Contemporary history

Paediatrics at King's College Hospital 50 years ago

PHILIP EVANS

King's College Hospital pioneered British paediatrics. It was the first teaching hospital to have a children's department, which was founded when George Frederic Still was invited to join the consultant staff in 1899. Still was himself a pioneer, being the first doctor to practise full time paediatrics as a separate specialty from adult general medicine. In 1906 he became the first professor of paediatrics.

Mind you, he was on his own. There were no clinical departments as we understand them. Now the nucleus of a department is an office, a secretary, and a telephone, with academics attached to the cell membrane. When I came here a generation after Still's arrival the department consisted of a ward and three outpatient clinics. The consultant had a coat hook, the half time registrar had a locker, and the house physician was shared with neurology—an appointment known as 'kids and nerves'.

Still had held the formative post of medical registrar and pathologist at the Hospital for Sick Children, Great Ormond Street. Some years later he was allowed to have an assistant physician, so the then incumbent of the post at Great Ormond Street, RS Frew, was appointed. Sixteen years later he retired to look after his private practice: remember that voluntary hospital consultants were not paid for their hospital work before 1948. When Frew left, Still simply arranged for the contemporary registrar from Great Ormond Street, Wilfrid Sheldon, to move to King's. Sheldon was 26 years old.

Sir Frederic Still retired in 1933. He had two wards—Pantia Ralli and Princess Elizabeth (Still was Princess Elizabeth's paediatrician; I don't know whether the Queen remembers her first doctor). When Still left, Pantia Ralli was taken away from young Sheldon and turned over to the psychiatrists. Sheldon went on alone for six years until I was appointed assistant in 1939.

Perhaps I should explain how I came to be here at all. In 1935 there was a vacancy for a medical registrar and pathologist at Great Ormond Street. George Newns and I applied, and he was appointed.

I knew he was registrar at King's so I telephoned for an appointment with Sheldon, went to see him in his rooms in Upper Wimpole Street, and said that I should like to apply for the forthcoming appointment.

Wilfrid Sheldon had an unnerving habit of not speaking until he was ready. A long Sheldonian silence ensued and then he said 'Very well, I will tell them not to advertise. Start on October the first'. You see how opportunism sometimes pays.

It was a half time job that paid £70 a year, but Sheldon got me to conduct two of his rheumatism clinics (one at King's and one at Walthamstow), and with charity tea parties and so on got me a small stipend to do research into juvenile rheumatism. At that time rheumatic fever and chorea were great scourges. The London County Council maintained two and a half large hospitals solely for children with rheumatic heart disease who were treated by bed rest for months or even years. With these payments, together with fees from tutoring and correcting papers for the London Correspondence College at three pence a question, I earned about £450 a year—a living wage.

My duties were to be in outpatients twice a week, and to do business rounds with the house physician, and twice weekly teaching rounds with the chief. These teaching rounds were processional: first went the chief with the house physician and sister, followed by a nurse wheeling a trolley with instruments and notes, then the students followed by the registrar (who did not speak unless spoken to) and, finally, a junior nurse whose job it was to go to any child who cried and whisk it off to the sluice room where the cries could not be heard. After 1948–50 it was thought repressive to insist on silence, and the peace of the ward round was destroyed for ever.

I travelled daily from Pimlico to Denmark Hill by tram, which meant that I arrived for Friday's round having read the latest *Lancet*, which Dr Sheldon (driving himself in his Wolseley) had not done. One up to me, sometimes.

Rheumatic fever and chorea accounted for one third of our patients. Apart from sodium salicylate for arthritis—very effective—bed rest was the mainstay of treatment, the aim being to rest the heart and limit its injury. We now know that lying flat is not the best way to rest the heart, but it may not have been totally stupid. I knew of a child in New York (where they were allowed to sit up on bed pans) who died while straining at stool.

Tuberculosis was not the pest that it had been in the 19th century but it was still common. Scurvy had almost disappeared, but rickets was often seen. Urinary tract infections were treated by making the urine alkaline with potassium citrate. Pneumonia was common, but was fortunately more benign in children than in adults. It was treated by good nursing alone until the introduction of sulphapyridine in 1938–9, but there was no antibiotic until penicillin became available in limited quantities after the war. Dr Sheldon did not always treat mild pneumonia with sulphapyridine, as he thought that it often made the children more ill than the pneumonia did.

Gastroenteritis was treated by modified feeding. In 1934 it was discovered that babies' veins could be used for drips, but each one required a cut down for the insertion of a Bateman needle or cannula. Treatment was empirical; blood electrolyte concentrations could not be measured.

The Ramstedt operation for pyloric stenosis cured a lot of babies, but the mortality was between 4 and 20%—mostly from gastroenteritis. This was the result of the babies being nursed in an open ward with no cubicles. We could not prevent gastroenteritis from spreading and yet could barrier nurse patients with typhoid with confidence. Patients with poliomyelitis were not isolated and yet the disease did not spread throughout the hospital, probably because of 'herd' immunity. Paracentesis of the ear drum was the commonest operation carried out, but tonsillectomy and circumcision were also widely practised. In season, there were usually a couple of empyemas being drained.

That was the 1930s—time to move to the 1940s. In 1939 war broke out and because heavy bombing was expected in London the hospitals were moved out. King's was transferred to Horton Mental Hospital at Epsom, but because of evacuation of children to the country the children's department (at least the doctors, sisters, and students) went to Cuckfield in Sussex where the workhouse had a modern hospital block, though it was not well equipped to start with. There was only one hypodermic syringe, which was the property of the senior nurse; when she was sacked she took it with her. After some weeks radiographic equipment was installed in the gas-

man's workshop. Pathology specimens were sent by post to a mental hospital 30 miles away, so we did not get many urgent tests done. Most of what we sent was throat swabs for the diagnosis of diphtheria until we got our own laboratory about a year later. This was converted from a ward that was freed when huts were built in the grounds to take the place of wards. There were no resident doctors, but there were lodgings in the nearby village.

The summer of 1940 was beautiful and we used to pause in our tennis to watch the Battle of Britain, though we did not appreciate what was happening until it was over. One morning I was teaching with my back to the window, when I thought I was losing the attention of the audience. I droned on, and when the session was over the students told me that they had been watching a 'dog fight' in the air. One plane was shot down. The local builder jumped in his car, drove to the site, and took the German pilot prisoner.

So rural life continued; we were busy but not too busy, and patients were treated and medical and nursing students taught.

When the department moved again in 1943 because the Canadian army wanted Cuckfield Hospital I was abroad. The next location of the King's paediatric unit was at Elfinward, Haywards Heath, which was a diocesan home for retired clergymen. I don't know what became of them, but people were always being displaced during the war.

When the war ended in 1945 King's returned to Denmark Hill, and by the time I got home in 1946 it was much as it had been before. I was assistant physician with two outpatient days and four beds, and no prospect of more until I was at least 52 years old because Wilfrid Sheldon was only eight years older than me. I was therefore tempted by an invitation to go and work at Guy's Hospital, where I would have an office and a desk and a telephone, and the promise of a secretary. What was more, the medical school would pay my salary. My income from my first three months in practice had been three guineas. The war saved me financially, as I got £650 a year in the Emergency Medical Service.

After I left Wilfrid Sheldon went on without an assistant for 18 months until the Governors appointed Dr Mary Wilmers a week or two before the National Health Service came into being in 1948, so she ushered in the new era.

Since then the department has gone from strength to strength, and the face of paediatrics has changed for the better. Sydenham's chorea inexplicably disappeared in 1939, as Wilfrid Sheldon was the first to point out in a letter to the *Lancet*. Sulphonamides, and later penicillin, were probably responsible for reducing the incidence of rheumatic fever. Post-

streptococcal nephritis disappeared later, but it was already attenuated except where the original New York strain persisted, as it did in Romania. Streptococcal cross infection in hospitals gave way to staphylococcal, and then *Pseudomonas* spp came in. The 'acute mastoid', so much feared, was not seen after the early 1940s.

Tuberculosis in children was ameliorated by better living conditions, and later by BCG vaccination, but it was more accurate diagnosis and treatment with streptomycin for adults that wiped it out in many communities.

This reduction in the incidence of infectious diseases freed medical attention to concentrate on hitherto intractable diseases such as liver and kidney failure, leukaemia, congenital heart disease, and the problems associated with gross prematurity.

Just think—it is 40 years since I saw a baby with congenital syphilis!

This article is based on the address given at King's College Hospital on 1 October 1988 to mark the retirement of Sir Eric Stroud from the Chair of Child Health.

Todd Ward at King's College Hospital in the 1930s.