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TRIAGE FOR HEALTH CARE IN A METROPOLIS: PARIS UNDER NAPOLEON

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SUMMARY

Paris under Napoleon offers the earliest example of medical patient triage in a metropolis. A central admitting office opened at the Hotel-Dieu of Paris in 1801 under the supervision of a municipal hospital council. It admitted about 22,000 patients in the first eighteen months. This number represented about 44% of all applicants; another 16,000 were admitted to various hospitals as emergencies; the rest were treated as outpatients and helped on the spot or referred to district welfare offices, dispensaries, and nursing homes. Thus the historian can discern a concerted effort by hospital authorities to keep indigent patients out of the hospital.

Planning for the health of a city is a very old idea and a recent one: Paris under Napoleon provides the first modern example of triage for health care in a metropolis. The municipal government of Paris wielded unprecedented power after General Bonaparte's coup d'etat of 1799[1]. Not only had the Revolution abolished all those corporations that had traditionally resisted modernization, but the government now appointed prefects and mayors: strong-willed leadership could thus impose innovation. Second, owing to Revolutionary confiscations, the government now owned plentiful real estate adaptable to hospital purposes. It could thus support the trend toward medical specialization by creating separate institutions for emergent fields such as der-

Key words: triage-outpatient - Paris - municipal hospital council - Napoleon

matology, neonatology, pediatrics, and psychiatry[2]. Third and most important, the French Revolution coincided with a revolution in medicine, and the municipal government could draw on a star-studded world of medical teachers and researchers for consultation and the supervision of health care — men such as Alibert, G. L. Bayle, Bichat, Corvisart, Cullerier, or Pinel[3].

The enlistment of medical talent was an urgent priority for Dr. Jean Antoine Chaptal (1756-1832), the minister of internal affairs under the Consulate from 1801 to 1804[4]. As one of his first public acts, and with help from Nicolas Frochot (1761-1828), the new prefect of the Seine, Chaptal created a Municipal Hospital Council with members drawn from the medical faculty, the National Institute, and other learned societies. But medical knowledge was not the only desideratum for health care: it was equally crucial to re-enlist Catholic charity, in particular the selfless work of the nursing orders ostracized by the Revolution. In this connection, Bonaparte's spectacular success in achieving a concordat with the pope in 1801 looms large, particularly since it coincided with the completion of the *Civil Code* (1802), with reorganized finances, administration, education, and justice. A central triage of patients seemed essential to orderly hospital modernization.

While the Paris city government thus commanded unique resources, it also faced an overwhelming task: the definitive Law of 16 Vendemiaire, Year V (7 October 1796) had declared that hospitals were primarily the responsibility of the municipalities. Thus Paris must now care for its indigent patients out of its own budget. And in that city of 600,000 inhabitants — 700,000 by 1815 — the number of sick and ailing indigents was 35,000 — about 5% of the population. That was the estimate of Jacques Tenon (1724-1816), author of the classic *Memoires sur les hopitaux de Paris*[5], adopted by the Poverty Committee of the National Constituent Assembly in 1790. According to that estimate, one fifth of the sick Parisian population required immediate attention for surgery, therapy or admission to the asylum or maternity ward; the rest needed custodial care in the hospice, foundlings

home, orphanage or nursing home, or the new national institutions for the deaf or blind[6]. For each of these groups, Paris boasted a specialized establishment[7].

Some Paris hospitals emerged from the Revolutionary decade transformed: most spectacular was the transfer, in the late 1790s, of the maternity service at the Hotel-Dieu to the Port Royal and Oratoire convents in the salubrious outskirts of town- a transfer supervised the 29-year-old head midwife, Marie Louise Lachapelle (1769-1821). A new hospital, headed by Michel Jean Cullerier (1758-1827), grouped all venereal disease patients by 1792. The mental hospital emerged owing to the creative work of Philippe Pinel (1745-1826) at Bicetre and the Salpetriere well-known owing to Michel Foucault's adverse publicity. On the northern outskirts, a dermatologic center arose at St. Louis under Jean Louis Alibert (1768-1837), and a Children's Hospital, the first in the world, opened its doors in 1802. The Charité was being architecturally transformed out of the confiscated headquarters of the Brothers of Charity: their chapel into a teaching ward for Nicolas Corvisart (1755-1821), its apse into an amphitheater that can still be visited, their dormitory into a women's ward. Today the former Charité on the rue des Saints Peres has become the Paris Medical Faculty. Thus the Revolutionary decade produced considerable creative change in the Paris hospital world. With so many specialized institutions ready to receive patients, eager to use them for teaching purposes and, as cadavers, for dissection and research, the stage was set for triage.

This triage was not a total innovation because the traditional principle of hospital admission in Paris under the old regime had been charity — but charity with rules. The Paris Hotel-Dieu admitted everyone, any time: Catholic, heretic, Moslem, and Jew; Parisian, provincial, or foreigner; surgical, medical, contagious, or agitated mental patient; man, woman, and child... Hence the murderous overcrowding for which medical historiography has relentlessly blamed the Augustinian nurses. They knew what they were doing, of course, only their principle of charitable

hospitality toward all the suffering poor ran counter to the medical profession's goal of using the hospital to treat the sick.

In contrast to the Hotel-Dieu, the Charité Hospital had always preferred the proteges of wealthy donors, admitted men only, specialized in surgery and reached fame for lithotomy. Like the Charité, the neighborhood hospitals (Necker, Cochin, St. André des Arts, and St. Merri) rejected applicants with known communicable diseases, pregnant women, and the mentally ill. Thus selectivity, if not triage, was an established tradition.

On March 22, 1802, a modernized central admitting office, manned by two physicians, Biron and Chamseru, and two surgeons, Parfait and Prat, opened at the Paris Hotel-Dieu. It had been *improved to the utmost*, wrote the architect, Nicolas Clavareau, in 1803. (He evidently liked his own renovations).

Before the Revolution, this office prejudice that prevailed so long against this hospital... The quarters were so dark that a light was needed at alltimes, even on bright days. One can imagine the drawbacks for the health officer and for the classification of illnesses.

Now, Clavareau continued,

... *it is light, clean, with all services properly housed, a large and well-lit registration desk, an examining room, separate dressing rooms for each sex, a washroom for new arrivals... a depository for patients' clothes... a superb and vast bedlinen department*[8].

Open daily from nine to four o'clock, the office processed 38,031 applicants in the first eighteen months of its existence. This means that the four doctors saw an average daily total of eighty-five citizen-patients, a heavy, but not totally impossible caseload of some twenty patients per doctor and per day[9].

The difficulties of an initial diagnosis were considerable, given the state of contemporary knowledge and the lack of reliable diagnostic tools. Should the physician admit a patient only if he knew that specific therapy was available, as in the case of scabies, ringworm, syphilis, dropsy, malaria, mental illness, kidney stones and surgery of the head or limbs? Or should he admit a person who *felt ill*, even if the physician could find

nothing wrong, that is, if he could identify no disease or disturbance of function?[10] In trying to assess the diagnostic criteria of the late eighteenth-century, the historian is constantly reminded how relative and changing are our notions of *health, illness* and disease. Many more diseases can of course be diagnosed accurately today, and a modern doctor would no doubt have hospitalized an even larger number of Parisian indigents, considering such syndromes as advanced malnutrition, anemia, alcoholism, or depression as illnesses. But he would know how to treat these, and his eighteenth-century colleague did not. Aggravating the doctor's dilemma was his realization that the overcrowded hospital presented a danger to the patient's health. On the other hand, the doctor knew that many poor applicants had no home or care-giver, they were in fact aspiring to hospital admission in order to secure food and shelter. They cried out for medical charity, as formerly dispensed by the Church. But the Revolution had disestablished the Church and was determined to replace charity with welfare, including hospital care. In the first 18 months of the bureau's existence, the doctors admitted 44% of the applicants — 21,888 persons: 1,913 to St. Louis, 2,584 to the Venereal Diseases Hospital, 1,592 to the Children's Hospital, but most to the Hotel-Dieu itself and to four small outlying general hospitals: St. Antoine, Cochin, Necker, and Beaujon[11]. In their triage, the admitting officials heeded the requirements of the new medical curriculum: ... *the needs of clinical teaching motivate us to leave few beds empty at the Charité*, read the report of 1804. *This hospital has a kind of privilege to select its patients, and to admit only certain kinds of illnesses. Thus 'eruptive' maladies, especially smallpox, are kept away, and almost all interminable chronic complaints, internal as well as external, and, generally speaking, all illnesses not demonstrably curable.*

... *women are only admitted to the Charité for clinical teaching, that is, if they present a degree of illness serious enough to warrant observation*[12]. When the doctors at Cochin complained about the monotonous stream of patients with *catarrhe epidemi-*

que [influenza?], the central admitting office acknowledged the protest. As soon as the illnesses of springtime showed more variety, we hastened to respond to the doctors' concerns and offer their skills more diversified cases[13]. But the doctors at the Charité did not obtain satisfaction when they complained that critically ill children were now kept at the Children's Hospital: the Hospital Council firmly countered that patient welfare must take precedence over the requirements of medical instruction[14]. For the mentally ill, the admitting officials turned into a *sort of legal jury*. They demanded testimony from a doctor and two *witnesses to acts of madness* before they committed a person reputedly insane. In the eighteen months under review, the doctors hospitalized 560 out of the 582 persons brought to the office. Thus, they questioned the petitioners' judgment in only 4% of the cases. From 1802 on, the Hotel-Dieu no longer admitted the mentally ill. Their destination kept shifting, to Charenton, the Salpetriere, and Bicetre, the Hospital Council trying to adapt to changing ideas about psychiatric care[15]. At the Babies' section of the Maternity Hospice a separate triage led the pediatrician Jean Abraham Auvity (1754-1821) to assign new arrivals to the well-baby ward, the infirmary, or a special high risk ward, under the supervision of a learned midwife, Madame Boivin (1773-1841).

Greatly to their dismay, the physicians at the central admitting office soon discovered that their triage accounted only for about 60% of all hospitalizations in the first eighteen months. An additional 16,143 patients were admitted directly to the several hospitals, on the authority of their physicians-in-chief. Surely these could not all be emergencies, such as traffic accidents, grave injuries, attempted suicides or murders, or imminent childbirth! Rather, their hospitalization remained a local arrangement between patients and doctors: the 2,432 emergency admissions to St. Antoine Hospital, against 336 sent by the central bureau, the 1,289 direct admissions to the Children's Hospital, and the 966 to Necker Hospital have another reason: sick people minded the long walk to the center of town, am-

bulances were unknown[16], cabbies expensive. It was simpler to apply directly to the district hospital. And the physician-in-chief, disdaining the opinion of a faraway administrator, preferred to make his own decision, thus reinforcing a popular habit that would grow over time[17]. Lamenting this lack of compliance, Dr. Claude Francois Duchanoy (1742-1827), one of the administrators, commented in his annual report of 1806 that ... *it would be desirable to limit these admissions... I impute only legitimate and pure intentions to the physicians and surgeons-in-chief. But they do not and cannot effect all admissions personally, and, once patients have been provisionally admitted, they appeal to the chief's humaneness and pity to let them stay*[18].

In fact, the chiefs fostered this policy and the independence of the specialized hospitals steadily increased. Having now analyzed hospital placements after triage or for presumed emergencies, we are intrigued to know the fate of the applicants who were refused hospital beds — 12,366 men, women, and children in those first eighteen months-or 24% of all who sought admission. Upon reflection it becomes clear that the admitting office served mainly to keep patients out of the hospital. And for good reasons: the hospital was a fever-ridden, overcrowded establishment, and a drain on the municipal budget.

The admitting officers functioned as a *jury and sentinel*, wrote Duchanoy[19]. Their scrutiny was needed because a number of malingerers or *faux malades* had long been making the rounds of hospitals, a *species of parasite who looks for free food and shelter*[20]. The doctors kept lists of these persons' names, ages, and domicile and even of their chief physical traits *so as to collect data permitting to recognize them when they would come again*. Almost 6,000 applicants found themselves rejected. This led to rumors of hard-heartedness that the Hospital Council vehemently denied[21].

But the doctors' objective was to proffer help, not to refuse it, and they had several alternatives to hospitalization: they favored referral to the district welfare offices partly because these contracted for the services of a local doctor and an

apothecary whom they reimbursed. The admitting office sent 1,795 patients to these establishments in the city's boroughs. They may also have sent patients to the five dispensaries of the Philanthropic Society of Paris[22].

Referral to the custodial hospice offered another option, to Bicetre, the Salpetriere, or the more attractive *Hospice des menages* where a minimal contribution secured a decent old age for married couples and widowers. A new institution, founded in the 1780s, foreshadowed interesting developments akin to our nursing homes: the Brothers of Charity then established at Montrouge a *maison de santé* that the Revolution later used for retired hospital employes. Along similar lines, but for wealthier clients, the *Maison Ste Périnne* in Passy offered supervised retirement. These shelters for the custodial care of invalid, ailing, and aged senior citizens can be conceptualized as the successors of the medieval monastic *infirmarium*, long a refuge for good care, isolation, and rest, and a quiet place where to die. Seen from a different perspective, the *infirmerie* of the late 18thcentury hospice, prison, or *dépot de mendicité* represents the only ward where doctors provided care[23]. These infirmaries may be conceived of as prospective teaching wards- an observation surely applicable to the experience of Cullerier and Pinel.

But available places in custodial institutions remained scarce, and the most efficient measure at triage was to counsel indigents on the spot: the admitting officer turned into an outpatient consultant. The four doctors at the Hotel-Dieu gave prescriptions, and 2,185 bandages and pessaries to 7,626 applicants, presumably for hernias, a prolapsed uterus, and related complaints that, in more refined circles, were called hypochondriacal or hysterical disorders — for which the poor had no time.

The Hospital Council expanded outpatient consultations for ringworm and scabies at St. Louis and the Children's Hospital and, finding that the Venereal Diseases Hospital had a sizeable waiting list, the council authorized it to use a consulting room for syphilitic outpatients and to distribute mercury-based medications[24]. In his 1816 report, the sanctimonious count Pastoret speaks of 3-4,000 persons per year, whose illness exists only in the imagination or apprehension, who come mainly to dispel preoccupations regarding their health, to know whether they may get married, travel, whether their doctors have really cured them,... persons who have other illnesses than those that motivated their request for a consultation. This accounts for the presence of 60, 80, sometimes 100 patients, especially men who are much more numerous.[25] These four consultation services at the Hotel-Dieu, St. Louis, Children's and V. D. Hospitals siphoned off thousands of potential inpatients. Within a year of the central admitting office's creation, daily census reports from every establishment provided data for a chart where the doctors could see at a glance which hospital had available beds. Also, every three months, the administrators and the physician-in-chief of each hospital reviewed their patient population so as to detect persons who had overstayed their welcome[25]. Three days of convalescence in the hospital, with the right to go out and seek work, was all the regulations now permitted.

Our first conclusion concerns these 24% of applicants who received outpatient consultations: this practice marks an important transition. No longer did they gratefully accept medicines dispensed at the door of a hospital or monastery pharmacy; they no longer stood in the street, but neither do we find a locale for the examination and treatment of outpatients at the Hotel-Dieu other than the examining rooms at the admitting office so proudly described by the architect Clavareau.

These outpatient consultations are the forerunners of outpatient *departments* in the mid-19th century hospital. They were less well adapted to the needs of the poor than the German *Polyklinik*, but served many more patients than the British dispensary where the eligible clientele was normally restricted by the subscribers. In Paris, since the Revolution, illness entitled the poor to health care[26].

But in the years 1806-1813, only 11% of the applicants were hospitalized, whereas 56% received oral advice, 16% bandages, and 6,5% written instructions. This means that the physician now enlisted the patient as participant in his own therapy. Given a bandage, the patient had to be shown how to change it; an appliance, how to use it; medication, when to take it. This new arrangement marks a transition to patient education and responsibility.

Thirdly, triage sharpened attention to diagnosis. Witness the numerous re-transfers of patients in the initial years[27]. Ultimately triage — launched as an administrative project — turned into medical policy. As of July 1, 1808, the V. D. Hospital regulated all its own admissions, soon followed by the new Pitie Hospital, opened in 1809[28]. Charenton ceased to accept mental patients: all women were sent to the Salpetrière for treatment (as of 1802) and men to Bicetre (as of 1807). The direct admissions at Necker reached close to 80%. The physician-in-chief could now be selective, particularly if he was a specialist: he welcomed the purposeful distribution of patients because it enhanced the quality of teaching and furthered research. It would be interesting to know whether the final outcomes of illnesses justified initial classifications, but the data for such an inquiry are not available. Nor can we say how triage affected the cost of care.

The admitting office itself took on new tasks: from 1806 on, it accepted real emergencies, from 4 p.m. to the next morning; it distributed aid to indigent mothers with nurslings (that is, it collaborated with the Society for Maternal Charity), medication to orphans serving apprenticeships and to foundlings in provincial foster-care, and admissions to the Tivoli Baths in the Seine. In other words, the admitting office, seeing that triage was launched, spread its health care net elsewhere[29].

What happened to the indigent who was turned away altogether, not judged ill enough to qualify for hospital admission and left to his own devices? He — and she — paid the price for the advantages that medical science and the municipal

budget of Paris derived from triage in that metropolis. Jean Francois Coste, the famous army doctor and inspector, surely reflects informed professional opinion when he wrote in his long article *Hopital* in the *Dictionnaire des sciences medicales* that the central admitting office is the institution whose influence and efficiency has done more than anything else to reduce the census of hospitalized patients. Impassive and unflinching in applying the rules, it has never deviated from its duty. It has fulfilled its mission profitably for humanity and for the budget[30]. Under the new regime, patients not ill enough for hospital admission had to fend for themselves.

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An earlier version of this paper was presented at the 60th annual meeting of the American Association for the History of Medicine in Philadelphia, PA, on 2 May 1987.

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[2] The most important book for understanding Paris hospital history during this time is IMBERT J., *Le droit hospitalier de la révolution et de l'empire*, Paris, Sirey, 1954. Imbert is about to publish *La Protection sociale sous la révolution*, Paris, Societé pour l'histoire de la securitè sociale, 1900. The Paris hospital history of the early Révolutionary period is portrayed in MACAULIFFE L, *La révolution et les hopitaux, annees 1789, 1790, 1791*, Paris, Bellais, 1901, and the political history in GILLET M.C.R., *Hospital Reform in the French Révolution*, Washington, D.C.: American University Ph.D. Thesis, 1978. The hospitals' real estate is examined in BONDE A., *Le domaine des hospices de Paris, 1789-1870*, Paris, Berger-Levrault, 1906.

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[8] CLAVAREAU N.E., *Mémoire sur les hopitaux civils de Paris* (Paris: Prault, 1805), 49 and 55.

[9] The numbers used for this essay derive from the tables in the admitting office reports; numbers given in the texts show slight discrepancies. Even when these outpatient consultations grew into outpatient departments in the mid-19th century, the physicians' case loads were astoundingly large. Dr. Robert Bridges, later famous as Poet Laureate, described his experience at St. Bartholomew's Hospital in London in the 1870s where *he personally, had to 'filter' over 30,000 patients a year, two-thirds of them new patients, at an average rate of one every 88 seconds.* Thirty-two years later, Sir Henry Butlin, PRCS, in his evidence to the King Edward's Hospital Fund Committee, recalled Dr. Bridges' experience and confirmed that *conditions are precisely similar at the present time.* He described how, in 1910, the casualty doors were thrown open between 8:00 and 10:00, during which as many as 1200 patients (half of them new patients) were sometimes admitted and dismissed during the morning by an assistant physician, an assistant surgeon, and a casualty physician. Throughout London the consultation time for casualties varied from one to three minutes, and it was repeatedly said with astonishing complacency that this was acceptable because casualty doctors acquired *great skill in rapid diagnosis. For follow-up attendances the time could be even shorter.* LOUDON I.S.L., *Historical Importance of Outpatients*, British Medical Journal, 1978, 1: 974-977. The quotation is on 976 temphasis added]. See also BRIDGES R., *St. Barthlomew's Hospital Reports*, 1978, 14: 167, and Sir BUTLIN H. in King Edward's Hospital

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[11] Seine. CGAHHCP. *Rapport du bureau central d'admission*, (Paris: An XII), Table IV. Table I gives the number of admissions as 22,470. Discrepancies stem from the fact that patients sent to the hospital of the Graduate School of Surgery (Hospice de perfectionnement) and to the asylums at Charenton and the Salpetrière were sometimes counted, and at other times not.

[12] Ibid., 7.

[13] Ibid., 9.

[14] SIGURET G.R., *Histoire de l'hospitalisation des enfants malades de Paris*, Paris, These medecine, 1907, 53 and CGAHHCP, 1803, 42.

[15] Seine. CGAHHCP. *Rapport du bureau central d'admission*, An XII, 2123. It is not clear, from the documents, whether one or two physicians' certificates were required; the report mentions: *des certificats d'officiers de santé et de deux témoins attestant les actes de folie.*

[16] This is not entirely true, for Tenon mentions *bilanders*, defined in a footnote as *boxes surrounded by curtains and fitted into four-wheeled stretchers with lower and upper bunks and four or eight horsehair mattresses, covered with washable leather. Each of these is set on a separate frame. A mattress is taken out, a patient is put on it and he is thus transported within the box. These mattresses have four handles for putting them in and taking them out.* TENON, *Memoires*, 416, n. 17.

[17] The Hospital Council's retrospective Table of Admissions for 1806-1813 confirms our observations for 1801-1802: the proportion of *emergency* or direct admissions remained high at the centrally located general hospitals, i.e. the Hotel-Dieu and Charité.

But at the four small outlying all-purpose hospitals (Cochin, Necker, Beaujon, St. Antoine) direct admissions regularly exceeded those sent by the central bureau. The most extreme case was Necker:

	1806	1809	1812
Hotel-Dieu			
total admissions	11,536	9,320	11,007
emergency "	3,001	3,535	2,173
	26%	31%	20%

	1806	1809	1812
Necker Hospital			
total admissions	1,039	1,036	1,335
emergency "	801	845	1,001
%	77%		

Adapted from Seine, CGAHHCP, 1816, Table III, p. 232.

[18] Seine. CGAHHCP. *Rapport du bureau central d'admission*, An XIII, 8-9.

[19] Seine CGAHHCP *Bureau d'admission*, An XIII, 3.

[20] Ibid., 27.

[21] We read this "Observation" in the 1806 annual Report: *The admitting office has been unjustly accused of having rejected truly ill persons*; here is a Table that proves the contrary:

admitting permits issued to	2,261 persons
direct admissions	10,698 persons
total	22,959 persons

But the total numbers of patients admitted to the hospitals was only 22,576 persons:

discrepancy:	383 persons

that is to that, 383 permits were not used. Thus 383 individuals who were authorized to enter the hospital decided to do without it and did not come. Surely they were not very sick and thus the accusations voiced against the Admitting Office are quite gratuitous. Seine. CGAHHCP. *Rapport... du bureau central d'admission pendant l'An XIII*, Table XVI.

[22] WEINER D. B., *The Role of the Doctor in Welfare Work: The Philanthropic Society of Paris*, in GOUBERT J. P. , ed., *La medicalisation de la societé francaise*, Historical Reflections/Reflexions Historiques, 4: 279-304.

[23] The work of Jean Colombier is particularly important as regards the enhancement of the infirmary. See, for example, ADAMS T. M., *Medicine and Bureaucracy: Jean Colombier's Regulation for the French Depots de mendicité*, BHM1978, 52: 529-542 and GREENBAUM L.S., *Scientists and Policitians: Hospital Reform in Paris on the Eve of the French Revolution*, in Consortium on Revolutionary Europe, 1750-1850, Proceedings, 1973, Gainesville, FL, University of Florida Press, 1975, 168-191.

[24] Seine, CGAHHCP, 1816, 235-236 and 84.

[25] Seine. CGAHHCP, 1816, 84.

[25] Seine. CGAHHCP, 1803, 29.

[26] On the dispensary see COPE Z., *The History of the Dispensary Movement*, in POYNTER F.N.L., ed., *The Evolution of Hospitals in Britain*, London, Pitman, 1964, 73-76, I. 5. LOUDON L., *The Origin and Growth of the Dispensary Movement in England*, BHM, 1981, 55: 322342, TROHLERN U., *The Influence of Dispensaries upon Medical Education and Research in Britain, 1770-1840*, [abstract] in Symposium on Clinical Teaching, Past and Present, Faculty of Medicine and University Hospital, University of Leiden, The Netherlands, August 27-29, 1986, 711. RUSER H.R., *Wandlung des Dispensairegedankens*, Zeitschrift zur aesammten Hygiene, 1977, 23: 766-768, and WEINER D.B., *The Role of the Doctor in Welfare Work.*

[27] The proper classification of patients was not a new goal. In March 1792, for example, the hospital commission ordered 152 epileptic women transferred from the Venereal Diseases Hospital to the Salpetrière. Archives de l'assistance publique à Paris. Document 136, liasse 120.

[28] The Pitié's census started slowly, with 1,931 patients in 1809. The big change came in 1812, when *emergency* admissions multiplied 100-fold, jumping from 114 (in 1811) to 1,483 while Admitting Office referrals declined by 3/5 and ceased in 1813. Seine. CGAHHCP, 1816, 232.
[29] Ibid., 224-226.
[30] COSTE J.F., *Hopital*, in Dictionnaire de sciences medicales, p. 496.

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Articoli/*Articles*

RELAZIONI MEDICHE BULGARO-ITALIANE NEL TERZO DECENNIO DEL SECOLO VENTESIMO

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SUMMARY
BULGARY-ITALY MEDICAL RELATIONSHIPS

The story of Bulgarian physician Ivan Raev is indicative to define the importance of medical relations between Italy and Bulgary. Ivan Raev was the inventor of the "Bulgarian cure" for treating lethargic encephalitis, and he obtained a lot of remarkable results also in Italy, working in Queen Elena di Savoia's service, and studying epilepsy and tubercolosis.

With Ivan Raev and many other healers, popular bulgarian medicine married the official one, giving her dates and methods. These methods showed their efficacy in curing patients not only in the biological context but also in the social one.

Al secondo Congresso Nazionale di Storia della Medicina, svoltosi in Bulgaria nella città di Velico Tornovo nel 1985, lo storico della Medicina italiano Prof. Luigi Stroppiana ha rilevato l'importanza delle relazioni culturali e scientifiche fra i diversi popoli. Condividiamo appieno la sua opinione: *la conoscenza delle tradizioni culturali dei popoli dovrebbe costituire infatti una parte essenziale degli scopi della Storia della Medicina*[1].

Proprio in quella occasione è stato rilevato che le relazioni nel campo della scienza in generale e della storia della medicina in particolare non possono e non debbono essere considerati in modo statico, ma come un processo di continuo perfezionamento ed evoluzione. Questo momento assume una particolare importanza nella discussione sulle relazioni mediche

Parole chiave/*Key words:* Bulgary-Italy - Medical Relationship - History