not comparative.



of GOSH and Sainte-Eugénie hospital records, however, also affords a much more nuanced view of their patient populations. During the first twenty-five years of their establishment (1852–1877) both hospitals housed a broad range of children with diverse conditions and hospital experiences, challenging a monolithic image of the “poor, sick child” in the second half of the nineteenth century. While the poor children from the city certainly received a lion’s share of attention from doctors, government officials, and social reformers, not all the patients and families who accessed these children’s hospitals were completely destitute nor were they simply passive beneficiaries of medical care.<sup>374</sup> Paying patients did exist at both children’s hospitals, but in varying degrees and forms, and payment was a source of concern for the patient families and guardians, as well as these institutions. From a medical standpoint, social position, economic circumstances, and environmental factors undoubtedly influenced a child’s chance of contracting specific diseases or developing certain medical conditions as well as affecting the probability of a partial or full recovery. Yet other related factors—the age of the patient, family choices, hospital-client relations, and the limited understanding about children’s diseases at this time—also played determining roles in the final outcome of these young patients. Some poor children showed remarkable resilience, and some diseases touched all classes of children, regardless of their family’s social position.

Comparing French and British child patients and their families raises important questions about specialized medical care for children in these two European capitals during this period, such as how young patient experiences matched up with the “official” administrative perception of these young hospital wards, the nature of parent involvement

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<sup>374</sup>See Tanner, and other essays in *Medicine, Charity and Mutual Aid: the Consumption of Health in Britain, c. 1550-1950*, 135-161. Anne Borsay and Peter Shapely, eds. (London: Ashgate, 2007).

in a child's treatment, and how experience and family circumstances might this affect a child's medical outcome. This type of comparison also underscores the socioeconomic factors that influenced the specific medical conditions of these children and the extent to which childhood diseases were an equalizing force among child hospital populations. Comparing information gleaned from these children's hospitals in London and Paris also reveals the complex ways that patients shaped the hospital settings that took them in. Hospital directors, physicians, and volunteers took great pains to mold Sainte-Eugénie and Great Ormond Street according to their standards of hospital organization and quality medical care, yet the records show that the human element intrinsic to the hospital experience produced change, compromise, and sometimes conflict.

#### Patient Eligibility and Family Choices: The Paris Example

The hospitals of Paris were considered pillars of social medicine, and Parisian children's hospitals were building blocks for the "improvement of society through medicine" by providing medical services to its youngest and most needy residents.<sup>375</sup> In the view of the state's public assistance administration, access to medical care in the capital's hospital system was a right (*droit*) for the neediest residents of the department, children included.<sup>376</sup> In theory, individuals were eligible for free medical care within the Paris hospital network if two key conditions were met: first, they needed to provide proof

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<sup>375</sup> S. Borsa and C.-R. Michel, *Des Hôpitaux en France au XIX<sup>e</sup> siècle* (Hachette, 1985), 69-72. The term "social medicine" was introduced by Jules Guérin in the *Gazette Médicale de Paris* on March 3, 1848, but the idea of improving society through medicine—the goal of public health—long preceded the word, as George Rosen and Dorothy Porter have emphasized in their global histories of public health. For the connection between puericulture, public health and hygiene, and medicine, see Pierre Huard and Robert La Plane, *Historie illustrée de la puériculture: aspects diététiques, socioculturels et ethnologique* (Paris, Roger Dacosta, 1979).

<sup>376</sup> Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP), 9L 154, L'Assistance publique, Circulaire 14 mai 1856.

of their indigence, or inability to pay for medical services; and second, the individuals needed to live within the boundaries the Department of the Seine (essentially the city of Paris, and after 1860, Paris and its suburbs) at the time of admission. Given a policy approach based on locality and need, a parent's or guardian's ability to secure admissions for their child at Sainte-Eugénie boiled down geographic and financial eligibility. In a sample of 770 children at this hospital, approximately 95 percent of the patients fit both eligibility requirements and received gratuitous care through public assistance due to their residential information and socioeconomic status, thus confirming an impression of the children's hospital as "*l'asile de misère*," the refuge of Paris's most impoverished child population.<sup>377</sup>

The other five percent of patients, however, did not fit these conditions. Since not all patients were Parisian nor were all completely destitute, the administration of l'Assistance publique distinguished between two sets of "exceptional" patient categories: paying (*malades payants/payantes*) and non-paying patients, and residents and non-residents (*étrangers*).<sup>378</sup> Patients fell into the *payant/payante* category if their families had the funds to partially or fully pay for the hospital's services, while others fell into the *étranger* category because they were not residents of the Department of the Seine.<sup>379</sup> These two categories always overlapped when the patient was not a resident of Paris. Lacking the "right" to free hospital care, non-residents seeking admission at any Paris hospital needed to provide proof to l'Assistance publique of their ability to pay for

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<sup>377</sup>Luc Passion and Michel Sorin, "L'Invention du patient: l'hôpital et l'enfant à Paris au XIX siècle," 191-200. In *Les Maux et les soins: médecins et maladies dans les hôpitaux parisiens au XIX siècle*, eds. Francis Demier et Claire Barille (Paris: Action Artistique, 2007), 193. Out of 770 patient register entries, 738 indicated that the patient resided in the Department of the Seine and did not include mention of payment.

<sup>378</sup>AP/HP 9L 154. L'Assistance publique, Circulaire de 19 mars 1855.

<sup>379</sup>AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, SAINTEEUGÉNIE (1Q 2/1-1Q 2/11), 1855-1876.

medical care in order to obtain written consent for admission, and so all admitted non-residents were paying patients.<sup>380</sup> The following communiqué exemplifies this administrative attitude: l'Assistance publique notified Sainte-Eugénie that if the Delambardy family, who lived in an unnamed place in the country (*campagne*), could not pay the daily rate (*prix de journée*) for the full eight days due, her young daughter would be sent back, “considering that she occupied a place that should be given to the indigent children of Paris.”<sup>381</sup>

With the intention of channeling Parisian public assistance dollars for the care of Parisians only, this guiding principle was enforced, but not entirely set in stone. In children's hospitals, humanitarianism could overrule doctrinaire regulations. In cases of extreme urgency or special cases that “absolutely require turning to the talent of the medical practitioners of the capital,” non-resident children could be admitted to a Paris hospital as long as l'Assistance publique was involved and maintained a close eye on those situations.<sup>382</sup> Due to these policies, paying patients and their families—resident and non-resident (*étranger*) alike—constituted one of the most vociferous groups at the children's hospitals. Negotiations about monetary payment (*versement*), non-resident admittance, or both generated a paper trail on many of these exceptional patients that demonstrate the abilities of some families to effectively navigate through the French children's hospital system.

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<sup>380</sup> AP/HP, 9L 154, L'Assistance publique, Circulaire 14 mai 1856.

<sup>381</sup> AP/HP, 9L 155, Letter from l'Assistance publique to Sainte-Eugénie, May 18, 1871.

<sup>382</sup> AP/HP, 9L 154, Circulaire de 19 mars 1855.

## Resident Paying Patients (*Malades Payants*)

Paying patients who resided in the Department of the Seine comprised the majority of exceptional patient admissions. Their experiences varied due to complex factors involved in determining hospital costs and family contributions, but their common residency in Paris or some other area encompassed within the Department of the Seine bound them together as an administrative category. Out of the 43 paying patients identified in the Sainte-Eugénie register, a majority were part of Parisian families headed by a male breadwinner who worked in small business or had a skilled trade.<sup>383</sup> Some of these families sought and paid for care at the children's hospital because they could not afford a private physician but made too much money to qualify for gratuitous care. This situation was likely the case for Henri Bission, son of a jeweler (*bijoutier*), admitted to Sainte-Eugénie in 1869 with a fracture, or Josèphe Thurot, son of a *maitre d'hôtel*, admitted with water on the knee (hydroarthrosis) in 1876. In other cases, collective family member earnings accumulated through unskilled or temporary work or income from unpredictable artistic trades may have pushed them just over the line to qualify for indigence. For example, in the Poinot family, the patient's father worked as a painter, his mother worked as a florist, and two other members at the residence were employed, yet

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<sup>383</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, SAINTEEUGÉNIE (1Q 2/1-1Q 2/11), 1855-1876. Of 43 paying patients in the study sample, the majority came from households headed a merchant (5), skilled worker such as such as a cobbler (1), tin worker (1), carpenter (1), jewelers (2), locksmith (1), carter (1), mechanic (1), costume maker (1), or joiner (1), or skilled artist like an actor (2), painter (2), or sculptor (1). Other households were headed by less-skilled, but gainfully employed, positions as a milkman (1), coachman (1), and cashier (1), box assembler (1), rock cutter (1) and shoe polisher (1), or in food and hotel service (4). Non-skilled workers designated by terms like *ouvrier*, *journalier*, or *employé* (8) comprised less than one-fifth of the total, while another four patient entries listed no parent occupation.

the family paid a reduced rate of twenty francs per month for their son's hospital stay at Sainte-Eugénie.<sup>384</sup>

For some Parisian families, money was not the main issue; the child's affliction was. Children with some acute conditions required surgical attention that only a hospital surgeon could provide. This situation was especially evident in cases of the croup, one of the most common respiratory illnesses noted in hospital registers, and prior to antibiotics and immunizations, one of the deadliest. Croup involved a severe inflammation of the larynx and the trachea, but most severe cases designated as croup were most likely associated with diphtheria. These "croup" patients often had so much difficulty breathing that doctors often performed tracheotomies on these children to open their air passages. Seven of the 43 paying patients underwent croup operations, which were typically last-minute desperate measures to save the child's life. The probability of a child surviving this operation was about fifty-fifty, and in this sample, three out of the seven made a full recovery. Socioeconomics had little to do with whether or not a child survived this type of invasive operation; children of wine merchants (3) fared no better or worse than those of cashiers (1), artists (2), or unskilled workers (1).<sup>385</sup> For the Scheppe and de Bardel families, convulsions associated with chorea—now known to be symptoms of a wide range of nervous disorders—led them to Sainte-Eugénie, but the amount of their household earnings had no bearing on the success or failure of this little-understood

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<sup>384</sup> AP/HP, 9L 155, Letter from l'Assistance publique to the hospital director of Sainte-Eugénie, June 28, 1858.

<sup>385</sup> These occupations roughly constituted a similar working-class socioeconomic stratum; however, Armand Husson's published works on working-class and indigent occupations in Paris distinguished between thirteen occupational categories ranging from industrial jobs to small shop workers and domestic servants to rag pickers, and he subdivided certain categories according to occupations with high, medium, and low wages. According to Husson's scheme, merchants and artists had a higher income potential than cashiers or unskilled workers. See Archives de Paris (AP), Husson Collection, D6Z/3, Tableau synoptique des professions, no. 2. n.d.

disease at the time.<sup>386</sup> In situations like these, certain medical conditions exerted an equalizing force on families, regardless of their socioeconomic status.

### Non-Resident *Malades Payants*

Due to a small, but steady stream of paying patients from Paris, little discretionary ward space was left open for paying patients from outside the Department of the Seine (*étrangers*). Admissions of *étrangers* recorded in the Sainte-Eugénie registers were much rarer, and in the words of Parisian public assistance administrators, *authorisations exceptionnelles*. Throughout the sample entries for this study, only three *étrangers* appeared, two of which involved twin sisters from Santiago, Cuba.<sup>387</sup> Looking beyond the register sample, a cache of nearly sixty letters about paying patients from l'Assistance publique to the hospital's directors between the years 1855 and 1880 reveals at least another sixteen children from other regions of France, including one of her African colonies, entered Sainte-Eugénie with l'Assistance publique's consent. The small number of non-residents that actually made it into the children's hospital's doors demonstrates the vigilance and success of the exclusionary policy, which also extended to the convalescent hospitals that exclusively served Paris children, like Berck-sur-Mer, as well as adult hospitals and houses of refuge within the capital city.<sup>388</sup> Yet, since over a quarter of the surviving letters about paying patients during this period involved out-of domicile

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<sup>386</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1865-1867 (SAINTEEUGÉNIE 1Q 2/6), entries #338 (Gustave Scheppe) and #722 (Gustave de Bardel).

<sup>387</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1865-1867 (SAINTEEUGÉNIE 1Q 2/6) entries #289 and #290, Lucie and Lucette Galland (twins) admitted for impetigo on February 2, 1866. The other non-resident was Clarise Beauvallet, daughter of a farmer from Loiret, admitted with eye disease on November 17, 1861, entry # 2517, SAINTEEUGÉNIE (1Q 2/4).

<sup>388</sup> AP/HP, Recuiles des arrêtes, instructions, et circulaires de l'Assistance publique, AP1J5, Circulaire de 19 juillet 1873.

situations suggests that while exceptional, the Paris hospital administration was no stranger to these types of requests.

The nature of the disease was the greatest determining factor for non-resident families seeking admission for their children at Sainte-Eugénie. For the three *étranger* patients in the register sample, all three had some type of non-life-threatening but virulent condition that required some type of specialized medical knowledge and treatment. Two of the cases involved twin sisters suffering from impetigo, a contagious skin disease, and the other patient was afflicted with either an eye infection or eye disease. Admission of these non-resident children was a win-win situation for both Sainte-Eugénie and the patient's families. Eye and skin conditions afforded the doctors of the children's hospital an opportunity to observe and treat a "specialty disease" (without great risk of death) while allowing the patients some chance of relief that their local doctors—in these cases, in Cuba and in Loiret—had little knowledge to treat effectively. Letters about the exceptional admission and gratuitous maintenance of *étrangers* that circulated between l'Assistance publique and Sainte-Eugénie between 1855 and 1880 also specifically mentioned diseases of the eyes and skin. In one particularly unusual case, the administration authorized a hospital examination for one young patient recently arrived from Africa with a "malady of the eye."<sup>389</sup> Upon the advice of the examining physician, the young girl did not return to Africa—where she probably contracted the eye condition—but remained at Sainte- Eugénie for treatment.

Other exceptional non-resident admissions involved special medical attention that only the hospital setting could provide: surgical procedures. The types of surgeries that

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<sup>389</sup> AP/HP 9L 155, letter from l'Assistance publique to M. de Brezin, Directeur de l'hôpital de Sainte-Eugénie, 11 March 1863, regarding the admission of Pauline Marie Guindrange.



attracted *étranger* patients to Sainte-Eugénie included operations to correct or ameliorate congenital conditions such as club feet (*pieds bots*) and cleft lips and palates, the removal of tumors, and other specialty operations. Particularly for families living in communes and department immediately surrounding the Seine, the opportunity for their children to have corrective surgeries outweighed the costs and efforts involved in seeking admission at one of the children's hospitals in Paris. Local family doctors, many of whom were trained in Paris and were aware of the capacity and capability of the children's hospitals in the metropolis, recommended this option to some parents and family members. Dr. Marjolin, Sainte-Eugénie's main surgeon, was the most commonly recommended doctor for specialty surgeries, and local doctors probably recommended the surgeon to the local public assistance bureau and asked that they add his request to their petition to l'Assistance publique.<sup>390</sup>

The following examples from Sainte-Eugénie show how some non-resident parents took the lead in obtaining health care for their child in this type of situation. In April 1874, a nine-year-old girl named Celine Jolly, the daughter of farmers from Seine-et-Oise, entered the children's hospital for surgery on her club feet. The Jolly family had either petitioned their local bureau of public assistance or wrote directly to the l'Assistance publique to acquire the authorization for their daughter—who was not a resident of Paris—to gain admission to the hospital. Either way, Charles Blondel, who succeeded Armand Husson as the director of l'Assistance publique, authorized her admission in a letter to the hospital director at Sainte-Eugénie, and Celine traveled between twenty and thirty miles with a family member to Paris in order to obtain the

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<sup>390</sup> AP/HP, 9L 155, letter from l'Assistance publique to Directeur de l'hôpital Sainte-Eugénie, 11 janvier 1869. In this letter, l'Assistance publique allowed special admission to a child from Marne for a specialty operation and informed the hospital that the child would be placed in the care of Dr. Marjolin.

operation. Some patients traveled even further, such as a young boy from Confolens, Charente, in the southwestern region of France, affected with a cleft lip (*bec de lièvre*) as well as a cleft palate (*division de voute palatine*). The child's local doctor in Confolens sought out the administration and requested the specialty surgery in Paris, which l'Assistance publique de Paris granted.<sup>391</sup> The families of these patients made the effort because only major urban children's hospitals offered these surgeries, and at the time, Sainte-Eugénie was the newest, best equipped, and best staffed out of all the options.

The equivalent of five percent (one or two per yearly sample of thirty-five), the annual number of paying patients—both Parisian and *étranger*—was small, but significant, considering that Sainte-Eugénie took in an average of almost 3,000 patients per year between 1855 and 1875. Their presence at all raises some important points about the exceptional patients and their families at the children's hospitals. Regardless of the state's residential and financial guidelines, some French family members figured out how to maneuver through the red tape of the Paris public assistance administration and gain entry for child patients who would not otherwise qualify for care at the children's hospital during the third quarter of the nineteenth century. These families sought care for their children at Sainte-Eugénie due to the real and perceived competence of the medical facility and its practitioners. Considering the limitations of pre-Pasteurian medical knowledge, the Paris children's hospitals were the top options available at the time, and some parents went above and beyond to make sure that their child had the best medical care at their disposal.

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<sup>391</sup>AP/HP, 9L 155, letter from l'Assistance publique to Directeur de l'hôpital Sainte-Eugénie, July 23, 1873. L'AP gave *autorisation exceptionnelle* for the young Balaud boy, and the parents agreed to make two payments: one for the *l'obturateur de la voute palatine* (the closing/sealing of the site) if necessary, and the other for the hospital stay. Since the letter mentioned that Dr. Thorin asked for the specialty surgery in Paris, his request may have carried some weight with the Paris administration.

## Patient Eligibility and Family Choices: The London Example

At the London's children's hospital, decisions about which, when, and how patients would be served stemmed from a quite different administrative structure than its Parisian counterpart, and as a result, GOSH developed a different set of eligibility criteria. As an autonomous charitable institution, GOSH admission policies were guided more by the collective practical and moral compass of its founders, its management and medical committees, and its supporting donors. As a result, the children's hospital on Great Ormond Street in London was not constrained by a centralized state policy that mandated that the majority of its patient population fit a specific regional and socioeconomic pattern, but rather, a mold that was guided by British middle-class sensibilities concerning moral and political economy. While one of its stated missions was to provide medical and surgical treatment to poor children and to offer medical advice to those not admitted to the institution, GOSH designed an intake process that first and foremost endeavored to admit only those patients that most "deserved" care.

The notion of "deserving" and "not deserving" stemmed from a long tradition of English Poor Law and British attitudes about poverty, charity, and social problems.<sup>392</sup> A "deserving" individual was generally considered to be poor through no fault of their own, but due to illness, accidents, loss of gainful employment, or a death in the family. An "undeserving" individual was poor on account of personal vices or "immoral" life choices, vagrants, unwed mothers, criminals, alcoholics, or able-bodied persons who were considered too lazy or undisciplined to work. In theory, sick children—along with

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<sup>392</sup> Peter Mandler, "Poverty and Charity: An Introduction," 1-37, in 13. Also Lynn Hollen Lees, "The Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth-Century London," 69-91, in *The Uses of Charity: The Poor on Relief in the Nineteenth-Century Metropolis*, ed. Peter Mandler (Philadelphia: University of Pennsylvania Press, 1990), 74.

widows or widowers, orphans, the elderly, or the disabled—would automatically fall into the deserving category, and for this reason, GOSH and later children’s hospitals attracted some of the greatest levels of charitable giving in London and throughout Great Britain.<sup>393</sup> The process of determining who “deserved” medical care was extremely subjective, however, and even the administrators at the children’s hospital could not escape the ingrained notion of deserving/undeserving poor. While the child’s medical needs came first and foremost, the moral and economic position of a child’s parents, guardians, or friends still flavored hospital-client relations. GOSH case notes and registers periodically noted when parents were “drunk,” “unruly,” or lazy,” expressions that allude to the frustration of doctors and staff when parental action threatened the health of the child. For example, after a parent took two-year-old Mary Cronin home against the hospital’s advice, the register remark noted that the patient was “removed by drunken father.”<sup>394</sup> While these attributes were no fault of the patient, he or she could be also removed from the hospital on account of a parent’s behavior.<sup>395</sup>

The English voluntary institutions’ preference for only serving the “deserving poor” is particularly evident in the GOSH infant nursery register. Traditional, conjugal family arrangements (mother-father) were the British preference, with a legally binding marriage and either one or both parents in the workforce, two of the major criteria for a “deserving” patient family. Out of 209 children admitted to the nursery between 1859 and

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<sup>393</sup> Keir Waddington, *Charity and the London Hospitals, 1850-1898* (London: Boydell and Brewer, 2000), 28, 116.

<sup>394</sup> HHARP database, GOSH patient Mary Cronin, admitted July 10, 1862, with scarlet fever and removed against advice on July 27, 1862.

<sup>395</sup> GOS/8/1. GOSH expected parents and friends of patients to be punctual, well-mannered, and compliant with all hospital rules and regulations. One set of rules from the 1860s stated “you are to conform in all respects to the rules laid down for your conduct, and failing to do so, you will be at once discharged.” “You” refers to both patient and guardian.

1861, an overwhelmingly majority belonged to households containing both father and mother, with either a male breadwinner or both parents employed.<sup>396</sup> Proof of marriage was also a consideration in the admissions process for the infant nursery, as the date of marriage ceremony and the name of the officiating parish church were listed for 29 out of 209 of the applicants.<sup>397</sup> Children of widows and widowers appear also appeared in the register, with a total of 12 children of widows and 6 children of widowers attending the nursery during the years of operation.<sup>398</sup>

In stark contrast, the infant nursery register lists only six single mothers (no father or father occupation listed), an indicator that in theory, unwed mothers were generally discouraged from applying. The unwed mother and her child faced a precarious existence in nineteenth-century Britain and France and in mid-century London, only three institutions provided aid to unwed mothers—GOSH not included.<sup>399</sup> Apparently GOSH administrators took a more lenient stance on hardworking single mothers, since they accepted to the nursery the children of unwed mothers with jobs. Five out of the six single mothers worked at trades ranging from dressmaker and waistcoat maker to charwoman and envelope folder, and only one of these mothers had no occupation listed

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<sup>396</sup>Based on a data sample of 200 attendees of the GOSH Infant nursery from 1859-1861, available at HHARP, <http://hharp.org/library/gosh/general/infant-nursery.html>, accessed October 15, 2014.

<sup>397</sup> Ibid.

<sup>398</sup> Ibid.

<sup>399</sup>These three charity institutions were the London Foundling Home, Queen Charlotte's Lying-in Hospital, and the General Lying-in Hospital, but this situation changed dramatically by the end of the century, when London housed nearly two dozen charities that aided unwed mothers and their children. See Ann Higginbotham, 84-86. For a thorough examination of the status of the unwed mother in London during this period. For the precarious situation of unwed mothers in Paris, France, see Rachel Fuchs, *Poor and Pregnant in Paris: Strategies for Survival in the Nineteenth Century* (New Brunswick, NJ: Rutgers University Press, 1992.)

in the register.<sup>400</sup> Since the infant nursery required a small payment for services, the mother's ability to pay was the most important factor, even if she was not married. Considering the infant nursery data, one could reasonably expect a similar set of attitudes toward unwed mothers and their children also played out at the inpatient and outpatient departments at GOSH. In contrast, family structure was not an eligibility concern at Sainte-Eugénie in the same way that more verifiable and objective information such as socioeconomic need and residency were. The hospital accepted with little question all Paris-born and paying or subsidized non-resident children regardless of whether they were an orphan or half-orphan, a child born of a legal marriage, or the natural child of an unwed mother. British and French children's hospitals had distinctive eligibility criteria, but different cultural attitudes about poor children and their families flavored these institution's admission policies in unique ways.

A brief description of GOSH's finances also helps to explain why voluntary institutions could afford to be relatively cautious about who they admitted. From the time GOSH opened in 1852 until the establishment of the British National Health Service in 1948, individual donations, subscriptions, legacies, and endowments supported the majority of the children's hospital's financial needs.<sup>401</sup> As a reward for their benevolence, donors of all stripes earned a stake in the governance of the children's hospital and were entitled to recommend a certain number of patients for admission each year, depending on their level of contribution. For a one-time donation of just over £31 or thirty guineas (a guinea was equivalent to one British pound and one shilling) an individual became a

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<sup>400</sup> HHARP, 1859-1861 Infant Nursery sample. Only Elizabeth Emerson, mother of (child id #87) Aldworth Emerson, age 2 months, did not list an occupation.

<sup>401</sup> GOS/6/1/1, GOSH Register of Life Governors.

life governor at GOSH, and between 1850 and 1890, the children's hospital granted 1,115 life governorships. Technically, subscribers who gave a set amount on a yearly basis, regardless of the amount, also gained some degree of authority in hospital management through their capacity to recommend patients. For example, during the 1860s, subscribers of two guineas and donors of twenty guineas could recommend one in-patient and five out-patients each year, and subscribers of five guineas and donors of fifty guineas could recommend up to four in-patients and twenty out-patients each year.<sup>402</sup> While subscriber and donor contributions were received with equal enthusiasm, donors with the largest gifts carried more weight, but due to space limitations, not all subscriber recommendations were able to be accommodated.<sup>403</sup>

In the absence of the overhead and oversight provided by a central head like l'Assistance publique, all aspects of GOSH's administration was handled cooperatively by two committees, the Management Committee and the Medical Committee. Corresponding to this dual enterprise GOSH's governors and medical staff jointly determined which patients would be admitted and when and where they would be placed. During the second half of the nineteenth century, hospital governors exercised the most authority, followed closely by the medical staff. An estimated 56.5 percent of GOSH admissions were prompted by governor requests, with 34 percent naming a specific governor and another 22.5 percent left unnamed. Another 40.5 percent of patients were admitted based on the authority of the medical staff, roughly 21 percent by senior

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<sup>402</sup> GOS/1/1, "Regulations in Reference to the Attendance and Admission of Patients," 1867.

<sup>403</sup> Ibid. Both 1863 and 1868 regulations added a caveat to cover this situation: "...but the size of the hospital, and its resources, do not at present admit of an extension of the privileges of subscribers." GOS/7/2/2, vol. 2. At least one GOSH Visiting Governor's Report made note of complaints from subscribers about the difficulties they experienced in obtaining admissions for patients who they recommended (Plumer, on March 18, 1868).

physicians, 15 percent by assistant physicians, and less than six percent by the assistant surgeon. The remaining three percent of patients entered the hospital on tickets that had been distributed by the hospital to supporters, who then gave the tickets to families as anonymous benefactors.<sup>404</sup> These percentages highlight how every echelon of the GOSH medical team (except nurses) played a significant role in admitting the hospital's young patients. Since senior and junior medical staff worked in the outpatient department on weekly rotations, they all had direct contact with the sick young children coming in for checkups, prescriptions, or minor and not so minor ailments, and they did not hesitate to recommend a patient's admission to GOSH.<sup>405</sup>

With responsibility over admissions divided between non-medical philanthropists on the one hand and medically-trained professional volunteers on the other, conflicts arose and created opportunities for strong leaders in both camps to thwart strict adherence to admission policies for their own motives. For example, the Management Committee created a standing rule that "no child applying for admission to the hospital be rejected until a reference has been made to a medical officer, except when the medical officer is absent," conferring the power to GOSH hospital staff or managing governors to refuse to admit a patient.<sup>406</sup> For example, medical staff more frequently admitted infants under the age of two, reporting medical "urgency" or "extreme risk to life" as the primary justification for bending the rules. In a small sample of underage patients admitted between 1852 and 1877, doctors admitted twelve out of sixteen patients, but the rest were

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<sup>404</sup> All percentage breakdowns of GOSH admission sources are found in Tanner, 142.

<sup>405</sup> The weekly rotation schedule was included on the GOSH "Rules and Regulations." Doctors and surgeons attended the outpatient department on separate days. For example, in 1863 and 1867, doctors were available on Mondays, Tuesdays, Thursdays, and Fridays, while surgeons were available on Wednesdays and Saturdays.

<sup>406</sup> GOS/1/2/4, Committee of Management Minute Book, Meeting of January 19, 1854.



anonymously admitted. Since no particular governor's or subscriber's name was listed next to any of these admitted infants, the practice of non-medical affiliates securing infant admissions was accepted, but frowned upon. While a handful of governors had a more compassionate stance on the issue, most of the governors eschewed the medical rationalizations and voiced a strong opinion that treating infants was a costly and futile enterprise.<sup>407</sup> In comparison, while the directors of l'Assistance publique, the in-house hospital management of Sainte-Eugénie, and Sainte-Eugénie's medical staff disagreed on certain issues, the last word on operations, admissions, and virtually every aspect of the Paris children's hospital lay with the central authority of l'Assistance publique.

#### Specialized Care for Small Patients

In contrast to the “exceptional” patients—paying or non-resident children—at Sainte-Eugénie, few patients that come through the doors at GOSH were exceptional. During the hospital's first twenty-five years, most GOSH in-patient care was provided at no cost to the families through charitable gifts and hospital fundraising activities.<sup>408</sup> Until 1891, the children's hospital required that patient families and friends obtain a letter from a governor, subscriber, or doctor prior to admission, although this practice fell into disuse

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<sup>407</sup> GOS/7/2/1, Visiting Governor's Reports. While Governors Bathhurst and Plumer complained about the presence of underage patients, Governor Owen had a different perspective. In his report on July 4, 1856, he made note of two infants admitted were exceptions to the rule, but highlighted how both patients were “very sad cases of disease, both nurtured and skillfully attended to by our medical officer.” In a database search for patients under the age of two, at least three one-year-olds were admitted to the hospital by governor's letter in 1861. The children all had routine illnesses with no note of urgency, including a case of bronchitis, a case of debility with ophthalmia, and a case of diarrhea.

<sup>408</sup> Tanner, 144, note 48. Andrea Tanner notes that “the reconciliation of perceived medical need and the ability of parents to pay a physician for treatment was a source of constant anxiety to the hospital...,” especially as the years progressed. In the 1870s, the hospital recruited the Charity Organisation Society to aid in assessing family income and contribution, and ultimately in 1909, a social worker, or almoner, was employed to do this work. See <http://hharp.org/library/gosh/general/hospital-almoner.html>.

much earlier.<sup>409</sup> Since the care for all GOSH inpatients was paid for by subscriptions from affluent sponsors, these children were all considered “special” children or children fortunate enough to receive medical care through benefactors.<sup>410</sup> One example of this benevolent attitude toward GOSH’s young patients was the introduction of “special” cots in 1868. Donated by philanthropic individuals or organizations, these special cots, or beds, were material gestures of charity and support for the institution, maintained through endowments, life donations, or annual contributions. The first cot established in 1868, “Aunt Judy’s Magazine Cot,” was the result of reader donations to the magazine’s cot fund, and each year new cots were added as the result of fund drives by other magazines (Quiver, 1868), schools, (Charterhouse School, 1875), and numerous memorials for family members or friends with personalized names such as the Lucas Cot (1868), the Amy Louisa Cot (1871), or the Marianne Cot (1875).<sup>411</sup> A young patient’s placement in a special cot was an honor, frequently recognized by a photograph of the patient, posed and dressed in their best clothes, with the cot name prominently in view; however, it did not correspond to preferential medical care. (See Figure 5.1)

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<sup>409</sup> Waddington, 33-34.

<sup>410</sup> Charities that focused on small children were extremely popular with the nineteenth-century British public, and as London’s first and only children’s hospital for almost twenty years, administrators banked on this enhanced sense of specialism. See Elizabeth Lomax, *Small and Special*.

<sup>411</sup> GOS/1/1, GOSH annual reports from 1868 on listed “Special Cots Maintained in the Wards of the Hospital” as a separate section following a list of all yearly donations and annual subscriptions.

Figure 5.1 Great Ormond Street Hospital Patient, ca. 1873



Source: HHARP Picture Gallery, [www.hharp.org](http://www.hharp.org).

At GOSH, patients hailing from outside the city faced much less scrutiny than *étrangers* seeking admittance at Sainte-Eugénie. In terms of the other sense of “exceptional” patients as the French understood it—residents from outside the Department of the Seine—a small, but not insignificant, number of GOSH patients came from outside London. Unlike the Paris hospitals, the scope of its private charity was not confined by region, and GOSH governors and doctors welcomed children from across the country. According to a search of non-Londoners attending GOSH, fewer than ten percent of in-patients (880 out of 9,098) travelled to the children’s hospital on Great Ormond from outlying counties between 1852 and 1872, and the majority of those counties were in districts adjacent to or near London. A closer look at the breakdown of

patients admitted from outside London during these years also reveals that the numbers of non-Londoners increased steadily in tandem with the general increase in total patients over time, with marked increases after 1864 and 1868 (see Table 5.1)

Table 5.1 Non-Londoner Admissions, by Two-Year Intervals, 1852–1871

Year Range	Total Number of Non-Londoners	Total Admissions	Percent of Non-Londoners
1852-1853	27	333	8.1
1854-1855	21	537	3.9
1856-1857	36	637	5.7
1858-1859	57	790	7.2
1860-1861	71	944	7.5
1862-1863	88	1,092	8.1
1864-1865	120	1,241	9.7
1866-1867	139	1,378	10.1
1868-1879	207	1,430	14.5
1870-1871	224	1,378	16.3

Source: *HHARP*: the Historic Hospital Admission Records Project (<http://www.hharp.org>), Kingston University.

An early debate on the hospital’s name even before its establishment reflects an inclination toward inclusiveness for admissions from outside the city. In part to avoid confusion and in part to maintain its independence from London hospitals, the preference for “Great Ormond Street Children’s Hospital” over “London Hospital for Sick Children” also reflects an embracing attitude towards non-Londoners.<sup>412</sup> At one point, the founders of the hospital even considered whether or not to add two extra beds for “special cases of children coming from the country” without previous correspondence with the hospital.<sup>413</sup> These beds never appeared because of space limitations, but the compromise confirms

<sup>412</sup>GOS/1/2/1, Minutes of the Provisional Committee, January 2, 1852.

<sup>413</sup>GOS/1/2/1, Minutes of the Provisional Committee, June 10, 1852.

that for the hospital, residency was not a concern. The hospital regulations clearly stated that in cases where patients come from the country, governors were “earnestly requested” to send word about the nature of the case a few days beforehand to the hospital staff, “in order that they may avoid the disappointment of finding that the Hospital is full, or that the case is not eligible for admission.”<sup>414</sup> By all accounts, GOSH governors and doctors wanted their children’s hospital to be “the” national hospital for sick children, and the model for all other future British children’s hospitals around the country.<sup>415</sup>

### Patients and Families: Choice and Agency

As the growing numbers of patients at both GOSH and Sainte-Eugénie attest, thousands of parents, guardians, or family members choose to place their child in the care of the children’s hospital. At both of these institutions, the gravity of the decision to go through with in-patient medical treatment must not be underestimated, especially in Great Britain, since GOSH was the first hospital of its kind. *Enfant-Malades*, the first Paris hospital operated for over fifty-years before Sainte-Eugénie appeared, and so generations of Parisians and people across France were aware of this type of medical establishment. In London, the children’s hospital “had to make its character to the poor,” and during the first month, while dozens of children were seen as out-patients, only two mothers trusted the hospital enough to leave their child in the inpatient ward.<sup>416</sup> Considering varying degrees of parental anxiety about their child’s illness, uncertainty about their ability to

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<sup>414</sup> GOS/1/1/1, “Regulations in Reference to the Attendance and Admission of Patients,” 1863, 1867, printed in the GOSH annual reports.

<sup>415</sup> GOS/1/1, 1875 Annual Report. The report mentioned that “city after city in different parts of England emulated the example of the founders of the institution,” as well as recently established children’s hospitals in London.

<sup>416</sup> GOS/1/1, 1853 Annual Report, 8-9.

nurse their children back to health, and reluctance to leave their children with others, the decision to seek out admittance at a children's hospital was not casual, and for many parents, it must have been a particularly intense experience.<sup>417</sup> This difficult decision, compounded by certain eligibility requirements, magnifies the family's or guardian's role in securing medical attention for a young patient.

After jumping through the admission hurdle, some patients' families continued to act as agents in the health and welfare of their child while they were in the hospital. While rarely intervening in medical issues, families and friends used their voices in other ways. At both hospitals, family members and guardians might take authoritative action in ways that either expanded or curtailed the limits of health care. At Sainte-Eugénie, they stepped forward to work out financial issues that threatened the continuation of patient care; other times they stopped hospital payments altogether. At GOSH, parents showed their support and gratitude for the hospital's charity by making small monetary contributions and following the rules and regulations; others distained the conventions. The most frequent use of parental or guardian authority at both hospitals was the complete removal of the child from the hospital, illustrating that the ultimate decision for keeping a child in hospital lay with the child's family, unless of course, death claimed the patient first. A last resort for some parents, the abandonment of children at the hospital was rare, but not unknown. At Sainte-Eugénie, some desperate parents left their child to the care of others, extending the role of the Paris children's hospital from medical provider to gateway to Enfants-Assistés, the institution for abandoned children.

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<sup>417</sup>Linda Pollock, *Forgotten Children: Parent-Child Relationships from 1500-1900* (Cambridge: Cambridge University Press, 1995) 133-34, 140-41.

Abandonment of patients at GOSH was even more unusual, but occasionally GOSH staff members also scrambled to find a suitable place for these patients left on their own.

The choices of the patient's family members complicate arguments about institutionalized social control, particularly the idea that hospitals were a conduit for medical and political surveillance, governance, and optimization of individuals and populations. Theorists like Michel Foucault and Jacques Donzelot in particular emphasize how medical institutions, practitioners, and the medical-legal discourses that they generated formed part of a "tutelary complex" aimed to control social behavior, particularly of the poorer classes.<sup>418</sup> The social control theory especially resonates with the institution of the children's hospital, since children were the future of the nation, and regulating and preserving their health was paramount to enhancing the French and British populations. However, the dependent status of children and the weight of parental authority mediated biopolitical aims of the children's hospital, and ultimately, a complex web of interested parties had a say in a child's hospital care: correspondence about patients circulated between hospital administrators, bureaus of public assistance, private charities, and their families. While doctors asserted a good deal of influence in the diagnosis, observation, and treatment of children, patient families also impacted doctor-

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<sup>418</sup> Michel Foucault's *Discipline and Punish: the Birth of the Prison* (Vintage, 1995), Part 3, "Discipline," 135-169, explores social control of individual bodies through disciplinary institutions, such as the school, the military, the asylum, and the hospital, and the process of accessing, disciplining, and regulating individuals through specific medical-legal technologies and practices within those institutions. Jacques Donzelot's *The Policing of Families* (Baltimore, MD: John Hopkins University Press, 1977) expands on Foucault's theory and identifies specific "tutelary complexes" that discipline the behavior of families and allow the state to govern families. Donzelot focuses on the role of social workers and psychiatrists at the end of the nineteenth-century, but does not address the role of children's hospitals or doctors earlier in the century. In his *The History of Sexuality, Vol. 1* (Vintage, 1990), Foucault argues that a child's sexuality also became a site of investigation and management also resonates with this study of children's institutions, especially his proposal that the "body of the child, under surveillance, surrounded in his cradle, his bed, or his room by an entire watch-crew of parents, nurses, servants, educators, and doctors, all attentive the least manifestations of his sex" was a form of social control, 98.

patient relations and placed limitations on a doctor's dominance. At the Paris children's hospitals, doctors and surgeons were doubly constrained by demanding family members on one hand and institutional bureaucracy on the other—as hired healers their own goals and interests could be eclipsed by parental authority, state authority, or both. During the years of this study GOSH doctors and surgeons donated their services, but they faced similar constraints generated by the hospital's management and its influential donors as well as attending patients and their families.

### Family Agency and Money Matters

Mothers, fathers, grandparents, sisters, brothers, cousins, aunts, and uncles advocated for child patients in various ways, and finances frequently spurred family involvement. At Sainte-Eugénie, finances were a common topic of client-hospital relations whether the family or a third-party, such as a local public assistance bureau, paid the necessary expenses. Some families took total responsibility for the children's hospital expenses, including the cost of the stay, medications, and any special surgeries or therapies. For example, on January 26, 1864, a thirteen-year-old patient from Clichy named Désirée Labourot was admitted with scrofula—an all-purpose medical term used to describe a variety of conditions ranging from skin disorders to chronic weakness to tuberculosis. Both her parents were dead, but her brother, an established baker, was able to pay for the hospital stay, which would have been quite an expense since her treatment lasted almost ten months.<sup>419</sup> In other cases, the local bureau of public assistance subsidized all or part of the cost of hospital care. Pauline Letteron, an *étrangère* patient from Seine-et-Marne, received treatment for several months each year during 1864, 1865,

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<sup>419</sup> AP/HP 9L 155, letter from l'Assistance publique to l'hôpital Sainte-Eugénie, November 1864.



and 1866, thanks to such an arrangement. A local bureau paid for all three of her hospital sojourns, which varied between a rate of 1 franc 75 centimes and 1 franc 86 centimes per day, depending on the year.<sup>420</sup> Even if their local public assistance handled the hospital costs, the families of étranger patients were bound to accrue related expenditures. Transportation to and from Paris, temporary lodging in the capital if they had no friends or family, and perhaps lost wages of a parent who accompanied their child for a portion or the entire duration of the hospital stay—these were all financial burdens that some parents were willing to pay in order to help their child get well.

At Sainte-Eugénie, some parents or family members who initially contributed to their child's hospital expenses found themselves in precarious economic situations. Lost income due to unemployment or sickness left some families unable to continue their health care payments to the Paris hospital. Some family members in this type of situation took a proactive stance and wrote to l'Assistance publique, claiming hardship and seeking either a reduction in their patient's daily rate or an exoneration from payment altogether. In cases involving stopped payments or requests for financial help, l'Assistance publique made formal inquiries into a family's or a guardian's economic situation. If the request was justified, or if removing the patient from the hospital threatened his or her chance of recovery, the administration either reduced the daily rate or offered to cover the remainder of the hospital bill. For example, in a letter dated September 18, 1855, Elisa Robardy informed the administration that the family fell on hard times and could no longer afford her son's daily rate.<sup>421</sup> Upon investigation, her story was validated and her five-year-old son Charles was allowed to remain at Sainte-

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<sup>420</sup> AP/HP 9L 155, letter from l'Assistance publique to l'hôpital Sainte-Eugénie, January 18, 1866.

<sup>421</sup> AP/HP 9L 155, letter from l'Assistance publique to l'hôpital Sainte-Eugénie, September 18, 1855.

Eugénie free of charge for the rest of his hospital stay. In early 1856, Eugénie Choquet wrote on behalf of her eleven-year-old daughter Pauline, who was admitted in November of the year before with a fever. As it turned out, the fever was actually an epileptic spell. When her daughter needed to remain in the hospital for months longer than anticipated, Madame Choquet—a dressmaker and single mother—needed public assistance to make the payments. L'Assistance publique responded by covering the additional 123 days of Pauline's treatment. If a family needed financial help and they made a strong case to l'Assistance publique, the administration often accommodated their needs.

Most families and friends were not required to pay for their child's hospital care at either Saint-Eugénie or GOSH unless the administration could prove that the family could afford it. Occasionally at GOSH, inpatient, outpatient, or convalescent home care involved additional efforts from families and guardians, some of which incurred an expense. Some patient families at GOSH struggled to pay for the rudimentary supplies required for the hospital stay or additional medical equipment or apparatuses. For example, the hospital provided a robe and slippers for patients, but children were expected to have clean, presentable clothing, and parents and friends were responsible for keeping it laundered.<sup>422</sup> Patients also needed to bring clean bottles with corks and cups for their medicine, an added expense that stretched an already poor family. When doctors or surgeons prescribed medications and special medical equipment, a patient's family or friends might be asked to contribute to the costs, and few refused. If a patient's family did not live in London, however, the additional expense of a medical instrument might be too much for a family already taxed by the transportation and lodging costs of a family member or members in the city. For example, after a seventeen-day hospital stay for ten-

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<sup>422</sup> Tanner, 140.

year-old Robert Bird, his parents decided not to pay for a device, probably a cast or brace for his curved spine.<sup>423</sup> Perhaps their residency outside of London compounded an already expensive hospital visit and influenced this decision. When the new GOSH building opened in 1875, a new system of pre-screening interviews by hospital clerks to determine a family's or guardian's ability to pay for medical services paved the way for occasions of strained hospital-client relations. When interrogated about family finances, some family members became so frustrated or offended that they left with their child before he or she could see a doctor.<sup>424</sup>

On the other hand, many family and friends expressed their gratitude to GOSH by contributing what little they had, and in the process they helped other more destitute patients and families. Within three years of the hospital's establishment, GOSH patient families set up a Samaritan Fund, which began as a little collection box near the front door for small gifts of money and grew into a flourishing investment fund made up of donations from the parents and friends of sick children, and later, generous benefactors. GOSH began to publish the Samaritan Fund transactions in its 1855 annual report, and in its first year, the fund raised over £65 total, including £29 in parent and family contributions, £13 from governors, £22 from the collection box, and the remainder from bank interest.<sup>425</sup> Like a discretionary purse, the Fund purchased a variety of items and services that arose on a need basis, such as boots, shoes, and clothes, irons, trusses, and other medical devices, cab fares, or even funeral expenses for patients.

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<sup>423</sup> HHARP, GOSH register listing for Robert Bird, admitted on May 21, 1860.

<sup>424</sup> Tanner 144.

<sup>425</sup> GOS/1/1, 1855 Annual Report.

Throughout the nineteenth-century, thousands of GOSH inpatients and outpatients benefited from the Samaritan Fund, and for many, the fund provided much more than a new pair of shoes, a jacket, or a dress. Other core fund expenditures were transportation costs, board, and lodging for patients at convalescent homes in Brighton, Margate, Mitcham, and others.<sup>426</sup> For some GOSH patients, the fund provided up to a month of much-needed convalescence, adequate nutrition, and clean surroundings, and for the poorest of residents this recovery time was essential to rebuilding their strength before returning home.<sup>427</sup> By the late 1870s, Samaritan fund contributions by generous benefactors superseded those of families and friends, but gifts from patient families continued. For grateful family members already receiving charity from the children's hospital, their small but steady gifts to the Samaritan Fund allowed them to personally express their appreciation in a collective and impactful way that also made a significant difference to families and friends with even less resources.

#### Family Authority, Medical Matters, and Patient Removals

At both GOSH and Sainte-Eugénie, family advocacy rarely involved direct requests concerning children's specific medical needs, since parents and other family members knew little of the classification, diagnosis, and treatment of childhood diseases.

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<sup>426</sup> By 1860, the total contribution to the Samaritan Fund was 105 £, over 91 contributed by parents and friends, and by the 1860s, the Fund showed a marked increase in expenditures on transporting and maintaining children at convalescent homes in the country and by the seas. By 1869, the Fund paid for 53 children to be sent convalescent homes outside the city and clothing and boots for 320 inpatients and 185 outpatients. GOS/1/1, 1861 and 1869 Annual Reports.

<sup>427</sup> GOS/1/1, GOSH Annual Reports for 1866-1880. In 1866 the Samaritan Fund sent 118 children to seven different convalescent homes, and in 1877, 85 children to six homes. By 1870, the fund was providing stays for 279 children at various convalescent homes including Cromwell House, GOSH's own convalescent branch in Highgate, outside of the city. In the late 1870s, anywhere between ten and sixty patients were sent to convalescent homes, excluding Cromwell House.

Most family members and friends brought little children to the hospital because they had few alternatives, and given their own limited medical knowledge, they most likely had little to say about what treatments patients would undergo once admitted to the hospital. During this period, very few ventured into the medical realm and asked for specific doctors or surgeons to treat their children. In the very formal setting of Sainte-Eugénie, hospital administrators mediated such requests, as in the situation of Amelie Poutrel. Amelie entered the children's hospital with a diagnosis of necrosis (*necrose*), a debilitating condition often related to tuberculosis that resulted in cellular degeneration, usually of the bone. In a letter from Armand Husson, head of l'Assistance publique, to the hospital director, the administration indicated that the patient's father had requested Dr. Marjolin, one of the hospital's most renowned surgeons at the time, to take charge of his daughter's treatment, which probably required surgical removal of the diseased bone tissue.<sup>428</sup> Based on recommendations by other doctors, family members, or friends, or previous experience with a certain medical practitioner, or knowledge of reputations or success rates with a particular surgical procedure or therapy, some French parents made such appeals. At GOSH, little evidence suggests that parents or guardians requested particular doctors during the first twenty-five years.<sup>429</sup> However, parents and guardians undoubtedly knew the attending doctors and surgeons through multiple visits to the outpatient clinic and undoubtedly sought out familiar faces if their child had an emergency attack or needed surgery.

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<sup>428</sup> AP/HP 9L 155, letter from l'Assistance publique to l'hôpital de Sainte-Eugénie, May 9, 1859.

<sup>429</sup> GOS/1/1, 1873 Annual Report, 8. GOSH's doctors and surgeons were volunteers, and their availability was more limited than the French children's hospital medical staff. Until 1863, GOSH only had one surgeon with a six-month appointment similar to an unpaid internship. That year, the hospital created a salaried house surgeon position, which added greater stability and success with surgical cases.

Even though hospital doctors and directors exerted their power as experts when it came to diagnoses and treatments, ultimately a parent or guardian had the power over their child's medical care. As their only weapon against the establishment when unsatisfied, unwilling, or without hope, they wielded this authority by refusing to consent to a surgery or treatment. Understandably, surgeries posed a problem for both French and British parents because of their invasive, traumatic, even brutal nature, and their high risk of death. Operations to extract tumors or diseased joints or limb were particularly unpopular, either because parents did not realize the seriousness of the condition, or because they feared the post-surgical consequences if a child lost part of an arm, a leg, or a foot, or a combination of both. For example at Sainte-Eugénie, eleven-year-old Marguerite Lauer did not have an operation to remove a tumor on her right elbow because her father Jacques would not allow it.<sup>430</sup> Parents of GOSH patients were also unwilling to consent to operations for diseased knee joints, ankles, and feet.<sup>431</sup> Parents might even initially consent to an operation and then retract their decision, such as nine-year-old Julia Jobson's parents did when GOSH proposed an operation for her "strumous tarsus."<sup>432</sup> Since the operation probably involved an amputation of foot at the ankle joint, her parent's withdrawal of their consent is comprehensible.

The typical family recourse was to simply curtail the hospital's access to their child and demand the young patient's early release from the hospital. In the decades after GOSH and Sainte-Eugénie opened, mothers, fathers, and other guardians increasingly

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<sup>430</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1861-1862 (SAINTEEUGÉNIE (1Q 2/4), patient record #1099, May 1861.

<sup>431</sup> HHARP, register entries for E. Pincott, admitted May 24, 1856, and Lucy Donovan, admitted August 5, 1876.

<sup>432</sup> HHARP, register entry for Julia Jobson, admitted September 5, 1860.

exercised their powers of parental authority and demanded that their children be returned to them. While some of this increase corresponds to greater numbers of total patients at both hospitals, if the record-keeping on the topic remained relatively stable, the proportion of parents removing patients gradually rose over time at both institutions. For example, at Sainte-Eugénie, records show only five instances of children willfully removed from hospital care between the years 1855 and 1870.<sup>433</sup> In contrast, between 1871 and 1876, fifteen children were taken at the express demand of a parent, with removals peaking in 1872 and 1875 and involving 11 percent (4 out of 25) of all patients in that sample year.<sup>434</sup> Part of this increase in parent intervention may be reflective of a general sense of uncertainty and upheaval among Parisians in the chaotic years following the Franco-Prussian War, the Paris Commune, and the forging of the Third Republic. On the other hand, parental reactions to greater state and medical intervention into working-class domestic life, as exemplified in new laws and reforms instituted by the Third Republic, may also explain this rise in parental action.<sup>435</sup> At GOSH, a similar pattern emerged, but less dramatically. Family-initiated removals in the first five years remained small, but significantly rose in 1861 and 1865, and again in 1873 and 1874.<sup>436</sup> (See Figure 5.2)

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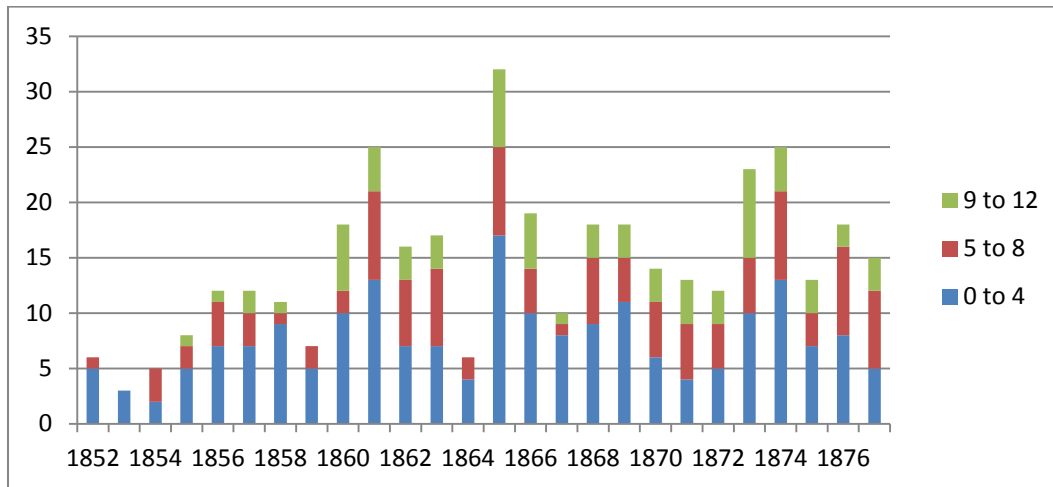
<sup>433</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1855-1870. Three patients were over the age of ten, one patient was three-years-old, and one patient was twenty months.

<sup>434</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1871-1876,

<sup>435</sup> For more on these reforms, see chapter 6 of this dissertation.

<sup>436</sup> HHARP, In 1852, eight children removed; 1853, three; 1854, five; 1855, eight; 1856, twelve; 1857, twelve; 1859, thirteen; 1860, eighteen; 1861, 25; 1862, sixteen; 1863, seventeen; 1864, six; 1865, 32; 1866, nineteen; 1867, ten; 1868, eighteen; 1869, eighteen; 1870, fourteen; 1871, thirteen; 1872, twelve; 1873, 23; 1874, 25; 1875, thirteen; 1876, eighteen, 1877, fifteen.

Figure 5.2 Family-Initiated Patient Removals at GOSH, by Age, for 1852–1877



Source: HHARP database, [www.hharp.org](http://www.hharp.org).

Mid-to late-nineteenth century parents and guardians in Paris and London removed children from the hospital for several reasons, and a combination of factors likely played some role in their decisions. Most GOSH and Sainte-Eugénie register entries do not offer clear explanations, only general statements such as “removed by parents,” “mother took child out,” or “father took child home,” yet select GOSH entries and case notes provide a general impression of the reasoning behind these choices. The most frequently cited reasons behind family-initiated removals include the patient’s tender age, or at the other end of the age spectrum, their needed economic contribution to the family unit; a parent’s fear of a child contracting a contagious disease in the ward or dissatisfaction with care or treatment options; or a family’s unwillingness to risk a child dying in the institution. Considering similarities in age ranges, medical conditions, and variety of family backgrounds for patients at these two hospitals, along with specific examples and some degree of speculation, French and British working-class parents and



guardians had similar reasons for removing their children from the hospital against doctor's orders.

At the Paris and London children's hospitals, the age of the patient had the greatest influence on whether a parent or guardian took a child home against the hospital's advice. In a sample of 770 Sainte-Eugénie patients, over half of all early release requests involved children under the age of five years (see Fig. 5.3). Similarly, an estimated fifty-one percent of patients removed from GOSH between 1852 and 1877 fell into the zero to four age bracket, and for all but two years during this period, this age group constituted the greatest number of family-initiated patient removals annually.<sup>437</sup> (See Figure 5.2) These percentages suggest that for many families, separation from a young patient was extremely difficult, even if they lived within walking distance of the hospital, which many of the families did. Even a short-term hospital stay took an emotional toll on parent and child, particularly on toddlers who were especially dependent on their mothers and aware of the separation.<sup>438</sup> A patient's constant "fretting" undeniably impacted family members as well, such as James Willie Painter's mother, who took out her not quite two-year-old son after only two days due to his agitated state. Her son had a severe case of pneumonia, but "he fretted so that the mother declined to leave him" at GOSH any longer.<sup>439</sup> Young children, who had never been apart from their family members, especially those under the age of three or four, posed logistical issues

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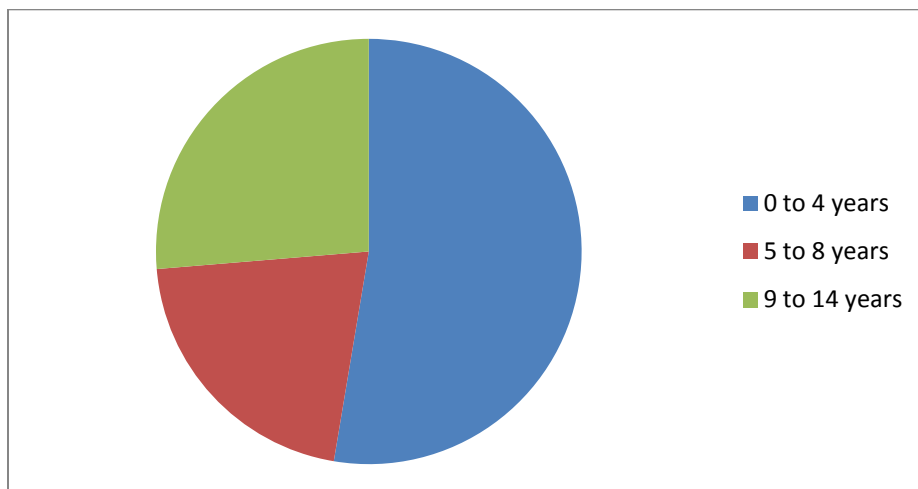
<sup>437</sup> HHARP. In a manual search of GOSH patients removed from the hospital during this period, a total of 386 patients of mixed ages were taken out of the hospital by parents or friends. Out of this total, 198 of the removals involved children under the age of five years old.

<sup>438</sup> See Tanner, 147-150. Pattern continued at GOSH, as Tanner's examination also finds toddlers represented the highest percentage of children taken out early from this children's hospital between 1852 and 1899.

<sup>439</sup> HHARP. register entry for James Painter, admitted with pneumonia on January 16, 1872.

for the hospital as well. Fretful and frightened by pain and separation from their family, the youngest patients could disrupt wards and exhaust hospital staff. Perhaps more importantly, the youngest patients were the most vulnerable to disease and acquired some of the most virulent, life-threatening medical conditions, such as diphtheria, measles, and whooping cough. If an infant or toddler patient contracted an infectious disease in the ward, as many children did, it could prove fatal. For example, when a patient of one-year and eight months acquired measles at GOSH while being treated for a tumor on her kidney, her mother took her home as soon as she recovered from the infectious disease.<sup>440</sup> As soon as a patient showed any signs of improvement, parents or friends removed the child to protect them from further contagion.

Figure 5.3 Family-Initiated Patient Removals at Sainte-Eugénie, by Age, 1855–1875



Source: AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1855-1876. (Based on nineteen patient removals listed in the admissions register.)

<sup>440</sup> HHARP, register entry for M. Elizabeth White, admitted on March 16, 1874. This type of iatrogenic infection, an condition caused by the poor or limited isolation facilities or staff negligence at the hospital, decreased with the widespread use of antiseptics, anesthesia, antibiotics, and better surgical techniques developed later in the century and in the early twentieth century.

When mothers and fathers took older patients away from the institution, removal could have been motivated by financial needs as much as emotional attachment or dissatisfaction with a medical outcome. For these families, a patient's hospital stay took a financial toll because the loss of the child's work earnings endangered the family's economic survival. In the second half of the nineteenth-century, despite increasing regulations on child labor and the move toward free and compulsory education in both France and Great Britain, working-class children under the age of fifteen regularly contributed to the household economy.<sup>441</sup> Sainte-Eugénie's registers listed male and female patients as young as ten who were working apprentices to florists, jewelers, printers, and masters of other trades. For some patients, certain details in the admissions register suggest that they played a supporting role in keeping the family afloat. For example, eight-year-old Jules Violet's mother removed him from the hospital after a week-long stay for a fracture of the left radius.<sup>442</sup> His father, a handyman (*homme de peine*), may have needed his son to accompany him on odd jobs, and Jules may have even obtained his injury working alongside his father. At GOSH, nine-year-old James Whittey of Drury Lane admitted with tubercular peritonitis, but after scant improvement, his mother took him home after only three days because his father "could not do without him."<sup>443</sup> Since the young boy was old enough to contribute to the household economy—even if while suffering from a tubercular condition he worked only part-time—the family may have decided that the hospital stay was not worth the cost of the child's labor.

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<sup>441</sup> Mandler notes that in nineteenth-century capitals like London and Paris, women and children's labor were particularly in demand, where upper classes needed domestic servants and finished luxury goods, and opportunities for delivery work and scavenging were available, 6.

<sup>442</sup> AP/HP, Registre d'entrées, L'Hôpital Sainte-Eugénie, 1865-1867 (SAINTEEUGÉNIE (1Q 2/6): patient record #658, March 1866.

<sup>443</sup> Tanner, 157.

Even if they did not earn wages, children contributed to the family economy in other ways. Especially for young girls, children as young as five or six were expected to mind the younger children and do domestic chores.<sup>444</sup> In the case of eleven-year-old Marguerite Lauer, the Sainte-Eugénie patient whose father denied her an elbow operation, the young girl's removal from the children's hospital may have been related to her duties at home. Her father, a widower, may have relied on Marguerite to manage the house, and if she had younger siblings, to be their caretaker. Mothers also relied on their young daughters to run the house and mind the babies, enough so that losing a daughter for an extended time was too difficult to bear. For example, a six-year-old girl named Louisa Summers suffered from heart pain, headaches, and difficulty walking, and her mother first took her to a local dispensary, then GOSH, when she noticed that her daughter could not hold a baby. The second of five children, Louisa was responsible for feeding the baby, and after eight days in the children's hospital, she was removed "by her mother's desire."<sup>445</sup> While frustrating to medical staff, domestic exigencies of working-class life could take precedence over a child's hospitalization and treatment for some families.

### Mothers and Fathers

A brief gender analysis of parental involvement at Sainte-Eugénie and GOSH demonstrates how mothers and fathers wielded influence in distinct ways. At both children's hospitals, the registers frequently indicated whether one or either parents or

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<sup>444</sup> Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1970-1918* (Oxford: Oxford University Press, 1993), 135, 154.

<sup>445</sup> This example is from Tanner, 157.

another family member demanded to take the child home. While both mothers and fathers figured prominently at Sainte-Eugénie, mothers especially took an active role in their child's hospital affairs when the patient was Paris-born. In my sample of 770 Sainte-Eugénie patients, mothers picked up their children from the hospital or requested their early removal more frequently than fathers. Mothers also initiated many of the formal requests to l'Assistance publique for a reduction in hospital fees, sometimes more than once. For example, Louise Nolin wrote to the administration in 1855 and in 1856 to renegotiate the daily rate for her son Eugene's stay at the hospital.<sup>446</sup> The family was Parisian, therefore in domicile, but was not considered indigent, and initially her son, who suffered from several chronic skin conditions, was admitted as a paying patient. Madame Nolin's first letter in late 1855 instigated a new inquest into the family situation, and when hardship was discovered, the daily rate was reduced. A few months later, she wrote a similar letter, but with the opposite effect. Her son's rate increased to 55 centimes per day due to the new information. As this example shows, while their requests might or might not pay off, determined working-class mothers in Paris worked hard to keep the hospital fees down.

At GOSH, mothers also figured prominently in their child's care, specifically when it came to removing the patient against hospital advice. Out of the 389 family-initiated removals at GOSH, "parents" (116) and "friends" (112) figured prominently as the instigators, but the most frequently mentioned family member listed was the mother (110).<sup>447</sup> Only eleven fathers, one grandmother, and one other relative made the GOSH

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<sup>446</sup> AP/HP, 9L 155, letter from Administration de l'Assistance publique to Directeur de l'hôpital de Sainte-Eugénie, June 25, 1856.

register, suggesting that mothers took the lead in hospital interactions more than fathers, and mothers made more of an impression with the hospital staff. The strong presence of poor London mothers at the children's hospital underscores the agency that poor women had within poor British families not just inside the household but with family relations with welfare institutions.

At Sainte-Eugénie, cultural differences also shaped familial involvement with the children's hospitals, particularly concerning which family member removed a patient from care. Fathers belonging to a distinct ethnic or cultural group or geographic area—Jewish fathers, foreign-born fathers, or fathers originally from departments outside the Paris could be the most authoritative. In some cases, a language barrier, a particular family situation, or general cultural mistrust might precipitate such a choice. For example, fathers who emigrated from the German states particularly stood out, with some making choices that effectively stopped treatments and removed patients from the institution. For example, Christine Jungmann, age 4, was admitted to Sainte-Eugénie with typhoid fever on July 26, 1861.<sup>448</sup> She stayed for nine days, but on August 4, her father, Henri Jungmann, a German-born cabinet maker, demanded that the hospital to release his daughter to him. The Jungmann family lived in the same neighborhood as the hospital—the faubourg Saint-Antoine—where many German immigrants lived and worked,

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<sup>447</sup> HHARP database, comprehensive search of all parent or guardian removals between 1852 and 1877. The terms “parents” and “friends” should be considered general terms, and these listings may have been shorthand for a parent, a relative, or guardian, depending on the recording style of the person filling out the register information. For example, between November 11, 1876 and December 6, 1877, “taken out by friends” was the only designation for the entire period, and therefore this indiscriminant use of “friends” appears to be a stylistic preference for the recorder at the time. Out of the remaining patients, another 26 removals were by an unspecified individual, probably a friend or parent; another two removals were by a parent, but with no indication of whether it was a mother, father, or step-parent; one patient was removed by a nurse, and another patient was removed by a newly appointed guardian; six patients discharged themselves.

<sup>448</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1861-1862 (SAINTEEUGÉNIE (1Q 2/4), patient record #1629, July 1861.

including Marguerite Lauer's family. Within close-knit immigrant communities of Paris, parents like the Lauers and Jungmanns likely counseled and supported each other when it came to their dealings with the children's hospital. Understandably, outsiders to Paris—foreign and French alike—appear less trusting and less willing to negotiate with Sainte-Eugénie's practitioners and policies than native Parisians who better knew the language and the administrative ropes.

### Summary

Some working-class family members navigated the ins and outs of the children's hospitals of London and Paris, negotiating with hospital and public assistance administrators and demanding what they believed was best for their children. From a medical standpoint, their actions and choices did not always serve the best interests of the child: patients went without operations, further treatments, or proper convalescence time. When in doubt about a procedure or course of treatment, families of patients at GOSH and Sainte-Eugénie had similar responses: remove the child from the hospital. Family members in these examples, however, had other alternatives: not to take their child to the hospital, or as hospital records show and other scholars have aptly demonstrated, to abandon their child to the institution.<sup>449</sup> Judgments aside, patients' families had choices: they discovered the options available to them and made their decisions, for better or worse. For most local Paris and London families, the mother was the most frequent intercessor and at the forefront of family-hospital relations.

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<sup>449</sup> Rachel G. Fuchs, *Abandoned Children: Foundlings and Child Welfare in Nineteenth-Century France* (State University of New York Press, 1982).

The choices that families faced and the sphere of action available to them depended on the children's hospital. At Sainte-Eugénie, strict policies for patient eligibility based on geographic domicile and a vigilant attempt to serve the local needy population translated into greater obstacles for families from outside the Department of the Seine seeking medical care for their child at the Paris children's hospital. In contrast, GOSH's willingness, if not alacrity, to accept non-Londoner patients was part of an effort to build its reputation as a national medical institution. Both children's hospitals fixated on the bottom line—finances and economy—yet a large, state institution predicated on the notion of poor child's "right" to medical service, Sainte-Eugénie deferred to the power of l'Assistance publique in matters of family financial responsibility. If a parent formally requested its aid, the administration would usually concede in the best interest of the child. In a smaller setting like GOSH, administrators, staff, and volunteers coordinated efforts to ensure that the neediest patients were served, while keeping a watchful eye that parents, friends, and families were "deserving" recipients of charity and did not abuse the system. Individual families were under greater scrutiny at GOSH, since anyone with a stake in GOSH leadership could influence decisions about admissions to the children's hospital, and for a short time, the infant nursery. Despite these slightly varied attempts by the Paris and London hospitals to regulate and monitor their populations, some parents worked hard to get their child's needs met on their own terms.

The examples here demonstrate that some families of patients in nineteenth-century children's hospitals were not passive recipients of state-funded hospital care. These families had choices and faced a range of dilemmas: how to obtain hospital care for their child, how to pay for it, and even when hospital care was freely provided,



whether to trust the medical establishment or to remove their child from the hospital altogether. All of these decisions also highlight the risks inherent to nineteenth-century children's hospital care: the risk of imperfect medical knowledge and procedures, the risk of their child contracting another infection in the ward, and the risk of their child dying in the hospital without family members at their bedside. The life-or-death stakes at the children's hospital were different for families than for doctors or institutional administrators. Even for the most compassionate doctor, a young patient was a "case," a success story or another tragic loss of life—and even for the most concerned administrator, a young patient was a number in the register, a statistic in the annual report, or another poor child whose parents could not pay the daily fee. Many working-class families did not have the luxury of reason, objectivity, or perspective; their choices about their children's' medical care were subjective, intimate, and permanent.

## CHAPTER 7

### BEYOND THE CHILDREN'S HOSPITAL: CHILD HEALTH IN LEGAL MEDICINE, SOCIAL REFORM, AND THE FAMILY

In the 1860 and 1870s, the expansion of hospitals to serve the poor, sick children of London and Paris was part of wider national initiatives aimed to improve the health and welfare of the youngest, most needy members of society, and interactions between patient families and hospital staff at hospitals like GOSH and Sainte-Eugénie underscored how institutionalized children's medicine could only go so far in protecting and preserving child health. This chapter explores how French and British doctors, reformers, and authors drew upon their pediatric knowledge produced within hospitals like Sainte-Eugénie and GOSH and circulated specific perspectives on children's health beyond the walls of the children's hospital in the second half of the nineteenth century. During this period, rising interests in child welfare spawned numerous societies and committees dedicated to the reduction of infant mortality and prevention of infanticide, safeguarding the health of child workers, and the prevention of child cruelty across France and Great Britain.<sup>450</sup> Infant protection advocates demanded protective measures for children in wet-nursing and foster care arrangements, while other reformers campaigned for children's removal from dangerous labor trades or abusive homes. These developments resulted in concurrent legislation in both countries: the regulation of the wet-nursing industry by the Roussel Law of 1874 ( France) and the paid childcare industry, notoriously called "baby-farming," by the Infant Protection Act of 1870 (Great

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<sup>450</sup> For an international overview of these events and historiography, see Hugh Cunningham, *Children and Childhood in Western Society since 1550*, 2nd ed. (New York: Longman, 1995).

Britain); a revised French child labor law in 1874 and a British Chimney Sweepers Act in 1875.<sup>451</sup> In both countries these reform efforts were spurred by the same desire that inspired state administrators and private philanthropists to build more children's medical care facilities—to preserve the health of children. With different players and different focuses, nineteenth-century initiatives to promote child welfare at work and at home and to provide medical care for sick children overlapped in subtle ways. A common denominator among them was the children's hospitals. The Paris and London children's hospitals admitted and treated urgently sick infants (despite age policies); children harmed accidentally or intentionally at their workplace or home; and in rare cases, children who were abandoned by their families. In the years before national compulsory education, children's hospitals were one of the few conduits through which medical and public health communities could reach poor children and families.

The connections between nineteenth-century Paris and London children's hospitals and various child protection movements reveal other national and international similarities in French and British social reform agendas concerning child health. In both countries, individuals and groups attempted to medicalize social issues that threatened to endanger the health and welfare of children by compromising their physical, emotional, and cognitive development: forensic physicians in the Paris hospital system like Ambroise Tardieu, women reformers like Maria Deraismes in Paris and Annie Besant in London, and a score of medical and non-medical authors of child and family hygiene

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<sup>451</sup> For the Roussel Law, see George Sussman, *Selling Mother's Milk: The Wet-Nursing Business in France, 1715-1914* (Urbana: Illinois University Press, 1982); for the Infant Protection Act see Richard Barnet, "Unwelcome Strangers": The BMJ and the Infant Life Protection Legislation, 1866-1872," Dissertation, University College, London, 2001; for French child labor laws of 1840, 1851, and 1874, see Lee Shai Weissbach, *Child Labor Reform in Nineteenth-Century France: Assuring the Future Harvest* (Baton Rouge: Louisiana State University Press, 1989); for the British Chimney Sweepers Act, see K. H. Strange, *Climbing Boys: A Study of Sweeps' Apprentices 1772-1875* (London: Allison and Busby, 1982).

manuals. Tardieu, Deraismes, Besant, and these authors all viewed a child's physical health as an object of protection that should be ensured through the enforcement or revisions in the law, better systems of education for children and mothers, or social reforms to assist poor families. Tardieu and Deraismes believed it was a crime to harm a child, either intentionally or indirectly through ignorance and poverty; Deraismes, Besant, and the authors of hygiene manuals proposed the empowerment of mothers through knowledge of better childbearing and childrearing practices as a solution to preserving children's health. Individually and collectively, the individuals detailed in this chapter medicalized social and moral issues, and in the process heightened public awareness of the importance of preserving children's health and well-being outside the walls of children's hospitals, dispensaries, and crèches. Courtroom testimony, reformers' writings and speeches, and hygiene manuals were important channels through which medical knowledge about children's health, disease, and hygiene dispersed into public forums in the second half of the nineteenth century.

British and French doctors produced pediatric knowledge, and the distribution of that knowledge to broader audiences took various forms. Some doctors like Ambroise Tardieu published their works in quasi-medical publications such as public health and social science journals and conference proceedings; others wrote domestic health manuals for public consumption. Reformers, legislators, social activists, and even feminists borrowed content from these sources, much of which derived from the experiences of doctors working in the chambers and operation theatres of children's hospitals, and integrated them into carefully-researched arguments on various child-related issues. Outside medical circles and the children's hospital, the preservation of

child health was rarely a topic of singular importance. As the examples of Tardieu, Deraismes, Besant, and others demonstrate, the topic of child health often accompanied and supported related issues, such as criminal law, family preservation, moral vigilance, women's legal or reproductive rights, or education, all of which were actively and increasingly debated in both countries throughout the second half of the nineteenth-century. Medical and non-medical writings examined in this chapter disseminated medical-based justifications for the protection of children for the larger public good of France and Great Britain, and these ideas swelled within and across national borders through written publications and international expositions and conferences.

### Medicalizing Child Abuse

Prior to the mid-nineteenth century, the physical maltreatment of children by parents, family members, and employers gradually became a recognizable and socially unacceptable practice. The work of Ambroise Tardieu, a forensic physician in the Paris courts, exemplified how one prominent and pioneering medical authority first began to interpret cases of child maltreatment from a medical perspective. A doctor who served in numerous posts throughout the Paris hospital system, Tardieu never served on the medical staff of Sainte-Eugénie, but he investigated criminal offenses involving children, some of whom possibly passed through the Paris children's hospitals and morgues as foundlings or older abandoned children or sick children who later died of abuse or extreme neglect. Tardieu published studies on controversial public health topics such as abortion and infanticide, but this chapter focuses on his body of work on the medical dimensions of physical and sexual child maltreatment. In three professional publications

on the topic spanning twenty years, Tardieu first mentioned child sexual abuse in a book-length treatise on general assaults against morals, *Etude médico-légale sur les attentats aux moeurs* (1857), which had seven editions, the last appearing in 1879. This work was followed by an article more specifically on child abuse, *Etude médico-légale sur les sévices et mauvais traitements exercés sur des enfants* (1860), published in the prominent journal, *Annales d'hygiène publique et de médecine légale*, and reprinted in Tardieu's final publication before his death in 1879, *Étude sur les blessures*. Tardieu's studies collectively illustrate novel medical-legal ideas about the physical cruelty and maltreatment of children that would not be widely accepted until the second half of the twentieth century.<sup>452</sup> His forensic work emphasized child maltreatment as a distinctive category, which coupled with a dedication to obtaining visible, scientific proof, added a new medical dimension to conceptualizations of child maltreatment at mid-century, which predominately centered on exploitation and health hazards in the workplace, and *attentats aux moeurs*, or sexual violence. Tardieu's professional writings also demonstrate the symbiotic relationship between medical science and the legal system in identifying and addressing the endangerment of children, the most vulnerable sector of the French public, and its future citizens. In his capacity as a physician, forensic expert, and prolific author, Tardieu typified the Paris medical-legal community and its objectives between 1857 and 1879 in three significant ways: he observed, defined, and wrote about his findings in medical treatises and journals; he participated in the medicalization and

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<sup>452</sup> While broader definitions of child maltreatment at the time included infanticide, abortion, child abandonment, neglect, this chapter considers child maltreatment according to Tardieu's definitions in the 1860s and 1870s: a distinct form of detectable, verifiable physical abuse, which may or may not involve sexual assault. For considerations of infanticide and abortion and shifting attitudes and policies towards them between 1800 to World War I, see Rachel G. Fuchs, *Poor and Pregnant: Strategies for Survival in the Nineteenth Century* (New Brunswick, NJ: Rutgers University Press, 1992), Chapters 8 and 9.

criminalization of physical (and sexual) abuses against children; and his worked with other public health efforts that sought to observe, categorize, and regulate threats to the general health and well-being of the social body.

Highly recognized in his field, Tardieu was a professor of legal medicine at the University of Paris (1861), Dean of the Faculté de Médecin (1864), and President of the French Academy of Medicine (1867), a position he held until his death in 1879. He practiced in several Parisian hospitals while teaching forensic medicine and serving as a court forensic physician. As a Paris hospital physician, he helped to identify medical solutions to public health and hygiene problems through his service on the first medical statistics commission of l'Assistance publique in 1860 and his authorship of *Dictionnaire d'hygiène publique et de salubrité*, a four-volume compendium of contemporary public health knowledge and the model for a later English-language version.<sup>453</sup> Tardieu's dictionary of public hygiene and health was a "complete and important collection" covering military, rural, and urban hygiene, burials, industrial hazards, child labor, schools, housing and sanitation, mines, marshes, ventilation, poisons, prostitution, penitentiaries, public assistance programs, epidemics (such as cholera) and plagues.<sup>454</sup> Tardieu's obituary appeared in the *Lancet*, suggesting his international prominence as a forensic physician and public health leader. The *Lancet* tribute celebrated Tardieu's clinical approach to forensic medicine—characterized by reviewing each case according to its physiological and medical features—and proposed

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<sup>453</sup> Alexander Wynter Blyth, *A Dictionary of Hygiene and Public Health; comprising sanitary chemistry, engineering, and legislation, the dietetic value of foods, and the detection of adulterations, on the plan of the 'Dictionnaire d'hygiène publique' of Professor Ambroise Tardieu* (London: Charles Griffin and Company, 1876), title page. For Tardieu's participation in the medical statistics commission of l'Assistance publique, see chapter three of this dissertation.

<sup>454</sup> H. Brochin, 'Bibliographie: Dictionnaire d'hygiène publique et de salubrité par A. Tardieu', *Gazette médicale de Paris*, série 3, no. 10 (1855):85.

that Tardieu's approach "revolutionised the subject of medico-legal medicine, and opened up new and fertile fields."<sup>455</sup>

By the second half of the century, practitioners of legal medicine like Tardieu projected an image of 'scientific justice', which married medical science with forensic proof in the service of the law.<sup>456</sup> Medical-legal experts, armed with new scientific knowledge of anatomy and physiology, claimed to surpass the inadequacy of prior research, stressed the need for accurate proof of the assault, and encouraged continued studies on the topic.<sup>457</sup> Anatomical examinations conducted by forensic physicians were the epitome of *le coup d'oeil*, or the medical gaze.<sup>458</sup> In sexual assault cases, the detailed medical exam involved the construction of physical indices with anatomical and physiological characteristics and measurements and corresponding sketches of the physical markers of sexual violations, creating what George Vigarello calls "a descriptive pathological grid of sexual injuries."<sup>459</sup> Through the vehicle of the medical exam, Tardieu observed that some crimes against children involved brutal physical, but not sexual, assault. In "*Etude médico-légale sur les sévices et mauvais traitements exercés sur des enfants*," Tardieu introduced a new medical-legal category of physical violence against a child, a new "point of view because of the victim's age, the composition of the wounds,

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<sup>455</sup> *Lancet* [anonymous], 'Dr. Ambroise Tardieu', Vol. 114 (1879): 102.

<sup>456</sup> For a study of nineteenth-century child sexual abuse in France, see James Donovan, "Combatting the Sexual Abuse of Children in France, 1825-1913" *Criminal Justice History: An International Annual*, 15 (1994): 59-93.

<sup>457</sup> Ambroise Tardieu, *Étude médico-légale sur les attentats aux mœurs* [1878], 7<sup>th</sup> ed. (Paris: Baillière, 1879), 34.

<sup>458</sup> This concept, popularized by Michel Foucault's *The Birth of the Clinic*, was a contemporary peer's description of Tardieu's work in his 1879 obituary in the *Lancet*, 102.

<sup>459</sup> George Vigarello, *A History of Rape: Sexual Violence in France from the 16<sup>th</sup> to the 10<sup>th</sup> Century*, trans. Jean Birrell (Malden, MA: Polity Press, 2001), 142.



the variety of violence, the variable nature of the damage, and the always grave, often terrible, consequences.”<sup>460</sup>

Tardieu based his article on 32 cases of child cruelty and abuse (*séVICES et mauvais traitements*) in which he served as a forensic expert.<sup>461</sup> Sexual violence was not a primary focus of this set of cases; only one reported observation involved sexual assault. Tardieu divided abuses into three primary types. The first was physical abuse such as hitting, kicking, pulling hair, and beating with objects such as whips, bottles, and sticks. One such case involved an eight-year-old boy who bore the marks of being beaten by a shoe, and his trunk had innumerable blotches and whip marks.<sup>462</sup> Tardieu noted that this type of abuse was the most common but that even if the injuries were non-life-threatening, they compromised a child’s health.<sup>463</sup> The second category included deprivations of all kinds—exposure to cold, starvation, lack of hygiene and exercise, or isolation and confinement in dark places. One of Tardieu’s cases involved an eleven-year old girl who was found starved, nearly frozen, and barely breathing. Her parents forced her to work long days, with only a half cup of water and two pieces of dry bread daily and inappropriate clothing for the cold weather.<sup>464</sup> Deprivations were often accompanied by physical injury, as the same young girl was also beaten regularly with a stick; the

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<sup>460</sup> Ambroise Tardieu, “Étude médico-légale sur les séVICES et mauvais traitements exercés sur des enfants,” *Annales d’hygiène publique et de médecine légale*, séries 2, no. 13 (1860), 36.

<sup>461</sup> Tardieu’s thirty-two cases are not a mirror on mid-century child abuse, but they offer insight on those experiences and forensic attitudes towards child abuse and its tragic ends. They involved reported cases that went to trial and only measure legal crime. Unknown numbers of reports of child abuse by parents or others never led to prosecutions (apparent crime) or went unreported (real crime). For more on historic criminal data, see Robert E. Nye, “Crime in Modern Societies: Some Research Strategies for Historians,” *Journal of Social History*, 11(1978): 492.

<sup>462</sup> Tardieu, 1860, Obs. V, 371.

<sup>463</sup> Ibid.

<sup>464</sup> Tardieu, 1860, Obs. VII, 375.

number and coloration of the girl's bruises indicated repeated and prolonged beatings. The least common but most disturbing category for Tardieu was torture: repeated burning with hot objects or corrosive fluids, mutilating or crushing body parts, suffocation, and forced ingestion of rotten food or excrement.<sup>465</sup> Particularly heinous, these cases were premeditated acts of torment, not spontaneous or drunken acts of violence. In many cases, Tardieu elaborated on the medical details of the injuries, such the size and type of injury, the various appearance or coloring of the scars, bruises and burns to determine if the injuries were recent or old, and other visible markers of injury.

Tardieu also explicitly tied cases of child abuse to criminality. In 1879, he included a word-for-word reprint of this 1860 article in his last medico-legal treatise, *Étude sur les blessures*, a 474-page volume on criminal injuries and homicide.<sup>466</sup> By inserting the article in the volume's Part I, "Injuries, Blows, and Homicides," he established a direct link between child maltreatment, serious crime, and mortal consequences. Tardieu stressed that physical maltreatment was too often matter of life and death for children. In 18 of the 32 cases that he reviewed in the article, the child died as a result of his or her physical injuries.<sup>467</sup> For Tardieu, this propensity for death meant two things. From a medical-legal perspective, physical abuse of children required the same scientific rigor and precision applied to forensic investigations of other crimes in determining the manner of death. Secondly, it elevated child maltreatment to a serious crime. For Tardieu, once child maltreatment became legible from a medical point of

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<sup>465</sup> Tardieu, 1860, Obs. XIV, 378. The case of Adelina D. was especially horrifying. Her parents restrained, burned, whipped, and poured acid on her wounds, and Tardieu also found signs of sexual abuse.

<sup>466</sup> Tardieu, 1879, 70.

<sup>467</sup> Tardieu, 1879, 367.

view, the forensic physician was able to apply that knowledge in order to punish the perpetrators of those crimes. He also stressed the importance of determining the result of injury and distinguished between purely scientific and medical-legal views of injuries: forensic physicians needed to be concerned with the type (nature) as well as the consequences of the injury. Tardieu classified these consequences according to a graded scale of less severe (*légères*), very severe (*graves*), or so severe to cause death (*mortuelles*).<sup>468</sup> Tardieu gave the greatest attention to cases with the most information about the victim and family, the highest levels of cruelty, and the worst consequences of the abuse, including death.

Despite the diverse form and instruments of child maltreatment, Tardieu's cases shared some common characteristics with Sainte-Eugénie patients who were victims of violent treatment at home or devastatingly neglectful parenting practices. The majority of the maltreated children in Tardieu's reports were abused by parents or step-parents and were very young; over half (17) of Tardieu's cases involved children under the age of six, and six of the youngest victims of maltreatment were still breast-feeding.<sup>469</sup> Between 1855 and 1876, only two Sainte-Eugénie patients were reported victims of child abuse, but the hospital registers suggest that many others entered the hospital with injuries—burns, fractures, contusions, scars—consistent with abusive or neglectful acts at home.<sup>470</sup> In the case of Pauline Frion, the police intervened when the hospital discovered that her

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<sup>468</sup>Tardieu 1879, 6.

<sup>469</sup>Tardieu, 1860.

<sup>470</sup> Archives de l'Assistance publique-Hôpitaux de Paris (AP/HP), Registre d'entrées, L'hôpital Sainte-Eugénie, 1855-1876. My sample only included two removals of children from parental custody as a result of child cruelty or abuse.

fracture was a result of her step-mother's "*mauvais traitements*."<sup>471</sup> If the child was extremely young and the home situation was deemed dangerous to the child's health, the state might get involved and send the child to the foundling hospital, such as Jeanne Pautier, age three, who suffered severe burns from hot water and whose mother was a laundress.<sup>472</sup> In two other cases, police investigated the deaths of two patients, age six and age two, admitted with severe burns, one of which was ruled as accidental death.<sup>473</sup> Due to their age and stated occupation, older patients may have acquired burns or fractures due to accidents at shops where they apprenticed or home-based work environments, poor supervision, or everyday childhood mischief.<sup>474</sup> For example, Fernand Delatre was hospitalized when a fellow apprentice hit him in the knee at the *atelier* where they all worked.<sup>475</sup> When patients between the age of one and three years suffered and possibly died from fractures and burns, a modern observer might question whether the injuries were accidental or intentional.<sup>476</sup> Some of these kinds of diagnoses

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<sup>471</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, #1655, Pauline Frion, age ten, was admitted with multiple contusions and burns on July 13, 1869, and the police determined her step-mother broke her arm and took her away on August 1, 1871.

<sup>472</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, #2593, Jeanne Pautier, age three, admitted on November 6, 1871 with "burns to the legs by hot water," and sent to Enfants-Assistés on November 29, 1871.

<sup>473</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, #1565, Jean Boltz, age 6, admitted on July 12, 1866, with burns to her trunk and arms died of "accidental burns while playing in the chimney at his home; #835, Marie Bertrand, age 2, admitted with burns on March 31, 1870,, died after her clothes caught fire at home.

<sup>474</sup> AP/HP, Registre d'entrées, L'hôpital Sainte- Eugénie, #600, four-year-old Justin Richardot, son of washers (*lingeres*) was admitted with burns on March 11, 1868.

<sup>475</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, #855, fourteen-year-old apprentice Fernand Delatre entered the hospital on April 23, 1874, after sustaining a strike to his knee. His attacker may have been a ward of the state, as Enfants-Rouges was notified of the event. This record is significant because a revised, more enforced child labor law appeared this same year.

<sup>476</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie. In the sample for 1856, three children under the age of three years were admitted with injuries consistent with intentional or unintentional violence, and one

recorded in the Sainte-Eugenie registers suggest that for some patients, family violence and maltreatment was a hazard to their health.

To stress the detrimental effects of child abuse on public health, Tardieu's submitted his article on child maltreatment to *Annales d'hygiène publique et de médecine légale*, the voice of public health reform in France.<sup>477</sup> As a forensic physician, Tardieu inherited a legacy of public health inquiries and reportage from prominent hygienists such as René Villermé and Jean-Baptiste Parent-Duchâtelet who were responsible for discovering the ill-effects of poor housing and hazardous work conditions on working-class health in the 1820s and 1830s.<sup>478</sup> Villermé in particular was concerned about unhealthy child labor conditions and advocated for a national child labor law, which he argued would be another step in promoting national public health.<sup>479</sup> While some public health issues, like disease control and effective sanitation, were clear cut and evident, others were not, such as the relationship between child cruelty and public health. Coincidentally, the article preceding Tardieu's 1860 *Etude* on child abuse was an investigation of the illnesses of brickyard workers, including children.<sup>480</sup> Another child-

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died. No police investigations were in the register for any of these cases. #10, two-year-old Arthur Consedieu, admitted on January 3, 1856, succumbed to burn wounds on January 26, 1856, while a two-year-old and three-year-old patient were admitted with fractures and later released.

<sup>477</sup> The journal's mission statement (Extract from the 1829 presentation of *Annales d'hygiène publique et de médecine légale*) highlights legal medicine's link to public health: "Medicine is not only intended to study and cure diseases; it has intimate relations with society. Medical consultants may assist the legislature in the creation of laws often enlighten the magistrates in their application of those laws, and alongside state administrations, work to maintain public health. This field of knowledge, thus applied to the needs of society, constitutes public health and forensic medicine."

<sup>478</sup> Ann La Berge, *Mission and Method: The Early Nineteenth Century French Public Health Movement* (Cambridge: Cambridge University Press, 1992), 154-177 provides a detailed discussion on these hygienists' works.

<sup>479</sup> Louis René Villermé, *Tableau de l'état physique et moral des ouvriers employés dans les manufactures de coton, de laine et de soie*, vol. 2 (Paris, J. Renouard, 1840), 83-91. Also La Berge, 169.

<sup>480</sup> R. Heise and E. Beaugrand, 'Maladies des ouvriers employés dans les briqueteries, traduit accompagné

related public health issue with medical consequences, child labor in dangerous trades drew the attention of reformers who exposed unhealthy workplace conditions for children and agitated for laws to protect young laborers from dire physical harm. Drawing on moral sensibilities toward children, reformers appealed for stringent reforms by referencing the physical abuse of children by employers, such as tortuous beatings, excessive physical labor, starvation, imprisonment, and even death.<sup>481</sup> By publishing his article in the *Annales d'hygiène publique et de médecine légale*, Tardieu attempted to add the physical maltreatment of children to the hierarchy of crime as a distinctive, observable medical category, and by extension, leverage it as a public health issue.

Tardieu's "Étude médico-légale sur les sévices et mauvais traitements exercés sur des enfants" proposed a new medical-legal category of child maltreatment, by first, medicalizing the phenomenon and creating categories based on the observed physical characteristics of abuse, according to type and consequence (life or death). Secondly, he criminalized child maltreatment within the domestic sphere, expanding state surveillance and judgment of parental disciplinary practices inside the home. Tardieu's work highlighted how child cruelty happened inside the home as well as in the workplace, and parents, not employers or perverse strangers, were the ones responsible for compromising their child's health and wellness. If magistrates, physicians, and the general public understood the home to be a place of protection and refuge for the child and where his or her innocence must be vigilantly guarded, Tardieu's case reports provided clear evidence

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de quelques observations', *Annales d'hygiène publique et de médecine légale*, séries 2, no. 13, (1860): 351. The authors reference Tardieu's *Dictionnaire d'hygiène publique*, with regards to the possible health risks to brickyard workers.

<sup>481</sup> Adolphe- Jérôme Blanqui, *Des classes ouvrières en France, pendant l'année*, Part 1. (Paris: Pagnerre, 1849): 253. According to Blanqui, a socialist reformer, society must 'take hold of [its] children and not abandon them before they have escaped the premature, criminal workshop labor that demoralizes and kills them.'

that this was an ideal that certain parents undermined and never reached. Regardless of the underlying issues, Tardieu brought to light examples of parents who, through cruel and abusive acts, endangered the health and well-being of their own children.

Women's Activism, Child Health, and the Nation: Maria Deraismes and Annie Besant

In France and Great Britain during the 1860s and 1870s, women reformers made their own mark in child protection activism, examining and offering medical explanations and solutions to some of the causal factors that led some parents to resort to acts of child abuse and neglect that forensic physician Tardieu investigated and prosecuted. In both Paris and London, middle-class women reformers turned their attention to family preservation and hygiene, the reduction of infant and child mortality, and the education of poor children, and they took active roles in foundling homes, infant schools and crèches, and children's hospitals and dispensaries throughout the nineteenth century. For example, from its inception GOSH attracted affluent women subscribers, some of whom became lady visitors who came to comfort, care for, and entertain young patients in the hospital or conduct home visits for children who returned home to convalesce. In France, *dames patronesses* became lady inspectors for French child protection societies, making home visits to poor mothers and educating them on proper health, hygiene and nutrition for their children. On both sides of the English Channel, some women's work with children's institutions overlapped with other public activities that supported various women's and children's causes. Middle-class women promoted infant health through their participation in societies that encouraged maternal feeding, the inspection of wet-nurses, and education on proper infant hygiene. Madame Hippeau became a French *dame patronesse* for the

Société de la protection de l'enfance and authored a home economics manual.<sup>482</sup> Mary Carpenter, a middle-class British reformer, tirelessly advocated for "Feeding Day Industrial Schools" that would provide meals and education for poor children and prevent future juvenile delinquency.<sup>483</sup> In the late 1870s, French and British women began to share their ideas and experiences at international congresses on women's rights, the first of which was held in 1878 in Paris. Rosters and programs of these early international feminist congresses of 1878 and 1889 in Paris presented a global cast of participants who discussed topics such as infant and child mortality, paternity law, and education, and charitable institutions that served mothers and children.<sup>484</sup>

This section highlights the activities of Maria Deraismes and Annie Besant, French and British reformers, respectively, who utilized the pen and the platform to raise awareness of risks to children's health and wellness vis-à-vis a women's struggles for legal, economic, educational, and reproductive rights during the 1860s and 1870s.<sup>485</sup> Both reformers emphasized the intimate connection between the health and wellness of mother and child, highlighting the significance of that relationship to the health of the nation. In

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<sup>482</sup>Eugénie Hippeau's *Mères et Nourrices* (Paris, Librairie du journal des jeunes mères, 1875) was an exposition of the history and organization of the sociétés protectrices de l'enfance of France. Hippeau's home economics manual, *Cours d'économie domestique*, had three editions. For other women's efforts, see Rachel G. Fuchs, *Poor and Pregnant in Paris: Strategies for Survival in the Nineteenth Century* (New Brunswick, NJ: Rutgers University Press, 1992), Chapters 4, 5, and 7, and Evelyne Diebolt, *Les Femmes dans l'action sanitaire, sociale et culturelle, 1901-2001: Les Associations face aux institutions* (Paris: Femmes et Associations, 2001).

<sup>483</sup>Jo Manton, *Mary Carpenter and the Children of the Streets* (London: Heinemann, 1976), 154-55, 228-29.

<sup>484</sup>For example, the Congrès Français et international de droit des femmes in 1889 convened representatives from France, Great Britain, Romania, Brazil, Italy, Austria, Germany, Switzerland, Ireland, Scotland, India, Belgium, Holland, Norway, Sweden, Finland, Denmark, Russia, Poland, Greece, Spain, and the US. The section on philanthropic organizations, which included reports on particular French orphanages, crèches, maternity hospitals, women's prisons, houses of refuge for abandoned young girls, and societies to prevent prostitution.

<sup>485</sup>Deraismes and Besant likely knew of one another; Besant attended the 1878 International Feminist Congress in Paris that Deraismes co-organized and presided over as president.



France, Deraismes proposed that poor mothers and children oppressed by paternal power suffered physically and morally in poverty, sickness, and ignorance, and only through their achievement of greater legal and educational rights could French women uplift theirs and their progenies circumstances. In Great Britain, Besant advocated for the reproductive rights and physical health of poor mothers and promoted family limitation practices among the British poor, including a variety of birth control techniques (which were illegal at the time). Crossing the boundaries between social, political, and medical aspects of public health and welfare, Deraismes and Besant framed their discussions of women's and children's health in scientific theories, national health statistics, and medical information to bolster their arguments about women and child protection. Deraismes weaved concerns over infant child mortality and depopulation in France into her arguments, while Besant used infant mortality rates to demonstrate the sad consequences of British overpopulation and to forward her proto-eugenic argument in favor of limited family sizes so that poor families could produce fewer, more healthy babies.<sup>486</sup> The logic behind both sets of arguments was that the improvement and edification of women would result in stronger, healthier children and ultimately contribute to a stronger, healthier nation.

As Accampo, Fuchs, and Stewart remind us, bourgeois men invented political ideology, studied medicine and hygiene, and administered social reforms.<sup>487</sup> Influenced

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<sup>486</sup> Stephanie McBride-Schreiner, "Risk and Reward: Annie Besant and Birth Control, 1874-1889." Unpublished Masters' Thesis, Department of History, Arizona State University, 2008, and "Reframing Reproduction: Public Health and Family Limitation in Late-Nineteenth Century Britain," paper presented at the Pacific Coast Branch American Historical Association 102<sup>nd</sup> Annual Meeting, Albuquerque, NM (August 6-8, 2009), and "*Les droits de l'enfant: Child Welfare, Paternal Authority, and the Civil Code, 1873-1889*," unpublished paper, Department of History, Arizona State University, 2010.

<sup>487</sup>Elinor A. Accampo, Rachel G. Fuchs, and Mary Lynn Stewart. *Gender and the Politics of Social Reform in France, 1870-1914*. (Baltimore: Johns Hopkins Press, 1995), 10.

by rhetoric and discourse of legislators, statisticians, and government administrators, French and British women reformers like Deraismes and Besant remained on the margins of those discussions. As women, they could not hold political office or vote for the reforms that they proposed, but they could speak and write about them in an attempt to persuade others to think about them in new ways. As pragmatists, feminists and other female reformers couched their demands in terms that emphasized family, education, and national regeneration or public health—an approach that was less threatening to the politicians drafting the reforms.<sup>488</sup> Some simultaneously rejected cultures of patriarchy and clericalism that circumscribed women’s social roles and placed legal, economic, and educational restrictions on women based on their reproductive or religious roles, which in their view also compromised the health and well-being of children.

For middle-class reformers like Deraismes and Besant, motherhood was a civic duty, and poor mothers needed to be better educated on how to better manage their family household and raise healthy and productive children. As middle-class women, however, most female reformers faced difficulties in promoting their ideas among poor women, the very persons that they were attempting to help. Female health visitors and social workers with an appreciation for, but no personal experience with, the challenges of working-class lives came into poor family homes to instill middle-class housekeeping and child-rearing principles.<sup>489</sup> Reformers’ attempts to impose middle-class values and practices often

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<sup>488</sup> Karen Offen, “Depopulation, Nationalism, and Feminism in Fin-de-Siècle France,” *The American Historical Review* 89, 3 (June 1984): 774. In a seminal article on Third Republic feminism, Offen demonstrated how republican feminists like Deraismes employed the same language as the prevailing republic rhetoric on population, patriotism, and motherhood to make their own arguments legible to her audience.

<sup>489</sup> See Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992), and her discussion on women charity workers in London, 52-59. Also Ellen Ross, 15-21.

appeared intrusive and judgmental to working-class women, and their responses to such interferences into their domestic affairs could be resentful, suspicious, and uncooperative.<sup>490</sup> Just as the mothers of GOSH and Sainte-Eugénie patients who preferred to remove their sick child from the hospital than obey the hospital rules, some poor mothers did not appreciate the counsel or interference by middle-class authorities.

### Maria Deraismes and a Child's Right to Health

The writings of Maria Deraismes, a champion of woman's rights in France, illustrate how one French feminist integrated the topic of child health into her fight for an expansion of women's legal and educational rights. Two of her publications, *France et Progrès* (1873) and *Les droits de l'enfant* (1876), specifically addressed the health and vitality of the nation—a topic that spanned every French political party and religious denomination at mid-century.<sup>491</sup> Her exposition of ideas reflects French anxieties about depopulation and infant mortality, juvenile crime and degeneracy, and the detrimental effects of industrialization and urbanization on public health that weighed heavily on the minds of politicians, physicians, engineers, and social reformers during the 1850s and 1860s and intensified after France's military defeat in the Franco-Prussian war and the

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<sup>490</sup> For examples, see Seth Koven, *Slumming: Sexual and Social Politics in Victorian London* (Princeton: Princeton University Press, 2004), 194-197. Ross provides many examples of British working-class mothers' aversions to health visitors and social workers for women's and children's welfare programs in chapter 7 of *Love and Toil*, and while many of these examples refer to the early twentieth-century infant welfare movement, the examples in the preceding chapter of this dissertation reflect similar attitudes at the children's hospitals in London and Paris.

<sup>491</sup> Maria Deraismes, *Les droits de l'enfant* (Paris: E. Dentu, 1887), 2. The opening line of this work is: "the child must be the object of all our concerns...never has it been more urgent to turn our attention to children, in order to healthfully pave the way for their destinies and to save them from arbitrary wills and laws."

civil violence of the Paris Commune in 1870 and 1871.<sup>492</sup> In the aftermath, an upsurge of social reform campaigns to “regenerate” French society led by bourgeois, republican legislators placed France’s future citizens—children—at the nexus of these concerns. A liberal republican, Deraismes supported these attempts to improve national health, but believed that the French legal system’s preservation of male authority, or *puissance paternelle*, prevented the full realization of those reforms. According to the French Civil Code, women and children were to be “ruled” by their husbands and fathers, which in Deraismes’s view, engendered a host of abuses against women and children. In *Les droits de l’enfant* in particular, Deraismes used the physical and moral health of children as the framework to convey her bourgeois, republican concern for national regeneration and her feminist commitment to dismantling male authority.

From the late 1860s until her death in 1894, Deraismes was a well-known feminist organizer, writer, and public speaker, whose strategic rhetoric and activism was a part of the “social theater” of politics during the Third Republic.<sup>493</sup> A leading “theoretician” of liberal republican feminism in the 1870s and 1880s, Deraismes, along with feminist collaborator Léon Richer, worked out the dominant feminist program at the time—*la politique des brèches* – the politics of making small gaps in the wall that patriarchy constructed to oppress women.<sup>494</sup> In 1878, she and Richer organized the First

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<sup>492</sup> Philip Nord, “The Welfare State in France, 1870-1914,” *French Historical Studies* 18, No. 3 (Spring 1994), 828-9, 832-3. For a more on the concept of degeneracy, see Robert Nye, *Crime, Madness, and Politics in Modern France: The Medical Concept of National Decline* (Princeton: Princeton University Press, 1984).

<sup>493</sup> Jean Elisabeth Pederson, *Legislating the French Family: Feminism, Theater, and Republican Politics: 1870–1920* (New Brunswick, NJ: Rutgers University Press, 2003).

<sup>494</sup> Claire Goldberg Moses, *French Feminism in the 19th Century* (Albany: State University of New York Press, 1985), 181-2; and Joyce Elizabeth Dixon-Fyle, *Female Writers Struggle for Rights and Education for Women in France, 1848–1871* (New York: Peter Lang, 2006), Chapter 4.

International Congress on Women's Rights held in Paris, a benchmark in French feminism as well as the international feminist movement.<sup>495</sup> Deraismes also led the French purity crusade to abolish the official regulation and inspection of prostitutes and was an avid advocate of legal support for abandoned mothers and paternity searches.<sup>496</sup> As Deraismes's breadth of causes suggests, women's and children's rights were intrinsically linked; it was nearly impossible to speak about the rights of the child without mentioning the rights of the mother.<sup>497</sup> Under the Code, married women and children shared the same legal status; they were minors under the yoke of the paternal power of husbands and fathers, or *puissance paternelle*.<sup>498</sup> Since a mother's circumstances invariably impacted her child's life for better or worse, the civil rights that Deraismes claimed for women—equal pay for equal work, equal education, and the ability to sue for divorce and paternity support—directly or indirectly involved children, and winning greater liberties for women would also benefit their living and unborn children.

Deraismes's use of the phrase "children's rights" coincided with changing ideas about the French family and its relationship to the nation and the law in the second half of the nineteenth century. Since the Revolution, conservatives and liberals of every creed and political party hailed the family as the cornerstone of French society, and in 1804, the Code systematized family relations to promote social order. Viewing the family as the

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<sup>495</sup> Karen Offen, *European Feminisms, 1700-1950: A Political History* (Stanford, CA: Stanford University Press, 2000), 151, 158.

<sup>496</sup> Patrick Kay Bidelman, "Maria Deraismes, Leon Richer, and the Founding of the French Feminist Movement, 1866-1878," *Third Republic* 3/4 (1977):41. Deraismes and Richer were also fellow Freemasons along in the 1860s.

<sup>497</sup> Deraismes, *Les droits de l'enfant*, 34.

<sup>498</sup> Concerning a women's status, Article 212 states that "the husband owes protection to his wife, the wife obedience to her husband." According to Articles 371-373, "a child, at every age, owes honor and respect to his father and mother; the child remains subject to their control until the child's majority or emancipation; the father alone exercises this control during marriage." See *Code Napoleon; or, The French Civil Code*, trans. George Spence (London: William Benning, 1827).

“nursery of the state” and family stability as a key to national strength, the Code aimed to “bring law and social behavior into harmony and to promote family feeling, which conduces so greatly to the sense of citizenship.”<sup>499</sup> The Code inscribed family governance in patriarchal terms, leaving the task of ordering the family up to the discretion of male head of households. Over time, the family came to be seen as both a victim of disorder and change wrought by urbanization, industrialization, and regime changes, as well as the greatest defense to counteract those disorderly effects.<sup>500</sup> This perceived erosion of the family, acerbated by the Franco-Prussian War, brought the cultural tradition of *puissance paternelle* under review, not only from feminist camps, but from reform-minded individuals working in the fields of medicine, the law, and public welfare institutions. In the face of destabilizing influences, patriarchs were falling short in their duties to protect and provide for their family members. Parental failures—paternal and maternal—were painfully evident in the Paris children’s hospitals where poor, sick children were constant reminders of the harsh toll that urban poverty, transitory living, or domestic strife had on young bodies.

Deraismes’s notion of children’s rights was also part of a broader agenda to strengthen and increase French population, and her ideas about children’s health dovetailed with the French infant mortality movement in the second half of the century. She understood child health to be a basic right of a child, and all children “had the right to the fundamental development of their physical and moral capabilities.”<sup>501</sup> Deraismes

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<sup>499</sup> Jean-Louis Halperin, *The French Civil Code*, trans. Tony Weir (London: University College of London Press, 2006), 17.

<sup>500</sup> For a more in-depth discussion on the Code’s privileging of paternal authority and its implications for families, see Rachel G. Fuchs, *Contested Paternity: Constructing Families in Modern France* (Baltimore: John Hopkins University Press, 2008), 54, 207.

was not a doctor or child development expert, but she recognized that the earliest years laid the foundation for the child's character, temperament, and opportunities.<sup>502</sup> She stressed how the state should “concern itself with the first years of breastfeeding and nutrition, a very important and influential period that is the foundation of the entire life and future health of the child. All the hygiene in the world would never be able to make up for the poor effects of an unhealthy early childhood.”<sup>503</sup> Her views echoed French doctors' concerns about infant mortality and the establishment of new laws and institutions to promote *puériculture*, or healthy child-rearing practices, especially improvement in the wet-nursing industry. Wet-nursing was most detrimental to the children of working-class mothers who paid other women to wet-nurse and care for the child until it was weaned, usually at a year—if they survived. Between 1861 and 1874, between one-third and one-half of the children sent out to wet-nurse died, constituting a “national calamity” and signaling the lack of information and medical support for mothers and nurses of the laboring classes.<sup>504</sup> First formed in Paris in 1865 and followed by later branches in French cities, the *Société protectrice de l'enfance* vowed to “protect infants from the dangers” of wet-nurses, who “far from parents, lack sufficient supervision and effective control.”<sup>505</sup> These societies, along with an Academy of Medicine Committee on the Mortality of Nurslings in 1867 and a permanent Committee

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<sup>501</sup> Deraismes, *Les droits de l'enfant*, 21. [*L'enfant*] a droit au développement intégral de ses facultés physiques et morales.

<sup>502</sup> *Ibid.*, 19.

<sup>503</sup> Deraismes, *De la dépopulation*, Appendix in *Les droits de l'enfant*, 90.

<sup>504</sup> Sussman, 126. For a discussion of other social reforms associated with the “moralization” of the working-class, including education, women's labor reforms, and maternal societies, see Accampo, Fuchs, and Stewart.

<sup>505</sup> M. F. Boudet, “*Sur l'origine et les œuvres de la Société protectrice de l'enfance*,” (Paris: Felix Malteste, 1869), 2.

on Infant Hygiene in 1870, helped pass the 1874 Roussel Law that monitored the wet-nursing business.<sup>506</sup> Espousing similar ideals about maternal nursing and child-rearing, Deraiques supported maternal societies and state-sponsored child care centers (*asiles* and *crèches*). At a Society for Maternal Nursing speech in 1883, she stated that "... the republic must counter the so-called depopulation, less by multiplying births than by practicing vigilance over maternal matters and judiciously caring for the young already living. [The republic] will furnish the French nation with a young guard composed of citizens with robust bodies and spirits."<sup>507</sup> These words present crucial strands of continuity in Deraiques's work that resonated with the aims of the Paris children's hospitals: her promotion of the Republic's surveillance over French children's health, and her emphasis on improved care for living children so as to build up their bodies and minds so that they may strengthen the nation.

Deraiques elaborated on this theme, highlighting the dangers to the child, and to the nation, when fathers fell short of their paternal obligations and abandoned families or hindered mothers from nurturing their children. Under *puissance paternelle*, women and children were dependent on their husband for protection and sustenance, so Deraiques highlighted how "if a husband was "ill, foolish, corrupt, or incapable, makes too little money, or becomes unemployed, the women and children of the family will suffer."<sup>508</sup>

Due to a ban on paternity searches, some fathers abandoned their natural children to the

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<sup>506</sup> Sussman, 128.

<sup>507</sup> Deraiques, "De la dépopulation," in *Les droits de l'enfant*, 96. Deraiques first delivered this speech at the Gobelins Theater on March 11, 1883. She delivered it again at the Société de l'allaitement maternel, and republished it in an appendix in *Les droits de l'enfant* (1887), later included in her *Oeuvres complètes*, Volume 3 (1895).

<sup>508</sup> From "Les droits des femmes," extract of a letter to the *Journal de Paris*, published in April 16, 1875, in Maria Deraiques, *Ce que veulent les femmes: articles et conférences de 1869 à 1891*, ed. Odile Karakovitch (Paris: Syros, 1980), 59.



care of single mothers, as common register entries of *fils natural* and *fille naturelle* in the Sainte-Eugénie hospital registers suggest.<sup>509</sup> Deraismes understood that these types of paternal neglect compromised the health of their children since their growth and development depended on sufficient nourishment, a nurturing upbringing, and safe, sanitary environments.<sup>510</sup> The thousands of child patients admitted to the Paris children's hospitals of Sainte-Eugénie and Enfants-Malades with diseases related to poor hygiene and nutrition, such as scrofula, ringworm, diarrhea, and rickets confirm that many poor Parisian parents struggled to provide what experts concluded constituted a healthy upbringing of their children. Even if they were aware of the experts' nutritional and hygienic standards—which most of them probably were not until it was too late—most poor families could not afford to provide even the child's basic needs. Completely stripped of parental care, some patients were abandoned at the hospital and became wards of the state because their parent or parents could not or would not meet their parental obligations.<sup>511</sup> While extremely rare, child abandonment occurred at Sainte-Eugénie. For example, Julie Moreau, age 3, admitted on Oct, 21, 1873, was “sent to Enfants-Assistés since her parents disappeared.” Other patient entries suggest abandonment, such as the entry for two-year-old Celestine Galez, hospitalized on July 2, 1863, with heart problems

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<sup>509</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie, 1856. For example, in 1856, between six and seven percent, or five out of 75 patients in the sample were listed as natural child with no father named. The register does not state if the father abandoned these women and children, and mother may have refused to name the father.

<sup>510</sup> Deraismes, *Les droits de l'enfant*, 19.

<sup>511</sup> AP/HP, Registre d'entrées, L'hôpital Sainte-Eugénie. Child abandonment at Sainte-Eugénie happened rarely. The only entry in my sample that explicitly mentioned abandonment was Julie Moreau, admitted on Oct, 21, 1873. Entry #1395, Celestine Galez, admitted on July 2, 1863. Both patients were sent to Enfants-Assistés, formerly Enfants-Trouvés.

and sent to the foundling hospital ten days later. Her father, a widower, likely gave the child to public care because he could not manage to care for the chronically sick toddler.

Like Tardieu, Deraismes was also concerned with child maltreatment, differentiating between abuses such as bodily harm, deprivation of basic needs, and what she termed intellectual or moral abuses, like child abandonment, the parental neglect of a child's educational needs, or a child's lack of proper supervision due to a parent's long work hours, lack of support networks, or money.<sup>512</sup> Poverty and abuse unfortunately went hand in hand, and some poor families lived in an atmosphere of violence, fear, and deprivation, a combination of forces that Deraismes noted could take a heavy toll on young children.<sup>513</sup> She understood that a child's physical and cognitive development was intertwined, and that physical abuse or neglect had long-term psychological and emotional effects. Since a child's brain "only forms and functions under hygienic and educational conditions," children raised in unsafe, unhealthy, and unsupportive family environments could not reach their full potential.<sup>514</sup> In conjunction with these forward views on child brain development, Deraismes was also ahead of her time in recognizing the traumatic effects that viewing or experiencing violence had on children. She stressed the negative impact of family violence on a child's developing brain, a topic that specialists are still trying to understand today. Deraismes's perception that "during

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<sup>512</sup> Deraismes employed the term *séVICES* to imply the idea of cruelty or force, a word that would later be codified in the law. Antoine-Marie Demante, *Cours analytique de Code civil*, Vol. IV, (Paris: E. Plon, Nourrit et Cie, 1884), 229. *Par séVICES il faut entendre les mauvais traitements...Le mot séVICES, par son étymologie, implique l'idée de cruauté, de rigueur barbare.*

<sup>513</sup> For a study of violence among the working-class in Paris, see Eliza Earle Ferguson, *Gender and Justice: Violence, Intimacy, and Community in Fin-de-Siècle Paris* (Baltimore: Johns Hopkins University Press, 2010). Ferguson notes that parenting was rarely a topic in legal cases of domestic violence and that children (legitimate or natural) infrequently figured in cases, 70-74. I would argue that this lack of attention reflects a paucity of the judiciary's and general public's acknowledgement and understanding of the effects of violence on young children.

<sup>514</sup> Deraismes, *Les droits de l'enfant*, 19.

childhood, a child's brain is "too tender" to develop properly in a terror-filled environment" suggests her sophisticated understanding and utilization of contemporary medical and psychological knowledge.<sup>515</sup>

If poverty, aggravated by *puissance paternelle*, was a certain risk to a child's health, then according to Deraismes, the problem was poor, uneducated, and unstable families. Linking the ill health of children and the nation with poverty, misery, and ignorance, Deraismes depicted working-class life as precarious, potentially deadly, and in need of some type of intervention. She spoke of "*l'intervention*" in proletariat families, as well as in the lives of the lower middle classes (*nouvelles couches sociales*), a growing social stratum of professionals and service workers.<sup>516</sup> The children's hospital was one type of intervention, but in Deraismes view, medicalization and moralization went hand in hand, and a complementary "moral" solution to child ill-health was a universal, secular education system. If poor, miserable, abandoned children or children exposed to hazards of the streets were "assisted and placed under the supervision (*surveillance tutelaire*) of a civic, republican education, rather than their arbitrary, prejudicial families, these children would benefit."<sup>517</sup> The education of working-class children, much like parent education about healthy child-rearing practices, was an important part of Deraismes's vision for a strong and vital Republic.<sup>518</sup> First, education would instill the Republic's future citizens

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<sup>515</sup>Ibid., 40. *Dans l'enfance, l'appareil cérébral est trop tendre, pour qu'il puisse avoir, dans un milieu rempli de terreur, un développement normal.*

<sup>516</sup> Odile Krakovitch points out that Deraismes rarely used the word "class" to describe the working class, but used the term, "*couche*" or stratum instead, possibly as a deliberate attempt to temper her bourgeois, republican discourse. *Ce que veulent les femmes*, 17.

<sup>517</sup> Deraismes, "*De la dépopulation*," 94. Note Deraismes's references to surveillance and tutelage.

<sup>518</sup>In Great Britain, some women reformers advocated for the education of mothers and children and the revision of paternity laws to prevent abandonment and infanticides, but they did not want the state to

with the republican principles of solidarity, equality, and liberty and would lift up children from oppressive, poor family situations. Second, through mandatory, universal education requirements, the state would “tame puissance paternelle” and supplant the father’s arbitrary will and neglect with reason, science, and secular morality.<sup>519</sup> For Deraismes, revising the Code to require obligatory education with equal curriculum requirements for boys and girls would not only offer children a safe place to develop physically and intellectually, but would achieve both of Deraismes’s goals: to regenerate the health of the nation while inculcating a moral code consistent with secular, republican, and science-based principles.

#### Annie Besant, Child Health, and British Women’s Reproductive Rights

Deraismes’s focus on nurturing and preserving the health of the present generation of children resonates with the ideals and objectives of the nineteenth-century children’s hospitals. Contrary to French pronatalists and some populationists that wanted to increase the birth rate, Maria Deraismes believed the greatest danger to the French population was the premature deaths of living children—not birth control—and one solution was to provide better care and attention to children’s physical development. Across the Channel, another British female reformer similarly supported medical solutions to British concerns about overpopulation—especially among the lower classes—and its attendant social ills such poverty, illegitimacy, prostitution, and child

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intervene in the commercial nursing industry because increased state inspections and licensing were detrimental to the livelihood of hard-working nurses. In the wake of the British Infant Protection Act of 1870, a committee of women formed to fight against the unfair regulation of working-class women by the state. See Committee for amending the law in point wherein it is injurious to women, “Infant Mortality: its causes and remedies” (Manchester: Ireland and Co., 1871), 7, 40-41.

<sup>519</sup> Deraismes, *Les droits de l’enfant*, 14.

mortality.<sup>520</sup> Annie Wood Besant, an early British birth control advocate and freethinker, believed that birth control, or family limitation, practices among the working classes was the best, most effective way to improve the health and welfare of poor British children.<sup>521</sup> She made it her quest to share the scientific knowledge of reproduction and contraception to all stations of British society, especially poor mothers whose physical health suffered from too many children and too many pregnancies. With colleague Charles Bradlaugh, Besant helped found the Neo-Malthusian League, an organization dedicated to changing negative attitudes towards family planning practices and educating individuals about effective contraceptive techniques, and she authored her own birth control pamphlet, *The Law of Population* (1878), which outlined the argument for conjugal prudence and provided detailed contraceptive techniques in simple, direct language.<sup>522</sup> Besant was not a scientist, but she viewed science as the cornerstone for understanding the world around her and recognized that scientific inquiry and empirical evidence as the key to pushing the birth control cause forward. She expounded upon the key tenets of Thomas Malthus's population theory and Charles Darwin's evolution theory to formulate her reasons why couples should practice family limitation, and she gleaned medical evidence to explain the health benefits that family limitation offered to mothers and children.

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<sup>520</sup>According to Eliza Ferguson, the family size of working-class Parisians was very small, with two or fewer children, and larger families usually comprised children from previous unions or marriages. See Ferguson, 70.

<sup>521</sup>Norman Himes, *A Medical History of Contraception* (Baltimore: Williams and Wilkins, 1936), xvi. Besant never used the phrase "birth control;" she and other advocates used the phrases conjugal prudence or family limitation. Margaret Sanger, the leader of the first organized birth control movement in the United States first coined the term in a 1914 article.

<sup>522</sup>Rosanna Ledbetter, *A History of the Malthusian League, 1877-1927* (Columbus: Ohio State University Press, 1976), xiv.

Besant's *The Law of Population* had roots in the Reverend Thomas R. Malthus's 1798 *Essay on the Principle of Population* and his theory on population theory inspired by rapid population growth and over-crowding in Britain.<sup>523</sup> By Besant's time, overpopulation and the health of the national population remained a concern, and British vital statistics had developed into an advanced science that informed public debates and policy decisions on the issue.<sup>524</sup> Besant drew upon these anxieties and linked them to her cause, particularly Malthus's proposal that British individuals had a duty to employ preventative, "birth-restricting checks" to control the population and to avoid bringing children into the world that they could not support.<sup>525</sup> Similarly, Besant believed early marriage, combined with conjugal prudence or family planning, was the best preventative check: "the numbers of children born after marriage should be limited and that such limitation is as much the duty of married persons as the observance of chastity is the duty of those that are unmarried."<sup>526</sup> For Besant, family planning went beyond a sense of personal duty; it was a national obligation. In her words, England as a whole would benefit "when parents resolutely determine to limit their family to their means, and stamp with moral disapprobation every married couple who selfishly overcrowd their home, to

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<sup>523</sup> See Chapter three of this dissertation for a discussion of nineteenth-century statistics and national population.

<sup>524</sup> Dorothy Porter, *Health, Civilization and the State: A history of public health from ancient to modern times* (London and New York: Routledge, 1999), 4.

<sup>525</sup> S. Chandrasekhar, *A Dirty, Filthy Book: The Writings of Charles Knowlton and Annie Besant on Reproductive Physiology and Birth Control and an Account of the Bradlaugh-Besant Trial* (Berkeley: University of California Press, 1981), 5. Malthus reasoned that since the human population could never increase beyond the level of subsistence needed to support it, necessary checks operated to keep population even with resources. He identified "positive checks," poverty, famine, disease, disaster, which increased the death rate, and "preventative" checks—moral restraints such as delayed marriage and conjugal prudence—to reduce the birth rate.

<sup>526</sup> Annie Wood Besant, *The Law of Population: Its Consequences, And Its Bearing Upon Human Conduct and Morals* (1879), in *A Selection of the Social and Political Pamphlets of Annie Besant*, ed. John Saville (New York: Augustus Kelley Publishers, 1970), 31.

the injury of the community of which they are a part.”<sup>527</sup> Besant framed her birth control argument in the familiar, authoritative Malthusian language and content to address a class-based issue of great national concern: unrestrained births within the lower classes and the poverty, disease, and death associated with it.

To further strengthen her case that birth control was the logical scientific solution to overpopulation, Besant drew upon evolutionary biology and portions of Charles Darwin’s *Origin of Species*. Influenced by Malthus’s essays, Darwin’s work echoed the necessity of checks to population to maintain the fragile balance of nature.<sup>528</sup> Besant accepted the theory of evolution and the principle of natural selection, the mechanism by which organisms evolve over time through a brute struggle for existence.<sup>529</sup> For Besant, however, the evolutionary process was different for man than for the rest of nature. Scientific checks to population like conjugal prudence and family limitation did for mankind what the struggle for existence did for the rest of the natural world; they maintained the natural balance, not as a result of brutal competition for resources, but through careful family planning and limited number of children per family unit. Expanding on Darwin’s ideas, Besant conceptualized the calculated practice of birth control as the triumph of the human mind and discipline over nature. Besant’s appropriation of Malthusian and Darwinian ideas and her advocacy for population control

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<sup>527</sup> Ibid., 36.

<sup>528</sup> Charles Darwin, *On the Origin of Species by Means of Natural Selection, or the Preservation of Favoured Races in the Struggle for Life* (London: John Murray, 1859). Malthus’s influence is implicit in Darwin’s third chapter, “Struggle for Existence,” where he accepts nature’s propensity for reproduction and references “checks” to reproduction.

<sup>529</sup> Besant, 10-11. She quoted Darwin’s theory of natural selection: “Every being, which during its natural lifetime produces several eggs or seeds, must suffer destruction during some period of its life, and during some season or occasional year, otherwise, on the principle of geometrical increase, its numbers would quickly become so inordinately great that no country could support the product. Hence, as more individuals are produced than can possibly survive, there must in every case be a struggle for existence.”

through family limitation resembled those of Social Darwinists like Francis Galton and Herbert Spencer who “socialized” Darwin’s ideas, and the later eugenics movement; however, she was not solely focused on eugenic principles such as the selective breeding of the “fit” and preventing births of the “unfit.”<sup>530</sup> Besant, Bradlaugh, and other neo-Malthusians emphasized the liberation that the knowledge and practice of birth control offered to individuals, men and women alike. In their view, contraceptive practice provided freedom from medical ignorance, freedom from restrictive religious attitudes about conjugal sex, and freedom from family poverty due to too many mouths to feed and bodies to clothes and shelter.

Besant was also concerned about the ways in which poverty, disease, and poor life choices related to individual health, specifically the health of mothers and children, and public health writ large. Medical discoveries, particularly information about women’s reproductive health, aided birth control arguments even though the majority of the contemporary medical establishment was antagonistic toward the idea of contraception, maintaining it did not constitute legitimate medicine and only encouraged sexual promiscuity, prostitution, and venereal diseases.<sup>531</sup> In contrast, Besant stated that birth control practice was comparable to sound medical care and that “to limit the family is no more a violation of nature’s laws, than to preserve the sick by medical skill” and sought out the few doctors whose opinions could support her case for birth control as a “healthy”

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<sup>530</sup>In Great Britain, the eugenics movement was hostile to the activities of the Neo-Malthusian League because they feared that the widespread availability of contraception would further decrease the birthrates of middle-class families, those whom the eugenicists wanted to reproduce more.

<sup>531</sup>Hera Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception, 1800-1975* (Oxford: Oxford University Press, 2004), 55. Also see Angus McClaren, *Birth Control in Nineteenth Century England* (New York: Holmes and Meier Publisher, 1978), 117; and J. A. Banks, *Victorian Values: Secularism and the Size of Families* (London: Routledge, 1981), 112.



practice.<sup>532</sup> Multiple pregnancies were hard on a mother's physical health, often eliciting negative effects such as "falling of the womb," or prolapsed uterus, leucorrhoea (vaginal infection), general weakness, and other diseases of the reproductive organs.<sup>533</sup> Besant also cited problems associated with over-lactation, another product of not spacing out births. If children are nursed longer than 12 months and pregnancy occurs while the mother is still nursing, it "is highly improper, as it not only injures her own health, and may bring on a miscarriage, but it is also prejudicial to her babe, and may produce a delicacy of constitution from which he might never recover."<sup>534</sup> These warnings from the medical community directly linked the health of mothers and families to the health of the child, a connection of which French and British doctors were already acutely aware. Some French children's doctors focused on the passing syphilis from mother to baby, such as Jules Parrot, who in the 1870s proposed that syphilis caused rickets.<sup>535</sup> In contrast, most British doctors attributed childhood rickets to the circumstances of poverty. For example, GOSH physician William Jenner believed that childhood rickets was caused by various circumstances of poverty: "the poorness of the mother's blood, feeding the child with nourishment unsuited to its wants and digestive powers and subsidiary causes, such as deficient light and impure air in overcrowded sleeping rooms."<sup>536</sup> Like Besant, Jenner understood that poverty hindered mothers from acquiring

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<sup>532</sup> Besant, *Law of Population*, 37.

<sup>533</sup> *Ibid.* 22.

<sup>534</sup> *Ibid.* 35.

<sup>535</sup> Elizabeth Lomax, *Small and Special*, 168. Most French and British doctors did not agree with Parrot's findings, and syphilis was a rare diagnosis at either GOSH or Sainte-Eugénie.

<sup>536</sup> Sir William Jenner, *The Practical Medicine of today: Two addresses delivered before the British Medical Association and the Epidemiological Society* (London: H. K. Lewis, 1869), 45.

healthy living spaces, proper nutrition, and knowledge about how to feed and care for their children.

A poor, anemic pregnant mother's weak constitution and lack of nutrition and hygiene compounded the health risks that she faced with high numbers of pregnancies and births, an already arduous task when a woman was in the best physical health. If a poor, unhealthy, and physically fragile mother had several children, she placed them all at risk for insufficient care and nutrition.<sup>537</sup> One particular example in the patient files at GOSH illustrates this unfortunate cycle: in the transcribed case notes for seven-year-old William Kean, admitted to the hospital with diabetes in 1863, the record stated that William was one of eleven children between the ages of one and 22, and six of his siblings had died of various diseases prior to his admission.<sup>538</sup> Furthermore, his mother had three miscarriages, which suggests that in addition to not practicing family limitation, she may have experienced general weakness and low immunity at some points of her child-bearing life. Even if young William's diabetes was completely unrelated to his mother's health, the quality of his diet and hygiene was likely compromised in such a large family with little means. At the height of his illness, William was drinking up to a quart of milk daily and a great deal of water. Considering fresh cow's milk was too overpriced for most working-class families, he probably drank tinned condensed milk, filled with sugar content that exacerbated his diabetic condition and unquenchable

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<sup>537</sup>Ross, 106-111. For Paris, Eliza Ferguson notes that large working-class families were the exception, not the rule, but occasionally a woman had numerous pregnancies. She gives an example of a Parisian assize court case involving a woman who had eleven pregnancies, of which only five children survived. See Ferguson, 70.

<sup>538</sup> *HHARP, Historical Hospital Admission Records Project*, William Kean, admitted on April 6, 1863, and died four weeks after his discharge on April 19, 1863 in a state weaker than he was admitted. The hospital doctors attempted to place him on a special diet, but he violently resisted.

thirst.<sup>539</sup> The Kean family circumstances and the sad consequences of large families, poverty, and poor maternal and child health was the equation that Besant sought to avoid through the promotion of birth control.

### Various Paths to Child Health and Hygiene

Representative of a different manifestation of the widespread focus on child health after 1850, the first international exhibition on childhood, *L'Exposition de l'Enfance* took place in Paris in November 1873, the same year that Maria Deraismes published her *France et Progrès*. The exhibition was a grand affair involving numerous officials and dignitaries with the express purpose of showcasing commercial products designed for “the health and pleasure of children.”<sup>540</sup> Displays included child-related products ranging from food stuffs to furniture to educational materials. Health-related items were a central focus: nourishment aids, like baby food (*fecules*), and food scales, and medical products ranging from pharmaceuticals, orthopedic supports, dental care, and herbal remedies. Other displays spanned from the basic to the more frivolous: clothing and blankets to baptismal and communion garments; cradles (*berceaux*) and carriages (*promenettes*) to ventilators, heating appliances (*fourneaux*), and model nurseries. The Exposition also paid significant attention to children’s intellectual development, and it showed off the latest games and toys geared towards toward sensory and cognitive development, and educational tools, such as books, maps and atlases, alphabets, globes, school furniture, and musical instruments.

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<sup>539</sup> Ross, 142-143.

<sup>540</sup> *Programme de l'Exposition universelle et internationale de tout ce qui a rapport à l'enfant, depuis son enfance jusqu'à son adolescence, au Palais de l'industrie*. [s.n.]: Paris. No. 2 (23 novembre 1873): 1.

This exposition on childhood provides an entry point to explore emerging child hygiene (British) or *puériculture* (French) movements and their endeavors to improve children's health and welfare in second half of the nineteenth century. While nationally distinctive, these British and French movements shared a common goal and composition. These movements were a heterogeneous sort, and like the childhood exposition, comprised of a medley of reform-minded administrators, doctors, pharmacists, businessmen, and concerned citizens—some of whom dedicated their careers to children's issues, and others like Maria Deraismes and Annie Besant, who jumped on the bandwagon of a popular topic and highlighted the importance of child health and hygiene as one of their many causes. Regardless of their primary *raison d'être* these individuals were united by a desire to improve their nation's social and political status through the promotion of childhood health and hygiene. As Pierre-Auguste Despaulx-Ader, the president of the French child protection societies (*Sociétés protectrices de l'enfance*), wrote: "the question of childhood is not only a question of hygiene, like some thoughtless minds would like to believe; it is a question of political and social economy and the first and most important facing governments."<sup>541</sup> That same sentiment was true in Great Britain where the National Association for the Promotion of Social Science, the foremost society for the advancement of British society, frequently entertained sessions on infant and child mortality, health, and education given by doctors, health officials, and other reformers and published the session papers and debates on the topics from its inception in 1857.

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<sup>541</sup>Pierre Auguste Despaulx-Ader, *Sociétés protectrices de l'enfance et de la société de mère de Paris en particulier; des causes de l'excessive mortalité des enfants en bas âge, légitimes ou illégitimes, et des moyens d'y remédier* (Paris: Felix Malteste, 1876), 10.

The complicated question of how to best improve the health and hygiene of children did not offer a singular solution; therefore French and British efforts took a variety of forms. In France, the very notion of childhood hygiene encompassed a wide range of topics, such as the protection of infant health (*santé du premier âge*); the reduction of infant mortality through maternal feeding and the monitoring of wet-nurses; the care of abandoned children and the prevention of child abandonment, including “moral abandonment,” or the parental neglect of a child’s basic needs; and primary education, including opportunities for physical exercise (*gymnastique*).<sup>542</sup> During the second half of the nineteenth-century the most active child hygiene advocacy in France emanated from philanthropic child protection societies led by prominent doctors and reformers, including women, and after 1870, through legislative actions by doctor-legislators of the Third Republic.<sup>543</sup> The first society was founded by Dr. Alexandre Mayer in 1865 in Paris, followed by a branch in Lyon (1866), in Havre (1869), in Tours and Pontois (1870), in Marseilles, Rennes, Essonnes, and Bordeaux (1873), and much later in Cannes and Constantine. The mother society in Paris had 70 medical inspectors supervising 197 children in 1867 and six years later in 1873, a total of 501 medical inspectors, 67 inspector delegates, and 172 patronage committees in eighteen French departments collectively aided 1,482 children.<sup>544</sup>

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<sup>542</sup> Henry Napias and A. J. Martin, *L'étude et les progrès de l'hygiène en France de 1878 à 1882* (Paris: G. Masson, 1882). Chapter one of this work is dedicated to the topic of childhood hygiene and covers all the topics mentioned above, 1-68.

<sup>543</sup> For a comprehensive look at Third Republic physician-legislators, see Jack D. Ellis, *The Physician-Legislators of France: Medicine and Politics in the Early Third Republic, 1870-1914* (Cambridge University Press, 1990). Ellis states that after the establishment of the Third Republic in February 1871, 33 medical men won seats in the new legislature, Ellis, 9.

<sup>544</sup> Despaulx-Ader, 17; also Hippeau, 17.

Similar concerns characterized the British child hygiene movement, although the situation in Great Britain was somewhat different. One twentieth-century British infant welfare advocate noted that French rhetoric about depopulation and decreased military strength first raised awareness of the tragedy of infant mortality, attracting attention in Great Britain as leaders also began to fear for the future health and vitality of the empire.<sup>545</sup> In contrast to poor French mothers, however, British mothers generally tended to suckle their infants rather than send them out to nurses in the country. Only unmarried mothers with no other options available sent their children out to nurse, and unlike the *nourrices* of France who breastfed their charges, British nurses were not lactating and fed the baby by hand.<sup>546</sup> As a result, commercial wet-nursing did not develop into the vast business that it did in France, and a centralized system of child protection societies did not simultaneously evolve around the paid child care business.<sup>547</sup> However, in the 1860s, spurred by notoriously publicized cases of infant deaths in the hands of country nurses, certain members of the British Medical Association (BMA) took the lead in attacking child neglect and death associated with the practice of “farming out” pauper children for paid care, notoriously called “baby-farming.”<sup>548</sup> Despite their good

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<sup>545</sup> G. F. McCleary, *The Early History of the Infant Welfare Movement* (London: H. K. Lewis, 1933), 36. McCleary dedicated a whole chapter to the French infant welfare movement (chapter 3), and especially noted nineteenth century institutions like Marbeau’s crèche and societies of maternal feeding, *sociétés d’allaitement maternelle*, founded first in 1876 to house expectant mothers prior to childbirth at a maternity hospital and to provide assistance to mothers who nursed their infants for up to one year. McCleary, 40-41.

<sup>546</sup> Ann Higginbotham, *The Unmarried Mother and Her Child in Victorian London, 1834-1914*, Dissertation, Indiana University, 1985, 64, 68.

<sup>547</sup> Hippeau, 8-9.

<sup>548</sup> Ruth Ellen Homrighaus, *Baby Farming: The Care of Illegitimate Children in England, 1860–1943*, Dissertation., University of North Carolina at Chapel Hill, 2003. Rev. ed., 2010, at Historytools, <<<http://www.historytools.org/babyfarming/baby-farming.html>>>. I agree with Homrighaus that the baby-farming disputes helped to awaken the public’s interest in child welfare and opened the door for more intensive intervention later on.

intentions, these BMA representatives demonized all commercial nursing based on a handful of criminal cases, and as some women reformers pointed out, their attack on nurses was missing the true problem and was prejudicial against women.<sup>549</sup> Despite their differences, these British and French child-centered movements highlight how child health and hygiene were national issues with social, political and medical dimensions.

Similar to the aims of the Paris and London children's hospitals, special attention to infant and child health and hygiene also formed part of a larger effort to "moralize" and educate the working classes, especially mothers and nurses, and rescue poor children from misery and degeneracy.<sup>550</sup> According to British and French middle-class perspectives on the state and the family, a strong nation needed stable families with knowledgeable women raising healthy babies. At the opening of the 1873 Paris exposition on childhood, President Honoré Arnoul proposed the best way to save infants and children was to encourage proper maternal care and nourishment.<sup>551</sup> Arnoul's statement further highlighted the same dilemma touched on by both Deraismes and Besant that faced doctors, legislators, and reformers in both France and Great Britain: a child's health and hygiene began at home, and many diseases and conditions were preventable with proper care and living environments. To properly raise and care for a child, a mother or nurse needed to know the best domestic practices and sound childcare techniques, as determined by the medical, public health, or education experts. British

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<sup>549</sup>Committee for amending the law in point wherein it is injurious to women, 7.

<sup>550</sup> Prior to the Third Republic, maternal charities provided assistance and moral guidance to poor families but anticlerical attitudes among some government leaders led to more secular social welfare and education programs. This gradual transition from religious-based charity to secular, government-administered welfare is examined in Christine Adams, *Poverty, Charity, and Motherhood: Maternal Societies in Nineteenth-Century France* (Urbana, IL: University of Illinois Press, 2010), 176-179.

<sup>551</sup>*Programme de l'Exposition universelle et internationale de tout ce qui a rapport à l'enfant*, 1. Arnoul wrote, *C'est être deux fois mère de nourrir soi-même et son enfant*.

doctor William Jenner suggested that the state should make health a compulsory subject in all schools, and infant nurseries should be attached to every national girl's school so students could learn proper childcare methods.<sup>552</sup> In the absence of such state control, some medical and non-medical experts reached out to mothers and nurses to impart useful information on how to raise healthy children. The proliferation of manuals about children's health and hygiene in France and Great Britain after 1860 reflects this endeavor to directly address the women in charge of children's care and nourishment.

In the second half of the nineteenth century, the publication of medical works on infant and child nutrition, hygiene, and physical education was vast. Any French or British treatise on childhood diseases contained a list of related medical studies on maternal feeding, lactation, the composition of milk, children's diets, infant hygiene, and children's physical and intellectual development. Written by doctors for doctors, these clinical works were useful in hospitals and private practices, but they only reached a wider public if a reformer or legislator cited their work as a medical example. Some medical professionals chose to directly address women and nurses, the audience that could apply medical know-how within the home and prevent children from needing to go to the hospital in the first place. In France, Dr. Alfred-Charles Caron, who originally coined the term *puériculture*, was one of the first doctors to publish a practical manual for mothers and nurses, *Le code des jeunes mères*. In his foreword, Caron admitted that his topic of study—children's hygiene from the beginning of life to adolescence—was not new, but his express goal to exhume the classic scientific texts and transform them into practical laws of hygiene for mothers and nurses was novel.<sup>553</sup> Similarly, Édouard Le

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<sup>552</sup> Jenner, *Practical Medicine*, 45-46.



Barillier, a Bordeaux children's hospital physician, also published a book on childhood health and hygiene for the use of non-specialists. Noting most volumes on the topic were not easily consultable, Le Barillier gleaned the most elementary and useful ideas for the physical education and diseases of children, added observations from his clinical work in the children's hospital, and crafted a work comprehensible to novices of medicine.<sup>554</sup> Dr. Etienne Ancelon, an "apostle of hygiene" and Third Republic doctor-legislator, wrote a general family hygiene guide in the 1850s, *L'art de conserver la santé*, that offered counsel on adult and child hygiene, including the proper care of babies.<sup>555</sup>

As Annie Besant's example demonstrates, one did not have to be a medical expert to write on medical topics. According to her publisher, Asa Butts, her birth control manual was "a scientific and medical work every way superior."<sup>556</sup> Other women drew upon their maternal experiences to claim credible authorship on the subjects of maternal and child health and hygiene. For example, an anonymous author with the pen name Madame E. V., mother of three children, authored a collection of essays offering advice to young mothers on how to feed and care for their child. According to the author, this particular genre of manual—a practical child-rearing and nursing guide for women written by a woman—was sorely needed in France, and her friends urged her to write one.<sup>557</sup> Published in 1883, the resulting work, *Conseils aux jeunes mères*, covered basic

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<sup>553</sup> Alfred-Charles Caron, *Le code des jeunes mères. Traité théorique et pratique pour l'éducation physique des nouveau-nés* (Paris: Gerner-Baillière, 1859), 2.

<sup>554</sup> Édouard Le Barillier, *Traité pratique de l'hygiène et des maladies de l'enfance*, 2<sup>nd</sup> ed. (Paris: Masson, 1860), vii.

<sup>555</sup> Ellis, 74-75.

<sup>556</sup> Besant, *Law of Population*, advertisement.

<sup>557</sup> Madame E. V., "Préface," *Conseils aux jeunes mères* (Paris: Guerin, 1883), n. p.

topics such as bathing and exercise, clothing and laundering, food and drink, teething, naps and bedtime routines, and childhood sicknesses. Madame E. V.'s access to medical information about children's diseases is apparent in her chapter on *maladies des enfants*, where she recommended small pox vaccination, discussed mild fevers and skin eruptions, and spent a considerable number of pages describing cute serious conditions such as measles, whooping cough, and croup.

These early works helped set the stage for later works on *puériculture* that combined the most recent medical knowledge on child health and hygiene with practical rules and methods for women to follow. For example, years later in 1887, Dr. Émile-Olivier Toussaint, a doctor for the inspection service established by the Roussel Law of 1874, compiled a practical guide for women who breastfed children. Like Caron and Le Barillier, Toussaint wanted to make medical information accessible to the women who needed it most. He went so far as to chastise doctors, professors, and statisticians who wrote books and reports on child health and hygiene but failed to offer any practical advice or a guidebook for inexperienced, nursing women.<sup>558</sup> Considering learned men were as much to blame for high infant mortality rates as the nurses that he inspected, Toussaint wrote a book in simple and clear language for nursing women to help them become better nurses. Toussaint also served as editor to an illustrated journal on early childhood, *La jeune mère ou L'éducation du premier âge* (*The Young Mother, or Education on Infancy*). By the end of the century, the popularization of child hygiene was heralded by Dr. Gustave Variot, physician at Enfants-Assistés and founder of the first Goutte de Lait (milk depot) of Belleville, Paris, in 1892. Variot contributed to the infant

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<sup>558</sup> Émile-Olivier Toussaint, *Hygiène de l'enfant en nourrice et au sevrage. Guide pratique de la femme qui nourrit* (Paris: Doin, 1887), iii.

health movement by publishing several editions of his manual *Hygiène infantile*, whose title he later changed to *L'art d'élever les nourrissons: hygiène infantile (The art of raising infants: infant hygiene)* so that mothers would immediately know the subject.<sup>559</sup>

In Great Britain, practical guides on maternal and child health and hygiene also made their way into the marketplace. Pye Henry Chavasse, one of the doctors who influenced Annie Besant's ideas and whose observations were cited in her birth control manual, *Law of Population*, wrote two popular health guides in the early 1870s that were published in Great Britain and the United States: *Advice to a wife on the management of her own health and on the treatment of some of the complaints incidental to pregnancy, labour and suckling*, which included an introductory chapter especially addressed to a young wife, and a child-rearing guide that also included information on the most common childhood diseases.<sup>560</sup> GOSH's founder, Charles West, also supported the role of mothers and nurses in promoting children's health. In the 1850s, he published *How to Nurse Sick Children*, a practical guide that was intended as a resource to nurses at the London children's hospital as well as to all women who have charge of young persons.<sup>561</sup> The *British and Foreign Medical Review* recommended West's book and encouraged more popular works on child health, stating that the intuition of mothers and nurses is not always best for the health of the child, but "nor is the blame to be had solely at the door

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<sup>559</sup>Gustave Variot, *L'art d'élever les nourrissons: hygiène infantile* (Paris: Hachette, s.d.), avertissement.

<sup>560</sup> Pye Henry Chavasse, *Advice to a wife on the management of her own health and on the treatment of some of the complaints incidental to pregnancy, labour and suckling* (New York: The American News Company, 1879), and *Advice to a mother on the management of her children and on the treatment on the moment of some of their more pressing illnesses and accidents* (New York: the American News Company, 1879).

<sup>561</sup>Charles West, *How to Nurse Sick Children* (New York: Wood, 1855). Charles West was an advocate for the professionalization of lay nursing and envisioned a training program at GOSH for children's nurses, and his manual was the first exposition of ideas on professional pediatric nursing. West asserted a clear hierarchy between doctor and nurse. On pages 15-20 he insisted on the doctor's primacy over the nurse and did not support women entering the field of pediatrics as doctors.

of the young mother of the child, but rather at the door of those who, with knowledge at their command, have failed to communicate it.”<sup>562</sup> While these are only a sample of French and British manuals on child health and hygiene written in the second half of the century, they demonstrate an important crossover between the world of medical professionals and general audiences, particularly mothers and nurses, in the realm of child health and hygiene. Understanding the deep connections between women’s and children’s health as well as the limits of preventative medicine at the children’s hospital, some doctors attempted to equip women with the knowledge to help them care for their young charges and protect them from disease and illness to the best of their ability.

### Summary

By raising public awareness of topics such as child abuse, child development, and child hygiene, and linking them to criminal behavior, ignorant and deficient parenting and nursing practices, and degenerate or declining populations, forensic physicians, social reformers, and hygiene experts borrowed from and expanded upon pediatric concepts and circulated specific perspectives on children’s health beyond the walls of the children’s hospital in the second half of the nineteenth century. In the process, they willfully intensified the “national interest” in child health and further medicalized childhood as a matter of public health. Aside from Tardieu, individual opinions and efforts discussed in this chapter were primarily focused on the local and national, but the similar issues at stake help to explain the striking parallels in French and British child labor laws and infant protection during the 1870s.

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<sup>562</sup> Ibid, Advertisement, section I.

From a Foucauldian perspective, the examples of Tardieu, Deraismes, and Besant exemplify how some French and British doctors and reformers pushed for greater social control measures. They supported some type of intrusion in domestic affairs to promote physical and moral health of the nation, and in particular, the health of its youngest, poorest members. Tardieu investigated the physical abuse of children in the home, which he identified as a criminal offense. In her *Les droits de l'enfant* speech, Deraismes argued that the state's ability "to establish a union between private and public life" was crucial to the protection of children's rights to health, education, and safety.<sup>563</sup> Similarly, Besant's efforts to bring birth control information to poor mothers corresponded to her vision for a powerful British empire populated with small, healthy families. The publication and distribution of popular hygiene manuals for families and children was a more subtle attempt to enter homes, push middle-class domestic values and practices on working-class families, and promote the author's concept of an ideal motherhood and childhood.

On another level, the examples presented in this chapter also demonstrate that an individual's attention to child health was not just about children in dire need, but a strategy to advance related goals. Bemoaning the plight of poor, unhealthy children could be a useful entry point into many other nineteenth-century topics of public concern, such as public health, population, poverty, prostitution, education, parenting, or crime. For example, Deraismes and Besant melded the familiar rhetoric of child protection with their larger twin goals of social reform and women's legal or reproductive rights. The concept of children's rights—the entitlements to healthy physical and intellectual development—provided Deraismes in particular a familiar framework to express her political interests in

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<sup>563</sup>Maria Deraismes, *Œuvres complètes de Maria Deraismes*, Vols. 1-3 (Paris : Balliere, 1895), 323. *Nécessité est d'établir l'alliance de la vie privée et de la vie publique.*

national regeneration and her dedication to freeing married women and their children from the oppression placed upon them by poverty and their social position. Experts on child hygiene continued to lament the persistent problem of child mortality, yet channeled their frustrations into producing popular manuals on domestic hygiene, home economics, and *puèriculture*. In the process, they brought important medical information to the mothers and caregivers who could make the greatest impact in preserving the lives of children and ultimately, helped to popularize a subject too often confined within medical circles.

## CHAPTER 8

### CONCLUSIONS

The primary premise of this comparative and transnational history of nineteenth-century children's medical institutions in Paris and London is that child health became a dominant concern in France and Great Britain—two of the leading European pioneers in pediatrics—nearly simultaneously. Poor, sick urban children were at the center of these concerns, and children's hospitals offered one solution to improve the health of French and British children. Using case studies of two French and British children's hospitals established in the 1850s, Sainte-Eugénie and Great Ormond Street Hospital, this study traced the beginnings of pediatric institutions, doctors, and bodies of knowledge that underscored the need to conserve children's physical health as a social responsibility and as a national duty. Through foundling hospitals, dispensaries, and finally, the first children's hospital in Paris, Enfants-Malades, childhood diseases and mortality emerged as public health problems that could be measured, analyzed, compared, and ameliorated through local and national initiatives and after 1850, by public health institutions like l'Assistance publique in Paris and the Metropolitan Boards of Health in London. After 1850, proactive state and philanthropic initiatives directly influenced the creation of GOSH and Sainte-Eugénie and later supported the expansion of current children's medical facilities, the establishment of new services, and the adoption and augmentation of the convalescent home system. Prompted by, and corresponding to these changes in children's medical care, public interests in childhood hygiene, development, disease, and mortality dispersed in various directions outside the walls of the Paris and London children's hospitals.

This crescendo of children's medical care between 1820 and 1890 was a central part of a nation-building agenda, which demanded increased public health provisions in France and Great Britain as the century progressed. The connection between child health, public health, and children's medical institutions was not new at mid-century. In 1817, John Bunnell Davis stressed the public health function of the children's dispensary, and he argued that medical care was equally as important to public health as sanitary improvements or urban restructuring:

“Public health at large is promoted and restored, and the population strengthened, whilst the credulous poor are shielded from the base and baneful treatment of the unprincipled empiric. Since the establishment therefore of dispensaries, the general health of the metropolis has been improved, a circumstance attributable also, it is true, to the widening of the streets, and their better ventilation, the abundant supply of water, and the removal of the sewers of all offensive matter, the number of country houses, which have drawn off a considerable portion of the population. . .”<sup>564</sup>

The promotion of public health to which Davis, and later children's hospital supporters, referred was directed towards the laboring and destitute classes. In the eighteenth and nineteenth centuries, European hospitals, including foundling homes and dispensaries, overwhelmingly served the urban poor.<sup>565</sup> Because foundling homes, children's dispensaries, and children's hospitals conspicuously serviced disowned and poverty-stricken children, eighteenth and nineteenth-century pediatric advancements were indisputably won on the bodies of poor children. Patient populations at the Paris and London children's hospitals shared several characteristics, as similar groups of poor, sick,

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<sup>564</sup> John Bunnell Davis, *A cursory inquiry into some of the principal Causes of Mortality among Children with a view to assist in ameliorating the State of the Rising Generation in Health, Morals, and Happiness, to which is added and account of the Universal Dispensary for Sick Indigent children* (London: Simpkin, 1821), 21.

<sup>565</sup>S. Borsa and C.-R. Michel, *Des hôpitaux en France au XIXe siècle* (Paris: Hachette, 1985), 48-49. Hospitals served sick individuals and families who could not afford the fees of private practice physicians.



urban youths displayed similar medical conditions and needs, like the patients with bronchitis illustrated in the introduction.

Since child health formed an integral part of the future of national public health, the nature of the patient populations of the Paris and London children's hospitals underscores the dual function of these institutions: to medicalize and moralize. The official missions of these hospitals were medically oriented: to provide medical care to poor children and to advance the study and knowledge of children's medicine. Yet, their medical missions could never be divorced from their social missions; children's medical institutions, like other charitable or public assistance organization in both France and Great Britain during this time also attempted to "moralize" and educate the laboring classes. The children's hospitals set down rules and regulations with the expectation that patients and their families would submit with compliance, respect, and gratitude, including attempts of the hospital staff to improve the moral, as well as the physical, health of the patients, and by extension their families. Not all family members conceded to hospital policies, and some went out of their way to obtain exceptional admissions for their children, negotiate the costs of care, or remove their children against medical advice. The lines between medicalization and moralization might blur, like when poor parents unintentionally placed their child's health at risk because of debilitating poverty, illness, or the inability to provide basic needs. French forensic physician Ambroise Tardieu's investigations of children who were abused or abandoned by their own families highlighted that some child endangerment was not accidental but criminal and "parents were too often the authors of violence."<sup>566</sup>

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<sup>566</sup> Ambroise Tardieu, "Étude médico-légale sur les sévices et mauvais traitements exercés sur des enfants," *Annales d'hygiène publique et de médecine légale*, séries 2, no. 13 (1860), 365.

The poor circumstances of most patients imparted a discernible class component to early children's medical institutions. British doctors especially expressed the need for children's hospitals along class lines, describing them as places where "the relief of the suffering of poor children" also served as the "place of instruction" for physicians of rich children.<sup>567</sup> Davis believed that since his Universal Dispensary offered opportunities for "treating infantine diseases in general, then might it eventually be expected, than an improvement in this department of science would ensue, and carry its benefits to the higher classes to an extent commensurate with the warmest Patronage."<sup>568</sup> Class bias informed even most reform-minded supporters, such as long-time GOSH President, the Earl of Shaftesbury, who did not hesitate to underscore these class divisions as he persuaded others to support GOSH: "it is there that skillful and eminent medical men acquire that minute and practical knowledge which they bring to bear upon the offspring of the rich; and I dare say many a child of an affluent family is saved to its anxious parents by the knowledge which has been acquired from the treatment of some poor wretched creature in a hospital like that in Great Ormond Street."<sup>569</sup>

French attitudes towards hospitals and the provision of social welfare were much less explicit about class difference. Based on the revolutionary principles of liberty, equality, fraternity, post-Revolution French hospitals theoretically provided a necessary state service to those in medical need. During the Second Empire under Napoléon III, however, the state's magnanimity was clearly evident in the dedication of two hospitals

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<sup>567</sup> Archives of Great Ormond Street Hospital (GOS), GOS/1/1, GOSH Annual Report, 1853, 7.

<sup>568</sup> Davis, 30.

<sup>569</sup> GOSH/1/1, GOSH Annual Report, 1863, 11. The Earl of Shaftesbury made this comment in his 1863 Festival speech, presented at GOSH's major annual fundraiser. The Earl served as GOSH president from 1854 until the early 1870s.

for poor Parisian children, Sainte-Eugénie in 1855 and l'Hôpital Napoléon (Berck-sur-Mer) in 1869, both named for the French sovereigns. As the French and British cases above demonstrate, the appeal of state and voluntary hospitals to affluent, munificent sponsors, a dynamic that Roy Porter calls the "hospital gift relation," was present in both French and British culture. "Gifting" the children's hospital through voluntary subscriptions or state subsidies was a form of nineteenth-century "institutionalized traditional paternalism," whereby affluent humanitarianism and stewardship toward the poor masked, or at least existed alongside, other aims of the donor.<sup>570</sup> French and British donors, doctors, administrators, and volunteers gained personal or professional prestige or charitable reputations for their association with children's hospitals. Whether doctors gratuitously provided their services, like in London, or if they were state employees, like in Paris, British and French doctors alike built their professional reputations and medical expertise through their work at the children's hospitals.

Pediatric specialization, professionalization, and institutionalization were gradual, correlated developments. Pediatric institutions fostered a distinctive group of practitioners dedicated to children's medicine and provided the necessary spaces for them to promote study and train in the field, to discover and improve techniques, practices, and procedures, and to promote and strengthen their medical specialty. The development of pediatrics in France and Great Britain did not occur in national vacuums, but were tied to French-British exchanges about pediatric knowledge, ideas, and institutions throughout

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<sup>570</sup> Roy Porter, "The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England," 149-178, in *The Hospital in History*, eds. Lindsay Granshaw and Roy Porter (London: Routledge, 1989), 172. Porter proposes that the "British voluntary hospitals was the classic medium through which, by joint subscription action, the polite and propertied initiated their own act of national renewal, meeting new social challenges through association, philanthropy, and culture." A similar French interpretation of this reciprocal exchange may be found in Marcel Mauss, *The Gift: forms and functions of exchange in archaic societies* [1922] (London: Routledge, 1990).

the century. From the eighteenth century on, medical publishing was a medium of Franco-British intellectual exchange on children's medicine, first through published treatises, then articles in medical journals, and eventually popular hygiene guides for a wide range of audiences. French and British doctors, public health officials, and reformers physically crossed the English Channel to observe one another's children's medical institutions. In the first half of the century, British doctors studied at the Paris children's hospital and brought home new pediatric ideas and practices; in the second half of the century, Paris officials revisited their own institutional designs for the children's hospitals and *crèches* after reviewing British versions. Dynamic developments in medical training, publishing, and observation fostered a transnational network consisting of physicians, surgeons, teachers, and students dedicated to better understand childhood disease and mortality and better preserve the physical health of the child.

Nineteenth-century efforts to provide institutionalized medical care for poor, sick children in Paris and London might be seen as processes with distinct local, national, and international dimensions. Transnational exchanges in the field of pediatrics reflected, and contributed to, other Franco-British relations in the areas of population and medical statistics collection and social reforms involving a wide range of child health issues, such as the prevention of infant mortality and infanticide, the regulation of child labor, and the protection children's physical, moral, and educational welfare. In both countries, the marriage between statistics and social reform was fruitful and devastating infant and child mortality rates were powerful catalysts for debate and action. As methods to achieve national revitalization, local and national statistics provided the numerical fodder to prompt legislators, reformers, and other leaders to effect legal changes and by the 1880s,

similar laws in France and Great Britain protected infants and children. For example, Parliament passed an Infant Protection Act In 1870, and France passed the Roussel Law in 1874, both of which attempted improve infant health through regulation of commercial nursing industries; both countries enacted laws that outlined parental responsibilities for their child's physical, moral, and educational needs and the consequences for failing to uphold their duties, such as the British Children's Charter and the French law on *abandon moral*, both passed in 1889.<sup>571</sup> Collectors of vital statistics and medical statistics pertaining to their patient populations, the children's hospitals of Sainte-Eugénie and GOSH indirectly contributed to these legislative protections and helped to bring the plight of poor, urban children into public view.

The medical, legislative, and social parallels between French and British child protective efforts, including the establishment of children's hospitals, were also shaped by international competition between nations. The events leading up to the establishment of pediatrics chairs at the Faculté de Médecin de Paris exemplifies this competitive spirit. Disturbed by the loss of French hegemony in clinical medicine and by the nation's slowness in developing teaching laboratories, the Ministry of Public Instruction and Culture, led by Inspector General E. Chauffard headed a commission in 1875 that urged an immediate reorganization of the clinics of the Paris school and force the creation of clinical courses in the specialties, as was common in Germany and Britain.<sup>572</sup> The

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<sup>571</sup> For the Law of 1889 and legal and social aspects of the concept of *moral abandon*, see Sylvia Schafer, *Children in Moral Danger and the Problem of Government in Third Republic* (Princeton: Princeton University Press, 1997), and for an overview of children abuse prevention activities in Great Britain, see George Behlmer, *Child Abuse and Moral Reform in England, 1870-1908* (Stanford University Press, 1982). According to Sylvia Schafer, the law on *abandon moral*, also known as the law on divestiture, defined parental abuse in a way that made parents themselves, and their own moral constitution, the main source of his or her child's possible moral endangerment, 71.

following year, the commission ordered that medical specialties like dermatology, pediatrics, ophthalmology, diseases of the urinary tract, and venereal diseases would be taught as complementary courses in special clinics at corresponding hospitals. The Paris commission lamented that in all the foreign faculties, chairs existed for these specialties, even if there were only children's hospitals in Berne, Berlin, Leipzig, Moscow, Munich, Pest, Prague, London and Margate, Vienna, and St. Petersburg.<sup>573</sup> By December 28, 1878, the Faculté had a permanent *clinique des maladies des enfants* at the Paris children's hospital, *Enfant-Malades*, and Dr. Jules Parrot was named its first chair.<sup>574</sup> Home to the first inpatient children's hospital, Paris and its medical faculty did not want to relinquish its role as a major pediatric center to any other European nation, including Great Britain.

Nineteenth-century French and British children's hospital had important distinctions, but their similarities tell us much more about the state of nineteenth-century children's medical care, institutions, practitioners, and patients. *Sainte-Eugénie* was a state institution and *GOSH* a private charitable institution, but with similar patient populations and socio-medical missions, these children's hospitals of Paris and London faced comparable medical and social challenges. In this sense, childhood disease among the poorest inhabitants of the French and British capital cities was a transnational phenomenon. Poor, sick, urban patients that moved in and out of these hospital's inpatient wards, outpatient departments, and convalescent homes were also future

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<sup>572</sup> Thomas N. Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1996), 270.

<sup>573</sup> Archives Nationales (AN), AJ/16/6310, Rapport sur la création de chaires cliniques spéciales à la Faculté de Médecine, April 18, 1878.

<sup>574</sup> *Ibid.*

members of French and British society, and as such, were worthy of medical care and national attention. Children's hospitals like Sainte-Eugénie and GOSH build upon a long and complex legacy of children's medical care and opened up new possibilities and challenges for the study of children's medicine, impacting their administrators, practitioners, and child patients and families in complicated and intersecting ways. The medicalization of childhood has a long history, and the Paris and London children's hospitals and their young patients are a significant part of that story.

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Databases, built in Microsoft Access, incorporate information provided by the Admission Registers of all four hospitals (plus those for Great Ormond Street's convalescent home, Cromwell House) and cover a period ranging from February 1852 (when Great Ormond Street's doors first opened) through to December 31, 1914. While the Great Ormond Street records are continuous for the whole period, the other hospital records cover shorter runs within these dates: for example Cromwell House records cover from 1869 to 1910.

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APPENDIX A

SAINTE-EUGÉNIE SAMPLE REGISTER ENTRIES: 1855, 1865, AND 1875

#	Name		Age	Parent* or Self Occupation	Domicile (arr.)	Dept. of Origin	Malady/ Diagnosis	Room Bed	Entry Date	Exit Date	Length of Stay (days)	Remarks
	First	Last										
1705	Leontine	Denis	12	clothier	Paris (5 <sup>th</sup> )	Seine	fever/ pneumonia	Marguerite 26	July 24 1855	Aug. 16 1855	23	None
2310	Alphonse	Mignon	8	caprenter	Paris (10 <sup>th</sup> )	Seine	wound/ femur fracture	Napoléon 23	Oct. 31 1865	Dec. 4 1865	34	Sent to Roches Guyon
1985	Georges	Poumon	5	pastry maker	Paris (2 <sup>nd</sup> )	Seine	fever/ croup	Benjamin 17	Sept. 17 1875	Sept. 19 1875	2	died croup operation

\*A patient's father and/or mother name(s) were also recorded in the register, indicating whether both parents were living or not (widow or widower) or if the patient was an orphan (no parent) or possibly a natural child (mother only).

Source: L'Assistance Publique-Hôpitaux de Paris (AP/HP)  
Registre d'entrées, Population malades hospitalisés, L'hôpital Sainte-Eugénie

1855-1856 (SAINTEEUGENIE (1Q 2/1)  
1865-1867 (SAINTEEUGENIE (1Q 2/6)  
1875-1876 (SAINTEEUGENIE (1Q 2/10)

APPENDIX B

GOSH SAMPLE REGISTER ENTRIES: 1853, 1863, AND 1873

#	Name		Age	Sex	Residence	Entry Date	Disease	Length of Stay (days)	Date of Discharge	Result	Remarks
	First	Last									
84	Maria	Milsden	4	F	London, no address	July 1 1853	<i>Cynache Trachealis</i> (croup)	0		Died	Died soon after entry
136	Ellen	Howe	11	F	Holborn, London	March 31 1863	scarlet fever	31	May 1 1863	Recovered	
337	Edward	Walker	5	M	Marylebone, London	Sept. 16 1873	debility	16		Recovered	Sent to Cromwell House

Source: Database, Historic Hospital Admission Records Project (HHARP), [www.HHARP.org](http://www.HHARP.org).

APPENDIX C

NOSOLOGY OF CHILDREN'S DISEASES, CIRCA 1820



# OUTLINE OF A Nosological Arrangement of Diseases in Children, Acute and Chronic,

ACCORDING TO THE SITUATION OF PARTS—KNOWN OR PRESUMED.

*Adopted by the Editor, in his Lectures on that branch of the Practice of Medicine which relates to the Diseases, and Medicinal Management of Children and Young Persons, delivered at the UNIVERSAL DISPENSARY FOR CHILDREN, St. Andrew's Hill, Doctors' Commons, and at the Southwark Station, St. Thomas's Street, near Guy's Hospital.*

DISEASES		DISEASES		DISEASES	
Seated in, principally, or in part manifesting their effects in the Head and Face.		Seated in, principally, or in part manifesting their effects in the Fauces, Larynx, and contiguous parts.		Seated in, principally, or in part manifesting their effects in the Trachea and Thoracic Viscera.	
<p style="text-align: center;"><i>Acute.</i></p> <p>Phrenitis Hydrocephalus Acutus Convulsio Tetanus Chorea Ophthalmia Oralgia Odontalgia Cyanache Parotidea</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Cephalalgia Hydrocephalus Chronicus Epilepsia Paralysis Convulsio Chorea Epistaxis Amentia</p>	<p style="text-align: center;"><i>Acute.</i></p> <p>Cyanache Tonsillaris Maligna Pharyngaea Trachealis Catarrhus Coryza Maligna Aphtha</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Cyanache Laryngea Chronica</p>	<p style="text-align: center;"><i>Acute.</i></p> <p>Tussis Pneumonia Pleuritis Hydrothorax Carditis Hæmoptysis Paraphrenitis</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Dyspnoea Asthma Syncope Incubus Singultus Phthisis Palpitatio Cordis</p>
DISEASES		Febrile Diseases		DISEASES	
Seated in, principally, or in part manifesting their effects in the Abdominal Viscera.		Without Eruptions.		With Eruptions.	
<p style="text-align: center;"><i>Acute.</i></p> <p>Cholera Gastritis Hepatitis Enteritis Peritonitis Splentitis Diarrhoea Dysenteria Vomitus Hæmatemesis Hæmorrhagis Intestinorum</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Dyspepsia Atrophia Tabes Vermes Ictericus Icterus Tormina Ascites Pyrosis Tympanites Gastrodynia Colica</p>	PHLOGOSIS.		<p>Synocha Synochus Typhus Febris Intermittens Remittens Hectica vel Chronica Remittens</p>	<p>Scarlatina Rubella Urticaria Erysipelas Erythema Variola Varicella Rosola Purpura Pemphigus Strophulus Pompholyx</p>
DISEASES		DISEASES		DISEASES	
Seated in, principally, or in part manifesting their effects in the Lymphatic System.		Seated in, principally, or in part manifesting their effects in the Medulla Spinalis.		PRINCIPALLY SEATED IN THE SKIN. WITHOUT PYREXIA.	
<p style="text-align: center;"><i>Acute.</i></p> <p>Anasarca Scrophula</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Anasarca Scrophula</p>	<p style="text-align: center;"><i>Acute.</i></p> <p>Convulsio Spasmus</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Paraplegia Spinalis</p>	<p>Lichen Prurigo Impetigo Ecthyma Scabies</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Leprosia Psoriasis Porrigio Tubercula (cum varietatibus)</p> <p>Pityriasis Ichthyosis Herpes Maculae</p>
DISEASES		DISEASES		DISEASES	
Seated in, principally, or in part manifesting their effects in the Ligaments.		Seated in, principally, or in part manifesting their effects in the Muscular System.		Seated in, principally, or in part manifesting their effects in the Osseous System.	
<p style="text-align: center;"><i>Acute.</i></p> <p>Rheumatismus</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Arthrodynia</p>	<p style="text-align: center;"><i>Acute.</i></p> <p>Convulsio Spasmus</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Convulsio Spasmus</p>	<p style="text-align: center;"><i>Acute.</i></p> <p>Cystitis Nephritis</p>	<p style="text-align: center;"><i>Chronic.</i></p> <p>Ischuria Diabetes Dysuria Incontinentia Urinae Hæmaturia</p>

Source: John Bunnell Davis, *Annals of the University Dispensary for Children* (London: Simpkin, 1816).

APPENDIX D

ESTABLISHMENTS OF INFANT SCHOOLS, NORTH LONDON,  
1820–1890

1820-1839

St. Marylebone (1828)  
St. Mark's (1831)  
St. Mary's, Paddington (1833)  
St. Margaret's (1834)  
All Souls (1835)

1840-1859

St. John's, Paddington (1840)  
Paddington Wharf (1848)  
St. John's Kensal Green (1850)  
Westbourne (1851), St. Michael's, Westminster (1851)  
All Saints, Paddington (1852)  
St. James (1854), Marshall Street (1854), Western (1854), St. Martin's (1854), Adelaide Place (1854)  
**GOSH (1859)**, St. Stephen's (1859)

1860-1879

St. Martin's, Castle Street (1861)  
St. James (1862)  
Nottingham Mews (1863)  
Trinity (1864)  
St. Mary Magdalene (1865)  
St. Peter's, Paddington (1867)  
St. Paul's, Paddington (1868)  
Christ Church (1871), St. Michael's, Paddington (1871), St. Saviour's (1871), St. Augustine's (1871)  
St. Peter's Eaton Square (1872)  
St. Augustine Mission (1874), Craven Chapel (1874), St. James (1874)  
Poplar Place (1875)  
Queen's Park (1877), St. Luke's (1877)

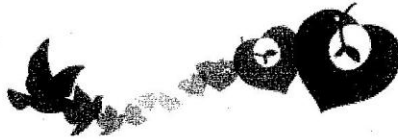
After 1880

Amberly Road (1881), Beethoven Street (1881), Campbell Street (1881)  
Kilburn Lane (1885)  
St. Mary's Bryanston (1888)  
Wilberforce School (1889)

Source: Westminster City Council, *Historical Notes on Westminster Schools*, Local History Resource, North Westminster Community School, 1960.

APPENDIX E

PERMISSIONS, L'ASSISTANCE PUBLIQUE-HÔPITAUX DE PARIS



**CONTRAT DE LICENCE DE REUTILISATION DES DONNEES PUBLIQUES DE  
L'AP-HP**

**ENTRE LES SOUSSIGNES :**

**L'ASSISTANCE PUBLIQUE – HOPITAUX DE PARIS**, établissement public de santé, sis \_\_\_\_\_, représenté par Madame Mireille FAUGERE, Directrice Générale, et par délégation, Patrice Guérin, dûment habilité aux fins des présentes en sa qualité de responsable du service des Archives de l'AP-HP,

ci-après dénommée « **l'AP-HP** »,

d'une part,

ET,

La Société \_\_\_\_\_, Société \_\_\_\_\_ (indiquer la forme et le capital de la société), inscrite au Registre du Commerce et des Sociétés sous le numéro \_\_\_\_\_, domiciliée \_\_\_\_\_, et représentée par \_\_\_\_\_, dûment habilité aux fins des présentes en sa qualité de \_\_\_\_\_,

*OU (si particulier)*

✓ M Stephanie McBride, né le 31/10/1972 à USA, domicilié(e) \_\_\_\_\_,

Ci-après dénommée par les mots : « **le Licencié** »,

d'autre part,

L'AP-HP et le Licencié étant ci-après désignés ensembles les « **Parties** » ou individuellement la ou une « **Partie** ».

**ETANT PREALABLEMENT EXPOSE QUE :**

✓ Par une demande du 21/11/2012, le licencié sollicite l'autorisation de réutiliser des informations publiques (énumérées précisément à l'article 3-1) détenues par le service des Archives de l'AP-HP. Cette demande fait l'objet d'une réponse favorable de la part de l'AP-HP.

En application de l'article 11 de la loi n°78-753 d u 17 juillet 1978, l'AP-HP définit librement les conditions de réutilisation des informations publiques produites par les services, hôpitaux et groupes hospitaliers de l'AP-HP. Conformément à l'article L 6143-7 du Code de la santé

Règlement général de réutilisation d'informations publiques détenues par le service des Archives de l'Assistance publique - 1  
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publique, les conditions ont été précisées par le règlement sur la réutilisation des informations publiques arrêté par la Secrétaire Générale en date du 29/05/2012.

La présente licence a pour objectif de préciser les conditions juridiques de réutilisation de ces informations publiques librement réutilisables.

**IL EST CONVENU CE QUI SUIT :**

---

**ARTICLE 1 : OBJET DU CONTRAT DE LICENCE**

Le présent contrat de licence :

- autorise le licencié à réutiliser les informations publiques mises à sa disposition par l'AP-HP,
- définit les conditions de cette réutilisation par le licencié, en contrepartie du paiement d'une redevance prévue à l'article 6,
- définit, si nécessaire, les conditions de la fourniture par l'AP-HP des informations publiques définies à l'article 3-1.

L'autorisation de réutiliser des documents sur lesquels des tiers peuvent avoir un droit d'auteur est accordée sans préjudice du droit des auteurs et de leurs ayants droit.

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**ARTICLE 2 : DUREE**

Le présent contrat de licence est accordé pour une durée de un an, à compter de sa signature par les deux parties.

Compte tenu du caractère ponctuel de la réutilisation envisagée, le présent contrat de licence est accordé pour la durée de l'exploitation, soit 70 années à compter de sa signature par les parties.

Le contrat de licence ne se renouvelle pas par tacite reconduction. A l'expiration du présent contrat de licence, si le licencié souhaite être autorisé à réutiliser les informations publiques au-delà de son terme, il devra formuler une nouvelle demande par lettre recommandée au plus tard deux mois avant le terme du contrat.

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**ARTICLE 3 : ETENDUE ET DESTINATION DES DROITS CEDES**

Le Licencié peut réutiliser les données pour la durée stipulée à l'article 2.

Le contrat de licence ne transfère pas la propriété des informations publiques au Licencié. Il s'agit uniquement d'un droit de jouissance de données dont il obtient la communication pour réutilisation dans les conditions du présent contrat.

**3-1 :** L'AP-HP concède au Licencié un droit personnel et non exclusif de réutilisation sur les informations publiques ainsi identifiées :

- dénomination des informations publiques :
- contenu :
- date de création ou date de dernière mise à jour :
- source et cote **B1314 ; B-1272 ; A-1654 ; IJA ; 28 PER 11**
- autres informations :

Règlement général de réutilisation d'informations publiques détenues par le service des Archives de l'Assistance publique - Hôpitaux de Paris - Contrat de licence - 29/05/2012

copy  
1J3  
1J5

### 3-2 : Mode transmission des données publiques :

Les informations publiques concernées seront :

- soit fournies par l'AP-HP au licencié sur le support suivant : (*indiquer support papier, multimédia ou numérique (CD, CD ROM, DVD, ...)*).
- soit reproduites par le licencié à ses frais et selon ses propres moyens.

Il est précisé que l'AP-HP a le choix du mode de transmission des données publiques en fonction des possibilités techniques relatives aux archives concernées, en fonction de l'état des documents et des données demandés.

### 3-3 : Type de réutilisation :

- Finalité commerciale suivante :
- Finalité non commerciale suivante :

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## ARTICLE 4 : OBLIGATIONS DU LICENCIÉ

**4-1 :** Le licencié s'engage, sans restriction ni réserve, à respecter les termes du présent contrat de licence, de la réglementation en général et du règlement relatif à la réutilisation des informations publiques produites et reçues par l'AP-HP.

Il s'abstient de tout usage contraire aux lois et règlements ou portant atteinte à l'ordre public et aux bonnes mœurs.

**4-2 :** Le licencié s'engage à ne pas utiliser les informations publiques pour une finalité distincte de celle prévue à l'article 3-3.

Toute autre utilisation devra faire l'objet d'un nouveau contrat de licence de réutilisation.

**4-3 :** Le licencié s'engage à ne pas concéder à des tiers au contrat de licence le droit de réutiliser les informations publiques identifiées à l'article 3-3. Toute opération aboutissant à la disparition du Licencié et à l'apparition d'une nouvelle société cocontractante est assimilée à la cession de la licence et dont donc donner lieu à la signature d'un nouveau contrat de licence.

**4-4 :** Le licencié s'engage à respecter les droits de propriété intellectuelle qui pourraient s'attacher aux données considérées en prenant contact avec leur titulaire ou ayants droit.

**4-5 :** Le licencié s'engage à indiquer pour chaque image ou données réutilisées, sans que ces mentions ne puissent être interprétées comme une quelconque garantie donnée par l'AP-HP :

- la source des données (sous la forme « Assistance Publique – Hôpitaux de Paris, Service des Archives, cote ») ;
- la date de mise à jour des informations publiques ;
- l'auteur, le titre du document s'il y a lieu (notamment pour les photographies, peintures ou dessins).

**4-6 :** Le licencié s'engage à ce que les informations publiques ne soient pas altérées ni leur sens dénaturé.

Il veille notamment à ce que la teneur et la portée des informations publiques ne soient pas altérées par des retraitements (coupes du texte ou de l'image altérant son sens, insertion de commentaires sans que ceux-ci puissent être clairement distingués du contenu initial, ...).

**4-7 :** Dans le cas où les informations publiques comporteraient des données à caractère personnel de personnes décédées, donnant lieu à la mise en place d'un traitement de données et pouvant porter préjudice à leurs ayants droit, l'AP-HP exigera préalablement à la mise à disposition des données pour réutilisation, la communication, par le Licencié, d'une autorisation de mise en œuvre du traitement par la Commission Nationale de l'Informatique

*Règlement général de réutilisation d'informations publiques détenues par le service des Archives de l'Assistance publique - 3  
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et des Libertés. Aucune donnée à caractère personnel concernant des personnes vivantes, ne sera communiquée par l'AP-HP, aucun consentement pour une quelconque finalité n'ayant été obtenu par l'AP-HP.

**4-8** : En cas de diffusion publique sur un site Internet, le licencié s'engage à réaliser un lien informatique depuis chaque image vers le site Internet du Service des Archives de l'AP-HP (<http://archives.aphp.fr/>).

**4-9** : Les obligations susvisées sont applicables durant toute la durée de réutilisation des informations publiques.

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#### **ARTICLE 5 : GARANTIE ET RESPONSABILITES**

**5-1** : Le licencié reconnaît et accepte que les informations publiques sont fournies par l'AP-HP en l'état, telles qu'elles sont détenues par lui dans le cadre de ses missions, sans autre garantie, expresse ou tacite.

**5-2** : Le licencié exploite les informations issues des informations publiques transmises, conformément aux termes de la licence et du règlement relatif à la réutilisation des informations publiques produites et reçues par le Service des Archives de l'AP-HP, sous sa seule responsabilité et à ses seuls risques et périls.

**5-3** : Tout dommage subi par le licencié ou par un tiers qui résulte de la réutilisation des informations publiques est de la seule responsabilité du licencié.

**5-4** : Le licencié supportera seul les conséquences financières en cas de recours formé par un tiers contre l'AP-HP fondé sur la réutilisation réalisée par le licencié.

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#### **ARTICLE 6 : DISPOSITIONS FINANCIERES**

Au titre de la réutilisation des données publiques de l'AP-HP, le Licencié devra s'acquitter d'une redevance.

**6-1** : Montant de la redevance

Le montant de la redevance éventuellement due par le licencié au titre de la réutilisation des informations publiques est fixé conformément aux tarifs définis par la décision du 29 mai 2012 de la Secrétaire Générale, et annexés au présent contrat.

**X** La présente licence est accordée gratuitement au licencié compte tenu du caractère non commercial de la réutilisation envisagée.

Le licencié devra s'acquitter annuellement et pour une année civile d'un montant de :  
\_\_\_\_\_ [somme en chiffres] euros \_\_\_\_\_ [sommes en toutes  
lettres] euros hors taxes en contrepartie du droit de réutilisation concédé par le présent  
contrat

Le licencié devra s'acquitter pour la durée de l'exploitation d'un montant de :  
\_\_\_\_\_ [somme en chiffres] euros \_\_\_\_\_ [sommes en toutes  
lettres] euros hors taxes en contrepartie du droit de réutilisation concédé par le présent  
contrat

**6-2** : Modalités de paiement de la redevance

La redevance est payée au plus tard trente (30) jours après la signature du présent contrat par les parties et selon les modalités de paiement indiquées sur le titre de recettes envoyé par l'AP-HP.



Le versement sera effectué à l'ordre du Trésorier payeur général de l'AP - HP au compte Banque de France ouvert sous le numéro : 7530000000 - Code Banque : 30001 - Code guichet : 00064 - Clé : 37.

La somme ainsi versée sera imputée sur le compte 748881 « Autres subventions d'exploitation - Exercice en cours » - Section budgétaire du \_\_\_\_\_ 90-.

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#### ARTICLE 7 : REFERENTS

Le référent du Licencié est :  
M. Stephanie McBride  
Adresse mél : 8611 East Fillmore St. Scottsdale, AZ 85257 USA  
Tél. : 001-602-751-4692

Le Référent de l'AP-HP est :  
M. P. Guérin  
Adresse mél : archives.aphp@sap.aphp.fr  
Tél. : 01 40 27 50 77

Les Référents sont les correspondants des Parties intervenant pour l'exécution du présent contrat. Le Licencié s'engage à se conformer immédiatement à toute indication formulée par le référent de l'AP-HP relative à la bonne exécution de la présente.

En cas de changement de l'identité de ces interlocuteurs, il appartient à chacune des parties de notifier ce changement à l'autre par lettre recommandée avec accusé de réception dans un délai de 15 jours à compter du changement.

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#### ARTICLE 8 : RESILIATION

La présent contrat pourra être résilié, sans indemnité, par l'une ou l'autre des parties, en cas de non-respect de ses engagements par l'une des parties ou pour cause de cessation d'activités de l'une des parties, quinze jours après notification à l'autre partie de la cause de résiliation, par lettre recommandée avec accusé de réception.

Durant ce préavis, le présent contrat continue à produire ses effets.

En cas de résiliation, le Licencié devra cesser toute réutilisation des données publiques objet du présent contrat de licence.

Toute modification au présent contrat devra se faire par avenant signé des deux parties.

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#### ARTICLE 9 : LITIGE : DROIT APPLICABLE / TRIBUNAUX COMPETENTS

Le Licencié déclare avoir pris connaissance et compris parfaitement le contenu du présent contrat. Il s'engage à en respecter et faire respecter le contenu.

Le présent contrat est soumis dans son intégralité au droit français.

En cas de litige s'élevant en relation avec l'exécution du présent contrat, les parties s'obligent à une phase préliminaire de conciliation pendant une période d'un mois à compter de la première réunion de conciliation.

En cas de désaccord persistant le tribunal administratif compétent sera celui de Paris, conformément à l'article R 312-1 du Code de Justice Administrative.

Y Fait à Paris, le \_\_\_\_\_  
En deux exemplaires originaux,

Pour la Société/le particulier

M semela

Signature

Pour l'Assistance Publique-Hôpitaux de Paris

M \_\_\_\_\_ **Patrice GUERIN**

Signature

Conservateur  
responsable du Service des Archives de l'AP-HP



APPENDIX F

PERMISSIONS, GREAT ORMOND STREET HOSPITAL FOR CHILDREN

**Great Ormond Street published engravings**

Nick Baldwin [Nick.Baldwin@gosh.nhs.uk]

**Sent:** Monday, July 22, 2013 3:00 AM

**To:** Stephanie Schreiner (Student)

**Attachments:** Hospital scene from 'Illus~1.jpg (545 KB) ; 4. west & jenner.jpg (928 KB)

Dear Stephanie,

Attached (I hope) are your requested illustrations, from the 'illustrated Times' and the more well-known engraving of Drs. West & Jenner conducting their ward round from the 1858 'London Illustrated'.

Nick

Nick Baldwin

Archivist & Curator

Great Ormond Street Hospital for Children NHS Foundation Trust

[Nick.Baldwin@gosh.nhs.uk](mailto:Nick.Baldwin@gosh.nhs.uk)

(+44) 020 7405 9200 X 5920

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Thank you for your co-operation.

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