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Patient Case Records of the Royal Free Hospital, 1902 – 1912

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ABSTRACT

This study has used patient case records of the Royal Free Hospital, London, to examine patient identity, agency, and experience, in relation to hospital treatment of the early twentieth century. The patient base was predominantly the young, lower working-class, but people of a wide variety of circumstances mixed on the wards. Patients used the hospital as a part of the mixed economy of healthcare, making consumer-like decisions at periods of ill-health as to where best to seek medical aid. The lifecycle of ill-health of the patients and their families has been examined according to the histories contained in the records. The frequency of infectious chest conditions stands out, which has raised issues relating to epidemiological transition hypotheses and the wider physical condition of the population during the period of this study. Hospital doctoring has been considered alongside the medical and surgical treatments afforded the patients, in order to understand the standard of care provided at the Royal Free in relation to that available in the wider medical market, and to reconstruct the patient experience of hospital treatment. Financial restraints and reluctance to abandon traditional remedies and techniques meant that it proved slow in adopting the new technologies of modern medicine. The familiarity of traditional medicine, however, would have made the patient experience less intimidating. Patient records are an under-used source, but they represent a significant aspect of hospital development and shared knowledge during a period when patients were attending multiple hospitals throughout their lives. The Royal Free has never before been the subject of an academic study, though its progressive attitude towards admission requirements, medical social work, and medical women, made it an important and influential voluntary institution of the nineteenth and early twentieth centuries.

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CHAPTER ONE

INTRODUCTION

This study uses patient case records of the Royal Free Hospital (henceforth RFH) to contribute towards our understanding of health, hospital medicine, and patient identity and experience during the early twentieth-century. Patient case records are a much under-used source, and no previous study has made use of a sample of this scale, which is significantly greater than all established studies of patients in nineteenth and twentieth century hospitals. The records of two physicians and two surgeons have been sampled from the years 1902-3, 1907 and 1912, with the purpose of identifying the typical patients of a voluntary hospital like the RFH, determining how they made use of the hospital in relation to the wider medical market, exploring the ailments suffered, and examining the nature of hospital medicine and treatment. The relationship held between the doctor and the patient will be examined and the experience of those treated at the hospital reconstructed.

This thesis therefore incorporates several advances to the history of medicine. Firstly, it will analyse the patients of the RFH in the ‘waiting room’ period of the early twentieth century that has fostered comparatively little empirical research. The current literature lacks any substantial discussion of the patient, meaning that we know extremely little about the identity of hospital patients and their experience of inhabiting such institutions as the RFH. The patient case records encompass personal details of the patients’ current illness, and health and treatment histories of the patients and their families, with the presiding practitioner clearly identifiable. The patients’ names, age, sex, marital status, occupation, and address are all contained in the records. This information will allow for a distinct analysis of the patient base of a central London voluntary hospital at the turn of the twentieth century to be compiled for the first time. Secondly, this thesis will place the RFH in the wider medical community of London by providing a rare and

valuable insight into how people made use of and experienced medical provision during this time. Patient and family histories contained in the records identify many of the reasons behind why patients sought treatment at various medical provisions throughout their lifetimes, including other institutions, dispensaries, or general practitioners. Whilst many patients acted as consumers when deciding to seek treatment at the RFH, others had no choice in the matter.

The third advance made by this thesis is to use patient records to give an impression as to the health of the London population during the early twentieth century, an issue that has been seriously understudied in medical history. The current ailments of the patients, their health histories and their family health histories contained in the records give a unique insight into the health of the patients, their families, and their ancestors. Information on the current illness of the patients allows for a spectrum of ailments treated at the hospital to be compiled, whilst the health histories of the patients and their families give an indication as to the wider health problems people suffered in their lifetimes. Fourthly, the medicines the patients received, the surgical procedures performed on them, and the care they received on the wards of the hospital will all be assessed in relation to each other for the first time. Such information will be obtained from the daily and surgical notes contained in the patient records. Moreover, information extracted from the patient records, including the length of patient stay at the hospital and the amount of contact patients had with their doctor, will be used in conjunction with other records, including the rules and regulation of the hospital and the almoners record book, to create a broad picture of life at the hospital for patients from admission to discharge and after. Through this reconstruction, the study will assess whether the RFH was typical in the treatment it provided patients as a voluntary hospital during the early century by comparing its treatments to that the patients in the sample had received elsewhere.

Finally, this thesis will bring the RFH into the current historiography. The RFH has been an important voluntary London centre of medical aid from the date of its foundation in 1828, but has never before been the subject of any academic study.¹ The RFH differed from other voluntary general hospitals of the early nineteenth century as patients did not require a subscribers' letter from a hospital benefactor to receive treatment. Instead, 'the poverty and disease of the afflicted' were said to be the only requirements needed for admission.² Institutional histories of London are few and have tended to focus on the voluntary and charitable hospital systems of the nineteenth century and on the system after the First World War.³ The years between the late nineteenth century and 1914, however, have absolutely and by comparison been neglected. The RFH archive holds surviving patient case records dating between the year 1890 and the 1920s, which therefore fit perfectly with the serious gap in the current historiography of the hospital. A range of administrative and financial records of the hospital also survive from the date of foundation, which can be used to trace the institutional development of the hospital and place it in the career structure of its honorary staff. Such information will add to our current lack of empirical perspective on how hospital doctoring fitted into the career patterns of physicians and surgeons throughout the nineteenth and twentieth centuries. The use of records from the RFH for the purpose of this project will therefore highlight its importance in the marketplace, broaden our understanding of the medical landscape of the metropolis during this period, and place the hospital in the historiography for the first time.

¹ The only current work relating to the Royal Free Hospital is the un-referenced, L. A. Amidon, *An Illustrated History of the Royal Free Hospital*, (Published by the Special Trustees for the Royal Free Hospital, London, 1996)

² Royal Free Hospital Archives (Henceforth RFHA): *General and Committee Minutes 1828-1839*, (RFH/1/2/1/1), p.1

³ Institutional histories of London include: B. Croxson, 'The price of charity to the Middlesex Hospital, 1750-1830', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 23-39, L. Granshaw, *St. Mark's Hospital, London: A Social History of a Specialist Hospital*, (Distributed for the King's Fund by Oxford University Press, Oxford, 1985), G. Rivett, *The Development of the London Hospital System 1823-1982*, (Kings Edward's Hospital Fund for London, Oxford University Press, Oxford, 1986), K. Waddington, *Medical Education at St. Bartholomew's 1123-1995*, (Boydell Press, Woodbridge, 2003)

Historiography

The history of medicine and healthcare has an enormous literature and a broad range of its topics are potentially relevant to this study. The most apparent, however, are those which consider the London hospital system, doctors and patients, and the health and healthcare of the population, during the late nineteenth and early twentieth century. Although these subjects often overlap in the current historiography, here they will be discussed separately in order that gaps in their literature can be best identified.

The London Hospital System

The historiographical landscape of the English hospital in the nineteenth and twentieth century is crowded.⁴ General surveys of administrative development intersect with socio-cultural, economic, and regional studies, along with histories of individual institutions.⁵

⁴ The most important works for this study being B. Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*, (Heinemann, London, 1964), E. H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848*, (John Hopkins Press, Baltimore, 1967), S. Cherry, *Medical services and the hospitals in Britain 1860-1939*, (Cambridge University Press, Cambridge, 1996), Croxson, 'The price of charity', M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, Translated from French by A. M. Sheridan, (Tavistock Publications, London, 1973), Granshaw, *St. Mark's Hospital*, L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989), J. Henderson, P. Horden and A. Pastore (Eds), *The Impact of Hospitals 300-2000*, (Peter Lang, Bern and Oxford, 2007), R. Porter, 'Hospitals and Surgery' in Roy Porter (Ed.) *The Cambridge History of Medicine*, (Cambridge University Press, Cambridge, 2006), pp. 176- 210, F. K. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund 1897-1990*, (Clarendon Press, Oxford, 1992), G. B. Risse, 'Hospital History: New Sources and Methods', in R. Porter and A. Wear (Eds.), *Problems and Methods in the History of Medicine*, (Croom Helm, New York, 1987), pp. 175-204, G. B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford University Press, Oxford and New York, 1999), Rivett, *The Development*, Waddington, *Medical Education*, J. Woodward, *To do the sick no harm: A study of the British voluntary hospital system to 1875*, (Routledge & Kegan Paul, London, 1974), K. Waddington, *An Introduction to the Social History of Medicine: Europe Since 1500*, (Palgrave Macmillan, Basingstoke and New York, 2011)

⁵ Abel-Smith, *The Hospitals*, Cherry, *Medical Services*, S. Cherry, 'Regional comparators in the funding and organisation of the voluntary hospital system, c. 1860-1939', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 59-76, Granshaw and Porter, *The Hospital*, J. Mohan, 'Caprice of charity' Geographical variations in the finances of British voluntary hospitals before the NHS', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 77-92, J. Mohan and M. Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain Past and Present*, (Office of Health Economics and Association of Chartered Certified Accountants, London, July 2001), Risse, *Mending Bodies*, S. Thompson, 'To Relieve the Sufferings of Humanity, Irrespective of Party, Politics or Creed?: Conflict, Consensus and

Administrative histories such as that of Abel-Smith and the financial histories of Cherry, Gorsky, Mohan, and Sheard, offer a crucial backdrop to the workings of healthcare providers of the nineteenth and twentieth century.⁶ Social histories such as that of Cartwright offer a general overview of the workings of the hospital system during the same period.⁷ These types of social histories often discuss the developments of the hospital in terms of deliberate progression towards the National Health Service. The works of Hodgkinson and Thane, for example, examine the charitable medical service of the nineteenth century as services additional to those of the state Poor Law and National Health Insurance Act.⁸ Regional studies of healthcare and provincial hospitals such as those of Cherry and Porter have contributed greatly to our overall understanding of the variations in healthcare across the nation, whilst those of Prochaska, Rivett, and Waddington have provided a focused insight into the hospitals of the capital.⁹ There are many overlapping themes in these histories, but those relevant to this study are twofold. The first is the growth of the hospital system in Britain from the eighteenth century and the second is the focus placed on charitable or voluntary hospitals.

The growth of the hospital system since the eighteenth century has been attributed to many factors, ranging from urbanisation to migration, industrialisation, social mobility, philanthropic pride, and changing health patterns, though the birth of clinical medicine is perhaps the most renowned.¹⁰ Ackerknecht and Foucault both attribute a radical change in

Voluntary Hospital Provision in Edwardian South Wales', *The Journal of the Society for the Social History of Medicine*, Vol. 16, No. 2, (2003), pp. 247-263, Waddington, *Medical Education*

⁶ Abel-Smith, *The Hospitals*, S. Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *Economic History Review*, Vol. L, No. 2, (1997), pp. 305-326, Gorsky and Sheard, *Financing Medicine*, Mohan and Gorsky, *Don't Look Back?*

⁷ F. F. Cartwright, *A Social History of Medicine*, (Longman, London, 1977)

⁸ R. G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871*, (The Wellcome Historical Medical Library, London, 1967), and P. Thane, *Foundations of the Welfare State*, 2nd Edition, (Longman, London, 1996)

⁹ R. Porter, 'The gift relation: philanthropy and provincial hospitals in eighteenth-century England', in L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989) pp. 149 – 178, Prochaska, *Philanthropy*, Rivett, *The Development*

¹⁰ J. Henderson, P. Horden and A. Pastore, 'Introduction. The World of the Hospital: Comparisons and Continuities', in J. Henderson, P. Horden and A. Pastore (Eds), *The Impact of Hospitals 300-2000*, (Peter Lang, Bern and Oxford, 2007), pp. 23-27, Waddington, *An Introduction*, pp. 148 - 157

the medical approach of the hospital in the early nineteenth century to the French Revolution.¹¹ Foucault has argued that this period saw a dramatic change in the European mechanisms of power, whereby medicine (particularly that in the hospital setting) became a tool to exert power and control over the human body.¹² According to Ackerknecht, ‘students and doctors from all over the world streamed into Paris for about six decades’ at the end of the eighteenth and early nineteenth centuries to learn of the new clinical medicine taught in the hospital setting.¹³ While previous medical knowledge was based on book learning and theory, new medical techniques became based on observation, autopsy and statistics.¹⁴ Lecture theatres would no longer be the basis of medical teaching. Instead, medical students would gain vital experience from observing the patients on the clinical wards of the hospital.¹⁵ The hospital was thus transformed from a hospice or sanctuary of primarily religious purpose to the centre and forefront of the new anatomical medical methods and techniques, turning it into what Porter has dubbed, ‘the medical power-house it has been ever since’.¹⁶ The new-found importance of ward teaching resulted in organised teaching hospitals emerging during the early nineteenth century.¹⁷ In addition, many voluntary hospitals were established to serve the need of medical teaching.¹⁸ By the twentieth century, Mohan and Gorsky claim that London

¹¹ Ackerknecht, *Medicine*, pp. xi-xii, Foucault, *The Birth*, p. xii-xiii

¹² Foucault, *The Birth*, D. Armstrong, ‘The Doctor-patient Relationship: 1930-80’, in P. Wright and A. Treacher (Eds.), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine*, (Edinburgh University Press, Edinburgh, 1982), p. 109, A. Digby, *Making a Medical Living; Doctors and patients in the English market for medicine, 1720-1911*, (Cambridge University Press, Cambridge, 1994), p. 93

¹³ Ackerknecht, *Medicine*, pp. xi-xii, and W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge University Press, Cambridge, 1994), p. 25

¹⁴ Ackerknecht, *Medicine*, pp. xi and 4, and L. Granshaw, ‘The rise of the modern hospital in Britain’, in A. Wear (Ed.), *Medicine in Society: Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 202-3

¹⁵ Granshaw, ‘The rise’, p. 203, and Porter, ‘Hospitals and Surgery’, p. 195

¹⁶ Bynum, *Science*, p. 25, J. Duffin, *History of Medicine: A Scandalously Short Introduction*, (Macmillan, Basingstoke, 2000), p. 204, Porter, ‘Hospitals and Surgery’, p. 195

¹⁷ Porter, ‘Hospitals and Surgery’, p. 196

¹⁸ V. Berridge, ‘Health and medicine’, in F. M. L. Thompson (Eds.), *The Cambridge Social History of Britain 1750-1950*, Vol. 3 (Cambridge University Press, Cambridge, 1990), pp. 206-7

contained thirty-one hospitals with medical schools.¹⁹ Such hospitals were staffed by honorary consulting physicians and surgeons, who were not paid a wage for their work, but took a fee from medical students for their training.²⁰ Though not paid, teaching hospital posts became highly sought after for the experience they gave the medical staff, the profitable connections they presented, and the opportunity they offered medical men to achieve a distinguished reputation.²¹ As Waddington has stated, such posts became increasingly incorporated into ‘the professional career structure of London’s medical elite’.²²

As the hospital system experienced clinical and educational reform, improvements were made in medical and surgical care and treatment.²³ Surgical advances led to a growing trust in the hospital’s capabilities as an institution of healing.²⁴ Granshaw has claimed that during the nineteenth century, ‘surgery changed almost beyond recognition’.²⁵ During the first half of the nineteenth century, only a small number of operations were attempted. Porter claimed that the most common were amputations ‘necessitated by accidents and by tubercular infections’.²⁶ If the patient survived the operation, infections were commonplace.²⁷ Cleanliness became of increasing importance to surgery throughout the century, and thus the work of Joseph Lister on antiseptics published in 1867 became central to the profession.²⁸ By the end of the century, the common use of antiseptics along with anaesthesia allowed surgeons to perform operations that were

¹⁹ Mohan and Gorsky, *Don’t Look Back?*, p. 37

²⁰ *Ibid*

²¹ Granshaw, ‘The rise’, p. 205, K. Waddington, *Charity and the London hospitals, 1850-1898*, (Boydell Press, Woodbridge, 2000), p. 12

²² Waddington, *Charity*, p. 12

²³ Henderson et al., ‘Introduction’, pp. 24-6

²⁴ W. F. Bynum, ‘The rise of science in medicine, 1850-1913’, in W. F. Bynum, A. Hardy, S. Jacyna, C. Lawrence, E. M. Tansey, *The Western Medical Tradition 1800 to 2000*, (Cambridge University Press, Cambridge, 2006), pp. 155-60, Waddington, *An Introduction*, pp. 120 - 143

²⁵ Granshaw, ‘The rise’, p. 210

²⁶ R. Porter, *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present*, (Fontana Press, London, 1999), p. 360

²⁷ Granshaw, ‘The rise’, pp. 210-11

²⁸ *Ibid*, p. 211

considered before to be too dangerous.²⁹ However, Waddington has warned of seeing the history of surgery as a part of a singular positivist narrative.³⁰ Professional, conceptual and technical developments all have to be taken into account when considering the emergence of new surgical techniques and practice.³¹ Moreover, issues relating to the ideas of individual surgeons and generational issues of knowledge transfer must be considered alongside the institutional context and external demands.³² That said, it has been argued that the early twentieth century was the ‘golden age’ for surgery.³³ It was also the period in which diagnostic methods and procedures which had come to the fore in the late nineteenth century, including bacteriology, pathology, and x-rays, came to be dominate hospital medicine.³⁴ Urine analysis and blood draws, for example, had become common practice.³⁵ Again, however, the up-take of medical innovations and technologies depended on many factors, and should not be considered as the result of inevitable medical progression and development. Reinartz has claimed that trends in medical innovation were influenced by factors including the social networks of practitioners, medical education, politics, cost of new technologies and the influence of lay supporters of medical charities.³⁶

²⁹ Bynum, ‘The rise of science in medicine’, pp. 155-60, M. A. Crowther, *The Workhouse System 1834-1929: The history of an English social institution*, (Batsford Academic and Educational Ltd, London, 1981), p. 167, Granshaw, ‘The rise’, p. 210-11, and O. Moscutti, *The Science of Women: Gynaecology and gender in England, 1800-1929*, (Cambridge University Press, Cambridge, 1990), p. 77

³⁰ Waddington, *An Introduction*, pp. 120-1

³¹ *Ibid*

³² *Ibid*

³³ *Ibid*, p. 138

³⁴ Bynum, ‘The rise of science in medicine’, pp. 165-88, J. D. Howell, ‘Hospitals’, in R. Cooter and J. Pickstone (Eds.), *Companion to Medicine in the Twentieth Century*, (Routledge, London and New York, 2003), p. 506, Waddington, *An Introduction*, pp. 198-207, 244-6, R. Wall, ‘Using Bacteriology in Elite Hospital Practice: London and Cambridge, 1880-1920’, *Social History of Medicine*, Vol. 24, No. 3, pp. 776-795

³⁵ Howell, ‘Hospitals’, p. 506, J. D. Howell, *Technology in the Hospital: Transforming Patient Case in the Early Twentieth Century*, (The John Hopkins University Press, Baltimore and London, 1995), pp. 69-102, 169-90

³⁶ J. Reinartz, ‘Mechanizing Medicine: Medical Innovations and the Birmingham Voluntary Hospitals in the Nineteenth Century’, in C. Timmerman and J. Anderson (Eds.), *Devices and Designs: Medical Technologies in Historical Perspective*, (Palgrave Macmillan, Basingstoke and New York, 2006), pp. 38-9

As general confidence in hospital medical technology and surgery increased, so too did the size of surgical units and number of patient beds.³⁷ Hospitals grew in size and day-to-day patient care depended largely on nursing staff.³⁸ Porter has explained that the nursing profession became a more efficient team in the hospital system during the later nineteenth century, as acquiring its own career structure as a result of hospital expansion.³⁹ Consequently, Moscucci and Crowther have both attributed higher standards of patient care, order, and hygiene to this newly organised nursing profession.⁴⁰ The higher standards of care would have helped to attract more people to the hospital at times of ill-health. These points will be considered in later chapters.

Internal factors within the hospital system, however, were not the only reasons historians have attributed for hospital growth during the nineteenth century. Hospitals were not self-contained institutions and their expansion is thought to have been influenced by external issues. For Prochaska, the rapid expansion of hospital accommodation during this period ‘had little to do with improvements in medical treatment’, but was instead caused by the isolation of infectious diseases, and the campaign against outdoor relief.⁴¹ The establishment of fever hospitals and infirmaries meant that patients at general hospitals were not at immediate risk of contracting infectious conditions, and thus made them safer places to receive medical aid. The New Poor Law of 1834 set to abolish outdoor relief for the able-bodied poor and medical relief available from the parish or workhouse.⁴² Whilst

³⁷ Crowther, *The Workhouse*, p. 167, Granshaw, ‘The rise’, p. 210-11, Howell, ‘Hospitals’, pp. 505-8, and Moscucci, *The Science*, p. 77

³⁸ For histories of nineteenth-century nursing see: B. Abel-Smith, *A History of the Nursing Profession*, (Heinemann, London, 1960), Bynum, ‘The rise of science in medicine’, pp. 161-2, R. Dingwall, A. M. Rafferty, and C. Webster, *An Introduction to the Social History of Nursing*, (Routledge, London, 1988), C. Helmstadter, ‘Building a New Nursing Service: Respectability and Efficiency in Victorian England’, *Albion: A Quarterly journal Concerned with British Studies*, Vol. 35, No. 4 (Winter 2003), pp. 590-621, C. Helmstadter, ‘Early Nursing Reform in Nineteenth-Century London: A Doctor-Driven Phenomenon’, *Medical History*, Vol. 46, No. 3, (July 2002), pp. 325-350, C. J. Maggs, *The Origins of General Nursing*, (Croom Helm, London & Canberra, 1983), Waddington, *An Introduction*, pp. 218-27

³⁹ Porter, ‘Hospitals and Surgery’, p. 196

⁴⁰ Crowther, *The Workhouse*, p. 167, Moscucci, *The Science*, p. 77

⁴¹ Prochaska, *Philanthropy*, p. 5

⁴² Moscucci, *The Science*, p. 77

Prochaska has argued that this would have increased the demand for hospital care, others have claimed that it had little effect on overall hospital growth. Smith, Mohan and Gorsky have stated that voluntary hospital beds remained a minority in the years before the National Health Service, leaving the workhouse infirmaries to continue to play a large role in treating the sick, alongside the aged and insane.⁴³ Crowther disagrees with this analysis, claiming that by 1911 the Poor Law provided nearly seventeen per cent of hospital beds in England and Wales, while voluntary hospitals provided nearly twenty-two per cent.⁴⁴ Although they did not make up the majority, Crowther has shown that the number of sick beds provided by the workhouses' increased from approximately 50,000 in 1861 to 121,000 in 1911.⁴⁵ Following Prochaska, Granshaw has argued that although advances in the medical profession would have undoubtedly had an impact on hospital expansion during this period, they cannot have dictated such expansion alone.⁴⁶ External social factors including the 'growth of trade, the expansion of towns, and increased geographical and social mobility among the continent's population' contributed to hospital development.⁴⁷ Hardy estimates that in 1851 around half of the nation's population lived in towns, but by 1901 four-fifths did so.⁴⁸ Cities expanded in size, with London increasing in population from approximately one and a half a million people in 1800 to five million in 1900.⁴⁹ Such a drastic rise in population and immigration in towns and cities, particularly in London, meant that the number of hospitals had to increase to meet health care demands.⁵⁰

An important area of hospital growth was that of specialist institutions, which could provide patients with expert treatment unlike that found via any other means of medical

⁴³ Mohan and Gorsky, *Don't Look Back?*, p. 37-8, F. B. Smith, *The People's Health 1830-1910*, (Croom Helm, London, 1979), p. 249

⁴⁴ Crowther, *The Workhouse*, p. 167

⁴⁵ Cartwright, *A Social History*, p. 158, Crowther, *The Workhouse*, p. 167

⁴⁶ Granshaw, 'The rise', p. 204

⁴⁷ *Ibid*, p. 200

⁴⁸ A. Hardy, *Health and Medicine in Britain since 1860*, (Palgrave, Basingstoke, 2001), p. 12

⁴⁹ Granshaw, 'The rise', p. 204, Porter, 'Hospitals and Surgery', p. 195

⁵⁰ Granshaw, 'The rise', p. 204, Hodgkinson, *The Origins*, p. 597, Porter, 'Hospitals and Surgery', p. 195

assistance.⁵¹ The nineteenth century witnessed the foundation of specialist institutions, including the Cancer Hospital in London (1851), the Hospital for Sick Children, Great Ormond Street (1852), and the Royal Hospital for Incurables in Putney (1854).⁵² By the 1860s there was at least six eye-hospitals in London and by 1919 there were nearly eighty hospitals for tuberculosis.⁵³ Historians have tended to link growing specialisation to changes in medical knowledge and technologies and increased patient demand, though Weisz and Waddington have also pointed to ‘doctors’ collective desire to expand medical knowledge, and (...) institutional pressures and administrative reforms’.⁵⁴ According to Granshaw, a newly found focus on individual organs of the body as centres of disease caused the specialist institutions to prosper.⁵⁵ Some were built on the principle of isolation, such as the municipal hospitals discussed by Sheard.⁵⁶ The 1875 Public Health Act made it compulsory to isolate infectious diseases, and so prompted authorities to erect hospitals which would treat such patients on a temporary basis.⁵⁷ These hospitals were also known as isolation hospitals, infectious diseases hospitals, and fever hospitals, and were separate from Poor Law and voluntary hospitals.⁵⁸ Women’s hospitals also began to appear in the capital during the nineteenth century, including the Hospital for Women in Soho Square, founded in 1842, and the Chelsea Hospital for Women, founded in 1871.⁵⁹ Moscucci claims that these hospitals occupied ‘a central place in the development of gynaecology as

⁵¹ Bynum, *Science*, p. 185, B. Croxson, ‘The Foundation and Evolution of the Middlesex Hospital’s Lying-In Service, 1745-86’, *Social History of Medicine*, Vol. 14, No. 1, p. 24, L. Granshaw, ‘Fame and fortune by means of bricks and mortar’: the medical profession and specialist hospitals in Britain, 1800-1948’, in L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989) pp. 199-220

⁵² Hodgkinson, *The Origins*, p. 597

⁵³ Prochaska, *Philanthropy*, pp. 3-5

⁵⁴ Waddington, *An Introduction*, pp. 152-4, and G. Weisz, ‘The Emergence of Medical Specialization in the Nineteenth Century’, *Bulletin of the History of Medicine*, Vol. 77 (2003), pp. 536-75

⁵⁵ Granshaw, ‘Fame and fortune’, p. 200

⁵⁶ S. Sheard ‘Reluctant providers? The politics and ideology of municipal hospital finance 1870-1914’, in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), p. 112

⁵⁷ *Ibid*, p. 114

⁵⁸ *Ibid*, p. 113

⁵⁹ Moscucci, *The Science*, pp. 75-6

a specialist practice', as physicians could gain vital experience on their wards of ailments unique to the female body.⁶⁰

The second theme of hospital histories is the attention paid to the charitable and voluntary hospital sector of England, which is credited to have undergone the most impressive growth of all hospitals during the eighteenth and nineteenth centuries.⁶¹ Historians have provided various figures in their attempts to demonstrate the nature of voluntary hospital growth. Digby claims that numbers of English voluntary hospitals had grown from one in 1720 to thirty-three by 1800, whilst Prochaska states that the number of charitably financed general hospitals increased to 130 by 1861 and to 385 by 1891.⁶² The average number of voluntary hospital beds in England given by Cherry was 11,000 by 1861, with 3,000 of these in London.⁶³ According to Berridge and Crowther, approximately eighteen and a half per cent of all hospital beds in England and Wales in 1861 were voluntary, and by 1911 this had increased to approximately twenty-two per cent.⁶⁴ Cherry estimates that voluntary hospitals provided for roughly twelve inpatients per thousand population by 1911.⁶⁵ Provincial voluntary hospitals have been discussed in the work of Porter, who has claimed that there were thirty-eight in England by 1800, all of which were framed on a similar administrative model.⁶⁶ Individual institutional histories for London have been surprisingly few, but include Heaman's study of St. Mary's, Ripman's of Guy's, Granshaw's of St. Mark's, and Waddington's of St. Bartholomew's.⁶⁷ Though these offer a detailed insight into the development and workings of each specific hospital, they often do so with limited context of the wider medical marketplace. Other

⁶⁰ Ibid, p. 75

⁶¹ Prochaska, *Philanthropy*, p. 5, Waddington, *An Introduction*, pp. 146-52

⁶² Digby, *Making a Medical*, p. 233, Prochaska, *Philanthropy*, p. 5

⁶³ Berridge, 'Health and medicine', p. 206

⁶⁴ Berridge, 'Health and medicine', p. 209, Crowther, *The Workhouse*, p. 167

⁶⁵ Cherry, *Medical services*, p. 24

⁶⁶ Porter, 'The gift', p. 150

⁶⁷ E. A. Heaman, *St. Mary's: The History of a London Teaching Hospital*, (Liverpool University Press, Liverpool, 2003), H. A. Ripman, *Guy's Hospital 1725-1948*, (Adprint, London, 1951), Granshaw, *St. Mark's*, Waddington, *Medical Education*

works have focused more broadly on the hospitals of London, such as those of Rivett and Waddington.⁶⁸

Historians have paid particular focus to the funding and admission policy of voluntary hospitals. St. Bartholomew's, St Thomas's, and Guy's were all partly funded by church endowments, but voluntary hospitals were managed by a volunteer governing body, and financed by the charitable contributions of subscribers.⁶⁹ In return for their generosity, subscribers could often choose which patients to recommend for treatment by giving them a subscribers ticket.⁷⁰ Such hospitals were therefore in competition over benefactors to attract and retain.⁷¹ Treatment for those patients was free, and provided by medical staff who contributed their services free of charge.⁷² By the late nineteenth century, however, the system of subscriber's tickets of admission was largely obsolete, as the medical staff admitted patients based on their condition. As Henderson, Horden, and Pastore have argued, the changing responsibility of patient admissions reflected the shift in power from the patron, to the physicians and surgeons, and eventually to professional administrators, such as almoners.⁷³ Whilst accident and emergency cases were admitted automatically, historians including Cherry and Cartwright have repeatedly shown that admission policies of voluntary hospitals often excluded those patients who were very young, mentally ill, pregnant, or believed to have an incurable or infectious condition, such as epilepsy or syphilis.⁷⁴ Bynum and Leff have suggested that voluntary hospitals only catered to patients after they were taken ill, and practiced no form of preventative medicine.⁷⁵ It is often

⁶⁸ Rivett, *The Development*, K. Waddington, *Charity and the London hospitals, 1850-1898*, (Woodbridge, 2000)

⁶⁹ B. Croxson, 'The Foundation', p. 24, Cherry, *Medical services*, pp. 44-5

⁷⁰ Cherry, *Medical services*, pp. 44-5, Granshaw, *St. Mark's*, p. 3, Mohan and Gorsky, *Don't Look Back?*, p. 36

⁷¹ Croxson, 'The Foundation', p. 23

⁷² Cherry, *Medical services*, pp. 44-5, Granshaw, *St. Mark's*, p. 3, Mohan and Gorsky, *Don't Look Back?*, p. 36

⁷³ Henderson et al., 'Introduction', p. 24

⁷⁴ Cartwright, *A Social History*, p. 158, Cherry, *Medical services*, p. 45, Mohan and Gorsky, *Don't Look Back?*, pp. 36-7

⁷⁵ Bynum, *Science*, p. 55, S. Leff, *The Health of the People*, (Victor Gollancz, London, 1950), p. 100

argued that such institutions only admitted interesting cases of illness derived from the ‘deserving poor’, in order to give the hospital a quick patient turn-over rate, and provide the medical staff the opportunity to practice their skills on unusual cases.⁷⁶ The number of patients seeking admission increased by the end of the nineteenth century as, according to Hardy, the public image of the hospital had changed dramatically from that of a charitable institution to a central means of medical care for the wider community.⁷⁷ The resulting demand eventually led to some patients paying for treatment at voluntary hospitals, which in turn contributed towards further expansion.⁷⁸

Doctors and Patients

The second key topic of literature for this study is that surrounding the doctors and patients of nineteenth and twentieth century Britain. Histories of doctoring during this period have tended to chart the political steps towards the professionalization of medical practice, often focusing on medical education, the Royal Colleges of Physicians and Surgeons, the Apothecaries Act of 1815, the Medical Act of 1858, and the gradual admission of women.⁷⁹ Those of the patients of this period are few and as explained by Bynum, have tended to focus only on ‘patients who contributed to medical discovery by having a peculiar condition or by being the first to receive a new diagnosis or therapy; and the great and good of history, whose ills historically inclined doctors viewed through what they call the “retrospectroscope”’.⁸⁰ The themes of this literature relevant to this study, however,

⁷⁶ Leff, *The Health*, p. 100

⁷⁷ Hardy, *Health*, p. 15, Prochaska, *Philanthropy*, p. 6

⁷⁸ Berridge, ‘Health and medicine’, p. 208, Prochaska, *Philanthropy*, p. 6

⁷⁹ Such as T. N. Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945*, (Oxford University Press, New York and Oxford, 1995), T. N. Bonner, *To the Ends of the Earth; Women’s search for Education in Medicine*, (Harvard University Press, Cambridge, 1992), Porter, *The Greatest*, pp. 348-359, Waddington, *An Introduction*, pp. 157-63, 182-4, K. Waddington, ‘Mayhem and Medical Students: Conduct, and Control in the Victorian and Edwardian London Teaching Hospital’, *Social History of Medicine*, Vol. 15, No. 1, (2002), pp. 45-64

⁸⁰ Bynum, *Science*, p. 208

are the development of hospital doctoring, the changing nature of the doctor-patient relationships, and the experience of being a patient.⁸¹

The medical profession was highly competitive and hospital posts offered physicians and surgeons a steady income and an environment in which to develop their skills. Although the surgeons and physicians of voluntary hospitals did not receive a wage, they did gain vital medical experience on the wards, and therefore had the opportunity to create a solid reputation for themselves in the wider field whilst presenting themselves as ‘benevolent and genteel citizens’.⁸² Woodward has claimed that many physicians were able to build up profitable private practices through the prestige and reputations attached to their work at charitable hospitals.⁸³ These were often sustained through the wealthy potential patients physicians would have met whilst working at various voluntary hospitals, as staff had the opportunity to make contact with the philanthropists who funded the hospitals in hope of enlisting them as future private paying patients.⁸⁴ Specialist hospitals acted as a means for expert physicians and surgeons to make a reputation and according to Granshaw, more importantly ‘enabled those on the edge of the profession to gain a crucial place within it’.⁸⁵ In some instances, practitioners also provided services to hospitals before the institution formally appointed a qualified equivalent, or before it had purchased a

⁸¹ The most important literature for this study: Armstrong, ‘The Doctor-patient’, Bynum, *Science, Digby, Making a Medical*, A. Digby, *The Evolution of the British General Practice 1850-1948*, (Oxford University Press, Oxford, 1999), Duffin, *History of Medicine*, M. E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, (Cambridge University Press, Cambridge, 1991), S. Jacyna, ‘Mr Scott’s Case: A View of London Medicine in 1825’, in Roy Porter (Ed.), *The Popularization of Medicine 1650-1850*, (Routledge, London and New York, 1992), pp. 252-86, J. Lewis, ‘Providers, ‘consumers’, the state and the delivery of health-care services in twentieth-century Britain’, in A. Wear (Eds.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 317 – 345, Porter, *The Greatest*, R. Porter, ‘The patient in England, c. 1660 – 1800’, in A. Wear (Ed.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 91 – 118, Risse, *Mending Bodies*, E. Shorter, *Doctors and Their Patients: A Social History*, (Transaction Publishers, London, 1993)

⁸² Waddington, *An Introduction*, p. 158

⁸³ Woodward, *To do the sick*, p. 23

⁸⁴ Granshaw, *St. Mark’s*, p. 3

⁸⁵ L. Granshaw, ‘Fame and fortune by means of bricks and mortar’: the medical profession and specialist hospitals in Britain, 1800-1948’, in L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989), p. 200

particular piece of equipment that the individual practitioner could supply.⁸⁶ Indeed, the only reason some hospitals had particular pieces of equipment was because it was privately owned by a member of its staff.⁸⁷ This meant that often, unless the practitioner donated equipment or left it to an institution on their retirement or death, if the staff member left one hospital for another, the technology moved with them.⁸⁸

Whilst the history of the medical profession (particularly in the institutional setting) has been accused of ignoring the patient, this group has begun to receive growing attention in recent years.⁸⁹ The identity and agency of patients, and how they manoeuvred through the complex medical market at times of ill-health is beginning to be questioned. As Waddington has pointed out, the patient base of a hospital would have differed depending on the institution, patient demand, the state and nature of ill-health, medical staff, financial resources (of the institution or individual), and medical knowledge and technology.⁹⁰ Specific patient groups have rarely been addressed by historians, although the work of both Shorter and Digby has drawn attention to women and children.⁹¹ Shorter claims that the ‘modern’ patient tended to include younger female patients and their children.⁹² By the twentieth century, women were more likely to seek professional medical treatment for themselves and their children, as they considered the doctor ‘not merely a man of science, but as a “confidential friend”’.⁹³

However, while there has been some attention paid to specific patient groups, historians have more usually drawn attention to the absence of the patient in medical

⁸⁶ Reinartz, ‘Mechanizing Medicine’, pp. 46-7

⁸⁷ Ibid

⁸⁸ Ibid

⁸⁹ J. Andrews, ‘Case notes, case histories and the patient’s experience of insanity at Garnavel Royal Asylum, Galsgow, in the nineteenth century’, *Social History of Medicine*, Vol. 11, (1998), pp. 255-282, Fissell, *Patients*, p. 149, Granshaw, ‘The rise’, p. 204, S. Jacyna, ‘Mr Scott’s Case’, p. 257, N. Jewson, ‘The Disappearance of the Sick-Man from Medical Cosmology’, *Sociology*, Vol. 10, (1976), pp. 225-44. Further debate in: F. Condrau, ‘The Patient’s View Meets the Clinical Gaze’, *Social History of Medicine*, Vol. 20, No. 3, (2007), pp. 525-540

⁹⁰ Waddington, *An Introduction*, p. 160

⁹¹ Digby, *Making a Medical*, p. 259, Shorter, *Doctors*, p.109-114

⁹² Shorter, *Doctors*, pp. 110-113

⁹³ Ibid

history overall.⁹⁴ One of the first historians to recognise this issue was Porter, who claimed that histories of the ‘the evolution of the medical profession, the development of clinical techniques, the rise of scientific medicine and the institutions within which it is pursued and practiced’ all presupposed the existence of the sick person, and did not explore their history.⁹⁵ Little work has been done to rectify the absence of the patient in history except for that which addresses the doctor-patient relationship.⁹⁶ The power and control the doctor was believed to have over the patient, particularly in the hospital setting, is the primary focus of such histories. Granshaw has argued that hospital patients were considered to be the perfect subjects for medical experimentation, as ‘poor and unable to complain, lessons learned from them could be applied to better-off patients’.⁹⁷ According to the work of Lawrence, the patients’ role or duty in the hospital setting was simply to follow the rules of decorum, and to let the medical men and students have access and control to all aspects of their ailments, diagnosis and treatment.⁹⁸ The patient thus became objectified, and according to historians such as Armstrong, any power patients had over their own body was lost with the ‘invasion of the ‘private’ body space’ that physical examination caused.⁹⁹ The work of Lawrence has shown that the constant inspection patients were subjected to on hospital wards turned them into public objects of clinical investigation.¹⁰⁰ These issues will be addressed in later in this study.

Much of the literature relating to the doctor-patient relationship includes debate over the place of the patient narrative in the process of diagnosis during the nineteenth and twentieth century. Historians including Fissell and Granshaw have stressed that the

⁹⁴ See: Bynum, *Science*, Porter, ‘The patient’, pp. 91 – 118

⁹⁵ Porter, ‘The patient’, p. 91

⁹⁶ Including: Armstrong, ‘The Doctor-patient’, pp. 109-122, Duffin, *History of Medicine*, Shorter, *Doctors*

⁹⁷ Granshaw, ‘The rise’, p. 203

⁹⁸ S. C. Lawrence, *Charitable Knowledge: hospital pupils and practitioners in eighteenth-century London*, (Cambridge University Press, Cambridge, 1996), p. 26

⁹⁹ Armstrong, ‘The Doctor-patient’, p. 110

¹⁰⁰ E. T. Hurren, ‘A Pauper Dead-House: The Expansion of the Cambridge Anatomical Teaching School under the Late-Victorian Poor Law, 1817-1914’, *Medical History*, Vol. 48, No. 1, (Jan. 2004), pp. 69-94, Lawrence, *Charitable Knowledge*, pp. 26-7

patients' narrative of their own illness became of less importance, if not totally obsolete in the process of diagnosis. The physical signs of illness as identified by the practitioner were considered to be more reliable.¹⁰¹ Diagnosis of ill-health was made through means of the 'clinical gaze' and physical examination at the hand of the medical professional, rather than through the patients' own description of their illness.¹⁰² The patient's illness was diagnosed based on their pulse rate, temperature, respiratory sounds, and through testing blood samples.¹⁰³ Concepts of disease and illness were changing from humoral beliefs in the unbalanced body as a whole, to the specific malfunction of an individual organ, or the diseased part.¹⁰⁴ The patient was no longer the subject of an individual ill-health experience, but was instead the location of the 'accident' of disease.¹⁰⁵ Common traits could therefore be identified across cases of illness.¹⁰⁶ Porter has stated that post mortems were used to trace ailments inside of the body so that practitioners could correlate external signs of illness with their knowledge of the internal workings of the body.¹⁰⁷ Moreover, the up-take of new technologies been blamed for distancing practitioners from their patients, as Howell has claimed, 'both literally and metaphorically'.¹⁰⁸ The works of Digby, however, has shown the continued place of the patient narrative in the process of diagnosis since the eighteenth century.¹⁰⁹ Digby states that 'History taking was an art, and hence there was assumed flexibility in the sequence of the general interrogation'.¹¹⁰ Crucially, a clinical history needed to include a personal and family health history of the patient, which

¹⁰¹ Fissell, *Patients*, p. 149, Granshaw, 'The rise', p. 204, Jacyna, 'Mr Scott's Case', p. 257, Jewson, 'The Disappearance', pp. 225-44. Further debate in: Condrau, 'The Patient's View Meets the Clinical Gaze', pp. 525-540

¹⁰² Ackerknecht, *Medicine*, pp. 4 and 15, Armstrong, 'The Doctor-patient', p. 110, Digby, *Making a Medical*, p. 93, Fissell, *Patients*, p. 149

¹⁰³ Fissell, *Patients*, p. 149

¹⁰⁴ D. Brunton, *Health, disease and society in Europe 1800-1930: A Source Book*, (Manchester University Press, Manchester, 2004), p. xii, Digby, *Making a Medical*, p. 93, Granshaw, 'The rise', p. 204, Porter, 'Hospitals and Surgery', p. 195

¹⁰⁵ Digby, *Making a Medical*, p. 93

¹⁰⁶ Granshaw, 'The rise', p. 204

¹⁰⁷ Porter, 'Hospitals and Surgery', p. 195

¹⁰⁸ Howell, *Technology*, p. 6

¹⁰⁹ Digby, *The Evolution*, p. 235, Fissell, *Patients*, p. 152

¹¹⁰ Digby, *The Evolution*, p. 235

could only have been obtained through asking the patient a sequence of questions.¹¹¹ More on which will be discussed later.

Whilst many histories have claimed that the patient lost all authority on the arrival of modern medicine, others have discussed aspects of healthcare over which they still demonstrated a degree of control. According to Porter, the sick of the seventeenth and eighteenth centuries were often ‘agents’ looking after their own healthcare, ‘playing active roles in managing their dealings with medical professionals and the institutions of regular medicine’.¹¹² Similarly, Digby has highlighted the choices of medical care available to patients throughout the nineteenth and twentieth century.¹¹³ Patients could make use of household or folk remedies, or seek the advice of practitioners such as herbalists, homeopaths, or registered doctors of orthodox modern medicine.¹¹⁴ If the decision was to visit a registered doctor, the patient had a wide choice due to the profession being so overcrowded.¹¹⁵ Digby claims that in deciding which practitioner to visit, ‘the social personality of the doctor’ was important to many patients, who sought treatment from doctor’s whom they felt they could trust.¹¹⁶ Practitioner who succeeded in sustaining a private medical practice were those who possessed qualities such as ‘Resourcefulness, adaptability, commonsense, and mental and physical resilience’, along with those who demonstrated ‘Patience, sensitivity, and sympathy’ towards the patient and their complaint.¹¹⁷ For the more affluent patients, good bedside manner was also a quality often sought after in a doctor.¹¹⁸

A small number of historians have focused specifically on the experience of the patient when seeking medical treatment. In the work of Risse and Jacyna, this has been

¹¹¹ Ibid

¹¹² Porter, ‘The patient’, p. 91

¹¹³ Digby, *The Evolution*, p. 224

¹¹⁴ Ibid

¹¹⁵ Ibid, p. 290

¹¹⁶ Digby, *Making a Medical*, p. 77

¹¹⁷ Ibid

¹¹⁸ Ibid

done through the use of case studies.¹¹⁹ Although the following two case study examples are arguably quite specific to time and place, as Bynum has stated, ‘Being a patient was (and is) an experience with identifiable universal features’.¹²⁰ Risse has reconstructed the ill-health experience of the tailor Johann Duschau, in late eighteenth century Vienna.¹²¹ Duschau is said to be a twenty-seven-year-old tailor, who probably worked in a shop for a low wage.¹²² During early November of 1797, Duschau ‘suddenly felt a cold chill sweeping over his entire body together with an oncoming headache’.¹²³ The case study continues to explain the poor living conditions of the tailor, and the fact that he could not afford any medical care until his symptoms became so unbearable that he sought hospital treatment.¹²⁴ As his condition was considered unusual, he came under the clinical observation of the Hospital Director.¹²⁵ The study goes on to reconstruct the patient’s experience of physical examination in the developing clinical setting of the hospital. The case study used by Jacyna focuses on the expectations of the patient when seeking out medical care.¹²⁶ The case is that of James Scott, a thirty-four-year-old accountant from Edinburgh, who began to notice a loss of strength in his limbs and back in the year 1823.¹²⁷ Jacyna claims that at this time, medical knowledge ‘did not constitute a discrete esoteric domain accessible only to the professional; it formed part of the common culture of gentlemen’.¹²⁸ This meant that patients of the middle and upper class could ‘evaluate and criticize the diagnosis and prescriptions’ of their medical advisers.¹²⁹ Such patients had certain expectations of their doctor, which in the case of Scott, appeared to be both a central role of his own narrative of illness, and the expectation that the doctor would

¹¹⁹ Jacyna, ‘Mr Scott’s Case’, pp. 252-86, Risse, *Mending Bodies*, p. 257

¹²⁰ Bynum, *Science*, p. 209

¹²¹ Risse, *Mending Bodies*, p. 257

¹²² Ibid

¹²³ Ibid

¹²⁴ Ibid, pp. 257-9

¹²⁵ Ibid.

¹²⁶ Jacyna, ‘Mr Scott’s Case’, pp. 252-86

¹²⁷ Ibid, p. 252

¹²⁸ Ibid, p. 255

¹²⁹ Ibid

subject him to a physical examination.¹³⁰ Case studies such as these provide a rare insight into the patient experience of the medical market.

Health

The third and final key topic of literature is that which considers the health of the population of Britain during the turn of the twentieth century. According to Haley, ‘No topic more occupied the Victorian mind than Health’, and this preoccupation continued into the Edwardian era.¹³¹ As the health of the population was, and is, influenced by many contributing factors, the relevant literature is vast and relates to everything from politics to weather patterns. The subject is most widely discussed in works relating to medicine and surgery, disease, mortality, poverty, public health and sanitation, industrialisation, and the foundation of the welfare state.¹³² For this study, the most applicable literature is that which relates to what is known as the ‘health transition’, and more specifically to the epidemiological transition and causes of ill-health.¹³³ According to Riley, the ‘health transition’ links ‘changes in mortality to those of morbidity, or sickness, and to the modern

¹³⁰ Ibid, pp. 255 - 257

¹³¹ B. Haley, *The Healthy Body and Victorian Culture*, (Harvard University Press, London, 1978), p. 3

¹³² Such works include; Berridge, ‘Health and medicine’, Brunton, *Health*, A. Digby and J. Stewart (Eds.), *Gender, Health and Welfare*, (Routledge, London, 1996), E. Garrett, A. Reid, K. Schürer, S. Szreter, *Changing Family Size in England and Wales: class and demography in England and Wales, 1891-1911*, (Cambridge University Press, Cambridge, 2001), I. Gazeley, *Poverty in Britain 1900-1965*, (Palgrave Macmillan, Basingstoke, 2003), L. A. Hall, *Sex, Gender and Social Change in Britain Since 1880*, (Macmillan Press, Basingstoke, 2000), B. Harris, M. Gorsky, A. Guntupalli, and A. Hinde, ‘Ageing, Sickness and Health in England and Wales during the Mortality Transition’, *Social History of Medicine*, Vol. 24, No. 3, (2011), pp. 643-665, B. Harrison, ‘Women and Health’ in J. Purvis (Eds.), *Women’s History: Britain 1850-1945. An Introduction*, (Routledge, London and New York, 1995), pp. 157 – 192, M. Kilbourne Matassian, ‘Death in London, 1750-1909’, *Journal of Interdisciplinary History*, Vol. XVI, No. 2, (Autumn 1985), pp. 183-197, J. C. Riley, *Sick, Not Dead: The Health of British Workingmen during the Mortality Decline*, (The John Hopkins University Press, Baltimore and London, 1997), Thane, *Foundations*, K. Waddington, ‘The Dangerous Sausage: Diet, Meat and Disease in Victorian and Edwardian Britain’, *Cultural and Social History*, Vol. 8, Issue 1, (2011), pp. 51-71

¹³³ J. C. Riley, *Rising Life Expectancy: A Global History*, (Cambridge University Press, Cambridge and New York, 2001), S. Szreter and G. Mooney, ‘Urbanization, mortality, and the standard of living debate: new estimates of the expectation of life at birth in nineteenth-century British cities’, *Economic History Review*, LI, 1 (1998), pp. 84-112

decline in fertility'.¹³⁴ Therefore, by 'focusing on causes of death and sickness, it suggests a strong link between demography and epidemiology'.¹³⁵ The epidemiological transition has been defined by Coudrau and Worboys as 'the transition of cause specific mortality, culminating in the twentieth century when degenerative replaced infectious disease as the main cause of death'.¹³⁶ There has been much debate surrounding the nature of disease in the nineteenth and early twentieth century, one of the most recent being that between Coudrau and Worboys (who have claimed that national epidemics were not that prevalent in the Victorian era and infectious diseases were not the most common cause of death) and Mooney (who in response has claimed that there is a substantial body of evidence which proves that infections were the main cause of death).¹³⁷ The current dominant opinion remains, however, that the nineteenth century was a period of mainly infectious diseases which gradually gave way to more prevalent chronic complaints by the Edwardian era. Debate has centred on the reasons for this shift put forward by McKeown, who claimed that factors relating to an improved environment and nutrition were most crucial.¹³⁸ Though McKeown's thesis has its supporters, there are those who believe that more weight should be placed on medical intervention and sanitary reform as reasons for the decline in infectious disease mortality, and on the influences which acted upon the increased prevalence of chronic conditions (discussed further in Chapter Five).¹³⁹

¹³⁴ Riley, *Rising Life Expectancy*, p. 7

¹³⁵ Ibid

¹³⁶ F. Coudrau and M. Worboys, 'Second Opinions: Epidemics and Infections in Nineteenth-Century Britain', *Social History of Medicine*, Vol. 20, No. 1, (2007), p. 147

¹³⁷ Coudrau and Worboys, 'Second Opinions', pp. 147-8, G. Mooney, 'Infectious Diseases and Epidemiological Transition in Victorian Britain? Definitely', *Social History of Medicine*, Vol. 20, No. 3, p. 596

¹³⁸ T. McKeown and R. G. Record, 'Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century', *Population Studies*, Vol. 16, No. 2 (Nov., 1962), pp. 94-121, Riley, *Rising Life Expectancy*, pp. 9-25

¹³⁹ For examples, see; S. Guha, 'The Importance of Social Intervention in England's Mortality Decline: The Evidence Reviewed', *Social History of Medicine*, 7, (1994), pp. 89-113, Hardy, *Health, A. Hardy, The Epidemic Streets; Infectious Disease and the Rise of Preventive Medicine 1856-1900*, (Clarendon Press, Oxford, 1993), pp. 293-4, p. 38, B. Harris, 'Public Health, Nutrition, and the Decline of Mortality: The McKeown Thesis Revisited', *Social History of Medicine*, Vol. 17 No.3 (2004), pp. 379-407, A. Hardy, 'Diagnosis, Death, and Diet: The Case of London, 1750-1909', *Journal of Interdisciplinary History*, Vol. 18, No. 3 (Winter, 1988), p. 400, B. Luckin and G. Mooney, 'Urban history and historical epidemiology: the case

In an attempt to understand the epidemiological transition, select histories have focused on the prevalence and mortality of specific diseases, the most common being those of cholera, smallpox, and tuberculosis.¹⁴⁰ The only work which has comprehensively tackled the mortality of numerous diseases in Britain is that of Hardy.¹⁴¹ Her work discusses the eight major endemic, and periodically epidemic infections which McKeown claimed contributed to the mortality decline of the nineteenth century.¹⁴² Whooping cough, measles, scarlet fever, diphtheria, smallpox, typhoid, typhus, and tuberculosis are all examined in terms of their affect on the national death-rate. It is claimed that during the 1860s ‘these diseases as a group contributed nearly 30 per cent of the total annual deaths in England and Wales. By 1900 nearly all were declining as causes of death, and their share of annual mortality had dropped to under 20 per cent’.¹⁴³ Hardy has also written on rickets and specific infectious children’s diseases, claiming that scarlet fever, diphtheria, measles, and whooping cough made the largest contribution to child mortality in the nineteenth century.¹⁴⁴ Gazeley claims that infant mortality rates in the early twentieth century were

of London, 1860-1920’, *Urban History*, Vol. 24, Pt. 2 (1997), p. 38, G. Mooney, ‘Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England and Wales’, *Social History of Medicine*, (1997), p. 54, S. Szreter, ‘Mortality in England in the Eighteenth and the Nineteenth Centuries: A Reply to Sumit Guha’, *Social History of Medicine*, 8, (1994), pp. 269-274, P. Weindling, ‘From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries’, in A. Wear (Ed.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 303 – 316, R. Woods and P. R. A. Hinde, ‘Mortality in Victorian England: Models and Patterns’, *Journal of Interdisciplinary History*, XVIII:I (Summer 1987), p. 53

¹⁴⁰ For examples see: L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (Clarendon Press, Oxford, 1988), R. J. Evans, ‘Epidemics and Revolutions: Cholera in Nineteenth-Century Europe’, *Past and Present*, Vol. 120 (1988), pp. 123-146, A. Hardy, ‘Smallpox in London: factors in the decline of the disease in the nineteenth century’, *Medical History*, Vol. 27 (1983), p. 111, G. Mooney, ‘“A Tissue of the most Flagrant Anomalies”: Smallpox Vaccination and the Centralization of Sanitary Administration in Nineteenth-Century London’, *Medical History*, Vol. 41 (Wellcome Institute for the History of Medicine, 1997), pp. 261-90, R. J. Morris, *Cholera, 1832: The Social Response to an epidemic* (Croom Helm, London, 1976), M. Pelling, *Cholera, Fever and English Medicine 1825-1865* (Oxford University Press, Oxford, 1978), B. Gutmann Rosenkrantz (Ed.), *From Consumption to Tuberculosis: A Documentary History* (Garland, New York, 1994), Sheard ‘Reluctant providers?’, p. 114, F. B. Smith, *The Retreat of Tuberculosis 1850-1950*, (Croom Helm, London, 1988)

¹⁴¹ Hardy, *The Epidemic*

¹⁴² *Ibid*, p. 3

¹⁴³ *Ibid*

¹⁴⁴ A. Hardy, ‘Rickets and the Rest: Child-care, Diet and the Infectious Children’s Diseases, 1850-1914’, *The Society for the Social History of Medicine*, Vol. 5, No. 3, (1992), p. 392

‘inversely related to the socio-economic status of males’.¹⁴⁵ Families of unskilled male labourers suffered twice the level of infant mortality than those of middle and upper class men.¹⁴⁶ Although the reasons for this difference are disputed, Gazeley states that differences in ‘nutritional attainment, which affect resistance to infectious diseases’ was probably one of the main elements of the class divide.¹⁴⁷ Lower class workers living in urban areas increasingly relied on milk transported into the cities by rail, which was ‘not cooled and often stood around for hours before being sold loose from the churn’.¹⁴⁸ The health of the working-class has further been discussed in the work of Riley, through the examination of friendly society records over the nineteenth and early twentieth century.¹⁴⁹ According to Riley, the health of the members of the Foresters national friendly society changed over the turn of the twentieth century in two ways: they lived longer, and they were sick more of the time.¹⁵⁰ This was partly the result of the ‘enhanced ability of late nineteenth-century doctors to enable people to live with their illnesses for longer periods’.¹⁵¹ The mortality decline therefore ‘added to the population men who fell sick less often yet stayed sick for longer periods, men whose deaths were deferred but more often in sickness than in wellness’.¹⁵²

Gazeley also points to the impact of women’s work on children’s health, such as the difficulty for a working mother to breastfeed her children.¹⁵³ This supports the argument made by Mooney, who claims that infant mortality was greatly influenced by two factors; ‘breast-feeding and environmental management’.¹⁵⁴ Similarly, infant mortality during the early Edwardian period is also discussed in the work of Dyhouse, who has

¹⁴⁵ Gazeley, *Poverty*, p. 57

¹⁴⁶ *Ibid*

¹⁴⁷ *Ibid*

¹⁴⁸ *Ibid*, p. 58

¹⁴⁹ Riley, *Sick, Not Dead*

¹⁵⁰ *Ibid*, p. 153

¹⁵¹ Harris *et al*, ‘Ageing, Sickness and Health’, p. 644

¹⁵² *Ibid*, p. 187

¹⁵³ *Ibid*, p. 56

¹⁵⁴ G. Mooney, ‘Did London pass the “sanitary test”? Seasonal infant mortality in London, 1870-1914.’ *Journal of Historical Geography*, Vol. 20, No. 2 (1994), p. 165

examined contemporary theories that blamed the employment of married women (who could not breast-feed) and working-class women (who were considered ignorant and incompetent in matter of infant care) for high infant mortality rates.¹⁵⁵ Contemporary understanding of child health has also been discussed by Pooley, who stressed the ‘perceived gulf between working-class neglect ignorance and middle-class trained care that was expressed in Edwardian indicatives to promote infant welfare’.¹⁵⁶ Indeed, according to Thane poor children were predictably shorter and thinner than children from higher social classes.¹⁵⁷ However, her work has also argued that despite severe poverty infant mortality began to ‘fall decisively, for the time in British history, from an average of 152.2 per thousand live births in England and Wales in 1898-1902, to 131 in 1903-09 and 111.8 in 1908-12’.¹⁵⁸

An important theme within the literature on health is the fear and anxiety of the higher classes over the physical and moral condition of the poor.¹⁵⁹ Prochaska claims that around the turn of the twentieth century more data became available on the health of the population.¹⁶⁰ Evidence such as Charles Booth’s *The Life and Labour of the People of London* (1889-1903) and statistics regarding the high numbers of British recruits deemed

¹⁵⁵ C. Dyhouse, *Girls Growing Up in Late Victorian and Edwardian England*, (Routledge & Kegan Paul Ltd, London, 1981), pp. 98-9, C. Dyhouse, ‘Working-Class Mothers and Infant Mortality in England, 1895-1914’, *Journal of Social History*, Vol. 12, No. 2 (Winter, 1978), pp. 248-267

¹⁵⁶ S. Pooley, ‘“All we parents want is that our children’s health and lives should be regarded”: Child Health and Parental Concern in England, c. 1860-1910’, *Social History of Medicine*, Vol. 23, No. 3 (2010), p. 545

¹⁵⁷ Thane, *Foundations*, p. 53

¹⁵⁸ *Ibid*

¹⁵⁹ See: T. Crook, ‘Accommodating the outcast: common lodging houses and limits of urban governance in Victorian and Edwardian London’, *Urban History*, Vol. 35, No. 3 (2008), pp. 414-436, Dyhouse, *Girls Growing Up*, pp. 134-8, Hall, *Sex*, Prochaska, *Philanthropy*, p. 49, E. P. Hennock, ‘Concepts of poverty in the British social surveys from Charles Booth to Arthur Bowley’ in M. Bulmer, K. Bales, and K. Kish Sklar (Eds.), *The Social Survey in Historical Perspective 1880-1940*, (Cambridge University Press, Cambridge and New York, 1991), pp. 189-216, L. Hollen Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700-1948*, (Cambridge University Press, Cambridge and New York, 1998), pp. 268-81, V. Kelly, *Soap and Water: Cleanliness, Dirt and the Working Classes in Victorian and Edwardian Britain*, (I. B. Tauris, London and New York, 2010), D. Taylor, ‘Beyond the Bounds of Respectable Society: The “Dangerous Classes” in Victorian and Edwardian England’, in J. Rowbotham and K. Stevenson (Eds.), (Ohio State University Press, Columbus, 2005), pp. 3-22

¹⁶⁰ Prochaska, *Philanthropy*, p. 49

unfit to fight in the Boer War both highlighted the poor health of the British population.¹⁶¹ According to Gazeley, it was likely that the spread of epidemic diseases was greatest in working-class overcrowded slum areas, but hindered in middle and upper class areas due to better housing and sanitation.¹⁶² As a result of such evidence, political concern began to focus on the health of the British workforce and the strength of its military capabilities.¹⁶³ Britain could not remain a dominant and competitive figure of the world if the majority of its population was unfit. Historians including Porter and Weindling have discussed the occupational health hazards associated with industrialization, which often reflected the poor working conditions and lack of health and safety measures.¹⁶⁴ In addition, Hall has explained that it was widely believed that there was a ‘differential birthrate, with the most ‘desirable’ classes failing to keep up their strength, while the ‘residuum’ proliferated recklessly’.¹⁶⁵ It was feared that the unhealthy lower classes would come to dominate the British population, and the virility of the more favourable classes would be permanently and irreversibly damaged. Moreover, Dyhouse has claimed that educated, usually middle-class girls, were thought to ‘have a tendency to suffer from over-ambition, to be anxious to excel, and to work too hard’.¹⁶⁶ It was important to keep this in check ‘for the girls’ own health and also in the interests of national efficiency and the race’.¹⁶⁷ Eugenics literature is also important to these arguments, but is too broad to consider here.¹⁶⁸

The final area of literature to be considered is that which examines the supposed causes of ill-health and the resulting state health and welfare policy implemented during

¹⁶¹ I. Gazeley and A. Newell, ‘Poverty in Edwardian Britain’, *Economic History Review*, Vol. 64, No. 1 (2011), pp. 52-71, Hall, *Sex*, p. 65, Prochaska, *Philanthropy*, p. 49

¹⁶² Gazeley, *Poverty*, pp. 57-8

¹⁶³ Prochaska, *Philanthropy*, p. 49

¹⁶⁴ Porter, *The Greatest*, pp. 400-1, 633, P. Weindling (Ed.), *The Social History of Occupational Health* (Croom Helm, London, 1985)

¹⁶⁵ Hall, *Sex*, p. 66

¹⁶⁶ Dyhouse, *Girls Growing Up*, p. 135

¹⁶⁷ *Ibid*

¹⁶⁸ Hall, *Sex*, Chapter 4: ‘Degenerating Nation? Anxieties and Protests in a New Century’, Porter, *The Greatest*, pp. 424, 639-41, See also; D. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity*, (Knopf, New York, 1985); The term eugenics was coined by Sir Francis Galton in 1883. It was considered to be the science that dealt with all influences which improve the inborn qualities of the race.

the Edwardian era.¹⁶⁹ Riley points to attempts by the United Nations in the 1950s to understand the health transition by dividing it into stages, with ‘the important causative factors changing stage to stage’.¹⁷⁰ It was claimed that prior to 1850 survival was enhanced by a higher standard of living, which manifested in better nutrition and better housing and clothing.¹⁷¹ Between 1850 and 1900 sanitary projects made the biggest impact on health improvements.¹⁷² After 1900, ‘a combination of factors came into play’, including economic development, public health, and biomedicine.¹⁷³ Indeed, Thane has pointed to the impressive number of official government investigations undertaken in the latter years of the nineteenth century which related to public health and welfare, including the Royal Commission on Housing of the Working Classes (1884-5), Aged Poor (1893-4), and Sanitary Laws (1871).¹⁷⁴ By the Edwardian era, much historical attention has focused on the Liberal Reforms, including the Education (Provision of Meals) Act of 1906, which sought to provide free school meals to children, the Pensions Act of 1908, and the National Insurance Act of 1911.¹⁷⁵ Moreover, Waddington has pointed to the role of food in the transmission of certain bacteriological diseases, which became a public health focus by the twentieth century.¹⁷⁶ Though pressure came from working-class people for more state funded healthcare, however, the Poor Law system remained well into the twentieth

¹⁶⁹ B. Harris, *The Origin of the British Welfare State: Social Welfare in England and Wales, 1800-1945*, (Palgrave Macmillan, Basingstoke, 2004), E. P. Hennock, *The Origin of the Welfare State in England and Germany, 1850-1914*, (Cambridge University Press, Cambridge, 2007), P. Thane, *Foundations of the Welfare State*, 2nd Edition, (Longman, London, 1996)

¹⁷⁰ Riley, *Rising Life Expectancy*, p. 8

¹⁷¹ Ibid

¹⁷² Ibid, p. 8, and ‘Sanitary Revolution’ section, pp. 64-72

¹⁷³ Ibid

¹⁷⁴ Harris, *The Origin*, pp. 1334, Hennock, *The Origin*, pp. 212-19, 227-34, 243-55, Thane, *Foundations*, p. 42

¹⁷⁵ Harris, *The Origin*, pp. 150-65, Thane, *Foundations*, pp. 69-80, P. Thane, ‘Non-Contributory Versus Insurance Pensions 1878-1908’ in P. Thane (Ed.), *The Origins of British Social Policy*, (Croom Helm, London, 1978), pp. 84-106

¹⁷⁶ Waddington, ‘The Dangerous Sausage’, p. 51

century, and it was by no means certain that we would end up with the modern welfare state or National Health Service.¹⁷⁷

Overall, whilst histories of the hospital, doctors and patients, and the health of the population, provide a contextual framework, there are considerable gaps in the literature which this study seeks to address. Firstly, whilst historians such as Cherry, Pickstone, and later Mohan and Gorsky have done much to develop our understanding of regional hospital networks and development, institutional histories for the largest urban areas, particularly London, remain surprisingly few in number.¹⁷⁸ Burdett lists over 130 hospitals in London for 1910, not including dispensaries, poor law infirmaries, and military hospitals.¹⁷⁹ Of these only a small number have been the focus of institutional histories.¹⁸⁰ Moreover, Granshaw, Lawrence, and Risse have criticised the narrative and positivist approach of past hospital histories, as many such works were compiled by doctors of the institutions and focused on their hospital in isolation.¹⁸¹ Such works rarely placed the chosen hospital in either its social or economic context in the wider medical community.¹⁸² This project seeks to address the neglected area of literature by drawing historical attention to the RFH, a revolutionary central London hospital which has never been the subject of academic study. The RFH was the first general voluntary hospital to offer treatment to patients without the need of a subscriber's letter, the first general hospital to be officially associated with the medical education of women, and the first hospital in London to appoint a Lady Almoner. By the period of this study, the RFH was providing medical treatment to both paying and non-paying patients, making it a valuable example of how the voluntary sector

¹⁷⁷ See: Hollen Lees, *The Solidarities of Strangers*, and E. T. Hurren, *Protesting About Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England, 1870-1900*, (The Boydell Press, Woodbridge, 2007)

¹⁷⁸ Cherry, *Medical Services*, Mohan and Gorsky, *Don't Look Back*, J. Pickstone, *Medicine and industrial society: a history of hospital development in Manchester and its region, 1752-1946*, (Manchester University Press, Manchester, 1985)

¹⁷⁹ Sir H. Burdett, *Hospitals and Charities 1910: A Year Book of Philanthropy and Hospital Annual*, (The Scientific Press Limited, London, 1910), pp. 239- 296

¹⁸⁰ Croxon, 'The Foundation', Croxon, 'The price of charity', Granshaw, *St. Mark's*, Heaman, *St. Mary's*, Ripman, *Guy's*, Waddington, *Medical Education*

¹⁸¹ Granshaw, 'The rise', p. 197, Risse, 'Hospital History', p. 175

¹⁸² Granshaw, 'The rise', p. 197, Lawrence, *Charitable Knowledge*, p. 22, Risse, 'Hospital History', p. 175

intersected with private practice. The study will place this important London hospital in the historiography for the first time, and so contribute towards our understanding of institutional medical provision in the metropolis of the twentieth century.

Secondly, the current historiography lacks any comprehensive study of the hospital patient or of hospital doctoring and its place in the wider career patterns of physicians and surgeons. Typical reference to hospital doctoring is in the context of the ward teaching that became popular in the nineteenth century, the experience gained from such posts, and the opportunities they offered doctors to meet potential clientele for their private practices.¹⁸³ The rules, routines, and techniques followed by hospital doctors during the early twentieth century are largely omitted from the current historiography. Equally, the patient has too often been absent from medical history, as we have seen above. Porter, Fissell, Bynum, Granshaw and Risse have criticised past histories of the hospital for having concentrated on the ‘great men’ such as the doctors or founding members, but rarely making mention of patients.¹⁸⁴ Porter has argued that patients are not ‘‘subhistorical’, timeless objects merely waiting to be treated by doctors who are part of progress’, but deserve a history of their own.¹⁸⁵ Risse has complained that hospital histories often ignore the prominent issues that result from hospitalisation, namely ‘dependence, depersonalisation, and isolation from family networks’.¹⁸⁶ Mooney, Luckin, and Tanner have claimed that in order to understand institutional mortality of London during the late nineteenth century, we need to understand how patients came to use institutions and how they interacted to ‘to produce highly

¹⁸³ Sir R. Bodley Scott, ‘Medicine in the Twentieth Century’, in V. C. Medvei and J. L. Thornton (Eds.), *The Royal Hospital of Saint Bartholomew 1123-1973*, (Saint Bartholomew’s Hospital Medical College, London, 1974), p. 188, Moscucci, *The Science*, p. 76, Woodward, *To do the sick*, p. 23

¹⁸⁴ Bynum, *Science*, pp. 208-9, Fissell, *Patients*, p. 148-170, Granshaw, ‘The rise’, p. 198, Porter, ‘The patient’, R. Porter, ‘The rise of physical examination’, in W. F. Bynum and R. Porter (Eds.), *Medicine and the five senses*, (Cambridge University Press, Cambridge, 1993), pp. 179 – 197, Risse, ‘Hospital History’, p. 175

¹⁸⁵ Porter, ‘The patient’, p. 91

¹⁸⁶ Risse, ‘Hospital History’, p. 175

interactive ‘patient pathways’¹⁸⁷. Porter has also argued that we also know very little about the conduct between the patient and the practitioner.¹⁸⁸ One of the few works to consider life on the wards of the modern hospital is that of Howell, who has broadly considered the arrangement of the public and private hospital wards over the turn of the twentieth century and the patient experience of developing technologies and practices including x-rays and surgery.¹⁸⁹

Overall, the identity of the hospital patient, the reasons for and nature of patient admission, treatment, and discharge, and the experience of institutional confinement have been regularly omitted from medical history.¹⁹⁰ There has been little attempt to fill the void with detailed empirical work.¹⁹¹ This study will focus on the patients’ identity, experience, and use of the RFH as not only a micro-study, but as a representation of the consumer behaviour of a portion of the population within the medical marketplace. We cannot expect to understand the history of medical practice without including the choices of medical care made by the individuals who would be its patients. The reasons behind how patients came to decide where to seek medical treatment had a profound impact on the changes and developments experienced by the medical profession over the last two centuries. The RFH patient records offer a unique insight into role of hospital doctors, the identity and experience of the patient as a consumer in the medical marketplace, and the interaction and relationship between the hospital doctor and the patient.

The third gap in the current historiography is that it pays little attention to the overall health of the people of London during the late nineteenth and early twentieth century. Whilst debates surrounding the epidemiological transition have tended to group infectious or chronic complaints together in order to discuss their overall mortality,

¹⁸⁷ G. Mooney, B. Luckin, and A. Tanner, ‘Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century’, *Social History of Medicine*, Vol. 12, No. 2 (1999), p. 231

¹⁸⁸ Porter, ‘The rise’, p. 179

¹⁸⁹ Howell, ‘Hospitals’, pp. 503-518

¹⁹⁰ Risse, ‘Hospital History’, p. 175

¹⁹¹ The few attempts include: Jacyna, ‘Mr Scott’s Case’, pp. 252-86, Risse, *Mending Bodies*, p. 257

comparatively little focus has been placed on the specific ailments from which people suffered throughout their lives.¹⁹² Work related to the health (and not mortality) of the London population are those which discuss the findings of Charles Booth during his surveys of the living conditions of the London poor between 1886 and 1902.¹⁹³ The histories of Thane and Prochaska both explain the findings of Booth's survey, and relate the categories of poverty Booth defines to the physical condition of the poor.¹⁹⁴ According to the findings, approximately eight and a half per cent of the people of London were living in the worst conditions of poverty, being ill-nourished and in constant want.¹⁹⁵ Even these works, however, do not address the overall health of individual people and families, and the collective ill-health they experienced throughout their lifetimes. This project will provide a much needed insight into the changing health of the population during the early years of the twentieth century. The use of patient case records allows for the patients' current illness, past health history and family health histories to be analysed. The examination of specific illnesses and injuries experienced throughout the patients' lives are vital to expanding our understanding of how the population experienced ill-health. Moreover, understanding how patients sought treatment for themselves and for their families is vital to understanding how people viewed health and well-being.

The fourth and final weakness with the current literature is that it lacks any considerable use of patient case records as an historical source.¹⁹⁶ Historians including Risse and Warner have discussed how patient case records can be of use to the historian by

¹⁹² Kilbourne Matassian, 'Death in London', pp. 183-197, Hardy, 'Rickets and the Rest', Hardy, *The Epidemic*

¹⁹³ C. Booth, *Life and Labour of the People in London*, 1st Series: Poverty, (Reprints of economic classics, Augustus M. Kelley, New York, 1969)

¹⁹⁴ Prochaska, *Philanthropy*, p. 49, and Thane, *Foundations*, p. 6-7

¹⁹⁵ Thane, *Foundations*, p. 7

¹⁹⁶ Exceptions being: J. Andrews, 'Case notes, case histories and the patient's experience of insanity at Garnavel Royal Asylum, Galsgow, in the nineteenth century', *Social History of Medicine*, Vol. 11, (1998), pp. 255-282, and S. T. Anning, 'A Medical Case Book: Leeds, 1781-84', *Medical History*, Vol. 28, (1984), pp. 420-431, A. Nuttall, 'Because of Poverty brought into Hospital:...' A Casenote-Based Analysis of the Changing Rose of the Edinburgh Royal Maternity Hospital, 1850-1912', *Social History of Medicine*, Vol. 20, No. 2, (2007), pp. 263-280, O. Riha, 'Surgical Case Records as an Historical Source: Limits and Perspectives', *Social History of Medicine*, Vol. 8, No. 2, (1995), pp. 271-283

examining their typical structure and explaining that they often contain the patient's name, sex, age, marital status, occupation, and residence, and will sometimes also include the patient's nationality, race, and religion.¹⁹⁷ In the case of hospital records, the date of admission and discharge are included as standard, as is a history of the patients' illness.¹⁹⁸ Similarly, Howell has discussed the appearance of newly efficient, scientific hospital records during the early twentieth century, which included forms, charts, and graphs, and has explored how their clinical and medical implications 'transcended the scientific and business intentions of their inventors'.¹⁹⁹ Andrews has claimed that before the historian can use patient records successfully, they must first comprehend 'how they were generated and kept, how and why their format changed over time, and what function they served'.²⁰⁰

By first considering their typical structure and content, Risse and Warner have shown that the patient histories contained in case records provide an insight into the patients' perspective of their own illness.²⁰¹ Histories provide 'a unique record of popular health beliefs among lower-class patients, notions of disease causation, and chronicles of self-help practices'.²⁰² Hospital case records also give an insight into the 'texture of hospital life', such as by recalling the visits between physicians and patients, the diet of the patients, the 'recovery or dying' of patients, and the practice of visiting from family and friends, and from medical students.²⁰³ According to Howell, patient records allow us to recreate some elements of the patients' experiences, so long as we read the records 'in a patient centred way and focus primarily not on knowledge claims but on what happened to hospitalized patients'.²⁰⁴ Such an approach has been adopted by Andrews, who used the

¹⁹⁷ G. Risse and J. H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, Vol. 5, No. 2, (1992), p. 190

¹⁹⁸ *Ibid*, pp. 185-6

¹⁹⁹ Howell, *Technology*, p. 43

²⁰⁰ Andrews, 'Case notes', p. 280

²⁰¹ Risse and Warner, 'Reconstructing Clinical Activities', pp. 183-205

²⁰² *Ibid*

²⁰³ *Ibid*, pp. 190-1

²⁰⁴ Howell, *Technology*, p. 14

patient notes of Glasgow's Royal Asylum to assess patient experience of madness and confinement.²⁰⁵

Historians including Bynum and Fissell, however, have claimed that such records are unreliable, as they can only represent the 'doctors' versions of the doctor-patient encounter'.²⁰⁶ This is the most common concern with using case records to get at the experience and agency of the patient, as such records were of course compiled by medical staff, for medical staff. Historians must be aware of what information was included and excluded from patient notes if they are to be used to address the patient in history. Andrews has highlighted potential issues, by warning that even if health information was forthcoming from the patient or their family and friends, clinicians often dismissed it in an attempt to assert their own expertise in diagnosis and treatment.²⁰⁷ The discursive nature of these records must therefore be considered when searching for the patients' 'voice' within them. A dialogue between the patient (and their family and friends) and the practitioner would have taken place, but often only the information the practitioner felt was relevant to the current condition of the patient would have been recorded. This does not mean that the patient lost their voice, or that the practitioner was necessarily the driving force in the medical encounter. The individual personalities of both parties must always be taken into account where possible. As we will see later in this study, patients acted as consumers in the medical market and agents to their own healthcare, and would not have been silenced by the doctor. Patient narrative was just as important an aspect of diagnostic procedure as the physical examination in the Edwardian era, as it remains today. The historian must be aware of that whilst the patient may not have written the record, or dictated what information to include within it, their voice can still be heard in health histories and throughout daily notes.

²⁰⁵ Andrews, 'Case notes'

²⁰⁶ Bynum, *Science*, p. 209, Fissell, *Patients*, p. 152

²⁰⁷ Andrews, 'Case notes', p. 263

Despite these few previous works, however, no history to date has made use of patient records on any scale. The central use of the RFH patient case records in this study will demonstrate their value and importance as an historical source by providing a unique insight into hospital medical practice and into the patients who made use of hospital care. The under-use of patient case records in the current historiography may reflect their limited availability and survival, but such records of the RFH survive in large numbers. This will allow this study to make use of a sample which is both statistically significant and of a significantly greater scale than any previous studies.

Key Aims and Research Questions

This project has three primary aims. Firstly, to contribute to the current historiography on the history of hospitals, doctor and patients, and the health of the population, by bringing a fresh insight into the inner workings and patient treatments of the RFH, and placing this into our current understanding of the hospital experience within the London medical market. Secondly, to reconsider the period between the turn of the twentieth century and the First World War, which the current literature has neglected to comprehensively address. Cherry has claimed that this was a period of ‘change’, but little empirical research means that we know comparatively little about treatment regimes, professional approaches of practitioners, population health, and patient experience during these years. Thirdly, to reconstruct the patient’s experience of ill-health throughout their lives through their contact with the RFH and to trace the treatment regimes they experienced, in order to help fill a significant gap in the literature. In order to achieve these aims, this study must ask five key research questions;

1. **Who were the patients?** The personal details and histories included in the patient records will be used to understand the social, residential and medical life-cycle of the patients. Information on the patients name, age, sex, marital status, address and occupation will be used alongside information on the patients' financial circumstances and travel history to construct a patient 'typology' for the RFH during the sample years. Individual case studies and quantitative analysis of ill-health and treatment will be assessed in relation to the patient life-cycle, which will improve our understanding of how people experienced and coped with illness throughout their lives and how long they waited before seeking treatment.

2. **What ill-health was suffered by patient of the RFH and their families?** Diagnosis information will be used to chart the current ailments suffered by patients of the RFH. Patient and family health histories detail the ill-health currently and previously suffered within family networks, providing a unique insight into the nature and collective experience of health and disease.

3. **What medical and surgical treatment was provided to patients at the RFH and how effective was that treatment?** Clinical extracts, operation descriptions and daily notes included in the patient records all provide an incredibly detailed insight into the treatment system at the RFH. Surgical and medical student textbooks and medical journal articles published between the late nineteenth and early twentieth century, will be used to assess the medicine and treatment provided. The records are sufficiently rich to make distinctions between the treatment regimes offered by different practitioners.

4. **How did the patient make use of the RFH as a part of the wider medical marketplace?** The patient histories contain detailed accounts of all of the previous treatment patients sought for both their previous and current illnesses. Patients sought medical assistance through a range of means, often depending on the nature of the illness or injury suffered, their financial situation, location of medical aid, the reputation of a particular medical individual or institution, or their dissatisfaction with previous treatment and their motivation to seek treatment through new means. The detail contained in patient histories will allow this study to place the RFH in the medical setting of the early twentieth century, and in doing so, provide a better understanding of patients as consumers within the medical marketplace of the metropolis during this period.

5. **What was the overall experience of the patients at the RFH?** The daily notes included in the records provided information as to the treatment the patient received, their comfort as expressed to the hospital staff and the frequency of the examinations of the doctor. This information, coupled with other hospital records including the 'Rules and Regulations' books, and annual reports, will allow this study to reconstruct life on the ward of the RFH, and examine what it would have been like to have been a patient. This information also enables the contact between the patient and practitioner to be reconstructed from the entry of the patient onto the ward. The treatment received by male and female patients by male practitioners will be critically analysed, and the language contained in the records will raise issues of knowledge and power within the doctor-patient hospital setting.

This study centres on the analysis of RFH patient case records, but will also make use of a wide range of other contemporary sources (including further hospital records, medical textbooks, journal articles, and newspaper reports). Quantitative and qualitative methodological approaches have been adopted during the completion of this project in order to best explore the source material. The hospital archive currently holds substantial numbers of patient records; there are over 250 volumes (boxes) of records each containing approximately 500 pages of record material. This project will make use of a sample of 480 of these case records selected based on four tiered sampling method; by staff member, year, season, and patient sex.²⁰⁸ Records have been selected from four male staff members; two surgeons and two physicians:

1. Physician Harrington Sainsbury, MD (Lond.), FRCP; Records survive 1900-1918 (30 boxes)
2. Physician J. Walter Carr, MD, BS (Lond.), MRCP, FRCS; Records survive 1902-1920 (35 boxes)
3. Surgeon Sir James Berry, KBE, FRCS, Hon DCC, MB BS; Records survive 1890-1920 (37 boxes)
4. Surgeon Edmund W. Roughton, BS, MD (Lond.), FRCS; Records survive 1891-1912 (22 boxes)

The records of these staff members were selected for this study as these men held the general medical and surgical positions at the hospital, and so their records best represent the wide range of cases treated at the RFH. In addition, their records survive in large numbers for the early twentieth century. An equal number of 120 records have been

²⁰⁸ Patient records will be referenced according to the four tiers of the sample method. Page numbers refer to the relevant bound series of case records. For example: Patient Case Record of the Royal Free Hospital (henceforth PR): *Edwin Lucas*, Sainsbury Men December 1902, p. 453

sampled from each staff member, meaning that half of the sample represents surgical patients, and the other half medical patients. This was an important aspect of the sampling process, as the study wishes to analyse the treatment methods of both physicians and surgeons, and explore the experience of both medical and surgical patients. The exclusion of the records of a female member of staff was a deliberate choice, as the records of female staff members do not survive in sufficient numbers to conduct a fair and representative comparison. Moreover, the study would have had to consider not only the relationship between the male member of staff and male and female patients, but also that of a female member of staff to her patients, which would have proved too broad an examination for this study alone to conduct.

In order that the study best represent the early years of the twentieth century, the sample years of 1902, 1907 and 1912 were chosen. It was decided not to sample the records of one single year, as this would have provided a cross section of the hospital patient base at one instance and not represent the patient base over the course of a substantial time frame. However, while the archive catalogue states that records survive, for example, in the case of Mr Roughton from the years 1891-1912, the records were found not to exist in a complete series running throughout these years, but for only random and inconsistent periods within this timeframe. This meant that the study needed to find years between 1900 and 1914 for which the records of all of the desired staff members survived. It was found that the only years in which the majority of the records of each staff member overlapped were 1902, 1907 and 1912. The records of Dr Carr do not survive before the year 1902, and so this was the earliest year for which the surviving records of all of the staff members overlap. However, while the records of Dr Sainsbury, Mr Roughton, and Mr Berry all survive for the entire year of 1902, the records of Dr Carr were found to be incomplete. Therefore, as the remainder of the records only overlapped in date during the selected years, it was decided that the sample for Dr Carr would come from the following

year. Equal numbers of forty records per staff member were sampled from each year 1902 (1903 in the case of Dr Carr), 1907 and 1912. This number was split equally between records of summer months, and winter months in each year. The records survive bound by discharge date, and so twenty records were sampled starting from the discharge date of July 1st, and twenty winter records from the discharge date of December 1st of each selected year. It is important for this study to sample records by season in order to gain an understanding of seasonal medical complaints and disorders.

The final aspect of the sampling method developed for this study is that half of the records sampled would be that of male patients and half of female patients. This meant that ten male and ten female patients were sampled per season, per year, per staff member. The reason for the equal number of male and female patients sampled for this study was twofold. The decision was one of practicality, as the surviving records have been bound by patient sex. More importantly, equal numbers of male and female patients will allow us to gain a fair understanding of the ill-health suffered by the population during this period, and will provide an insight into the experience of both male and female patients at the hospital. This aspect of the sample, however, does mean that this study cannot know or compare which sex made more use of the hospital during the sample years. Overall, the nature of the sample represents a viable method in comparison to other users, and the amount of detail contained in each patient record makes it unreasonable to expect this study to have examined a larger number.

Quantitative analysis will enable this study to calculate the average and most common patient age, marital status, occupation, and distance travelled from their place of residence to the RFH. Such analysis will also be conducted into the ailments contained in the records, and allow for this study to calculate the most common injuries, diseases, and complaints treated at the hospital. Qualitative analysis of the patient histories contained in the records will allow this study to speculate as to the financial circumstances of many of

the patients, by considering and comparing such details as to the patients living conditions, previous treatments, and travel histories. The use of case studies will be employed to discuss in detail those patients who represent either the typical or non-typical patient base of the hospital, and those who appear in the sample of records on more than one occasion. Census records of the RFH will also be analysed in order to determine whether the sample is representative of the patient base. Moreover, a control sample of twenty patient case records has also been randomly sampled from the same time period.

Whilst the sample of patient case records will form the basis of this study, this project is source intensive and will use record linkage methods to make use of a wide range of further source material. Financial records, committee minutes, letters, newspaper reports, and textbooks written by employed practitioners will be used to reconstruct the general history of the institution. The records of the Samaritans Fund, administered by the Ladies Visiting Committee until 1895, the Dresden Assistant Fund, established in 1904, and records of other charitable committees working with the RFH will be a valuable source in our understanding of the relationship held between the patient and the hospital in the wider community. These sources will be supplemented with Almoners Reports, Nursing and Matron records, copies of the Rules and Regulations 1892-1914, and Chaplaincy records, which are all pivotal to our understanding of the patient experience of the hospital and will help reconstruct the typical daily routine of an in-patient at the hospital.

Chapter Structure

This study will be divided into five further chapters. The following chapter, ‘The Royal Free Hospital and Staff’ will construct a relevant institutional history of the RFH and place it in the current historiography. The RFH has never before been the subject of an academic history, making this chapter essential to providing context for this study. Once a history of

the hospital has been established, this study will be in the position to place the RFH in the context of the wider medical marketplace for the first time. This history will be compiled through the use of hospital annual reports, Board meeting minutes, contemporary newspaper articles, and other surviving hospital ephemera. The third chapter of this project, entitled 'Patient Identity' will analyse the patient information contained on the cover pages of the case records, including the patients' name, age, sex, marital status, occupation and address, in order to establish the patient base of the RFH during the early twentieth century. This chapter will present a detailed analysis of the patient identity of an institution for the first time, and thus make an original contribution to the minimal literature on the patient in history. It is vital to the remainder of this study to understand the 'typology' of patients seeking treatment at the RFH in order that their ailments, experience, and use of the hospital can be understood in relation to the wider population. Chapter four, 'The Royal Free Hospital in the Wider Medical Market' will assess the patient treatment histories in order to recall the other means of medical assistance the patients and their families had made use of in their lifetimes. This information will be used to assess how patients made consumer choices within the medical marketplace, and will enable this study to place the RFH in our understanding of that marketplace for the first time.

Chapter five, 'Patient Health' will consist of a detailed analysis of the diseases, complaints and injuries suffered by the patients in the sample records. The patients' current complaint, personal health history, and family health history will be examined in this chapter in order to contribute towards the current literature on the health of the population during the nineteenth and twentieth century. In chapter six, 'Treatment and its Results', the medical and surgical treatment techniques and procedures will be examined through the daily notes contained in the patient case records. The literature on hospital medical and surgery during the early twentieth century is minimal, and so this chapter will act to widen our understanding of hospital development by addressing the specific medicine, treatments,

and surgical procedures practiced at a central London voluntary hospital. The frequency of contact between the medical staff and the patients as indicated in the records will also broaden our understanding of the doctor-patient relationship within the hospital setting. The rules and regulations book and the annual reports will be used alongside the patient records in order to reconstruct the patient experience of being treated at the RFH. Findings relating to the length of patient stay, the rules they needed to abide by on the wards and the contact they had with medical staff will all be used to gain an insight into hospital patient life. The final chapter, 'Conclusion', will present an overview of the findings of this project, and assess its value and impact on the current literature on hospital history, patient identity and experience, and population health.

Overall, through the use of patient case records the patient base of a central London voluntary hospital during the early twentieth century will be identified and their health examined. The patient experience of hospital life and treatment will be reconstructed and assessed. The position of the RFH in the wider medical market will be considered, and it will be placed in the historiography for the first time.

CHAPTER TWO

THE ROYAL FREE HOSPITAL AND STAFF

In order to examine the patient case records of the Royal Free Hospital (henceforth RFH) it is first essential to compile a relevant hospital history as a resource for the remainder of this study. The origin and content of the records, and the wider London context in which they were generated, can only be understood with a history of the institution from which they emerged. As discussed in the previous chapter, the RFH has never been the subject of an academic institutional study. A history of the hospital will therefore not only give the RFH a history in its own right, but will also allow us to place it in the wider medical marketplace of London for the first time.

Institutional histories exist in many forms and structures.¹ As discussed in the introduction to this study, the widespread hospital expansion and growth of the eighteenth and nineteenth century, voluntary and charitable hospital systems, and the place of the hospital in the wider medical marketplace, have been the major themes of hospital histories to date. These histories can be further divided into those which have focused on administration, economy and finance, on the social and cultural standing of the hospital as

¹ The most important institutional histories for this study are; B. Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*, (London, Heinemann, 1964), E. H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848*, (John Hopkins Press, Baltimore, 1967), S. Cherry, *Medical services and the hospitals in Britain 1860-1939*, (Cambridge University Press, Cambridge, 1996), B. Croxson, 'The price of charity to the Middlesex Hospital, 1750-1830', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 23-39, R. Porter, 'Hospitals and Surgery' in Roy Porter (Ed.) *The Cambridge History of Medicine*, (Cambridge University Press, Cambridge, 2006), pp. 176- 210, M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, Translated from French by A. M. Sheridan, (Tavistock Publications, London, 1973), L. Granshaw, *St. Mark's Hospital, London: A Social History of a Specialist Hospital*, (Distributed for the King's Fund by Oxford University Press, Oxford, 1985), L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989), F. K. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund 1897-1990*, (Clarendon Press, Oxford, 1992), G. B. Risse, 'Hospital History: New Sources and Methods', in R. Porter and A. Wear (Eds.), *Problems and Methods in the History of Medicine*, (Croom Helm, New York, 1987), G. B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford University Press, Oxford and New York, 1999), G. Rivett, *The Development of the London Hospital System 1823-1982*, (Kings Edward's Hospital Fund for London, Oxford University Press, Oxford, 1986), K. Waddington, *Medical Education at St. Bartholomew's 1123-1995*, (Boydell Press, Woodbridge, 2003), and J. Woodward, *To do the sick no harm: A study of the British voluntary hospital system to 1875*, (Routledge & Kegan Paul, London, 1974)

an institution, on regional variations in the hospital system, and those which discuss individual hospitals only.² There is of course much overlap of these themes depending on the focus and objective of histories, particularly those of individual institutions. Granshaw's social history of St. Mark's Hospital discusses the changing nature of the hospital throughout the nineteenth and twentieth centuries in terms of the patients, nursing structure, and the specialism's of the hospital.³ Croxon has discussed the history of the Middlesex Hospital both in terms of its relationship to charitable funding and the evolution of the hospital's lying-in service.⁴ Waddington's history of St. Bartholomew's is based on the medical education provided there from its foundation in 1123, and discusses issues including the scientific influences of the late nineteenth-century, the impact of war, and the place of women in medical education.⁵ While the history of the RFH presented in this chapter will inevitably reflect many of the structures and themes of these past hospital histories, its purpose is to be used as a resource for the findings and debates in the chapters that follow. With this purpose in mind, it will focus primarily on the period from the hospitals' foundation in 1828 through until the 1920's. This will allow for an understanding of the development and ethos of the hospital prior to the first decade of the twentieth century (the time period under analysis for this study), the business of the hospital during that decade, and the direction of the hospital in the years immediately following.

In order to provide a relevant history of the RFH, the following key themes will be considered when discussing its changing nature over the nineteenth and early twentieth centuries. Firstly, the founding of the hospital must be discussed in order to gain an initial

² Abel-Smith, *The Hospitals*, Cherry, *Medical services*, Gorsky and S. Sheard, *Financing Medicine*, Granshaw and Porter, *The Hospital*, J. Mohan and M. Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain Past and Present*, (Office of Health Economics and Association of Chartered Certified Accountants, London, July 2001), Risse, *Mending Bodies*, Waddington, *Medical Education*

³ Granshaw, *St. Mark's*

⁴ Croxon, 'The price of charity', and B. Croxon, 'The Foundation and Evolution of the Middlesex Hospital's Lying-In Service, 1745-86', *Social History of Medicine*, Vol. 14, No. 1, pp. 27-57

⁵ Waddington, *Medical Education*

understanding of the principles on which its character and purpose were to depend. The changing rules of admission will also be discussed in order to understand the changing types of patient treated at the hospital over time, and help us to determine why the patients in the records were treated at the RFH instead of any other institution. It is also important that the administrative and financial details relating to the hospital be discussed at this stage of the study in order that the reasons behind the treatment the patients received and their overall experience of the hospital can be more fully discussed in later chapters. Moreover, in order to gain as comprehensive an understanding as is possible of the place of the RFH in the wider medical community, it is also essential to highlight its relationship with the London School of Medicine for Women (later known as the London Royal Free Hospital School of Medicine for Women), and the staffing policies of women at the hospital more generally. For example, Dr Mary Scharlieb was appointed in 1902 as the first female to be permanent physician to a general hospital, and the first Lady Almoner, Miss Mary Stewart, was appointed in 1895. Once the history of the RFH has been compiled, the staff relevant to this project will be discussed. As detailed in the introduction to this study, the patient case records selected for this project are those of the two physicians, Dr Harrington Sainsbury and Dr Walter Carr, and of the two surgeons, Sir James Berry, and Mr Edmund Roughton. In analysing the records of these medical men, it will be essential to have an understanding of their medical backgrounds in order to identify and justify any differing medical techniques and practical approaches to patient treatment.

The Royal Free Hospital, 1828-1920: An Overview

The story of the origin of the RFH is first recalled in the founding minutes. In the winter of 1827, the young surgeon Mr. William Marsden found a poor and dying woman, after

midnight, on the steps of St. Andrew's Churchyard, in Holborn, London.⁶ The woman was no more than eighteen years of age, and was most probably a prostitute suffering from a related ailment.⁷ Not possessing a subscriber's letter, the young woman was refused treatment at the neighbouring hospitals and died two days later.⁸ The 'difficulty and danger' of the limited medical care available to the sick poor through the system of obtaining a subscriber's letter in order to be admitted to a voluntary hospital, caused Marsden to set about founding a medical charity whereby 'poverty and sickness should alone be the passport for obtaining free relief'.⁹ On February 14th 1828, Marsden and a collaborative group of twenty-seven other gentlemen held a meeting in the Gray's Inn Coffee House with the intention that it was 'expedient to found a Charitable Institution in this Metropolis for the gratuitous cure of syphilitic and other contagious diseases'.¹⁰ By March of the same year, a four-storey house at 16 Greville Street, Hatton Garden, was rented for the purposes of this charity, and by April, the 'London General Institution for the gratuitous cure of Malignant Diseases' was open to the public at this address, acting as an out-patient dispensary with a home visiting service.¹¹ Through the influence of Sir Robert Peel, the patronage of King George the Fourth was obtained for this new charity, and in 1829 the Duke of Gloucester became its President.¹² On the death of George the Fourth in 1830, King William became the Hospital Patron until his passing in 1837, when Queen Victoria took up the position for the remainder of the century.¹³ The name of the hospital was changed in 1833 to 'The London Free Hospital', and again in 1835 to simply

⁶ Royal Free Hospital Archives (Henceforth RFHA): *The Eighty-Third Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1910*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), p. 10

⁷ *Eighty-Third Annual Report 1910*, p. 10, and L. A. Amidon, *An Illustrated History of the Royal Free Hospital*, (Published by the Special Trustees for the Royal Free Hospital, London, 1996), p. 13

⁸ *Eighty-Third Annual Report 1910*, p. 10

⁹ *Ibid*

¹⁰ RFHA: *General and Committee Minutes 1828-1839*, (RFH/1/2/1/1), p. 1

¹¹ *General and Committee Minutes*, pp. 9-11.

¹² *Eighty-Third Annual Report 1910*, p. 10

¹³ *Ibid*

‘The Free Hospital’.¹⁴ It was under the Patronage of the newly crowned Queen Victoria that the name of the hospital was changed to the ‘Royal Free Hospital’, the name by which the institution has been known ever since.¹⁵ The title of Patron was passed from Victoria on her death to her successor, King Edward VII, in 1901.¹⁶

The story of the RFH foundation shares similar features with those of other voluntary hospitals of the eighteenth and nineteenth centuries. An individual or small group set to establish a dispensary or hospital, usually in rented accommodation, to serve a specific group in the community or those suffering from a specialist condition. Although founded over a century earlier, the Westminster Hospital first opened in a rented building in Petty France as a result of a small group of professional men who sought to address the plight of the poor sick people of Westminster.¹⁷ The London Infirmary (known today as the Royal London Hospital) was opened in 1740 in a rented house on Featherstone Street with the object having been ‘The relief of all sick and diseased persons and, in particular, manufacturers, seamen in the merchant service and their wives and children’.¹⁸ Similarly, the Great Northern Hospital was founded in 1856 by Sherard Freeman Statham, an assistant surgeon at University College Hospital, to serve mainly the workers on the King’s Cross and Euston railways.¹⁹ Also in 1856, the Fulham and Hammersmith General Dispensary (today the West London Hospital) opened in a six-roomed house in Queen Street, Hammersmith, to provide medical attention for the poor of the district.²⁰

Whilst the origin of the RFH was not dissimilar to that of many other voluntary institutions of the period, what was unique was that it was founded on the principle that no

¹⁴ *General and Committee Minutes*, p. 192, and Amidon, *An Illustrated History*, p. 16

¹⁵ *Eighty-Third Annual Report 1910*, p. 10

¹⁶ *Ibid*

¹⁷ C. Dainton, *The Story of England’s Hospitals*, (Museum Press, London, 1961), p. 62

¹⁸ Dainton, *The Story*, p. 71, Royal London Hospital Archives and Museum (henceforth RLHAM): *Administrative History*, Records of the London Hospital, Whitechapel, (LH/N-LH/MP)

¹⁹ London Metropolitan Archives (henceforth LMA): *Administrative History*, Royal Northern Hospital, Royal Northern Hospital Group, (H33/RN)

²⁰ Hammersmith and Fulham Archives and Local History Centre (henceforth HFA): *Administrative History*, Administrative Records of the West London Hospital, (DD/815)

subscriber's letter of recommendation would be required to seek admission (which will be discussed further in the following section). By the late 1830s, in-patient treatment was steadily increasing at the charity, and 16 Greville Street was no longer large enough to accommodate the treatment of the increasingly popular institution. In 1839, the adjoining house, number 17 Greville Street, was purchased in order to increase the number of in-patient beds from thirty to seventy-two.²¹ However, the increasing number of patients treated at the hospital meant that in 1842, the hospital Committee purchased a much larger site on Gray's Inn Road.²² The premises were those formerly used as the barracks of the Light Horse Volunteers, with an archway entrance into the four wings enclosing the central quadrangle.²³ This layout remained unchanged until the North Wing was re-built in 1856 as a memorial to the death of His Royal Highness the Duke of Sussex, the Grand Master of the Freemasons of England, and a benefactor to the hospital.²⁴ In 1863, the freehold of the hospital was purchased, and in 1876 the South Wing was enlarged to contain fifty additional beds and a new Out-Patient Department erected.²⁵ This Wing was re-named the 'Victoria Wing' in honour of Her Majesty Queen Victoria (see Figure 2.1).²⁶ In 1879 the Central Block was reconstructed to provide accommodation for the nursing staff and medical students.²⁷ The only remaining original part of the barracks, the front building, was reconstructed during the early 1890s, and the new 'Alexandra Building' was opened in 1895 by the Prince and Princess of Wales.²⁸ In 1897 the hospital became part of the newly formed Central Hospital Council for London.²⁹ This consisted of representatives of all the

²¹ Amidon, *An Illustrated History*, p. 19

²² Eighty-Third Annual Report 1910, p. 11

²³ Amidon, *An Illustrated History*, p. 25, *Eighty-Third Annual Report 1910*, p. 11,

²⁴ *Eighty-Third Annual Report 1910*, p. 11

²⁵ *Ibid*

²⁶ *Ibid*

²⁷ *Ibid*

²⁸ Anon, 'Royal Free Hospital', *The Times*, Issue: 34636, Col: G, (Tuesday July 23, 1895), p. 4, *Eighty-Third Annual Report 1910*, p. 11

²⁹ RFHA: *The Seventieth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1897*: Annual Reports 1895-99 : Book A11 (RFH/1/2/2), p. 17

Figure 2.1: The Royal Free Hospital front buildings (the Sussex and Victoria Wings) on Gray's Inn Road, 1898, (Wellcome Images)

London general hospitals which had medical schools.³⁰ By 1900, the Council requested a census of all patients treated at the RFH on a single chosen day of the year, and by 1902 an annual census of all in-patients was taken on the second Sunday in January.³¹ The census reported primarily on the addresses of the patients in order to determine if the hospital was located in the area of London in which it was most needed. The results of the census continually stated that the hospital was 'well situated for its work, and receives a larger proportion of its patients from the immediate neighbourhood of the Hospital'.³²

³⁰ Ibid

³¹ RFHA: *The Seventy-Third Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1900*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 17, and RFHA: *The Seventy-Sixth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1903*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 14

³² RFHA: *The Seventy-Eighth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1905*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), p. 16

The physical expansion and development of the hospital over the course of the nineteenth century was not unusual, as the voluntary hospital system grew to meet popular demand. The Great Northern Hospital underwent numerous moves in the 1860s necessitated by the arrival of the Metropolitan Railway Company and in the 1880s formed part of an amalgamation to become the Great Northern Central Hospital, which opened on Holloway Road in 1888.³³ The Fulham and Hammersmith General Dispensary took the title of the West London Hospital in 1863, and in 1868 purchased the leasehold of Elm Tree House on Hammersmith Road, adding new wings in 1871, 1883, and 1898.³⁴ During the late 1890s and the first decade of the twentieth century, the RFH undertook the addition of ‘new lavatories, kitchens, polished teak floors, electric lighting, and other improvements to the wards’.³⁵

In the Sussex and Victoria Wings, electric lifts were also installed.³⁶ In 1907, two new operating theatres were erected on the top of the Sussex Wing, and a Mortuary Chapel was provided thanks to the funds raised by the Ladies Association (a group which will be revisited later in this chapter).³⁷ Also in 1907, the need for more nursing accommodation pushed the hospital into purchasing the lease of 32 Mecklenburgh Square.³⁸ In 1910, a waiting room was erected to accommodate the out-patients who were receiving massage treatment, and in 1912 the construction of a new Out-Patient Department began, which would consist of a new Casualty department, Physician’s and Surgeons’ room, Maternity Department, operating theatres, Students’ Quarters, and accommodation for twenty-four

³³ LMA: *Administrative History*, Royal Northern Hospital

³⁴ HFA: *Administrative History*, West London Hospital

³⁵ *Eighty-Third Annual Report 1910*, p. 11, and RFHA: *The Sixty-Ninth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1896*: Annual Reports 1895-99 : Book A11 (RFH/1/2/2), p. 14

³⁶ *Eighty-Third Annual Report 1910*, p. 11

³⁷ RFHA: *The Eightieth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1907*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), pp. 13 and 21, and *Eighty-Third Annual Report 1910*, p. 11

³⁸ *Eightieth Annual Report 1907*, p. 13

nurses.³⁹ During the First World War, the War Office requisitioned the newly built Helena Building, which contained three wards, and equipped it as an officers' hospital containing 140 beds.⁴⁰ Once the building was returned to general use in 1918, plans were made to convert part of it into a new Maternity Unit, which opened in 1920.⁴¹

Admission Policy

The types of cases which received treatment at the RFH continually developed over the course of the nineteenth and twentieth centuries. During the early years of the charity's existence, the London General Institution's primary patient base was those suffering from malignant diseases. Indeed, the minutes of the Quarterly Meeting of the Committee held on January 7th 1830, proudly stated that 'many female patients have called at the Institution to say, that they have reformed their lives and returned to their former occupations, when but for the assistance so reasonably rendered, each of them must probably have abandoned her life of honest industry and added one more victory into the crowded ranks of intemperance and prostitution'.⁴² During the 1850s some patients received money and clothes upon being discharged, especially the many 'unfortunate females' who were able to use the money to return home to their families.⁴³ The treatment of patients who suffered from venereal disease was not unique to the RFH (the Lock Hospital was founded in 1746) but such treatment was limited.⁴⁴ By August of 1833 a special general meeting of the

³⁹ *Eighty-Third Annual Report 1910*, p. 15, and RFHA: *The Eighty-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1912*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), p. 17-18

⁴⁰ Amidon, *An Illustrated History*, p. 41

⁴¹ *Ibid*, p. 42

⁴² *General and Committee Minutes*, p. 68

⁴³ RFHA: *History of the Royal Free Hospital with the Twenty-Seventh Annual Report, &c. of the Committee of Management, 1855*: Annual Reports 1855-58 : Book A3 (RFH/1/2/2), p. xviii

⁴⁴ Dainton, *The Story*, p. 93

governors resulted in a revision of the rules and Bye Laws of the institution.⁴⁵ The name of the charity was changed to the ‘London Free Hospital’ which would be a general institution for the gratuitous cure of malignant and *other* diseases.⁴⁶ It was not unusual for a voluntary hospital to have been established for a specialist patient base and to have expanded once means allowed. Two such examples are the London Infirmary (founded to serve manufacturers and seamen in the merchant service) and the Great Northern Central Hospital (established to serve mainly railway workers) discussed in the previous section. In 1845 however, the RFH came under public scrutiny in *The Morning Chronicle* for refusing to admit female patients who suffered from consumption due to lack of space on the wards.⁴⁷ It then became known that there were empty beds available, but that these were being kept for patients suffering from venereal disease.⁴⁸ By 1846 the hospital had designated an entire ward to the care of such patients.⁴⁹ The Free Hospital (as it was then known) still clearly considered itself a hospital for sufferers of venereal disease above all others by the mid-nineteenth century.

Beyond the ill-health of the patients, officially ‘poverty and sickness’ were the only requirements needed for receiving free medical care from the hospital.⁵⁰ It was apparent from the early years of the Institution, however, that the admission policy was in fact much more rigid. By 1830 many homeless applicants had been refused treatment and medicine on the grounds that ‘giving them medicine, without being able also to afford them shelter and common necessaries would prolong their misery without alleviating their disorders’.⁵¹ In 1865 it was stressed in the annual report of the same year that those classes of people

⁴⁵ *General and Committee Minutes*, p. 192

⁴⁶ *Ibid*, p. 193

⁴⁷ Anon, ‘The Royal Free Hospital’, *The Morning Chronicle*, Issue 23741 (Friday, November 28, 1845), p. 6

⁴⁸ *Ibid*

⁴⁹ Amidon, *An Illustrated History*, p. 15

⁵⁰ *Eighty-Third Annual Report 1910*, p. 10

⁵¹ *General and Committee Minutes*, p. 67

who were better suited to the medical care provided by the Poor Law were not the typical patients of the hospital.⁵² The report stated that the;

‘usual clients of Medical relief are not the lowest average of the populace, whose natural resource is the union. There is a more respectable class of artisans, and labourers, to whose manly sense of independence parochial relief is a degradation, whom, nevertheless, a few weeks of sickness would reduce to pauperism, but for the timely intervention of Medical Charity.’⁵³

This admission policy was one which remained with the hospital throughout the nineteenth and early twentieth centuries, although by the late 1890s it was continually stressed in the almoner’s reports that all such applicants would at least receive first aid before being referred back to the Poor Law.⁵⁴ It seems somewhat a contradiction that patients suffering from venereal disease, possibly the most immoral of all ailments affecting the general populace during the nineteenth century, were treated with the intention of improving the lives of the individuals and the moral character of the Metropolis, whilst other patients were refused treatment altogether for being too poor. During the cholera epidemic of 1832, however, the London General Institution was the only hospital to treat the persons afflicted, regardless of their class or social standing, admitting over seven-hundred cholera victims to the small premises at Greville Street.⁵⁵ In the later scare of 1848, two of the large wards of the hospital were occupied with afflicted pauper children taken in from Tooting.⁵⁶ Of the 158 children admitted, 154 were ‘rescued from pressing, and probably fatal, peril’.⁵⁷ In total, the hospital treated over 6,150 patients afflicted with cholera during

⁵² RFHA: *Report of the Royal Free Hospital, with List of the Governors and Subscribers, 1865*: Annual Reports 1864-69 : Book A5 (RFH/1/2/2), p. xv

⁵³ Ibid

⁵⁴ *Seventieth Annual Report 1897*, p. 12

⁵⁵ RFHA: *Report and List of the Governors and Subscribers to the Royal Free Hospital, 1849* : Annual Reports 1848-54 : Book A2 (RFH/1/2/2), p. viii

⁵⁶ Ibid, p. xv

⁵⁷ RFHA: *Report, January 1850*: Annual Reports 1848-54 : Book A2 (RFH/1/2/2), p. xiii

the 1848 epidemic.⁵⁸ During the 1880s, cholera was still considered to be a threat to the Metropolis by the Hospital Committee, and so two wards of the Gray's Inn Road site (one for men and the other for women) were directed to be used for the reception of cholera victims if the need presented itself.⁵⁹ Incidentally, no such epidemic occurred. By the late 1890s, the 'Regulations as to the Admission of Patients' qualified not the types of ailments which would be admitted for treatment at the RFH, but those which would be refused.

'Persons suffering from advanced Consumption, Insanity, Palsy, and Fits, being rarely benefited by admission, or from infectious and eruptive complaints, being dangerous to other patients, are not eligible for admission. Patients recently discharged from other Hospitals, or those who, upon examination, are deemed incurable, are not suitable for reception.'⁶⁰

This admissions policy reflected that of other voluntary hospitals during this period, which according to historians including Prochaska and Cherry, excluded the mentally ill and those who suffered from infectious or incurable complaints.⁶¹

In-patients were admitted to the RFH on a daily basis and where possible were expected to bring 'a change of linen, towel, knife, fork, spoon, comb, and brush'.⁶² As of 1886 all in-patients were provided with tea, sugar, and butter, which had until this date been supplied in part by the patients themselves, or by their family and friends.⁶³ This provision cost the hospital approximately £300 per year.⁶⁴ In-patients were issued with two Visitor's Cards, and only the two persons in possession of those cards were allowed to visit

⁵⁸ *Twenty-Seventh Annual Report 1855*, p. xvii

⁵⁹ RFHA: *Report, January, 1885, with List of the Governors and Subscribers*: Annual Reports 1881-85: Book A8 (RFH/1/2/2), p. 15

⁶⁰ RFHA: *The Seventy-First Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1898*: Annual Reports 1895-99 : Book A11 (RFH/1/2/2), p. 28

⁶¹ Cherry, *Medical services*, p. 45, Prochaska, *Philanthropy*, p. 5

⁶² *Ibid*

⁶³ *Sixty-Ninth Annual Report 1896*, p. 13

⁶⁴ *Ibid*

the patient at the same time.⁶⁵ Visiting hours were only between the hours of 2 p.m. and 4 p.m. on a Sunday, and between 3.30 p.m. and 4.30 p.m. on a Thursday.⁶⁶ Exceptions were made in cases of serious illness, when visitors were admitted at all hours.⁶⁷ The out-patient department was also open daily (except on Sundays) for general medical and surgical cases, but only between the times of 12.30 p.m. and 1 p.m. for new cases, and between 1.30 p.m. and 2 p.m. for old cases.⁶⁸ If the patient needed to see a specialist, such as that of the diseases of women, or that of the diseases of the eye or skin, they could only be seen two days a week at 9 a.m.⁶⁹ As of 1870 the number of beds in each ward was reduced from twenty-four to sixteen, and cases of a medical and surgical nature were separated.⁷⁰ By the late 1890s the hospital contained 170 beds of which the majority were allotted to general medical and surgical cases.⁷¹ In total, ninety-three beds were allocated to male patients, and seventy-seven to females.⁷² While twelve beds were kept for female patients suffering from gynaecological disorders, the eighteen beds allotted to accident victims were only for the use of male patients, who it must have been assumed were more likely to have suffered from industrial occupational injuries.⁷³ The average weekly cost of each bed occupied during the year 1900 was £1. 8s. 10d., and by 1905 was £1. 11s.⁷⁴ By 1906 the number of beds at the RFH was similar to that of the Great Northern Central Hospital (162 beds) and Kings College Hospital (224), but was far out-numbered by those of St Bartholomew's (670), the London (914), and Guy's (600) hospitals.⁷⁵

⁶⁵ Ibid

⁶⁶ Ibid

⁶⁷ Ibid

⁶⁸ Ibid, p. 29

⁶⁹ Ibid

⁷⁰ RFHA: *Report, January 1870, with List of the Governors and Subscribers: Annual Reports 1870-75* : Book A6 (RFH/1/2/2), p. 12

⁷¹ Ibid

⁷² Ibid

⁷³ Ibid

⁷⁴ *Seventy-Third Annual Report 1900*, p. 16, *Seventy-Eighth Annual Report 1905*, p. 19

⁷⁵ Statistics on hospital services were downloaded from the Voluntary Hospitals Database at <http://www.hospitalsdatabase.lshtm.ac.uk>. This is an online version of a database initially constructed at the University of Portsmouth as part of a research project funded by the Leverhulme trust. Creation of the online

By the late nineteenth and early twentieth centuries the RFH became involved in the admission of patients with specific treatment needs. In 1899, the hospital responded to the application of the Medical Department of the War Office, and agreed the use of twenty beds when required, for the ‘reception and treatment of sick and wounded soldiers’ from the War in South Africa (the Boer War).⁷⁶ The Maternity Department opened on July 1st 1903, and within its first six months treated 132 cases.⁷⁷ In 1904 the staff treated 349 women in their own homes, and in 1905 this number had risen to 431.⁷⁸ Both the Rontgen Ray and Electrical Departments were founded in 1904 and during that year over 500 patients were examined with the Rontgen Ray screen and over 180 cases were photographed.⁷⁹ The Electrical Department treated over 800 patients continuously during the same year.⁸⁰ X-rays had been used at the hospital prior to the department having been founded, as they were at other hospitals. St Bartholomew’s had first used x-rays in 1896, the same year Rontgen announced his discovery.⁸¹ Furthermore, during 1913 the RFH entered into negotiations with the public authorities with the object of securing the recognition of the hospital as a centre for the treatment of tuberculosis under the National Insurance Act of 1911.⁸²

The number of in-patients increased over the course of the nineteenth century with the expansion of the wards and the number of available beds, and the improvement in

version was made possible by a grant from the Wellcome Trust. I am grateful to Martin Gorsky and John Mohan for permission to reproduce this material.

⁷⁶ RFHA: *The Seventy-Second Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1899*: Annual Reports 1895-99 : Book A11 (RFH/1/2/2), p. 11

⁷⁷ *Seventy-Sixth Annual Report 1903*, p. 18

⁷⁸ RFHA: *The Seventy-Seventh Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1904*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 15, *Seventy-Eighth Annual Report 1905*, p. 16

⁷⁹ *Seventy-Seventh Annual Report 1904*, p. 15

⁸⁰ *Ibid*

⁸¹ www.nationalarchives.gov.uk/hospitalrecords: The National Archives Hospital Database: St Bartholomew’s Hospital, R. Porter, *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present*, (Fontana Press, London, 1999), p. 606

⁸² RFHA: *The Eighty-Sixth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1913*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), p. 18-19

treatments and general productivity. In 1885, the total number of in-patients was approximately 1,810.⁸³ This had increased to just over 2,220 by 1905, and to 2,500 by 1913, meaning that the sample for this study represents approximately one-fifth of annual in-patient numbers of the early twentieth century.⁸⁴ These figures are similar to the number of new in-patients treated at the Great Northern Central Hospital (which treated 2,165 new in-patients in 1911), the West London Hospital (2,422 in 1911), the Westminster Hospital (2,402 in 1911), and King's College Hospital (2,790 in 1911).⁸⁵ These general voluntary hospitals were all comparatively small, however, in relation to St George's (which treated 4,456 new in-patients in 1903 and 7,956 in 1911), St Bartholomew's (7,851 in 1911), Guy's (9,161 in 1911), and the London Hospital (which treated 12,460 in 1903 and 16,121 in 1911).⁸⁶ The number of out-patients who received advice and medicine at the RFH during 1885 was approximately 20,800, but this number more than doubled by 1905, when approximately 45,000 out-patients received treatment.⁸⁷ This meant that the hospital had a comparatively large out-patient department in relation to those which treated similar in-patient numbers. King's College Hospital (which treated 15,737 out-patients in 1906), the Westminster (23,266 in 1906), the Great Northern Central Hospital (30,236 in 1906), and the West London Hospital (34,652 in 1906), all treated less out-patients annually.⁸⁸ Even at St George's Hospital, which treated approximately three-times as many in-patients by the end of the first decade of the twentieth century, the number of out-patients treated in 1906 was only slightly higher than those treated at the RFH (47,766).⁸⁹ The larger general voluntary hospitals however, such as St Bartholomew's

⁸³ *Report, January, 1885*, p. 13

⁸⁴ *Eighty-Sixth Annual Report 1913*, p. 14, *Seventy-Eighth Annual Report 1905*, p. 15

⁸⁵ <http://www.hospitalsdatabase.lshtm.ac.uk>.

⁸⁶ *Ibid*

⁸⁷ *Report, January, 1885*, p. 13, *Seventy-Eighth Annual Report 1905*, p. 15

⁸⁸ <http://www.hospitalsdatabase.lshtm.ac.uk>.

⁸⁹ *Ibid*

(which treated 124,906 out-patients in 1906) and the London Hospital (224,380 in 1906), treated much larger out-patient numbers.⁹⁰

Whilst under treatment at the RFH, patients had to follow the rules and regulations or would be removed from the wards. When still the ‘London General Institution’, patients were to behave in a silent and orderly manner, keep their prescriptions under cover, and furnish themselves with Gallipots and Bottles to contain their medicine.⁹¹ By the first decade of the twentieth century there were many more in-patient regulations. Patients were expected to bring a change of linen, and were not get up from bed or leave the ward without permission.⁹² Patients were divided by sex and were to stay on their respective wards.⁹³ All convalescent patients were to assist on the wards when required to do so, and no conversation was allowed after 8.30 p.m.⁹⁴ Patients and their visitors were also forbidden to bring alcohol or any other provisions onto the wards of the hospital.⁹⁵ Howie’s work on the complaints procedure of early nineteenth century provincial hospitals has shown that these rules were not unique to the RFH, as many provincial hospitals implemented the same regulations.⁹⁶ Howie argued that it was appreciated from the beginning of the hospital movement that a procedure for complaints was essential in an environment where patients were confined for long periods of time, and ‘wholly at the mercy of those who cared for them’.⁹⁷ It was also acknowledged that if the institution had a bad reputation fewer donations would be made towards its upkeep, as the ‘standing of the hospital in its community was the keystone to its survival’.⁹⁸ Initial responsibility for the

⁹⁰ Ibid

⁹¹ *General and Committee Minutes*, p. 18

⁹² RFHA: *Rules and Regulations, 1904-1914*, (RFH/1/3/6/2), p. 70

⁹³ Ibid

⁹⁴ Ibid

⁹⁵ Ibid

⁹⁶ W. B. Howie, ‘Complaints and Complaint Procedure in the Eighteenth- and Early Nineteenth-Century Provincial Hospitals in England’, *Medical History*, Vol. 25, (1981), p. 347: At the Royal Salop Infirmary, Shrewsbury, patients were expected not to swear, play cards or dice, or obtain any provisions or liquor. They were expected to attend daily prayers and, if able bodied, work at the infirmary during their convalescence.

⁹⁷ Ibid, p. 345

⁹⁸ Ibid, p. 362

investigation of complaints in provincial hospitals lied with the house visitors only.⁹⁹ If any patient had cause for complaint at the RFH, however, they were to inform either the House Visitor, the Secretary, the Medical Officers, or the Lady Superintendent.¹⁰⁰ It would appear therefore, that patients had more ample opportunity to make formal complaints against the staff or institution than those patients at many other such institutions nationwide. Nevertheless, it would appear that complaints were reasonably rare, as it is stated in the Almoners Report of 1903, that ‘not a single case of complaint had been made during the past year to the Hospital Authorities, although every facility for so doing is afforded to the patients’.¹⁰¹

Financing the Royal Free Hospital

The RFH was financed in the main by a combination of annual subscriptions, donations, legacies, and the Hospital Sunday and Saturday funds. By 1853, twenty-five years after its foundation, the number of contributors who subscribed to the charity had risen from 926 in 1828, to 36, 214, with the total number of contributors in those twenty-five years being over 440,000.¹⁰² Any person who donated more than one guinea annually was entitled to become a Governor to the hospital and was entitled to one vote on the Committee of Management for every guinea subscribed, while any person who donated more than ten guineas became an immediate life governor.¹⁰³ Fundraising events, including Festival Dinner’s at the Freemasons’ Tavern, were held in honour of the hospital in order to attract more subscribers.¹⁰⁴ In 1863, Charles Dickens acted as Chairman to such a dinner, and stated in his address that ‘because people in general are, thanks God! disposed to be humane, and to do right and to do good, this great capital teems with institutions for the

⁹⁹ Howie, ‘Complaints’, p. 347

¹⁰⁰ *Rules and Regulations*, p. 70

¹⁰¹ *Seventy-Sixth Annual Report 1903*, p. 20

¹⁰² *Twenty-Seventh Annual Report 1855*, p. xx

¹⁰³ *General and Committee Minutes*, p. 3

¹⁰⁴ For an example of a Festival Dinner, see RFHA: *Report, January 1875, with List of the Governors and Subscribers: Annual Reports 1870-75* : Book A6 (RFH/1/2/2), p. 12

relief of the indigent sick'.¹⁰⁵ In qualifying why the public should donate specifically to the RFH, Dickens stated that the 'distinguishing character of the Royal Free Hospital is amply expressed in its simple name. It *is* a free hospital... no recommendation is needed by the suffering creature that seeks admission; no letter from a governor or subscriber has with difficulty to be hunted out.'¹⁰⁶ The amount of donations made varied annually, and often reflected the demands of other causes. In 1899, one of the many letters appealing for funds that appeared in *The Times* newspaper claimed that the hospital had suffered 'a considerable falling off in contributions owing to the pressing claims of the various war, [and] Indian famine'.¹⁰⁷ The National Insurance Act of 1911 also caused for the number of donations to the hospital to decrease.¹⁰⁸ Subscriptions were withdrawn or reduced as the Act made provision for medical treatment, 'the cost of which, under the Act, would be compulsorily provided for in the case of the majority of persons seeking relief at this Hospital'.¹⁰⁹

The total annual income of the RFH from subscriptions in 1908 was £1,495, a figure which of all the voluntary general hospitals in the capital was only lower at St Thomas'.¹¹⁰ A near identical sum was raised at the Westminster (£1,496), and slightly more at the Great Northern Central Hospital (£1,839) and King's College Hospital (£1,988), but the larger hospitals raised considerably more through subscriptions (St

¹⁰⁵ British Library: *Speech of Charles Dickens as Chairman of the Anniversary Festival Dinner of THE ROYAL FREE HOSPITAL, Held at the Freemason's Tavern, on the 6th May, 1863* (London: Wyman and Sons, Great Queen Street, Lincoln's-Inn Fields, W.C), p. 4

¹⁰⁶ *Ibid*, p. 5

¹⁰⁷ *Seventy-Third Annual Report 1900*, p. 15

¹⁰⁸ *Eighty-Sixth Annual Report 1913*, p. 15

¹⁰⁹ *Eighty-Sixth Annual Report 1913*, p. 15, RFHA: *The Eighty-Fourth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1911*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), p. 13,

¹¹⁰ Sir H. Burdett, *Hospitals and Charities 1910: A Year Book of Philanthropy and Hospital Annual*, (The Scientific Press Limited, London, 1910), pp. 166-7, and R FHA: *The Eighty-First Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1908*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), p. 16

George's raised £4,472 in 1908 whilst the London Hospital raised £14,179).¹¹¹ The annual income from donations, however, was more than even some of the larger hospitals of the metropolis. In 1908 the RFH made £2,567 from donations, which was more than that donated to St Bartholomew's (£1,670), the Westminster (£1,509), St George's (£2,055), and the West London Hospital (£1,096).¹¹² Whilst treatment was free, and no medical officer or servant of the institution were 'permitted to take any fee or reward either directly or indirectly' at the cost of losing their position, patients could still make donations through the use of street boxes.¹¹³ It was reported in 1860 that the hospital had received over £57 in the previous year through street box donations, a portion of which was made in farthings, the 'lowly gratuities of the poorest of poor'.¹¹⁴ In 1908 the hospital made £133 from street boxes, which was considerably more than that collected through such means for St Thomas's (£12), St George's (£81), and the Westminster (£53), but much less than that received by Guy's (£304), the Great Northern Central (£513), and the London Hospital (£818).¹¹⁵ The RFH was clearly a popular hospital amongst the general public, who donated generously to the charity in comparison to other similar sized hospitals of the capital.

Grants made by the Prince of Wales Hospital Fund were a further source of income throughout the nineteenth and early twentieth centuries.¹¹⁶ The Fund often made special grants towards structural improvements, such as in 1899 and 1900 when it gave £500 per year towards additions to the Nurses Quarters.¹¹⁷ On the death of Queen Victoria and the Succession of Prince Edward to the throne in 1901, the fund became the King Edward's Hospital Fund, which made a usual minimal annual subscription to the hospital of £750

¹¹¹ Burdett, *Hospitals*, pp. 166-7

¹¹² *Ibid*

¹¹³ *General and Committee Minutes*, p. 5, and RFHA: *Report, January 1860: Annual Reports 1859-63 : Book A4 (RFH/1/2/2)*, p. xix

¹¹⁴ *Report, January 1860*, p. xix

¹¹⁵ Burdett, *Hospitals*, pp. 166-7

¹¹⁶ For information on the King's Fund, see: Prochaska, *Philanthropy*

¹¹⁷ *Seventy-Third Annual Report 1900*, p. 13

and often made additional special donations.¹¹⁸ In 1908 the RFH received £2,000 from the King's Fund plus a special additional donation of £1,500 which was to be used towards the construction of new operating theatres.¹¹⁹ In comparison to other general hospitals of London, however, the £2,000 donation by the Fund was amongst the smallest it made (the Westminster also received £2,000 in 1908), as others received between £3,000 and £12,000 during the same year.¹²⁰ The RFH was also the recipient of money from contributory schemes, including the Metropolitan Hospital Sunday Fund and Hospital Saturday Fund. The Sunday Fund raised money by initiating special church collections in over 1,800 congregations on a designated Sunday in June of each year.¹²¹ Prochaska claims that the Sunday Fund was collecting approximately £40,000 a year by the mid-1890s.¹²² During 1885, the hospital received just over £1,200 from the Fund and in 1908 this number had increased to £1,462.¹²³ The Saturday Fund was set up in the 1870s and raised money from the working-classes, 'through workshop, factory, and street collections on payday', and made around £20,000 a year by the later 1890s.¹²⁴ According to Porter, such insurance schemes were a part of the working people establishing their 'right' to hospital admission, as they arranged for admission tickets to hospitals for those who made contributions.¹²⁵ Of course at the RFH, no system of admission tickets existed in the first place. During 1885,

¹¹⁸ RFHA: *The Seventy-Forth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1901*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 13, RFHA: *The Seventy-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1902*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 15, *Seventy-Eighth Annual Report 1905*, p. 19

¹¹⁹ *Eighty-First Annual Report 1908*, p. 16

¹²⁰ Burdett, *Hospitals*, pp. 166-7

¹²¹ Prochaska, *Philanthropy*, p. 10

¹²² *Ibid*

¹²³ Burdett, *Hospitals*, pp. 166-7, *Report, January, 1885*, p. 22

¹²⁴ Prochaska, *Philanthropy*, p. 10

¹²⁵ Porter, *The Greatest*, p. 380, and A. Tomkins, "The excellent example of the working class': Medical welfare, contributory funding and the North Staffordshire Infirmary from 1815', *Social History of Medicine*, Vol. 21, No. 1, (2008), pp. 13-30

the hospital received just over £230 from the Saturday Fund and in 1908 this had risen to £308.¹²⁶

By far the largest means of income during the early twentieth century was from legacies, which were funds left to the hospital on the death of charitable individuals. Legacies were a constant but fluctuating source of income, though often provided the majority of annual income by the late nineteenth century.¹²⁷ In some cases, the legacies left came with terms respecting their use. The Dresden Assistance Fund was established in 1904 through a bequest left to the hospital in the Last Will and Testament of Mr Dresden, of a one-fifth share in the residue of his estate (estimated to realise about £35,000), with the intention of re-establishing the health of ‘needy poor in-patients’.¹²⁸ The Fund was used for such means as to provide patients with treatment at convalescent homes, provide medical appliances and warm clothing, and occasionally for treatments including the use of Mineral Waters.¹²⁹ In 1908 the legacies amounted to £6,606, which was a respectable figure given the hospitals relatively small size.¹³⁰ In relation to the total annual ordinary income by the early twentieth century (ordinary income sources were all of those excluding legacies and donations for special purposes), which in 1908 amounted to £9,327, the extraordinary income from legacies were vital to the hospitals survival.¹³¹

The London School of Medicine for Women

¹²⁶ Burdett, *Hospitals*, pp. 166-7, *Report, January, 1885*, p. 22

¹²⁷ Reinartz, ‘Charitable bodies: The funding of Birmingham’s voluntary hospitals in the nineteenth century’, in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), p. 41, RFHA: *Report of the Committee of Management for the Year 1890, with Accounts, Medical Reports and a List of the Governors: Annual Reports 1890-94: Book A10 (RFH/1/2/2)*, p. 13, *Seventieth Annual Report 1897*, p. 13, *Twenty-Seventh Annual Report, 1855*, p. xvii

¹²⁸ RFHA: *Dresden Assistance Fund Report Book, February 1904-June 1947*, (RFH/6/CF/1), pp. 2 -8, *Seventy-Seventh Annual Report 1904*, p. 20, *Seventy-Eighth Annual Report 1905*, p. 21

¹²⁹ *Seventy-Eighth Annual Report 1905*, p. 23

¹³⁰ Burdett, *Hospitals*, p. 166

¹³¹ *Ibid*

The London School of Medicine for Women (henceforth the LSMW) was a pivotal part of the hospital's identity and needs to be discussed in order to place the RFH in the wider medical community of London at the turn of the twentieth century. On the hospital's foundation in 1828, the rules and regulations stated that no medical officers were to take pupils to the establishment.¹³² This attitude towards medical teaching on the wards of the hospital had changed dramatically by the mid-century, when in 1854 preliminary steps were taken by the Committee to establish a medical school, but no sufficient accommodation was available on the premises.¹³³ The plan to incorporate medical teaching onto the wards was invariably left on hold, until the hospital was approached by supporters of the LMSW. In 1874 the School was founded by a small group of men and women, led by Sophia Jex-Blake.¹³⁴ It was situated in a small rented house near Brunswick Square, and offered courses in anatomy, physiology, and chemistry.¹³⁵ Three years later, after much lobbying by the School's supporters including Charles Darwin, Lord Shaftesbury, and Thomas Huxley, the RFH agreed to provide clinical teaching to the students on its wards, making it the first hospital in England to provide such a service to women.¹³⁶ By 1896, the Council of the LMSW proposed to officially incorporate the School with the hospital, and in 1898 it was incorporated under the 'Companies Act', and the name was subsequently changed to the 'London (Royal Free Hospital) School of Medicine for Women' (henceforth the SMW).¹³⁷

The number of students attending the SMW had risen dramatically by the early twentieth century. In 1881, the then LSMW had twenty students, but by 1890, this number had risen to 115, of whom thirty-four entered at the commencement of the Winter Session

¹³² *General and Committee Minutes*, p. 4

¹³³ *Twenty-Seventh Annual Report 1855*, p. xviii

¹³⁴ Amidon, *An Illustrated History*, p. 32, Porter, *The Greatest*, pp. 356-8; For more on how women entered the profession see: Waddington, *Medical Education*, pp. 296-307

¹³⁵ *Ibid*

¹³⁶ *Ibid*

¹³⁷ *Seventy-First Annual Report 1898*, p. 15, *Sixty-Ninth Annual Report 1896*, p. 15,

of 1890-91.¹³⁸ By 1894 the School had 150 students, and twenty-five of these went on to qualify as Medical Practitioners.¹³⁹ At the close of 1899, the school had 216 students, though this number shrank by 1908 to 146, and in 1912 stood at 179.¹⁴⁰ Many of the students of the SMW went on to present themselves for examinations at the University of London and the University of Ireland, achieving distinguished grades and medals.¹⁴¹ By 1909, women medical students could present themselves for examinations at the Royal College of Physicians and the Royal College of Surgeons, after the SMW was recognised by the examining boards.¹⁴² It was not until 1948, with the arrival of the National Health Service, that the first two male students were admitted to the School, and the name was consequently changed to the 'Royal Free Hospital School of Medicine'.¹⁴³

As the female students received medical instruction on the wards, they would have been involved in the examination and treatment of many of the patients recalled in the sample records. From 1901 the RFH hired female graduates of the SMW for six month periods as House Physicians and Surgeons.¹⁴⁴ The annual report of 1902 lists Miss Turnbull as House Surgeon, along with Miss Hamilton as House Physician.¹⁴⁵ There were also female staff members holding the positions of Assistant Physician for Disease of Women and Curator of Museum, Anaesthetist, Medical Registrar, Surgical Registrar, Clinical and Assistant Pathologist, Medical Electrician, Matron, Housekeeper, and female Nurses and Almoning team.¹⁴⁶ By 1912 there was also a female Superintendent of Physical

¹³⁸ RFHA: *Report, January, 1881, with List of the Governors and Subscribers: Annual Reports 1881-85: Book A8 (RFH/1/2/2)*, p. 13, *Report, January, 1885*, p. 14, *Report of the Committee 1890*, p. 15

¹³⁹ RFHA: *The Sixty-Eighth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1895: Annual Reports 1895-99 : Book A11 (RFH/1/2/2)*, p. 15

¹⁴⁰ *Eighty-Fifth Annual Report 1912*, p. 17, *Seventy-Third Annual Report 1900*, p. 18

¹⁴¹ *Report of the Committee 1890*, p.16

¹⁴² RFHA: *The Eighty-Second Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1909: Annual Reports 1905-10 : Book A13 (RFH/1/2/2)*, p. 18

¹⁴³ Amidon, *An Illustrated History*, p. 34

¹⁴⁴ *Seventy-Forth Annual Report 1901*, p. 15

¹⁴⁵ *Seventy-Fifth Annual Report 1902*, pp. 8-9

¹⁴⁶ *Ibid*

Exercise and Massage, In Patient Masseuse, and Obstetric Assistant.¹⁴⁷ It was a former student of the School, Miss Woodward, M.D., who was listed as Clinical and Assistance Pathologist in 1906, as Curator of the Museum in 1907, and as Curator and medical Registrar in 1908, who became the first woman to be admitted as a member of the Royal College of Physicians.¹⁴⁸ Although female staff such as nurses would have been a common sight in general hospitals, patients would not have experienced treatment from female medical students anywhere other than the RFH. According to Waddington it was not until the First World War that seven of the twelve London hospital schools admitted female clinical medical students from the SMW, due mainly to a mixture of staff shortages and falling incomes.¹⁴⁹

The Staff of the Royal Free Hospital

The medical and surgical staffing of the RFH developed extensively over the course of the nineteenth century to match the developing medical and surgical approaches and treatment techniques. The initial medical staff of the Institution consisted of only one Consulting Physician, Consulting Surgeon, Surgeon, Assistant Surgeon, and Resident Apothecary.¹⁵⁰ While the Surgeon and Assistant Surgeon were to attend the establishment daily, the Consulting staff members were only to visit the institution at least once per week.¹⁵¹ This was a small team, even in comparison to the initial staff of hospitals founded nearly a century earlier (the Middlesex, founded in 1745, had a physician, three surgeons, and an assistant surgeon soon after opening).¹⁵² In 1849, the medical staff of the Institution consisted of little more than one physician, three surgeons, a dentist, a cupper, and an

¹⁴⁷ *Eighty-Fifth Annual Report 1912*, pp. 8-9

¹⁴⁸ *Eighty-Second Annual Report 1909*, p. 18

¹⁴⁹ Burdett, *Hospitals*, p. 215-222, Waddington, *Medical Education*, p. 303

¹⁵⁰ *General and Committee Minutes*, p. 3

¹⁵¹ *Ibid*, p. 4

¹⁵² Dainton, *The Story*, p. 78

apothecary.¹⁵³ By 1890 the staff had grown considerably to include over sixteen physicians, surgeons, and assistants, as well as an anaesthetist and registrar.¹⁵⁴ The Registrar was appointed in 1888, which was reported to have resulted in a ‘much more complete record being kept of the patients’ diseases treated, and has proved a great advantage post to the Medical Staff and Students’.¹⁵⁵ This appointment may well be the reason behind why the surviving patient case records date from 1890. The hospital had also formed a Drugs Committee, which examined and reported on drug samples supplied to the hospital.¹⁵⁶ It was also the first general hospital to appoint a female physician as a permanent member of the medical staff. Dr. Mary Scharlieb was appointed Physician for the Diseases of Women in 1902, and held the post until her retirement in 1908 when she became a Consulting Physician.¹⁵⁷ By 1910 the hospital had numerous specialist staff, including an Ophthalmic Surgeon, a Surgeon for the Diseases of the Throat, Nose, and Ear, a Surgeon for the Diseases of the Skin, and a Radiographer and Medical Electrician.¹⁵⁸

Although the medical staff were an essential part of patient treatment, more daily contact would have been had with nursing staff, who would have carried out most of the patient care and thus shaped their experience of hospital life. The nurses were employed through the British Nursing Association until June 30th 1884, when the Association terminated their agreement with the hospital.¹⁵⁹ As a result, the RFH made careful inquiries into how other London hospitals managed their nursing staff and decided it possible to undertake its own nursing, but kept the majority of the nurses which had been employed through the Association.¹⁶⁰ The scale of the nurse’s wages was revised so that they were in accordance with those at other hospitals and they were provided with uniforms free of

¹⁵³ *Report 1849*, p. vii

¹⁵⁴ *Report of the Committee 1890*, p. 6

¹⁵⁵ *Ibid*, p.14

¹⁵⁶ *Report, 1881*, p. 14

¹⁵⁷ *Eighty-First Annual Report 1908*, p. 19, *Seventy-Fifth Annual Report 1902*, pp. 8, 18 and 19

¹⁵⁸ *Eighty-Third Annual Report 1910*, pp. 8-9

¹⁵⁹ Porter, *The Greatest Benefit*, p. 379, Report, January, 1885, p. 14

¹⁶⁰ *Ibid*

charge, which up to that point had been paid for by the nurses themselves.¹⁶¹ The Committee of Management appointed a Miss Carberry as Lady Superintendent of Nursing, a role which she had already filled for some years under the British Nursing Association.¹⁶² By the late 1880s the Trained Nurses' Institute was founded at the hospital, which employed twelve nurses by 1890, all of whom were trained in the RFH.¹⁶³ By 1901 the hospital employed forty-eight nurses, exclusive of the Matron.¹⁶⁴ Upon the resignation of Miss Wedgwood, the position of Matron was filled by Miss Cox Davies in 1905, formerly the Matron of the New Hospital for Women.¹⁶⁵ At the end of 1911, the nursing staff consisted of sixty-four members, excluding the Matron, Assistant Matron, and Sister Housekeeper.¹⁶⁶ These members consisted of twelve Sisters, fifty-two Nurses, one Maternity (District) Nurse and one Supernumerary Nurse.¹⁶⁷

As well as physicians, surgeons, and nurses, the patient experience of the RFH would have been shaped by an array of other staff members currently omitted from the historiography. As discussed in the previous section, medical students of the SMW would have been involved in patient treatment, often taking up responsibilities as dressers.¹⁶⁸ Administrative staff including the medical officer, clerk, and registrar, were essential to the running of the hospital, as were the staff which worked towards the general upkeep, such as the housekeeper, porter, engineer, and male servant staff. Working away from the ward were staff whom the patients would not have had contact, but whose work was an important aspect of their treatment. The pharmacist and dispenser ensured patients could receive correct drugs and medicines, whilst the pathologist worked to identify abnormalities in bodily samples. Visitors also played an important role in the daily routine

¹⁶¹ Ibid

¹⁶² Ibid

¹⁶³ *Report of the Committee 1890*, p.17

¹⁶⁴ *Seventy-Forth Annual Report 1901*, p. 16

¹⁶⁵ *Seventy-Eighth Annual Report 1905*, p. 21

¹⁶⁶ *Eighty-Fourth Annual Report 1911*, p. 20

¹⁶⁷ Ibid

¹⁶⁸ 'Regulations for Casualty Dressers' and 'Directions for Dressers and Regulations for Students' in *Rules and Regulations*, pp. 22 and 28

of the hospital. The Chaplain offered religious support and moral guidance, and thanks to gifts made by the London City Mission, could provide patients with bibles upon leaving the hospital.¹⁶⁹ The Ladies' Association and Visiting Committee also became a valuable source of patient assistance. The aims of the Committee members was to 'promote the objects of the Royal Free Hospital', by collecting presents, either in money or in kind, for the use of the hospital, and providing garments for the use of the patients.¹⁷⁰ By 1903, the Association comprised of Members and Associates. Members undertook 'to give, or collect, at least One Guinea in each year towards the funds of the Hospital', while Associates strived to collect five shillings for the purposes of the charity.¹⁷¹ Members of the Committee visited the wards and administered the Samaritan Fund.¹⁷² The RFH was not unique in the presence of a Samaritan Fund, as other such funds existed at other hospitals by the early twentieth century (including St Bartholomew's and St Thomas's hospitals).¹⁷³ Funds at the hospital were used to purchase comforts for the use of the in-patients, including 'Easy Invalid Chairs, Dressing Gowns, and warm clothing'.¹⁷⁴ During 1894, 152 patients were sent to convalescent homes through the organisation of the Committee and the newly appointed Lady Almoner.¹⁷⁵ The Committee also established a Tea and Coffee Stall in the Out-patient Department, where refreshments could be purchased at low prices, but were free for those patients proved to be too poor to contribute towards their medical treatment.¹⁷⁶

In 1894 the RFH became the first hospital in Britain to appoint a Lady Almoner, a position created as a result of the alleged abuse of the Out-patient Department by patients

¹⁶⁹ *Report, January 1860*, p. xvii

¹⁷⁰ *Rules and Regulations*, p. 80, RFHA: *Ladies Association Minutes 1902-1929*, (RFH/6/CF/3), pp. 1-5, *Seventy-Sixth Annual Report 1903*, p. 24

¹⁷¹ *Ibid*

¹⁷² *Sixty-Eighth Annual Report 1895*, p. 17

¹⁷³ Burdett, *Hospitals*, pp. 282 and 288

¹⁷⁴ *Ibid*

¹⁷⁵ *Ibid*

¹⁷⁶ *Sixty-Eighth Annual Report 1895*, p. 17

who were able to pay for medical advice and treatment elsewhere. In response, the Managing Committee of the hospital arranged for the Charity Organisation Society (henceforth C.O.S.) to investigate the circumstances of the patients applying for treatment.¹⁷⁷ Miss Mary Stewart, an experienced member of the C.O.S., was appointed almoner to the out-patient department in order that any abuses of the charitable system of relief might be prevented.¹⁷⁸ Stewart retired from the position in 1899 due to ill-health and the vacancy was filled by Miss Brimmell.¹⁷⁹ By 1905, the work of the Almoner's Department had increased to such an extent that it was necessary to appoint a second almoner, Miss Lucy, and by 1911 a Miss Hamilton is also appointed to the post.¹⁸⁰

The almoners' role was essentially to act as a gatekeeper to the hospital, means testing patients in order to determine whether they were eligible for free medical treatment, and made to make a contribution towards their care if they were found to be able to afford to do so. The position also entailed the organisation of out-patient treatment beyond the means of the RFH. The almoner acted as a link between the hospital and other means of medical care, such as by arranging convalescent care for patients or by introducing relevant cases to other charitable agencies, such as the Invalid Children's Aid Association, the Clergy, the Provident Medical Association, and friendly societies.¹⁸¹ As of the 1880s, the Worshipful Company of Merchant Taylors often donated places at their convalescent home at Bognor to the hospital, which the almoner would distribute at her discretion.¹⁸² The Office also trained almoners for other institutions, such as Miss Mudd, who worked with the department for six months in order to gain the practical experience required to take up her duties at St. George's Hospital.¹⁸³ While it was not possible for the almoner and her

¹⁷⁷ *Report, January 1875*, p. 12

¹⁷⁸ *Sixty-Eighth Annual Report 1895*, p. 14

¹⁷⁹ *Seventy-Second Annual Report 1899*, p. 19

¹⁸⁰ *Eighty-Fourth Annual Report 1911*, p. 59, *Seventy-Eighth Annual Report 1905*, p. 24

¹⁸¹ *Seventy-Eighth Annual Report 1905*, p. 24

¹⁸² *Report, January, 1881*, p. 14

¹⁸³ *Seventy-Second Annual Report 1899*, p. 19

team to interview and assess the means of every out-patient, it was considered that the knowledge that such inquiries took place acted as a deterrent to those who would potentially abuse the system of free medical relief.¹⁸⁴ Nevertheless, by 1900 Miss Brimmell and her team interviewed 7,138 of the 16,270 out-patients treated at the hospital, and claimed that of those patients interviewed the percentage of cases considered unsuitable for continued charity had declined from thirty percent in 1895, to fifteen percent in 1900, and to nine percent in 1901.¹⁸⁵ However, these numbers do not necessarily include all of the patients the almoner and her team visited in their own homes.¹⁸⁶

The Staff of the Sample Records

Whilst it is important to recognise the variety of staff employed at the RFH, the sample method of this study is based on the patient records of the two physicians, Harrington Sainsbury and John W. Carr, and the two surgeons, Sir James Berry and Edmund W. Roughton. In order to understand the medical approaches and treatments ordered by these men at the RFH, it is first vital to understand their personal and professional backgrounds.

Dr. Harrington Sainsbury (1853-1937) received the majority of his early medical education on the continent, before joining the medical school of University College Hospital, London, in 1875 at the age of twenty-two.¹⁸⁷ In 1879 he graduated as M.B. with honours in forensic medicine at the University of London, and in 1880 proceeded to the M.D. degree.¹⁸⁸ Before joining the staff of the RFH as Assistant-Physician in 1885, he had worked as House-Physician at Pendlebury, Manchester, and as a Clinical-Assistant at the

¹⁸⁴ Ibid

¹⁸⁵ *Seventy-Third Annual Report 1900*, p. 27, *Seventy-Forth Annual Report 1901*, p. 19

¹⁸⁶ *Seventy-Fifth Annual Report 1902*, p. 23

¹⁸⁷ 'Obituary: Harrington Sainsbury', *The Lancet*, Vol. 229, Issue 5915, (9 January 1937), p. 115

¹⁸⁸ Ibid

Great Ormond Street Children's Hospital.¹⁸⁹ While on the staff of the RFH, he was also physician to the City of London Hospital for Diseases of the Chest, Victoria Park, as of 1886, and was examining physician to the Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.¹⁹⁰ Sainsbury became a physician to the RFH later in the 1880s and retired from position in 1913 after reaching the age limit for service upon the active staff, and instead became a Consulting Physician for his remaining years.¹⁹¹ During his career, Sainsbury was most well known for his work in the field of cardiology, and for his interest into the constitutional action of many pharmaceutical remedies. His work on pharmaceuticals began early in his career, as in 1882 he wrote in collaboration with Sidney Ringer and later contributed to his 'Handbook of Therapeutics'.¹⁹² In 1906, he published the small text-book 'Drugs and the Drug Habit', which set out the theories underlying medical treatment by drugs to an audience of lay public.¹⁹³ In 1909, he published 'Principia Therapeutica', which aimed to warn clinicians of being 'engulfed in the flood of new remedies'.¹⁹⁴

Dr. John Walter Carr (1862-1942), was born in London and educated at University College School and Hospital.¹⁹⁵ He qualified in 1884, and took his London degree in the following year with first-class honours in medicine, surgery and midwifery.¹⁹⁶ A member of both the Royal College of Physicians and of the Royal College of Surgeons, he had a keen interest in all departments of medicine.¹⁹⁷ He worked with the diseases of the chest at the Brompton under Douglas Powell, and with diseases of the nervous system at University College Hospital under Charlton Bastian.¹⁹⁸ In 1889 Carr took up the honorary

¹⁸⁹ 'Obituary: Harrington Sainsbury', *The Lancet*, p. 115, *Sixty-Eighth Annual Report 1895*, p. 13

¹⁹⁰ 'Obituary: Harrington Sainsbury', *Tubercle*, Vol. 18, Issue 6, (March 1937), p. 279

¹⁹¹ *Eighty-Sixth Annual Report 1913*, pp. 17-18

¹⁹² 'Obituary: Harrington Sainsbury', *The Lancet*, p. 115

¹⁹³ *Ibid*

¹⁹⁴ *Ibid*, H. Sainsbury, *Principia Therapeutica*, (Methuen & Co., London, 1906)

¹⁹⁵ 'Obituary: John Walter Carr', *The Lancet*, Vol. 240, Issue 6216, (17 October 1942), p. 470

¹⁹⁶ *Ibid*

¹⁹⁷ *Ibid*

¹⁹⁸ *Ibid*

appointment of Assistant-Physician to the Victoria Hospital in order to gain experience in the treatment of children, and in 1893 undertook the same position at the RFH, where he treated all manner of complaints and diseases.¹⁹⁹ In his works ‘Medical Ambitions and Ideals’ and ‘A Medical Utopia’, he set out the dangers he foresaw in a state run medical service, and the ‘tonsil-less, appendix-less, vaccine-filled being which this benevolent autocracy might be expected to produce’.²⁰⁰ Carr was awarded the CBE in recognition of his work at the hospital for officers carried out at the RFH during the First World War, and served as Censor to the Royal College of Physicians from 1926-28.²⁰¹

Sir James Berry (1860-1946) was a Surgeon to the RFH from 1888-1919, but was also a well renowned traveller, linguist, and archaeologist.²⁰² In 1882 he took the conjoint qualification at St. Bartholomew’s Hospital, and in 1885 graduated B.S, and obtained the F.R.C.S.²⁰³ He acted as House-Surgeon at St. Bartholomew’s, Surgeon to the Elizabeth Garrett Anderson Hospital, and was on the staff of the Alexandra Hospital for Diseases of the Hip, before joining the staff of the RFH.²⁰⁴ In 1890 he was appointed Surgeon with charge of in-patients at the hospital, and was Superintendent of the museum.²⁰⁵ Berry was known internationally as the pioneer of surgery for cleft palate and hare lip and for the operation of goitre, and in 1912 published the related ‘Harelip and Cleft Palate’.²⁰⁶ His medical interests also included the diseases of the thyroid gland and the use of plastic surgery.²⁰⁷

Edmund Wilkinson Roughton (c. 1863 – 1913) was educated at St Bartholomew’s and at the University of London.²⁰⁸ In 1883 he took the membership of the Royal College

¹⁹⁹ Ibid

²⁰⁰ Ibid

²⁰¹ Ibid

²⁰² ‘Obituary: Sir James Berry’, *The Lancet*, Vol. 247, Issue 6395, (23 March 1946), p. 444

²⁰³ Ibid

²⁰⁴ Ibid

²⁰⁵ Ibid

²⁰⁶ Amidon, *An Illustrated History*, p. 120

²⁰⁷ ‘Obituary: Sir James Berry’, p. 444

²⁰⁸ ‘Obituary: Edmund Wilkinson Roughton’, *The Lancet*, Vol. 181, Issue 4686, (21 June 1912), pp. 1775-6

of Surgeons of England and obtained the gold medal for medicine at the final examination for the M. D. Lond. degree, the gold medal in obstetric medicine for the M. B. degree, and the gold medal in surgery and the University scholarship at the examination for the B.S. degree.²⁰⁹ Roughton held a junior appointment at St Bartholomew's before taking up a Fellowship at the Royal College of Surgeons in 1886.²¹⁰ In 1890 he became demonstrator of anatomy at St. Mary's hospital and was appointed assistant surgeon at the RFH to take charge of out-patients.²¹¹ At the RFH he became a lecturer on surgery for the SMW, surgeon in charge of the Throat and Ear Department, and in 1904 became the surgeon in charge of in-patients.²¹² He also became a visiting surgeon to the National Dental Hospital, and in 1898 wrote a Text-Book of Diseases of the Mouth.²¹³

It is clear that all four of these medical men were well established and well respected members of the profession by the time they served on the staff of the hospital. Their educations and career paths were quite typical of medical professionals of this period, having moved between posts at various institutions. The awards and achievements they amassed, however, marked them out as outstanding students with a well-rounded knowledge of medicine and great potential in their respective specialist areas of interest. Patients at the RFH were evidently under the treatment of physicians and surgeons at the very top of their fields.

Concluding Remarks

Overall, the RFH was an extremely important central London voluntary hospital of the nineteenth and early twentieth centuries. The institution was the first to admit patients without the use of subscriber's letters of recommendation, and to provide free treatment to

²⁰⁹ Ibid, p. 1775

²¹⁰ Ibid

²¹¹ *Report of the Committee 1890*, p. 15

²¹² *Seventy-Seventh Annual Report 1904*, p. 19

²¹³ 'Obituary: Edmund Wilkinson Roughton', p. 1775

those patients who were considered to be of good moral character but unable to afford private medical care. Financed primarily by benevolent donations and legacies, the hospital was a popular and fashionable charitable cause, having attracted influential supporters such as Charles Dickens. The institution stood out from others with an initial admissions policy which favoured women who suffered from venereal disease. Given that the dispensary was founded in an era of hospital specialisation, however, this policy is perhaps not surprising.²¹⁴ The hospital underwent a typical period of development during the nineteenth century, witnessed by many other hospitals of the capital and the provinces alike that sought to expand and modernise. Although the hospital remained one of the more modest sized medical institutions of London, it boasted a comparatively large out-patient department by the late nineteenth century. By this period, the admissions policy and treatment facilities had developed to include patients who suffered from a wide range of ailments and disorders. Like all other general hospitals, however, it continued to refuse treatment to those who suffered complaints of the dangerous, contagious nature.

Whilst the RFH was representative of other voluntary hospitals of the nineteenth century in terms of its administration and finance, it was extraordinary and progressive in terms of its attitudes towards women in the medical profession. Having been the first general hospital to associate itself with the medical education of women through the LSMW, the hospital stood apart from other institutions in a period when sexist attitudes and beliefs prevented women from entering the profession. In a similar move, the RFH became the first general hospital to appoint a female physician to a permanent post, by hiring Mary Scharlieb as Physician for the Diseases of Women in 1902. Moreover, although not a medical post, the hospital also became the first to appoint a Lady Almoner in 1895. The appointment and presence of Mary Stewart marked a shift in the attitudes towards who was considered morally and financially eligible for free hospital medicine and

²¹⁴ Dainton, *The Story*, Chapter VI

treatment. The appearance of almoners (often trained at the RFH) at other voluntary hospitals across the country is a testament to the training and performance of the first almoners at a hospital which was ahead of its time. The patient records do not provide enough detail on the specific role of these women for this study to focus on them, but their importance will be expressed throughout later chapters.

The history of the hospital contained in this chapter provides an indication as to the information we might expect to find in the patient case records, particularly in terms of the patient typology and disease profile. Given that the RFH was well known for being a free hospital for poor patients who needed no letter of recommendation in order to be admitted, it is reasonable to expect to find patients who could not afford to pay for medical treatment elsewhere. That said, the presence of the almoner suggests that some of these patients were believed by hospital officials to have been in the position to afford such treatment. It would also be logical to expect to find patients who were being treated for conditions which related to the specialism's of the medical staff, or perhaps those considered to be interesting teaching cases for the students of the SMW. At this stage the types of patients and the conditions from which they suffered can only be speculated. These topics will be examined in the coming chapters, taking into consideration the history of the hospital discussed here. To begin, the following chapter will examine the identity of the patients in the sample case records. Knowing the identity of the patient base will help us to understand the type of ill-health patients suffered, and will allow us to better place the RFH in the wider medical market of London by examining how patients made use of the hospital in relation to other means of medical assistance.

CHAPTER THREE

PATIENT IDENTITY

Patient identity has been a seriously neglected aspect of medical history.¹ We know little of patients on an individual level or of the collective patient base of hospitals (and of other institutions) during the early twentieth century. It is essential, however, that we establish who the patients of the Royal Free Hospital were, in order to understand why they suffered from particular forms of ill-health, and how they made use of the hospital in relation to the wider medical market. We cannot fully explore the treatments the patients received at the hospital or the conduct and relationship between the patient and the practitioner unless we recognise the different people who sought medical aid.

For the most part, historians have tended to discuss the ‘patient’ in statistical terms, by acknowledging and including the patient in the history of the medical tradition, but rarely attempting to understand the person or peoples behind the term. As discussed in the introduction to this study, Bynum has suggested that in the history of twentieth century medicine only two types of patient have been discussed, those who contributed to contemporary medical discovery and those whose ills were viewed by doctors in retrospect.² Similarly, Digby has claimed that the historiography of women as patients has

¹ The few works which have discussed the patient include: D. Armstrong, ‘The Doctor-patient Relationship: 1930-80’, in P. Wright and A. Treacher (Eds.), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine*, (Edinburgh University press, Edinburgh, 1982), pp. 109-122, W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge University Press, Cambridge, 1994), A. Digby, *Making a Medical Living; Doctors and patients in the English market for medicine, 1720-1911*, (Cambridge University Press, Cambridge, 1994), M. E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, (Cambridge University Press, Cambridge, 1991), L. Granshaw, ‘The rise of the modern hospital in Britain’, in A. Wear (Ed.), *Medicine in Society: Historical Essays*, (Cambridge University Press, Cambridge, 1992), S. C. Lawrence, *Charitable Knowledge: hospital pupils and practitioners in eighteenth-century London*, (Cambridge University Press, Cambridge, 1996), R. Porter, ‘The patient in England, c. 1660 – 1800’, in A. Wear (Ed.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 91 – 118, R. Porter, ‘The rise of physical examination’, in W. F. Bynum and R. Porter (Eds.), *Medicine and the five senses*, (Cambridge University Press, Cambridge, 1993), pp. 179 – 197, G. B. Risse, ‘Hospital History: New Sources and Methods’, in R. Porter and A. Wear (Eds.), *Problems and Methods in the History of Medicine*, (Croom Helm, New York, 1987), p. 175-204, E. Shorter, *Doctors and Their Patients: A Social History*, (Transaction Publishers, London, 1993)

² Bynum, *Science*, p. 208

focused either on ‘clinical progress, heroic endeavours of male doctors, and ensuing benefits to women’ or on ‘the sexual politics of sickness and the exploitative, self-interested nature of doctors’ interventions’.³ Indeed, historians such as Armstrong and Lawrence have only discussed patients in terms of how they were objectified by the medical profession in the clinical hospital setting, whilst Fissell and Granshaw have examined the changing importance of patient narrative in the process of diagnosis.⁴ As a result of these types of histories, patients have tended only to have been discussed in relation the ‘great men’ of the hospital, and have not been the focus of their own history.⁵ The nature of patient admission, treatment, discharge, and their experience of institutional confinement remains a mystery, as hospital histories have ignored the prominent issues that resulted from hospitalisation.⁶

In 1992 Porter claimed that whilst the history of the sick ‘cannot be written in the same sequential way in which one tells the chronicle of medicine and doctors’, patients still deserved a history in their own right.⁷ By 1994 Bynum claimed that the ‘process of trying to recapture what it was like to be a more ordinary patient has now begun’.⁸ Since that time, however, the work of only a small number of historians has addressed specific groups of patients in history since the eighteenth century. Shorter and Digby have both drawn attention to women and children as patients.⁹ Shorter claimed that in the nineteenth century women and children started to see the doctor for the first time.¹⁰ These patients were so numerous that they became the ‘keystone of modern medical practice’, a point echoed by Digby who emphasised the importance of the expanding field of gynaecology to

³ Digby, *Making a Medical*, p. 259

⁴ Armstrong, ‘The Doctor-patient’, pp. 109-122, Fissell, *Patients*, p. 149, Granshaw, ‘The rise’, pp. 202-3, Lawrence, *Charitable Knowledge*, pp. 26-7

⁵ Porter, ‘The patient’ pp. 91 – 118, Porter, ‘The rise’, pp. 179 – 197

⁶ Risse, ‘Hospital History’, p. 175

⁷ Porter, ‘The patient’, p. 91

⁸ Bynum, *Science*, p. 208

⁹ Digby, *Making a Medical*, p. 259, Shorter, *Doctors*, pp. 109-114

¹⁰ Shorter, *Doctors*, pp. 109-110

women patients during the nineteenth century.¹¹ Other historians have used case studies as a means of bringing the patient into the focus of history. In Risse's discussion of the medicalisation of the hospital, he reconstructed the ill-health experienced by a tailor in the late eighteenth century.¹² The interaction between twenty-seven-year-old Johann Duschau and the hospital is one of the only attempts in the historiography to personalise the patient in order to understand the choices people made in regards to their medical care. Similarly, Jacyna has discussed the transmission of medical knowledge from professional to lay contexts by using the example of James Scott, a thirty-four-year-old Edinburgh accountant, who sought treatment from various consultants for loss of strength in his limbs.¹³ Jacyna argued that the physical examination was not simply a tool of medical intrusion and power, but was a means of diagnosis thought credible by the patient, and one they expected be performed on them as part of a thorough examination.¹⁴

Beyond these few works of the early 1990s there has been little attempt to bring the patient to the forefront of medical history.¹⁵ Digby stated in 1999 that we 'still know relatively little about sickness behaviour in the distant past – the characterization of illness, the preferences of sufferers, and conventions governing behaviour'.¹⁶ Today we still know extremely little about the identity of hospital patients and their use and experience of medical institutions. This chapter will address the gap in the historiography by examining the identity of the patient base of the Royal Free Hospital (henceforth the RFH) during the early twentieth century. No previous study has used patient case records to reconstruct the patient base of an institution. The sample records provide a unique insight into the people

¹¹ Digby, *Making a Medical*, p. 254, Shorter, *Doctors*, p. 110

¹² G. B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford University Press, Oxford and New York, 1999), pp. 257-9

¹³ S. Jacyna, 'Mr Scott's Case: A View of London Medicine in 1825', in R. Porter (Ed.), *The Popularization of Medicine 1650-1850*, (Routledge, London and New York, 1992), p. 255

¹⁴ *Ibid*

¹⁵ One exception being: J. Gillis, 'The History of the Patient History since 1850', *Bulletin of the Social History of Medicine*, Vol. 80, No. 3, (Fall 2006), pp. 490-512

¹⁶ A. Digby, *The Evolution of the British General Practice 1850-1948*, (Oxford University Press, Oxford, 1999), p. 224

who sought medical treatment at the hospital, as each contains the patient's name, age, sex, marital status, occupation, and address. Patient health histories will also be examined in order to gain an appreciation of travel habits and previous occupations, which allude to the financial circumstances of many of the patients. We can therefore begin to construct a patient 'typology' for the RFH at the turn of the twentieth century by developing a personal picture of the hospital patients and differentiating between normal and unusual cases. The chapter will begin with a discussion of patient case records as a source of patient identity. It is important that before we explore the information contained in the records we understand how the records were compiled and how they have been sampled for this study. This will be followed by an examination of the RFH patient base according to each category of patient information recorded on the front cover of the records. The patient name, sex, age, marital status, occupation, and address, all need to be analysed separately in order that a detailed picture of the RFH patient base can be compiled. As the patient base is revealed, speculative discussions regarding how and why patients came to be treated at the hospital will be undertaken, although these issues cannot be fully addressed until the following chapters.

Patient Case Records

Patient case records are an excellent source of patient identity. No other source can provide such a detailed representation of the patient base of an institution. As we analyse the information such records contain, however, we must remain aware of factors which may affect their reliability. The name of the patient, for example, may have been spelt incorrectly, which would cause a problem if we were searching for other case records of the same person (or indeed beyond this study, if we were looking to match their case with other contemporary records, such as employment material or census records). In some

instances the name in the record may have been incorrect altogether due to a mishap in communication between the patient and the staff. The patient may well have been at the RFH unaccompanied and not in a fit mental or physical state to provide any information recording their identity.

When analysing the sex of the patients contained in the records, we must remember that the patient sex was part of the sampling method. This was the result of surviving patient case records having been divided and bound by the staff member, the year of treatment, and by the sex of the patient. This meant that theoretically, equal numbers of male and female patients were sampled for this study. It may have been the case that many more patients of one sex than the other frequented the RFH over the course of the sample years, but this cannot be reflected in the sample. There is one occasion in the sample where a female record has been inter-bound with male records, and so there is one more female in the sample, and one less male.¹⁷ This is the case of Grace W. Berry, aged six months, whose case was found in the sample of male patients of Dr. Sainsbury in the winter of 1907.¹⁸

The age of the patients contained in the sample are particularly revealing when used to assess the life-cycle of ill-health suffered by the patients and how they made use of various means of medical aid throughout their lifetimes. We must be aware, however, that the ages given by patients may not always have been correct.¹⁹ Patient age has been included in all of the sampled records except in the records of three of the four nurses of the RFH.²⁰ This information was most probably omitted from the records as the nurses would have been well known to the staff. When counting the ages contained in the remaining 477 records, it must also be noted that some patients were treated at the RFH on

¹⁷ Royal Free Hospital Patient Case Record (henceforth PR): *Grace W. Berry*, Sainsbury Men December 1907, p. 1203. It is unknown whether Grace Berry was related to the surgeon Sir James Berry.

¹⁸ *Ibid*

¹⁹ A. Perkyns, 'Age checkability and accuracy in the censuses of six Kentish parishes, 1851-1881, *Local Population Studies*, Vol. 50, (1993), pp. 19-38

²⁰ PR: *Nurse Dodd*, Carr Women December 1907, p. 745, PR: *Nurse Joll*, Carr Women July 1912, p. 262, PR: *Nurse Barmer*, Roughton Women December 1902, p. 950

Figure 3.1: Royal Free Hospital Archive: Patient Case Record: *Elizabeth Webb*, Berry Women
December 1907, p. 788

more than one occasion, and so appeared in more than one record in the sample. There are eleven individuals whom appear in more than one record; ten of whom appear twice, and the remaining one appearing in three records in total.²¹ This means that although there are 477 records containing patient age, the sample reflects only 465 total patient ages (and 468 total patients when counting the three nurses whom had no age recorded). In some of these cases, patients are recorded in the notes of one physician or surgeon, and then appear again at a later date, sometimes in the notes of a different member of staff.²² Fortunately, in these cases the age of the patients did not change between visits to the hospital, and so their ages need only be counted once when tallying the total number of individuals. In other cases, records of a patient's previous treatment had been bound alongside that of the current complaint.²³ In some of these cases, the age of the patient may be different between old and new records.²⁴ In such cases, the age of the patient recorded for use in this study is always the one contained in the record for the current complaint.

The occupation of the patient listed in the record is telling as to their social class and financial circumstances. It is important to consider, however, that occupational labels can be interpreted in different ways. As we will see later in the chapter, the occupational label of 'house' appeared frequently in the case records (see Figure 3.1). Whilst we might assume that this meant housewife, it may also have referred to domestic servants or

²¹ Patients who appear in more than one records are: PR: *Florence Brown*, Sainsbury Women December 1907, pp. 811-828, who appears in three consecutive records in the sample, PR: *Frederick Clark*, Roughton Men July 1902, p. 406, who also appears in: PR: *Frederick Clarke*, Roughton Men December 1902, p.563, PR: *Ada Cook*, Carr, Women December 1912, pp. 413-427, who appears in two consecutive records in the sample, PR: *Elizabeth Gizzi*, Berry Women July 1902, p. 451, who also appears in: PR: *Mrs Gizzi*, Berry Women December 1902, p. 806, PR: *John Hinton*, Sainsbury Men July 1907, p. 740, who also appears in: PR: *John Hinton*, Berry Men December 1907, p. 944, PR: *Lily Keep*, Sainsbury Women December 1912, pp. 706 and 709, who appears in two consecutive records, PR: *John Kenny*, Roughton Men July 1912, pp. 681-691, who appears in two consecutive records, PR: *Mary Ann Maynard*, Sainsbury Women July 1907, pp. 507-523, who appears in two consecutive records, PR: *Alice Sinfield*, Sainsbury Women July 1902, p. 272, who also appears in: PR: *Alice Sinfield*, Berry Women July 1902, p. 460, PR: *George Sinkett*, Carr Men July 1907, pp. 636-641, who appears in two consecutive records, PR: *Charlotte Vandersteen*, Sainsbury Women December 1912, pp. 674-683, who appears in two consecutive records.

²² See footnote 21: cases of *Alice Sinfield*, and *John Hinton*.

²³ For example, see the three case records of *Florence Brown*, bound together in Sainsbury Women December 1907, pp. 811-828, even though the first two records are dated from January-February 1907, and June-July 1907

²⁴ Such as is the case of *Florence Brown*, who was nineteen-years-of-age in her first two records and twenty-years-of-age in the third and current record.

housemaids. In other instances, the occupation listed was very vague, such as 'labourer' or 'porter'. Whilst these labels provide us with the type of work these individuals undertook, we gain no understanding of the employer or the specific form of labour performed. The address listed in each case record also alludes to the social class of the patient, and should theoretically indicate how far patients were willing to travel in order to receive medical treatment at the RFH. The problem with using the listed address to determine how far patients were willing to travel, however, is that some patients may not have come to the RFH directly from their home address. In instances when a patient was involved in an accident or emergency (often in the workplace) they would have come to the RFH straight from the scene. Similarly, some patients may have listed their family home address even though they would not have been staying there, such as domestic servants who lived with their employer, or people who were visiting the capital from further afield.

Overall, whilst these issues must be considered when using patient case records, they do not overshadow the wealth of information relating to patient identity such records contain. The name of the patient listed in the record might indicate as to their social status or the relationship they held with the hospital. The even sample of male and female patients will allow for an equal representation of the identity of both sexes to be compiled throughout the chapter, and of the ill-health suffered by both sexes to be examined later in this study. The age and occupation of the patients also help to identify patterns of disease amongst the population. The age and marital status of the patients provides an insight into how people made use of the medical market at different stages of their lives, whilst the patient address provides an indication of the locality from which the general patient base derived. The remainder of this chapter will take into account the potential issues with the information contained in the records as it examines each of the categories of patient identity.

Patient Name and Sex

Only so much information about an individual or collective patient base can be obtained from a name alone, but it can reveal something significant. On some occasions the name of the patient provided enough information to the hospital staff that nothing else needed to be recorded on the cover page, such as in the case of ‘Nurse Dodd’.²⁵ As she was an employee of the RFH, the case record did not need to contain other personal details. In most instances, however, the patients’ full name was noted in the case record. Occasionally the patient was referred to by their surname only, such as Mrs Mortimer and Miss Campbell, which may have been a reflection of either their social class, or more likely, of the fact that they were known to the hospital staff.²⁶ The patient Elizabeth Gizzi, for example, was referred to by her full name in summer of 1907, but was listed as Mrs Gizzi when she returned to the RFH in the winter of the same year.²⁷ Having returned to the RFH within only a few months of last being discharged, Gizzi may well have been remembered by the staff member who re-admitted her, which meant that recording her full name was unnecessary. That said, none of the other patient in the sample who were discharged and readmitted were referred to by their surname only second time around. The name of the patients can also reflect the cultural and ethnic diversity of those who sought assistance at the RFH, such as ‘Ismail Hoosaine’.²⁸ The staff at the RFH were clearly unfamiliar with this surname as they spelt it differently throughout the record, and as Hoosaine was ‘unable to talk English’, he could not have corrected them.²⁹ Moreover, the clinical abstract informs us that the patient was a ‘Hindoo’ (or Hindu), which spelt incorrectly suggests that

²⁵ PR: *Nurse Dodd*, Carr Women December 1907, p. 745

²⁶ PR: *Miss Campbell*, Berry Women December 1902, p. 818, PR: *Mrs Mortimer*, Sainsbury Women July 1902, p.293

²⁷ PR: *Elizabeth Gizzi*, Berry Women July 1902, p. 451, PR: *Mrs Gizzi*, Berry Women December 1902, p. 806

²⁸ PR: *Ismail Hoosane*, Sainsbury Men December 1907, p. 1144

²⁹ Ibid

the staff were unfamiliar with the religion.³⁰ Given that no other record in the sample noted the religion of the patient, the presence of a Hindu at the RFH was clearly unusual.

As explained in the previous section, the equal number of male and female patient case records in the sample means that it cannot reflect on which sex made more use of the RFH during the early twentieth century. Annual reports of this period offer no insight, as they do not include patient figures divided by sex (except to provide numbers of gynaecological and maternity patients).³¹ The fact that the RFH allocated more beds to male patients than female, however, demonstrates that the hospital was expecting to treat more male patients overall.³² This assumption is proved correct by the census of 1911, which list 151 patients at the RFH (a similar figure to the 160 patients sampled per year for this study), of which eighty-three were male and sixty-eight were female.³³ These figures represent a patient division according to sex of fifty-five per cent males and forty-five per cent females. Although these figures are similar, they reveal that the RFH was attended more frequently by male patients during the early twentieth century. At a similar sized institution such as the Great Northern Central Hospital (henceforth the GNCH) and the slightly larger King's College Hospital (henceforth KCH), this division remains near identical. The census of 1911 lists 154 patients at the GNCH, of which seventy-nine were male (fifty-one per cent) and seventy-five were female (forty-nine per cent), whilst 196 patients were listed at KCH, of which 101 were male (fifty-two per cent) and ninety-five

³⁰ Ibid

³¹ RFHA: *The Seventy-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1902*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), pp. 30-3, RFHA: *The Eightieth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1907*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), pp. 35-7. , RFHA: *The Eighty-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1912*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), pp. 42-8

³² *Seventy-Fifth Annual Report 1902*, p. 33

³³ The National Archives (henceforth NA): The 1911 Census: Institutional Records: *Royal Free Hospital, Gray's Inn Road, St Pancras, London, Enumeration District: 29*

were female (forty-eight per cent).³⁴ These figures reveal that the RFH was typical in treating near equal numbers of male and female patients in relation to similar sized institutions, and thus proves the sample method of this study to be representative of the wider hospital patient base. Collectively, the patient sex divisions of these hospitals illustrate that whilst women may have been the keystone of modern medical practice in the nineteenth century, by the early twentieth century male patients were visiting hospitals slightly more frequently than females.³⁵

Patient Age

The age of the patients is a crucial aspect of identifying the patient base of the RFH. Table 3.1 presents the distribution of patient ages which appear in the sample according to age group and staff member. The first of the two totals in the table represents the total number of ages contained in the sample (three records did not contain a patient age), whilst the second reflects the total number of ages after the additional records of those patients who appear in the sample more than once have been subtracted.³⁶ The totals do not alter greatly and the overall percentage of patients in each age category remains the same. The most immediate observation to be made from the table is that the RFH treated patients of all ages. Indeed, the age of the patients in the sample ranged from two-month-old Harry Larratt to eighty-year-old Thomas Dingle.³⁷ Whilst the age range of the patients in the sample is extremely broad, it was those patients aged between one and nine years, those in their twenties, and those in their teens who made up the three largest groups. If we were to count all patients under the age of nine years alongside the infants aged one year and

³⁴ NA: The 1911 Census: Institutional Records: *Great Northern Central Hospital*, Holloway Road, Upper Holloway, Islington, Enumeration District: 24, NA: The 1911 Census: Institutional Records: *King's College Hospital*, Portugal Street W. C, Strand, St Clement Danes, London, Enumeration District: 12

³⁵ Shorter, *Doctors*, pp. 109-110

³⁶ See footnote 21

³⁷ PR: *Harry Larratt*, Carr Men July 1903, p. 517, PR: *Thomas Dingle*, Sainsbury Men December 1912, p. 677

Table 3.1: *Patient Age Distribution by Staff Member*

Age	Sainsbury	Carr	Berry	Roughton	Total of all Ages Recorded *	Total Number of Patient Ages ^γ
Under 1	9	6	2	1	18 (4%)	18 (4%)
1-9	30	29	18	19	96 (20%)	95 (20%)
10-19	11	10	30	29	80 (17%)	77 (17%)
20-29	19	24	27	27	97 (20%)	94 (20%)
30-39	18	19	19	16	72 (15%)	70 (15%)
40-49	23	10	8	12	53 (11%)	50 (11%)
50-59	6	11	9	7	33 (7%)	33 (7%)
60+	4	9	7	8	28 (6%)	28 (6%)
Total	120	118 - 2 Nurses	120	119 - 1 Nurse	477	465

*Minus the three missing nurses' ages

^γ Total number of individual ages in sample minus the twelve ages of patients who appear in the sample more than once and three missing nurses' ages.

under, however, we find that the total number of children made up twenty-four per cent of patients, and were thus the largest age group. This is not surprising given that parents were (and still are) likely to seek professional medical treatment for their children at times of ill-health. The age distribution of patients at the GNCH suggests that the young patient base of the RFH was quite typical for a hospital of its size (sixty-one per cent of patients at the RFH were under thirty years of age). The census records of 1911 indicate that the largest age group at the GNCH was also children under the age of nine (who made up twenty per cent of the 154 patients), followed jointly by patients aged in the teens, twenties, and thirties (each group having been eighteen per cent of total patient numbers respectively).³⁸ At the slightly larger KCH, however, children aged nine years and under were one of the smallest patient groups (consisting of fourteen per cent of the 196 patients), as patients in

³⁸ NA: The 1911 Census: *Great Northern Central Hospital*

their thirties and forties were the most numerous (having made up forty per cent of all patients).³⁹ These figures demonstrate that unlike the RFH and the GNCH, not all hospitals in the capital catered predominantly to a young patient base. In order to understand the age distribution of patients at the RFH, we must examine the age of the patients in the sample records according to the presiding staff member, the year and season of treatment, and the patient sex. Patterns of age in relation to these categories will help us to identify how patients came to use the RFH and why they suffered from particular ill-health in the following chapters.

Firstly, the table shows a noticeable difference between the number of children treated by physicians and surgeons. It is clear that far more patients under the age of nine years were treated by the physicians Sainsbury and Carr than by the surgeons, which suggests that there were persistent childhood medical complaints present during the first decade or so of twentieth century London. The particularly low numbers of infants under the age of one year treated by the surgeons Berry and Roughton was probably due to the fact that these patients were too young to operate upon. The age distribution of teenagers and patients in their twenties in the sample, however, shows that the surgeons treated close to three times the number of teenagers than did physicians, and considerably more patients aged between twenty and twenty-nine. This may be a reflection of a high number of occupational complaints and accident and emergency cases of these age groups, or of complaints related to the specialties of the surgeons. Berry was a specialist of cleft palate and hair lip operations and although these conditions would have been suffered from birth, operations to correct them would have been ongoing throughout the patients' childhood and teenage years.⁴⁰ Roughton had a particular interest in diseases of the mouth, and so he may have been treating young adult patients for conditions relating to poor dental

³⁹ NA: The 1911 Census: *King's College Hospital*

⁴⁰ See Chapter Two

hygiene.⁴¹ Of the remaining age groups the numbers of patients treated by all staff members remained relatively even, except that the number of patients aged between forty and forty-nine years treated by Sainsbury was over twice the number treated by Carr.⁴² Although at this stage we cannot know what ailments these patients suffered, it is likely that patients of this age may have been receiving treatment for long-term or chronic complaints such as heart disease, on which Sainsbury was an expert (having been well known for his work in cardiology).⁴³

Secondly, the age distribution of patients remained relatively similar in each of the three sample years. This suggests that similar complaints affected the same age groups throughout the early twentieth century, and that the age distribution of patients who made use of the RFH to receive treatment for such complaints remained constant. That said, whilst children made up the largest group of patients in the sample their overall numbers decreased between 1902 and 1912.⁴⁴ This indicates that childhood complaints were becoming less prevalent over the course of the decade, or that fewer children were being brought to the RFH. There was also a noticeable increase in the number of adults aged over sixty years treated in 1907 compared with the other sample years.⁴⁵ If we examine the sample records by season, it further becomes clear that most of these patients were treated in the winter months.⁴⁶ Equally, more children aged between one and nine years were treated in the winter months of 1907, as opposed to more having been treated in the summer months of 1902 and 1912.⁴⁷ These results may represent the prevalence in 1907 of

⁴¹ Ibid

⁴² Sainsbury treated twenty-three patients aged forty-four to forty-nine, whilst Carr treated only ten patients of the same age group.

⁴³ See Chapter Two

⁴⁴ The total number of patients aged under nine years of age in 1902 was forty-two, which dropped to thirty-six in 1912.

⁴⁵ Patients aged over sixty years in 1902 was eight, in 1907 was thirteen, in 1912 was seven.

⁴⁶ In 1907, five patients aged over sixty were treated in the summer months vs. eight in the winter months.

⁴⁷ Fourteen patients aged under nine years appear in the summer 1907 sample, and twenty-two appear in the winter 1907 sample. In 1902, twenty-five patients aged under nine years appear in the sample, vs. seventeen who appear in winter 1902, and in 1912, twenty patients under the age of nine years were treated, vs. sixteen who appear in the sample of winter 1912.

an infectious complaint to which children and the elderly were particularly susceptible, and may reflect harsh winter weather conditions.

Lastly, when we compare the patient age distribution by sex, we find that whilst the largest group of patients overall was those aged nine years and under, the majority of these patients were male.⁴⁸ Young boys were perhaps more prone to catching infectious complaints or suffering from accidents as they were more likely to spend time in company and on physical pursuits. The next two largest age groups were patients in their twenties and those in their teenage years, which both contained mainly female patients.⁴⁹ As we have already established that more patients in these age groups were treated by surgeons than by physicians, it stands to reason that the majority of patients aged between ten and twenty-nine were female surgical patients. The most obvious assumption would be that these patients were receiving gynaecological treatment, however, such cases would have been under the care of Mrs Scharlieb or Miss Vaughan, the Physician and Assistant Physician for the Diseases of Women respectively (as discussed in the previous chapter).⁵⁰ These women must have been suffering from some form of general surgical complaints, perhaps related to occupational accidents. Similarly, the higher number of male patients in their thirties may have been largely the result of occupational health hazards and injuries.⁵¹ Women also made up slightly larger patient numbers aged between forty and fifty-nine, but by this age chronic complaints such as cancer or diabetes may have been the explanation.⁵² The number of males aged over sixty was nearly double the number of females in this age group, which is surprising given that life expectancy for women was higher during this

⁴⁸ The total number of male patients aged under nine years was sixty-four, while the total number of female patients of this age in the sample was fifty.

⁴⁹ Of patients aged ten-nineteen years, forty-three were female and thirty-seven male. Of patients aged twenty-twenty-nine years, fifty-seven were female, and forty were male.

⁵⁰ See Chapter Two, and *Seventy-Fifth Annual Report 1902*, pp. 8-9

⁵¹ Patients aged thirty-thirty-nine were made up of thirty-two females and forty males.

⁵² Patients aged forty-forty-nine were made up of twenty-eight females, twenty-five males. Patients aged fifty-fifty-nine were made up of seventeen females and sixteen males.

period.⁵³ This suggests that men of this age were either more liable to ill-health as they were still undertaking physical outdoor work, or that the type of ill-health they suffered was more likely to require hospital treatment than that suffered by females of the same age.

Overall, the patient base of the RFH during the early twentieth century was made up predominantly of young patients. The largest age group in the sample were children, who were mainly males and were most frequently treated by physicians. This suggests that a childhood infectious complaint, more likely to have been spread between boys, was common in the capital. The second and third largest patient age groups were those in their twenties and teenagers, both of which were made up of mainly female surgical patients. As previously discussed, these results may reflect conditions related to occupational ill-health. The patterns of age distribution remained relatively similar throughout the sample years, except for the winter of 1907, which saw an unusually higher number of children and elderly patients being treated.

Marital Status

The cover page of the case record also provides a space to indicate the marital status of the patient (Figure 3.1: box labelled M. S. or. W). This information provides an insight into how the RFH was viewed and used by the wider community. If we tally the marital status totals of all four staff members we find that the largest number of patients were single (thirty-seven per cent), followed by those who were married (twenty-nine per cent), and those who were widowed (four per cent).⁵⁴ A large number of case records did not contain

⁵³ Patients aged sixty plus were made up of ten females and eighteen males. See: C. Edwards, M. Gorsky, B. Harris, A. Hinde, 'Sickness, insurance, and health: assessing trends in morbidity through friendly society records', *Annales de Démographie Historique*, (2003), pp. 131-167

⁵⁴ Of the total marital statuses recorded in the sample, there were 176 single patients, 142 married patients and eighteen widowed patients.

the marital status of the patient (thirty per cent).⁵⁵ The census of 1911 shows that the distribution of patients by marital status at the RFH was similar to that at both the GNCH and at KCH, where single patients also made up the largest groups.⁵⁶

At the RFH all four staff members consistently treated more single females than single males.⁵⁷ The surgeons both treated considerably more single than married patients of both sexes, but the higher number of single females were likely those aged between ten and twenty-nine, who we know made up the majority of surgical patients.⁵⁸ The physicians each treated similar numbers of married and single patients, but overall they both treated more married males.⁵⁹ This seems somewhat strange given that the physicians treated the highest proportion of male children in the sample (who cannot have been married). These figures can be explained by the high number of cases in which no marital status was recorded (the second largest group of the sample).⁶⁰ The majority of cases in this group were made up of male patients, which would reflect the high numbers of males aged nine years and under.⁶¹ For example, nine-year-old Edwin Lucas had no marital status noted in his case record, but he must have been single.⁶² There are cases where the patient was an adult and the marital status was not recorded on the cover page, such as in the case of

⁵⁵ No marital status was recorded in 144 cases. The marital statuses of the patients as they appear on the cover page of the records have been counted, but in some cases, while the status has gone unrecorded on the cover page, it has been referred to in the contents of the record itself, but these references have not been counted in the overall tally.

⁵⁶ NA: The 1911 Census: *Great Northern Central Hospital* : Total patients 154: sixty-three (forty-one per cent) single, forty-nine (thirty-two per cent) married, four (three per cent) widowed, thirty-eight (twenty-four per cent) not noted, NA: The 1911 Census: *King's College Hospital*: Total patients 196: eighty-five (forty-three per cent) single, seventy-five (thirty-eight per cent) married, seven (four per cent) widowed, twenty-nine (fifteen per cent) not noted.

⁵⁷ Sainsbury treated twenty-eight single women, fourteen men. Carr treated eighteen single women, sixteen men. Berry treated thirty single women, twenty-two men. Roughton treated twenty-seven single women, twenty-one men.

⁵⁸ Berry treated thirty-four married patients and fifty-two single patients, and Roughton treated twenty-eight married patients and forty-eight single patients.

⁵⁹ Sainsbury treated eighteen married females and twenty-three married males, Carr treated ten married females and twenty-nine married males. However, Sainsbury treated twenty-eight single females and only fourteen single males, and Carr treated eighteen single females and sixteen single males.

⁶⁰ The number of cases where no marital status was recorded equals 144 in the total sample.

⁶¹ The total number of males with no marital status recorded was eighty, compared to sixty-four females.

⁶² PR: *Edwin Lucas*, Sainsbury Men December 1902, p. 453

thirty-five-year-old Herbert Brooks.⁶³ In many cases this information may have been deemed irrelevant to the health and treatment of the patient, and so the treating physician or surgeon must not have felt it necessary information to include in the patient history. The marital status of the patient would have been extremely useful information to other staff members or divisions of the hospital, however, such in instances when a next of kin needed to be identified and contacted. Furthermore, the almoner and her team would have needed to know the marital status of the patient as it would have been an important aspect of the patient means test (to determine how much a patient could afford to contribute towards their treatment).⁶⁴ The fact that the medical staff did not include the marital status of the patient in all of the case records implies that the medical team and the wider divisions of the hospital (such as the almoner's office) worked independently of each other, and thus the medical staff did not consider the patient information other departments might require.

Occupations

One of the most useful insights into the patient base of the RFH is gained through examining patient occupations. This information can allude to the financial standings of the patient and their family, as an occupation could often indicate the patients' class and status in society. The occupation of the patient may also explain the nature of the ailment from which they suffered. In total the patients recorded in the sample held over 120 different occupations. The most frequently held occupation was 'School', which was listed in the case records of seventy-one individuals.⁶⁵ This is not surprising given that the largest and third largest age groups of patients were those aged between one and nine years

⁶³ PR: *Herbert Brooks*, Sainsbury Men December 1902, p. 458

⁶⁴ For information on the role of the almoner, see Chapter Two

⁶⁵ The total number of male patients with 'school' as occupation was thirty-five and the total number of females with the same occupation was thirty-six, equalling seventy-one total.

and those aged between ten and nineteen years respectively.⁶⁶ From the patient histories contained in the records we can learn much more about the types of school children were attending.⁶⁷ In the case of thirteen-year-old Elsie Eke, it is stated in her patient history that she attended a ‘cripple school’ until two years previously.⁶⁸ Similarly, the history of eleven-year-old Ernest Felix claims that was a resident at a ‘cripple home’ for a period up until January 1911.⁶⁹ However, whilst patients aged between ten and nineteen made up nearly thirty-seven per cent of the total patients in the sample, the occupational group ‘School’ made up only fifteen per cent of the total patients.⁷⁰ This suggests that a large number of the patients aged nineteen years and under were not in school. Indeed, the patient Alice Lierke was a thirteen-year old box maker, Esther Lockwood was a seventeen-year-old Mantle Maker, and Thomas Camp was a seventeen-year-old Porter.⁷¹ Other children would have been too young to work or to attend school, and would therefore have had their occupation recorded as ‘Nil’ or ‘None’ along with unemployed adults.⁷² This group was made up of fifty-two individuals (eleven per cent of the patient total), which made them the third largest occupational group in the sample, after ‘School’ and ‘House’.⁷³

Patients with the occupation of ‘House’ numbered sixty and were all female, and are therefore assumed in this study to be housewives.⁷⁴ As explained in the ‘Patient Case Records’ section of this chapter, this occupational label is somewhat problematic, as it may have also referred to women in household employment. Similarly, seven other patients

⁶⁶ See Table 3.1: Patients aged one-nine years number ninety-six/ ninety-five, and patients aged ten-nineteen years number eighty/ seventy-seven.

⁶⁷ The occupation ‘School’ was held by seventy-one patients, making up fifteen per cent of the total patients in the sample.

⁶⁸ PR: *Elsie Eke*, Sainsbury Women July 1912, p. 478:1

⁶⁹ PR: *Ernest Felix*, Roughton Men December 1912, p. 1095:1

⁷⁰ See Table 1: patients aged one-nine (twenty per cent) plus those aged ten-nineteen (seventeen per cent); Occupational group ‘School’ is fifteen per cent of total.

⁷¹ PR: *Alice Lierke*, Sainsbury Women July 1907, p. 484, PR: *Esther Lockwood*, Sainsbury Women December, 1902, p. 467, PR: *Thomas Camp*, Sainsbury Men July 1907, p. 749

⁷² ‘Nil’ or ‘none’ groups make up fifty-two patients (eleven per cent of the total)

⁷³ Occupations ‘School’ contained seventy-one patients in total (fifteen per cent of the total occupations), and ‘House’ contained sixty patients (thirteen per cent of the total occupations), and ‘nil’ and ‘none’ contained fifty-two patients (eleven per cent of the total occupations).

⁷⁴ Occupation ‘House’ contained sixty patients (thirteen per cent of the total occupations),

were listed with the occupations ‘Home’, ‘Housework’ and ‘Housemaid’.⁷⁵ Of the remaining occupations in the sample, ‘Porter’, ‘Labourer’, and ‘Servant’ made up the next three largest groups of patients.⁷⁶ Those patients working as servants were all female, which suggests that this label was used to describe domestic servants in household employment and indicates that ‘House’ did refer to housewives as suspected. Porters and labourers were all male except in the case of Elizabeth Wells, who lived at ‘The Union – East Grinstead’, and so probably carried out her ‘labour’ as part of the workhouse regime.⁷⁷ On the whole, the occupations of patients in the sample keep to the stereotypes we would expect of early twentieth century British society. Both male and female working class occupations did, however, range in their typical pay and associated respectability. Lower working class male occupations included ‘flower seller’ held by Harry Cox, ‘Potman’ (someone who worked in a pub collecting and washing dirty glasses) held by Walter Cobb, or ‘Turner’ (a street performer), held by Sidney Roberts.⁷⁸ Female occupations of a similar level included ‘Boxmaker’ held by Florence Brown, ‘caramel wrapper’ held by Agnes Strutton, or ‘Chambermaid’ held by Florence Wilson.⁷⁹ There were jobs that both male and female patients possessed, such as in the cases of both Annie Evans and John Knight, who were both cooks.⁸⁰ For all of patients holding such occupations, the wages would have been low and the working conditions most likely poor. The large number of apparently working class patients seeking treatment at the RFH is not

⁷⁵ ‘Home’ was the occupation of only one patient, ‘Housework’ the occupation of three patients, and ‘Housemaid’ of three patients.

⁷⁶ The occupation ‘Porter’ was held by nineteen patients in total, including ‘Super Porter’, ‘Postal Porter’, ‘Timber Porter’, ‘Coal Porter’, ‘Porter Clerk’, and ‘Railway Porter’ and ‘Porter’ (3.9% of the total occupations). The occupation ‘Labourer’ was held by eighteen patients (3.7% of the total occupations), and the occupation ‘Servant’ was held by sixteen patients (3.3% of the total occupations).

⁷⁷ PR: *Elizabeth Wells*, Berry Women July 1902, p. 443

⁷⁸ PR: *Harry Cox*, Carr Men December 1912, p. 996, PR: *Walter Cobb*, Roughton Men December 1912, p. 1077, PR: *Sidney Roberts*, Berry Men July 1907, p. 606

⁷⁹ PR: *Florence Brown*, Sainsbury Women December 1907, pp. 811-835, PR: *Agnes Strutton*, Roughton Women July 1907, p. 357, PR: *Florence Wilson*, Carr Women December 1903, p. 526

⁸⁰ PR: *Annie Evans*, Sainsbury Women 1907 July, p. 490, PR: *John Knight*, Roughton Men December 1902, p. 601

surprising, given that the hospital was established as a centre of free healthcare for those unable to afford to pay for medical treatment.

There are, however, examples of occupations in the sample which we would consider to be of a higher working class or middle class stature. Working class occupations of a higher respectability and pay held by patients being treated at the RFH included ‘Police Constable’, held by William Ward, ‘Storekeeper’ held by Philip Roher, and ‘Boarding House Keeper’ held by Mary E. Fernie.⁸¹ There were also many skilled occupations held by female patients in the sample which would have presumably earned them a slightly higher wage than such occupations as a cleaner or waitress, such as ‘Dressmaker’ held by Margaret Blachic, or ‘Surgical Instrument Fitter’ held by Eliza Reicke.⁸² Occupations which indicate that the patient was perhaps middle class included ‘Salvation Army Officer’ held by Elizabeth Dickes, or ‘Mission Woman’ held by Alice Se Good.⁸³ We might also assume that the position of ‘Manager’ held by Frederick Howard might indicate that the patient was of a higher social class.⁸⁴ Indeed, in the case of Edward Jarvis (a forty-five-year-old Solicitor’s Clerk) the patient history states that he had been passed by an Insurance Officer.⁸⁵ This means that Jarvis was financially eligible to make contributions towards health insurance, and this was probably the means by which he paid for his treatment at the RFH. By the late nineteenth century many patients treated at the RFH were means tested by the almoner and her team in order to establish how much they could afford to contribute towards their medical treatment.⁸⁶ The presence in the sample of patients who may have been made to pay towards their care demonstrates that many people

⁸¹ PR: *William Ward*, Carr Men December 1912, p. 968, PR: *Philip Roher*, Roughton Men December 1912, p. 1079, PR: *Mary E. Fernie*, Berry Women December 1912, p. 686

⁸² PR: *Margaret Blachic*, Carr Women July 1903, p. 313, PR: *Eliza Reicke*, Berry Women December 1907, p. 773

⁸³ PR: *Elizabeth Dickes*, Carr Women July 1903, p. 303, PR: *Alice Se Good*, Carr Women July 1907, p. 361

⁸⁴ PR: *Frederick Howard*, Carr Men July 1903, p. 520

⁸⁵ PR: *Edward Jarvis*, Carr Men December 1903, p. 967

⁸⁶ See Chapter Two

made use of the RFH for reasons other than wanting to receive cheap or free healthcare (a point which will be considered in the following chapter).

Overall, it is clear that people from many different occupational backgrounds chose to seek medical treatment at the RFH in times of ill-health. Though we cannot tell from the patient records alone which of these patients received free treatment at the hospital and which had to pay towards their care, we can see that the hospital treated patients who lived in a wide range of financial situations. This meant that patients with respectable positions in society would have mixed with lower working class patients on the wards of the hospital. We can also not know until we have examined the ailments from which the patients suffered whether any of the patients sought treatment for occupational related problems, such as injuries in the workplace. However, with the large number of young patients in the sample, and the high number of physical occupations the patients held (including labourers and servants), it is clear that occupational related ailments would have been suffered by some of the patients.

Addresses

The address listed in the case records indicates the types of lodgings the patients were able to afford and the conditions they were likely to be living in, which in turn may help to explain some of the ill-health from which they suffered. Knowing the patients' place of residence also provides a good indication of how far they were willing to travel in order to receive treatment at the RFH, which is essential to our understanding of how patients made use of the hospital as part of the wider medical market (to be explored in the following chapter). As explained in the 'Patient Case Record' section of this chapter, however, the patients may not have travelled directly from their home address to the RFH, as they may have needed to attend the hospital from their place of work or from the site of an accident.

Alternatively, the patient may not have been living at the address they provided in the case record (such as domestic servants, who would have lived with their employer but may have provided their families home address as a place for correspondence). Whilst these factors are important to consider, the address of the patient listed is still relevant, as it may well have represented the distance the patient travelled to the hospital in many cases. It also indicates the likely distance of the patient's family from the RFH (which is important when considering how far family members were able to travel in order to visit the patient), and the distance the patient would have to travel in order to receive any follow-up out-patient treatment.

Table 3.2 (on the following page) categorises the patients in the sample by the distance as the crow flies of the address listed in the case records to the RFH.⁸⁷ We can see from the table that those patients who lived within one mile and those who lived between one and five miles of the hospital made up the vast majority of the patient base.⁸⁸ The patients who lived within one mile resided in areas such as Grays Inn, Clerkenwell, Pentonville, Kings Cross, St Pancras and Holborn. Those who lived between one and five miles derived from areas including Clapham and Lambeth in the south of the capital, the West End and Notting Hill in the west, Camden and Tottenham in the north, or Bethnal Green and Shoreditch in the east. In total, the patients who lived within five miles of the RFH made up approximately seventy-eight per cent of all those in the sample.⁸⁹ This indicates that the hospital was principally used by local residence, for reasons we might

⁸⁷ Distance is as the crow flies and is approximate. Cases where the address is illegible or the address cannot be found have been calculated separately to those who had 'no fixed abode' or 'nil' address, or cases where the address box was left blank – these have been categorised as 'no address. In cases where the street could not be located (in many cases they no longer exist), the estate or region has been the point of measurement. For example, in the case of 'Manor Cottages, East Finchley', East Finchley has been used as the point of measurement from the RFH.

⁸⁸ See Table 3.2: Patients who lived within one mile of the RFH numbered 196, and patients who lived between one and five miles numbered 179 in total. Together these two categories of patients made up seventy-eight per cent of the total patients in the sample.

⁸⁹ Patients who lived within five miles of the RFH number 375, making up seventy-eight per cent of the 480 total patients in the sample.

Table 3.2: *Distance (in miles) between the Patient Address and the Royal Free Hospital*

Distance	Male Patients	Female Patients	Total (approx %)
Within 1 mile of the RFH	112	79 (+ 5 who lived at the RFH)	196 (41%)
Between 1 and 5 miles	93	86	179 (37%)
Between 5 and 10 miles	15	23	38 (8%)
10 and 20 miles	4	7	11 (2%)
20 and 30 miles	4	8	12 (3%)
30 and 40 miles	1	5	6 (1%)
40 and 50 miles	-	5	5 (1%)
50 and 60 miles	-	1	1 (less than 1%)
60 and 70 miles	2	3	5 (1%)
70 and 80 miles	1	-	1 (less than 1%)
80 and 90 miles	-	1	1 (less than 1%)
90 and 100 miles	1	-	1 (less than 1%)
Over 100 miles	-	4	4 (1%)
No address (Nil, No fixed abode, etc.)	4	2	6 (1%)
Cases where address is illegible or cannot be found.	3	11	14 (3%)
Total	240	240	480

assume to be based on convenience.⁹⁰ These findings are echoed in the RFH annual report of 1907, which included internal hospital census records that listed the place of residence of all patients in the wards on a Sunday in January since 1902.⁹¹ The vast majority of patients were always found to have derived from the neighbouring parishes such as St Pancras, Islington, and Holborn.⁹² The report concluded that the residence of the patient base showed that the RFH was ‘well situated for its work’.⁹³

Although the majority of the patients in the sample lived in local proximity to the hospital, there were patients who lived much further away. Many patients lived between

⁹⁰ Further reasons why patients sought treated at the RFH will be discussed in the following chapter.

⁹¹ *Eightieth Annual Report 1907*, p. 16

⁹² *Ibid*: In 1902 the hospital census listed 149 patients, ninety-seven lived in neighbouring parishes. In 1907 the hospital census listed 152 patients, ninety-nine lived in neighbouring parishes.

⁹³ *Ibid*, p. 17

five and ten miles of the hospital, in areas such as Greenwich, Kew, and Fulham.⁹⁴ Others lived over ten miles away, often in towns and villages in the surrounding counties of Middlesex, Essex, Hertfordshire, and Kent.⁹⁵ Smaller numbers derived from towns over thirty miles from the RFH, such as Leighton Buzzard in Bedfordshire, or Aylesbury in Buckinghamshire.⁹⁶ Of all of the patients treated by the physicians, the vast majority lived within ten miles of the hospital, and none lived further than fifty miles away.⁹⁷ This indicates that most medical cases sought treatment at the RFH base on the convenience of its location. In contrast, the thirteen patients who lived further than fifty miles away from the hospital were all surgical cases.⁹⁸ Patients appear to have travelled from as far as Cornwall, Wales, Dover, Great Yarmouth, and the Isle of Wight to receive surgical treatment at the RFH.⁹⁹ These figures come as no surprise, as patients who sought general medical help and advice could do so at any hospital, and would therefore have sought one out which was in close proximity to their home. Patients requiring surgery, however, would be more likely to consider the institution and surgeon best equipped and trained for the procedure required. This indicates that the RFH offered highly regarded specialists in surgery, which we know to have been true of Berry (who specialised in operations for hair lips and cleft palates).¹⁰⁰

It is interesting to note that more male patients in the sample lived within five miles of the RFH than female patients.¹⁰¹ This might be accounted for by the high numbers of male children under the age of nine years appearing in the sample records, as parents

⁹⁴ Patients who lived between five and ten miles from the RFH numbered thirty-eight.

⁹⁵ Patients who lived between ten and twenty miles from the RFH numbered eleven.

⁹⁶ Patients who lived over thirty miles away from the RFH totalled twenty-four.

⁹⁷ Number of patients treated by physicians who lived within ten miles of the RFH was 218 (ninety-one per cent of the 280 Sainsbury and Carr patient records sampled)

⁹⁸ Berry treated seven cases, Roughton treated six.

⁹⁹ PR: *Mary Creeth*, Roughton Women December 1907, p. 549, PR: *Mary E. Fernie*, Berry Women December 1912, p. 686, PR: *Dora Green*, Roughton Women July 1912, p. 374, PR: *John Knight*, Roughton Men December 1902, p. 601, PR: *Mary Williams*, Berry Women July 1912, p. 495

¹⁰⁰ See Chapter Two

¹⁰¹ See Table 3.2: Males patients who lived within five miles of the RFH totalled 205, female patients numbered 170.

would have been likely to seek medical aid for their child as locally as possible (to their home or place of work), both in order for them to receive treatment quickly and to make it easier for the family to visit the child if they were admitted the hospital.¹⁰² Whilst the number of patients who lived a considerable distance from the RFH was substantially lower than those who lived within the five mile radius, those patients who did live further from the hospital were mostly females.¹⁰³ There is the possibility that such patients were visiting London at the time they were struck with ill-health or had moved to the capital from the countryside to work, such as in domestic service roles. If these patients had travelled from their home addresses, however, it demonstrates that the hospital offered superior or specialist care in female disorders, and that it held a reputation worthy of women such as Mary Williams to travel over 180 miles from North Wales and Dora Green to travel nearly 250 miles from Cornwall, in order to receive treatment.¹⁰⁴

Some patients arrived at the RFH from another institution, which provides an insight into the place of the hospital in the wider medical market. The patient Rebecca Roberts came from a convalescent home at Grays, Essex, and Florence James came from Nazareth House (an old people's home) in Oxford.¹⁰⁵ The decision made by these patients to travel a long distance in order to seek treatment at the RFH would not have been made in haste, but would have been carefully planned as a reflection of the long-term healthcare the patients required. In other cases, patients were sent from criminal institutions, such as the 'Remand Home' or 'Base of Detention'.¹⁰⁶ Institutions such as these were not well equipped to deal with serious medical complaints, and as both of these examples were located on Pentonville Road (only a short distance from the RFH) it was likely that the

¹⁰² Sixty-four male patients under the age of nine years were counted in the sample.

¹⁰³ See Table 3.2: Female patients outnumber males in all distance categories over five miles from the RFH, except in that of 90-100 miles, where one male patient is recorded, and no females.

¹⁰⁴ PR: *Mary Williams*, Berry Women July 1912, p. 495, PR: *Dora Green*, Roughton Women July 1912, p. 374

¹⁰⁵ PR: *Florence James*, Roughton Women December 1902, p. 947, PR: *Rebecca Roberts*, Berry Women December 1902, p. 832

¹⁰⁶ PR: *Rosa Chandler*, Carr Women December 1912, p. 396, PR: *Harry Oppenheim*, Roughton Men July 1912, p. 650

RFH was the closest medical institution where treatment could be had for free. Moreover, other hospital may have refused to treat criminal patients. There are also examples of patients in the sample who lived at workhouses, such as Frederick Choppin who came from Edmonton Union, or Elizabeth Wells who lived at ‘The Union – East Grinstead’.¹⁰⁷ These institutions must not have been in the position to treat the medical needs of the patients at their own infirmaries.

The majority of patients, however, appear to have lived in houses or flats which they rented. Many of these addresses no longer exist, such as Little Claredon Street, the home of Louisa Mallett in 1902, which appears to have been demolished to make way for St. Pancras Railway Station.¹⁰⁸ Similarly, there are examples of patients who lived in the Beaconsfield Buildings at Islington, which were demolished in the 1970’s to build Bingfield Park. The Beaconsfield Buildings were block dwellings for the labouring classes built by the Victoria Dwelling Association during the late 1870s.¹⁰⁹ These buildings were divided into blocks, and housed patients including Edward Powell, a street musician who lived in J Block, and Thomas Camp, a porter who lived in C Block.¹¹⁰ They were built ‘to provide healthy and comfortable homes for artisans, more especially for the class termed labourers and persons earning small wages’.¹¹¹ In 1877, an article in the *British Medical Journal* described the impressive sanitary conditions of a newly constructed Beaconsfield Building at Battersea;

‘Each tenement in the artisans’ dwellings and each block of four rooms for those of the labourers are entirely separated from others by an open-air space, so that in case of fever and smallpox there would be little danger of the epidemic spreading....Each tenement has a constant supply

¹⁰⁷ PR: *Frederick Choppin*, Carr Men July 1907, p. 604, PR: *Elizabeth Wells*, Berry Women July 1902, p. 443

¹⁰⁸ PR: *Louisa Mallett*, Sainsbury Women December 1902, p. 472

¹⁰⁹ J. N. Tarn, *Five Per Cent Philanthropy: An account of housing in urban areas between 1840 and 1914*, (Cambridge University Press, London, 1973), p. 94; Anon, ‘The Victorian Dwellings For Artisans’, *The British Medical Journal*, Vol. 1, No. 861 (Jun. 30, 1877), p. 821

¹¹⁰ PR: *Edward Powell*, Sainsbury Men December 1912, p. 684, PR: *Thomas Camp*, Sainsbury Men July 1907, p. 749

¹¹¹ Anon, ‘The Victorian Dwellings For Artisans’, p. 821

of fresh water, the use of a wash-house, a coal-bunker, and dust-shoot, and generally great care has been taken to insure to the tenants all the advantages of the best known sanitary appliances.’¹¹²

There are also examples of patients who lived at one of the Peabody Buildings, which were blocks of small flats erected by the trustees of the Peabody Donation Fund, intended for the respectable working classes.¹¹³ The infant Edna Griffiths lived in a Peabody Building on the Farringdon Road with her mother.¹¹⁴ The average rent was less than two shillings a week per room, which included the ‘free use of water, laundries, sculleries, and bath-rooms’.¹¹⁵ Some male patients also made use of Rowton Houses, or ‘Poor Man’s Hotels’, which had begun to appear across the capital in the 1890s.¹¹⁶ The aim of these houses (established by the Rowton and Guinness Trust) was to ‘provide working men without a home with clean, comfortable houses, where good food and accommodation could be obtained at the smallest possible cost’.¹¹⁷ It was believed that there was a class of working men, including artisans, clerks, shop assistants, and men looking for work, who had to ‘keep up a semblance of respectability with next to nothing to do it on’, which is why the nightly rate at a Rowton House was a reasonable six pence.¹¹⁸ The fact that some RFH patients lived in Beaconsfield and Peabody Buildings, and lodged at Rowton Houses, demonstrates that whilst they would have been in low wage employment, they would have been considered by contemporaries as members of the respectable working class.

Other addresses provide an insight into how the patient earned a living. Whilst the occupation of Patrick Hinchon was listed as labourer, it is his address, ‘The Gravel Pits,

¹¹² Ibid

¹¹³ Anon, ‘The Peabody Fund And Its Improved Dwellings’, *British Medical Journal*, Vol. 1, No. 1000 (Feb. 28, 1880), pp. 336-7

¹¹⁴ PR: *Edna Griffiths*, *Berry Women* December 1907, p. 794

¹¹⁵ Anon, ‘The Peabody Fund And Its Improved Dwellings’, p. 337

¹¹⁶ PR: *Albert Clark*, *Berry Men* December 1902, p. 37, PR: *Arthur Durand*, *Sainsbury Men* December 1907, p. 1191: both patients lived at Rowton House at King’s Cross, which opened in 1895 and contained 677 beds.

¹¹⁷ Anon, ‘Rowton Houses.’, *The British Medical Journal*, Vol. 2, No. 2033 (Dec. 16, 1899), p. 1693

¹¹⁸ Anon, ‘Rowton Houses.’, pp. 1693-4

Bromley, Kent', that tell us the type of labour in which he was involved.¹¹⁹ Similarly, the occupation of Amy Bonn was listed as housemaid, but it is her address that informs us that she worked at the RFH, whilst Elizabeth Millar was a maid who lived at Mount 'Vernon' Hospital, and Amelia Weaver was a servant who lived at St. Andrew's Hospital in Winsor.¹²⁰ In some cases patients were in the unfortunate position of having no fixed address, such as the unemployed James Boundy or the flower seller Harry Cox.¹²¹ Although it might be assumed that these patients spent much of their time sleeping on the streets, the health history of Cox stated that he 'divides his time between flower-selling and frequenting infirmaries', indicating that he habitually slept in institutions such as the RFH where he would not have been expected to make a financial contribution towards his care.¹²² The appearance of homeless patients in the sample records demonstrates that the admissions policy of the RFH had developed since the 1860s, when homeless applicants were considered to be cases for Poor Law medical provision.¹²³

The patient health histories contained in the case records often included information regarding the patient's previous living arrangements and circumstances. In the case of fifteen-year-old Ethel Popplewell, we learn from her history that she 'lives in orphanages', though we would not have known this from her recorded address, 'Lambert House, Margaret Rd, Ramsgate'.¹²⁴ Histories also provide an insight into the living arrangements of the patients' family, such as in the case of Edward Fulit, a thirty-three-month-old who himself was 'put out to a nurse at High Wycombe', while his two brothers lived in Dr. Barnardo's home.¹²⁵ More generally, the health histories of Emily Oliver tells

¹¹⁹ PR: *Patrick Hinchon*, Sainsbury Men July 1907, p. 722

¹²⁰ PR: *Amy Bonn*, Roughton Women July 1907, p. 342, PR: *Elizabeth Millar*, Berry Women July 1912, p. 468, PR: *Amelia Weaver*, Carr Women July 1912, p. 231

¹²¹ PR: *James Boundy*, Sainsbury Men December 1907, p. 1211, PR: *Harry Cox*, Carr Men December 1912, p. 996

¹²² PR: *Harry Cox*, Carr Men December 1912, p. 997:1

¹²³ RFHA: *Report of the Royal Free Hospital, with List of the Governors and Subscribers, 1865: Annual Reports 1864-69* : Book A5 (RFH/1/2/2), p. xv

¹²⁴ PR: *Ethel Popplewell*, Berry Women July 1907, pp. 415-416

¹²⁵ PR: *Edward Fulit*, Carr Men July 1907, p. 628:1

us that she was raised in ‘very comfortable circumstances’, while that of William Spummet claims that he ‘as a child, sometimes lacked the necessities in life’.¹²⁶ Other histories detail changes in circumstances the patient may have undergone, such as in the case of Charlotte Aldridge (a thirty-nine-year-old housewife) which stated that her ‘Circumstances have not been good and since the death of her husband five years ago she has had to work very hard – sometimes having to go short of food’.¹²⁷

Previous overseas residence and travel habits can also be determined, as medical staff needed to know if a patient had been exposed to a foreign disease. One interesting example is that of Millie Thompson, a forty-one-year-old woman with no occupation, who lived in the both the Malay States and Africa before catching ‘sprue’, a tropical disease.¹²⁸ On her return to England, she was treated for this disease by Sir Patrick Mason, founder of the London School of Hygiene and Tropical Medicine (founded in 1899).¹²⁹ We cannot know for certain the reason for Thompsons travels, but she was recorded as being single, not widowed, and held no occupation, which indicates that she may have come from a higher class family with enough wealth to travel.¹³⁰ For most of the working class population of the early twentieth century, however, worldwide travel was not an affordable option. That said it is clear from the patient histories that many patients had visited or lived in other countries. The thirty-three-year-old Anastasia (Arthur) Reyes caught a fever in Spain as a child, while Nellie Farrier, a thirty-two-year-old bottle labeller developed ‘low fever’ in while in India.¹³¹ Some patients lived overseas for a considerable time, such as

¹²⁶ PR: *Emily Oliver*, Sainsbury December 1902, p. 477, PR: *William Spummet*, Sainsbury Men July 1902, p. 28

¹²⁷ PR: *Charlotte Aldridge*, Sainsbury Women December 1907, p. 802:1

¹²⁸ PR: *Millie Thompson*, Sainsbury Women July 1907, pp. 536-537

¹²⁹ *Ibid*, p. 538, and J. W. W. Stephens, ‘Manson, Sir Patrick (1844–1922)’, rev. Mary P. Sutphen, *Oxford Dictionary of National Biography*, Oxford University Press, 2004; online edn, Jan 2008 [<http://www.oxforddnb.com/view/article/34865>, accessed 8 Sept 2011]

¹³⁰ PR: *Millie Thompson*, Sainsbury Women July 1907, p. 536

¹³¹ PR: *Anastasia (Arthur) Reyes*, Carr Men December 1907, p. 995, PR: *Nellie Farrier*, Carr Women December 1907, p. 707:1, Further examples include: PR: *John S. Tillbrooke*, Carr Men December 1907, p.991, who suffered malaria and enteric in South Africa: PR: *James Greenwood*, Carr Men July 1912, p. 596, who had malaria whilst in South Africa and Philadelphia: PR: *Thomas J. Thomas*, Berry Men December 1907, p. 964:1, who suffered ague in Brazil thirty-five years previous.

the draper Ernest Mitchell, who lived in Africa for nine months, and Thomas Murphy, a brace maker, who lived in Gibraltar for seven years.¹³² Other patients travelled as members of the armed forces. Patrick Hinton travelled to Zululand with the army, Arthur Beasley to India, and Arthur Durand was a Sailor in Malta.¹³³ Much of the patient base therefore represented a mobile and well travelled population, not simply low level working class people who were living on the bread line, unable to afford to leave London.

Overall, the address of the patients in the sample show that the RFH catered predominantly to local residence, but that many patients were willing to travel much longer distances in order to receive treatment. This was especially the case for patients seeking surgical treatment, who in some cases travelled hundreds of miles for operations. While most patients appear to have lived in rented accommodation (including residences purpose built to house the working class population), we have seen that many came from other institutions such as convalescent homes, old people's homes, and other hospitals, which were usually a considerable distance from the RFH. This shows us that whilst the hospital was mainly used by local residence, it also had a place in the systems of long-term healthcare required by many patients from further afield. The presence of homeless patients in the sample, along with those from workhouses and remand homes, suggests that the admissions policy of the RFH has become less rigid by the early twentieth century. As discussed in the previous chapter, although the official promise of the hospital was to admit anyone suffering from poverty and sickness, in practice patients considered to be too poor or morally undeserving were referred to the Poor Law throughout the nineteenth century.¹³⁴ Alternately, the previous addresses and travel habits of some patients suggests that they could have afforded to contribute towards their treatment at the RFH or to pay for treatment elsewhere. Of course, whilst patients may have been in the financial position to

¹³² PR: *Ernest Mitchell*, Sainsbury July 1907, p. 729, PR: *Thomas Murphy*, Sainsbury Men July 1907, p. 697

¹³³ PR: *Patrick Hinton*, Sainsbury Men July 1907, p. 723:1, PR: *Arthur Beasley*, Carr Men December 1903, p. 960, PR: *Arthur Durand*, Sainsbury Men December 1907, p. 1193

¹³⁴ RFHA: *General and Committee Minutes 1828-1839*, (RFH/1/2/1/1), p. 67, *Report 1865*, p. xv

have travelled overseas in the past, their circumstances may well have changed by the time they sought medical treatment at the RFH. Patient addresses therefore tell us much more than simply the distance people were willing to travel to receive medical treatment, as they provide us with an insight into the living conditions and social and financial circumstances of the patient base.

Conclusion

Having examined the identity of the RFH patient base during the early twentieth century, this chapter has addressed a seriously neglected group in the current historiography. By evaluating the personal patient information contained in the case records we are able to construct patterns of patient ‘typology’ for a central London voluntary hospital for the first time. As no previous study has surveyed the patient base of a hospital on this scale, census material has been the only comparable source regarding patients at other London hospitals. Nevertheless, it would appear from the census data of the GNCH and KCH that the patient base of the RFH was broadly representative of that at other similar sized voluntary hospitals of the capital.

The most common ‘type’ of patient in the sample records was male children, treated by physicians most frequently in the summer months. This can be explained by boys having spent more time outdoors and in company than girls, particularly in the summer, and by the willingness of parents to seek professional medical treatment for their children. These were closely followed by single female surgical patients aged between ten and twenty-nine. As young women joined the workforce and spent more time in company they would have been exposed to many conditions for the first time. The fact that high numbers of these women required surgical treatment suggests that they had been involved in work related accidents or specialist complaints for which they were prepared to travel

from across the country to receive treatment at the RFH. The vast majority of the patient base, however, lived within five miles of the hospital, which demonstrates that it was used by most as a means of convenience. The occupational label of 'school' reflects the large number of child patients treated at the hospital, though we have seen that some children worked in order to contribute towards the household income. Of the other occupations listed in the sample records, male labourers and female housewives and servants were the most frequent. Although these occupations indicate that the patient base was predominantly lower working class, some patients appear to have held upper working class (and perhaps even lower middle class) jobs, such as Salvation Army Officer and Police Constable.¹³⁵ Patients lived in a wide range of accommodation, but the appearance of specially commissioned working class flats and hostels in the records suggests that the hospital largely catered to the lower working class to whom it was intended.

Overall, establishing the typical patient of the RFH provides us with a unique and valuable insight into the section of the population who most attended the hospital during the early twentieth century. Whilst the typical patients described above represent the majority, however, they do not reflect the variety of different patients who would have mixed on the wards of the hospital. It has become clear that the RFH catered to the working class, but the case records have shown that the means and circumstances of patients differed quite dramatically. On the one hand, the hospital had become part of the medical healthcare routine of patients who appear to have been in the position to have afforded to seek private treatment (such as Millie Thompson, the patient who travelled the Malay States). This highlights the acceptance of the hospital as a socially suitable means of medical care, and reminds us that it had become the centre for treatments which could not be had in the home. Others were not quite so comfortable, but could still afford to contribute towards their care (such as through medical insurance schemes). The majority of

¹³⁵ PR: *Elizabeth Dickes*, Carr Women July 1903, p. 303, PR: *William Ward*, Carr Men December 1912, p. 968

patients however, appear to have been in low wage employment, which if lost would have tipped them over the poverty line. The fact that these people worked hard to stay in work made them 'respectable' in the eyes of contemporary social observers, and ideal patients for charitable hospitals like the RFH. Patients who were decidedly unrespectable, however, were not refused treatment at the hospital as they had been during the nineteenth century. Given that homeless individuals, Poor Law cases, and criminals, were some of the most destitute of all the London population, their eventual admission to the hospital demonstrates that attitudes towards what made a patient 'deserving' of charitable medicine had evolved by the early twentieth century.

Now that the patient base of the RFH has been established, the following chapter can explore the place of the hospital in the wider medical market. The RFH was one of many means of medical assistance available to patient during this period and so only when the circumstances behind how and why patients came to the RFH have been examined can it be understood as a centre of healthcare. Equally, we need to be aware of how the hospital was used by patients in order to identify patterns of ill-health and treatment in later chapters.

CHAPTER FOUR

THE ROYAL FREE HOSPITAL IN THE WIDER MEDICAL MARKET

Patient agency and choice within the mixed economy of healthcare in early twentieth-century London has been overlooked in the current historiography. The reasons and motivations behind how and why patients came to seek treatment at various available means of assistance are essential to our understanding of the medical market, yet have never been comprehensively considered. Whilst the previous chapters have explored the history and identity of the Royal Free Hospital (henceforth RFH) and its patient base, this chapter examines why patients attended the hospital in relation to the wider medical economy. We cannot analyse the patient ailments and treatments in the following chapters without first understanding how the hospital was used by patients at times of ill-health.

The medical market of early twentieth-century London was diverse, consisting of numerous institutions, organisations, and private practitioners.¹ As discussed in the introduction to this study, histories of the English hospital systems of the nineteenth and twentieth centuries are numerous.² Cherry estimates that there were over 43,000 voluntary

¹ This study is concerned with general medical care and so will not discuss specialist health providers, such as mental asylums.

² Hospital histories include: B. Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*, (Heinemann, London, 1964), E. H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848*, (John Hopkins Press, Baltimore, 1967), S. Cherry, *Medical services and the hospitals in Britain 1860-1939*, (Cambridge University Press, Cambridge, 1996), B. Croxson, 'The price of charity to the Middlesex Hospital, 1750-1830', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 23-39, M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, Translated from French by A. M. Sheridan, (Tavistock Publications, London, 1973), L. Granshaw, *St. Mark's Hospital, London: A Social History of a Specialist Hospital*, (Distributed for the King's Fund by Oxford University Press, Oxford, 1985), L. Granshaw and R. Porter (Eds.), *The Hospital in History*, (Routledge, London and New York, 1989), L. Granshaw, 'The rise of the modern hospital in Britain', in A. Wear (Ed.), *Medicine in Society: Historical Essays*, (Cambridge University Press, Cambridge, 1992), R. Porter, 'Hospitals and Surgery' in R. Porter (Ed.) *The Cambridge History of Medicine*, (Cambridge University Press, Cambridge, 2006), pp. 176- 210, F. K. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund 1897-1990*, (Clarendon Press, Oxford, 1992), G. B. Risse, 'Hospital History: New Sources and Methods', in R. Porter and A. Wear (Eds.), *Problems and Methods in the History of Medicine*, (Croom Helm, New York, 1987), G. B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford University Press, Oxford and New York, 1999), G. Rivett, *The Development of the London Hospital System 1823-1982*, (Kings Edward's Hospital Fund for London, Oxford University Press, Oxford, 1986), K. Waddington, *Medical Education at St. Bartholomew's 1123-1995*, (Boydell Press, Woodbridge, 2003), J.

hospital beds in England and Wales by 1911, and according to Burdett, London alone played host to over 130 hospitals by the same period.³ Dispensaries were also a popular means of medical assistance, particularly from the mid-nineteenth century, when provident dispensaries based on penny-a-week contributions became typical.⁴ Loudon claims that in 1800 England had thirty-eight general dispensaries, with approximately one hundred thousand yearly admissions, but by 1910 there were over one-hundred dispensaries in London alone.⁵ Workhouse infirmaries had their own dispensary systems, though historians have often claimed that Poor Law medical provision was only used as a last resort, usually by individuals with a limited kinship network. The workhouse often provided care for patients who were considered unlikely to benefit from hospital treatment, such as the elderly and the incurable.⁶ Crowther and Cherry estimate that in 1861 the number of beds provided by the workhouse was 50,000, and by 1911 this had risen to over 120,000.⁷ Alternatively, paying for private medical care was an option for those who could afford it. For the many private practitioners who operated both in the Metropolis and throughout the rest of the country during the nineteenth century, Porter has claimed that the market could be lucrative though was also 'competitive and insecure'.⁸ Indeed, Digby has claimed that it was increasingly over-supplied by the late nineteenth century.⁹ Prior to seeking any professional medical assistance, however, patients were likely to have exhausted all self-medication techniques available to them. Often passed down through

Woodward, *To do the sick no harm: A study of the British voluntary hospital system to 1875*, (Routledge & Kegan Paul, London, 1974)

³ Sir H. Burdett, *Hospitals and Charities 1910: A Year Book of Philanthropy and Hospital Annual*, (The Scientific Press Limited, London, 1910), pp. 239- 296, Cherry, *Medical services*, p. 46

⁴ Cherry, *Medical services*, pp. 42-3, H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870*, (Cambridge University Press, Cambridge, 1987, republished 2008)

⁵ Burdett, *Hospitals*, pp. 297-308, I. S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, Vol. 55 (1981), pp. 322-42

⁶ Croxson, 'The price of charity', p. 29, Granshaw, 'The rise', p. 209, S. Leff, *The Health of the People*, (Victor Gollancz, London, 1950), p. 98

⁷ Cherry, *Medical Services*, p. 46, M. A. Crowther, *The Workhouse System 1834-1929: The history of an English social institution*, (Batsford Academic and Educational Ltd, London, 1981), p. 167

⁸ R. Porter, *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present*, (Fontana Press, London, 1999), p. 348

⁹ A. Digby, *The Evolution of the British General Practice 1850-1948*, (Oxford University Press, Oxford, 1999), pp. 23, 154, and 155

generations of family networks, home-made remedies were a cheaper option than seeking private medical advice. Patent remedies or ‘quack’ cures were also popular, often having been advertised as miracle cure-alls.¹⁰ These forms of self-medication were common as they could have been applied at a time convenient to the patient, meaning that they would not have had to take time out of work to attend a hospital or practitioner.

However, whilst the various medical options available to patients are a commonplace of the current historiography, the nature of patient choice within the complex medical market has been neglected. Historians such as Porter and Digby have claimed that patients acted as ‘agents’ who controlled a degree of own healthcare from as far back as the seventeenth century.¹¹ Digby has highlighted some of the factors which would have impacted on patient agency, such as the importance of the doctor’s personality to the patient when deciding which to visit.¹² But whilst historians have claimed that patients made calculated consumer choices in the medical market, empirical evidence and examples of such are limited.¹³ Moreover, as the RFH has not been considered in the current historiography, it has never been examined as a healthcare option available to patients in relation to the wider medical market. Equally, the relationship between the hospital and other health and welfare providers has never been examined, though such relationships would have been vital to the wider treatments available to the patients of the early twentieth century.

This chapter will therefore make three contributions to our understanding of patient healthcare during the early twentieth century. Firstly, it will determine how and why patients came to be at the RFH as a means of understanding patient choice in the wider

¹⁰ E. Shorter, *Doctors and Their Patients: A Social History*, (Transaction Publishers, London, 1993), p. 121

¹¹ R. Porter, ‘The patient in England, c. 1660 – 1800’, in A. Wear (Ed.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), p. 91

¹² Digby, *The Evolution*, p. 224

¹³ Case studies which demonstrate a degree of patient agency in the eighteenth and nineteenth centuries include: S. Jacyna, ‘Mr Scott’s Case: A View of London Medicine in 1825’, in R. Porter (Ed.), *The Popularization of Medicine 1650-1850*, (Routledge, London and New York, 1992), pp. 252-86, and G. B. Risse, ‘Vienna, 1750-1800, Seeking Care: A tailor’s fate’, in *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford University Press, 1999), p. 257

medical economy of makeshifts.¹⁴ As was discovered in the previous chapter, the patients were predominantly young and working-class, and depended on free healthcare in order not to fall into absolute poverty. In some instances, patients may not have had a choice as to where they sought medical care. This was particularly true of children, as parents or carers would have decided the most appropriate means of treatment on their behalf. Most patients, however, made calculated decisions as to where to seek medical help based on factors such as availability, location, affordability, and reputation. Secondly, it will locate the RFH in the wider medical market through an examination of treatment options patients sought before attending the hospital. Self medication methods, private practitioners, club and dispensary doctors, chemists, and other medical individuals were all used by patients throughout their lifetimes along with hospitals and other institutions. As hospital histories of London are few in number, understanding the place of the RFH will contribute towards our understanding of the hospital system of the metropolis. Moreover, by examining how the hospital fitted into the wider market we can better understand the ailments which were admitted and the treatments it provided in later chapters.

Thirdly, the chapter will explore the networks and relationships held between the RFH and other medical healthcare providers and charities. Such relationships would have helped to determine the patient experience of the health care systems of the early century. The practice of record sharing allowed patients to choose the most suitable hospital at different times of ill-health and not be tied to one institution. As the RFH was staffed by consulting physicians and surgeons who also worked at other institutions and held private practices, they could use their networks to the advantage of the patient. Aftercare treatments will also be examined, as it was often part of the hospitals' role to find suitable healthcare facilities for patients once they were deemed suitable to be discharged, such as

¹⁴ For further discussion surrounding the 'economy of makeshifts' used by the poor see: S. King and A. Tomkins, *The poor in England, 1700-1850: an economy of makeshifts*, (Manchester University Press, Manchester, 2003)

at a convalescent home or sanatorium. By considering the aftercare treatment, this study can better place the hospital in the wider medical market of the early twentieth century and better understand the healthcare options available to its patients. The chapter will begin with a source discussion. The patient health histories contained in the case records (collected in the initial process of diagnosis) are the primary source for this chapter, as they provide an insight into previous medical treatment patients had undergone prior to their visit to the RFH.

Patient Case Records

Patient case records provide a unique insight into the means of medical assistance patients made use of at times of ill-health. There are, however, several factors that must be remembered when analysing patient records. Firstly, whilst most of the health histories contained in the patient records appear to be full and detailed, not all previous medical assistance may have been remembered or disclosed by the patient at the time they were questioned. Indeed, there are case records which do not recall any previous medical treatment.¹⁵ Even if only self-medicated, it is highly unlikely that adult patients had never before suffered any form of ill-health worthy of medical treatment. Such examples more likely represent either the inability of the patient to remember their complete health history or their unwillingness to share the information with the hospital staff. They may also represent the lack of detailed health questions asked, or that the information gained was considered irrelevant to their current condition. That said, the case history of fifty-nine-year-old Amelia Satham claimed that she had never been ill before, except for the

¹⁵ Royal Free Hospital Patient Case Record (henceforth PR): *Herbert Potts*, Sainsbury Men December 1912, p. 697, PR: *Alexander Sutcliffe*, Sainsbury Men December 1912, p. 691, PR: *Eliza Sweet*, Sainsbury Women July 1912, p. 449, PR: *Marion Watson*, Sainsbury Women July 1912, p. 454

occasional bilious attacks.¹⁶ In contrast, Susannah Turlow, also aged fifty-nine years, had suffered from many ailments throughout her lifetime but no previous treatment was recalled.¹⁷ From February 1903 the patient was ill for six weeks with influenza, and was told she had quinsy by someone unnamed in her case record.¹⁸ She also suffered “Milk fever” twice as a child, bronchitis, rheumatic pains, measles and a rash all-over her body twenty years ago, and had always suffered from a sore throat.¹⁹ Either she never sought medical treatment for any of these complaints, or more likely, the treatment details were not considered relevant to her present condition by the staff.²⁰ The history of seventy-two-year-old William Godding also appears to be only that relevant to his current case.²¹ Having gone to the RFH suffering from cystitis, Godding’s history stated that he had stones in his bladder crushed four years previously at the London Hospital, and that he saw a doctor for his current complaint.²² It is highly unlikely that aged seventy-two years these conditions were the patient’s first experiences of ill-health, but no other complaints were recorded. Whilst it is important to consider the possibility of such flawed histories appearing in the sample records, however, it would appear that they are in the minority.

The second factor that must be considered is that even in the instances where previous medical treatment had been noted, some health histories only included partial details of that treatment. The history of Elizabeth Malin, for example, did not provide the name of the doctor under whom the patient was previously treated.²³ The five-year-old Frederick Clarke was reported to have been in hospital for diphtheria in 1898, but which hospital is not noted, whilst the history of George Collins claimed that he was ‘ordered to wear a truss

¹⁶ PR: *Amelia Satham*, Carr Women July 1907, p. 343

¹⁷ PR: *Susannah Turlow*, Carr Women December 1903, p. 535

¹⁸ *Ibid*

¹⁹ *Ibid*

²⁰ *Ibid*

²¹ PR: *William Godding*, Berry Men July 1912, p. 701

²² *Ibid*

²³ PR: *Elizabeth Malin*, Sainsbury Women December 1907, p. 863

to hold up the hernia', but no note is made of who made this order.²⁴ The history of George Kinston stated that he previously had a neck gland removed, and that of Charlotte Vandersteen stated that she was operated on for stones in her rectum four years prior to her current visit to the RFH, but neither record stated where these procedures took place.²⁵ In other cases, details of the medicine or procedures patients had been treated with had not been recorded. The health histories of Alice Keeley and Annie Day both claimed that these patients had been under treatment for anaemia, but did not include details as to what that treatment had entailed or of any medicines prescribed.²⁶ The absence of treatment details may have been the result of the patient not having been able to recall the name of the doctor or hospital from which they received assistance, which indicates that they were not the patients' usual means of medical care. Alternately, the absence of details in the records may have been the result of the medical staff member not recording it in the case note, as it was not considered relevant or of importance. The detail contained in the majority of patient histories, however, suggests that the staff at the hospital could be meticulous in the information they put into the case notes. In the patient history of Florence Brown (see Figure 4.1) the hospitals of St Bartholomew's, the Middlesex, and the City Road Chest Hospital, are all listed along with St Luke's Infirmary, when it could simply have been noted that the patient had been at or in four institutions in the past.²⁷

A third factor that must be remembered when using patient records for the purpose of identifying how patients made use of the medical market is that we cannot know where patients sought treatment for the remainder of their lives after their stay at the RFH. Although details are usually given of aftercare organised through the hospital, often convalescent homes, their use of the medical market may have changed later in their lives.

²⁴ PR: *Frederick Clarke*, Roughton Men December 1902, p. 563, PR: *George Thomas Collins*, Roughton Men December 1902, p. 559

²⁵ PR: *George Kinston*, Berry men July 1912, p. 673, PR: *Charlotte Vandersteen*, Sainsbury Women December 1912, p. 674

²⁶ PR: *Annie Day*, Carr Women December 1903, p. 552, PR: *Alice Keeley*, Sainsbury Women July 1912, p. 473

²⁷ PR: *Florence Brown*, Sainsbury Women December 1907, p. 811

This is particularly true of the many child patients who were brought to the hospital by their parents. Later they may have made very different choices as to where to seek medical treatment as adults in a market which would have developed in the post-war period. This does not undermine the details contained in the records, however, as they provide a snapshot of how patients of the early twentieth-century were, and had been, making use of the medical assistance available to them. Moreover, in the cases of patients that had provided detailed health histories and subsequently died at the hospital, their entire life-cycle of ill-health and treatment choices can be examined. Overall, the case histories are imperfect but even allowing for their deficiencies their number and the information they contain provides fascinating insights into a spectrum of healthcare at, and related to, a key London hospital.

The Wider Medical Market

In order to understand how patients made use of the RFH in relation to the wider medical market, we must examine any other means of medical assistance patients sought before coming to the hospital. We also need to identify the length of time that lapsed between the patient becoming ill and them seeking treatment, and determine, where possible, the reasons behind the patients' choice of medical assistance. The most common previous means of medical assistance reported were private medical professionals, other London hospitals, and self medication, although these were only three of many options available to people at times of ill-health.

For most patients, self medication was the first choice of treatment at times of ill-health as it was convenient and often cheaper than seeking professional medical advice. Riley claims that during the early stages of ill-health the sick typically tried to deny their

symptoms.²⁸ People tended to attempt self-diagnosis and treated themselves accordingly.²⁹ Family and community networks were crucial in sharing knowledge of self-medication techniques, such as how to prepare home-made remedies. They would also have been important in providing home care and nursing, and in looking after the household when a friend or family member was laid-up. When it was a child who was suffering ill-health, family and friends of the parents would often have shared care and babysitting duties, particularly if the parents were in work. Older generations were often still relied upon for medical advice, meaning that quite dated methods of self-help may have been passed down from family members who had first practiced them over half a century before.

Self medication involved the use of everyday food-stuffs, often mixed together to make home-made remedies based on recipes passed down through generations, or purchasing patented medicines available from local chemists, pharmacies, or through mail-order.³⁰ According to Berridge, most people dealt with common ailments themselves, as ‘free dispensaries, poor law infirmaries and out-patient departments of the voluntary hospitals provided a limited form of orthodox medical care’.³¹ She claims that the turn of the twentieth century was a ‘transitional period’ when both folk medicine (based on herbs, flowers, and roots) and professional medicine had a place in the population’s medical experience.³² Indeed, self medication methods appeared frequently in the case records of the RFH. A common complaint for which patients self-medicated was constipation, often having taken different forms of aperients including rhubarb pills and liquorice powder.³³ Rhubarb was known to be a natural purge, and was often given to patients who suffered

²⁸ J. C. Riley, *Rising Life Expectancy: A Global History*, (Cambridge University Press, Cambridge and New York, 2001), p. 91

²⁹ *Ibid*

³⁰ See: V. Berridge, ‘Health and medicine’, in F. M. L. Thompson (Ed.), *The Cambridge Social History of Britain 1750-1950*, Vol. 3 (Cambridge University Press, Cambridge, 1990) p. 186, Shorter, *Doctors*, pp. 62-9

³¹ *Ibid*

³² *Ibid*, pp. 186 and 190

³³ PR: *Alice Lierke*, Sainsbury Women July 1907, p. 484, PR: *Thomas Murphy*, Sainsbury Men July 1907, p. 696, PR: *Ellen Spencer*, Sainsbury Women December 1902, p. 495, PR: *Clara Stringer*, Berry Women July 1912, p. 479, PR: *Mary Turner*, Carr Women December 1912, p. 428

from bowel conditions as part of their diet.³⁴ Liquorice was used to hide the taste of unpleasant medicines and in its powdered form contained the aperients senna and sulphur, which caused it to act as a laxative.³⁵ Similarly, castor oil (or ‘Oleum Ricini’ as it often appeared in the case notes) was often taken as a purge, for instance in the case of Philip Rober, who had suffered from abdominal pains caused by colic.³⁶ Patients also often self medicated for chest complaints, particularly bronchitis.³⁷ Charles Hambrook took the expectorant Terebene (a preparation of oil of turpentine) on a sugar cube to help clear his chest.³⁸ As many of the patients who suffered from chest complaints were children, it was their parents (notably their mothers) who administered medication. The mother of thirteen-month-old Sarah Farlton gave her ‘Ipecac’ for her broncho-pneumonia cough.³⁹ Ipecacuanha was a ‘prompt emetic secured from the root of a Brazilian plant’, which according to Cushny, increased ‘the secretion of the bronchial mucous membrane’ and rendered it more fluid so that it could be coughed up more easily.⁴⁰ Cushny claimed in 1899 that it ‘was formerly largely used as an emetic, but is less suitable for this purpose than apomorphine’, which suggests that by the early twentieth century Ipecacuanha was falling out of fashion with medical professionals as an emetic.⁴¹ The fact that it was still available to and used by the general public during this period, however, is a reminder that the transition of knowledge and medical alternatives from the profession to wider society happened gradually, often leaving the public using medicines and techniques considered outdated.

³⁴ H. Morten (revised by Florence Taylor), *The Nurses Dictionary*, (Faber and Faber, London, 1942), p. 298

³⁵ *Ibid.*, pp. 158, 211, and 311

³⁶ Morten, *The Nurses*, pp. 70, 87, PR: *Philip Rober*, Roughton Men December 1912, p. 1079, see also: PR: *Dorothy Seaton*, Sainsbury Women December 1902, p. 499

³⁷ As we will see in the following chapter, chest complaints were common amongst the working-class population during the early twentieth century, despite improvements in public health standards. See: F. Condrau and M. Worboys, ‘Second Opinions: Epidemics and Infections in Nineteenth-Century Britain’, *Social History of Medicine*, Vol. 20, No. 1, (2007), pp. 147-158

³⁸ Morten, *The Nurses*, p. 341, PR: *Charles Hambrook*, Sainsbury Men December 1902, p. 511

³⁹ PR: *Sarah Farlton*, Carr Women December 1903, p. 523

⁴⁰ A. R. Cushny, *A Textbook of Pharmacology and therapeutics or the Action of Drugs in Health and Disease*, (LEA Brothers & Co., Philadelphia and New York, 1899), p. 336, Morten, *The Nurses*, p. 196

⁴¹ Cushny, *A Textbook*, p. 335

Quinine was another substance found in the case records to have been self-medicated by patients, but not prescribed to patients at the RFH. Benjamin Clarke, who was suffering a suspected onset of Multiple Sclerosis, had taken it in 1901 for stiffness and tiredness in his legs, but his condition did not improve.⁴² Quinine had been thought by practitioners including Cushny to treat forms of neuralgia, or pains in the nerves, and so perhaps Clarke believed it would help to improve his symptoms.⁴³ It was also believed that quinine initiated uterine contractions and could cause abortion.⁴⁴ Though Shorter has claimed that the ‘the great take-off in quinine for abortion seems to have occurred only after the First World War’, its appearance in the sample records suggests that its use was common earlier in the century.⁴⁵ Whilst Cushny claimed in 1899 that abortion ‘so seldom occurs after quinine that pregnancy is no objection to its administration’, abortion was the result of Phoebe Porter self-medicating the drug in 1912.⁴⁶ The diagnosis of quinine poisoning and abortion recorded for Porter shows that by 1912 the effects and use of the drug as an abortion agent was well recognised by the medical staff and by the general public.⁴⁷ Beliefs to the contrary were clearly outdated. This shows a relatively quick transition of knowledge between both the medical profession and the lay public of the use of quinine for abortion over the early twentieth century. This is not surprising, given that in an era when methods of contraception were limited, methods of how to abort a pregnancy without having to frequent a back-street abortionist would have spread through the community quickly by word of mouth.

Other forms of self-medication performed by the patients, however, were being routinely applied in the hospital setting as well, such as the use of hot fomentations or

⁴² PR: *Benjamin Clarke*, Carr Men December 1903, p. 974

⁴³ Cushny, *A Textbook*, p. 360

⁴⁴ Morten, *The Nurses*, p. 291

⁴⁵ E. Shorter, *Women's Bodies: A Social History of Women's Encounter with Health, Ill-Health and Medicine*, (Transaction Publishers, New Jersey, 1991, Second Printing 1997), p. 213

⁴⁶ Cushny, *A Textbook*, p. 360, PR: *Phoebe Porter*, Carr Women July 1912, p. 224

⁴⁷ PR: *Phoebe Porter*, Carr Women July 1912, p. 224

mustard plasters on painful swellings.⁴⁸ The practice of washing wounds with antiseptic solutions such as iodine or Chlorate of Potash was also common by patients prior to seeking any professional medical assistance.⁴⁹ Patent remedies were another means by which patients could self-medicate. The patient Ada Cook had suffered from a sore throat and so gargled the antiseptic Condy's Fluid (permanganate of potash) and the mother of Ernest Marini gave him Steven's Powder to treat bronchitis.⁵⁰ The record of Arthur James does not list the specific cures he took for the pain he suffered in his abdomen, but it was noted that he 'takes medicines he has seen advertised from time to time, with no benefit'.⁵¹

Overall, the wide spread patient knowledge of how different substances could be prepared and used for medical purposes is evident in the case records, and the importance of family and community networks cannot be overstated. Patent remedies had been gaining popularity throughout the nineteenth century, but the case records show that people still relied upon home remedies to treat many conditions. Presumably, they relied on what little ingredients they could afford, which would have been used in recipes that were passed down through generations and updated based on new medical information gained via word of mouth. It is not surprising that self-help methods were the first choice for many patients and their families, as they could control their own treatment, and negotiate it around their daily lives.

The health histories also reveal that patients had previously sought medical advice or treatment from private doctors. Patients acted as agents by carefully choosing which doctor to visit. They may have visited a trusted family physician, or been recommended by a friend or family member to visit a practitioner who held a good reputation in the community. They often chose different doctors depending on the nature of their ill-health

⁴⁸ PR: Sidney Thompson, Roughton Men July 1907, p. 634, PR: *Nellie Thoroughgood*, Roughton Women December 1912, p. 605, see also: PR: *Emily Puke*, Roughton Women December 1907, p. 544

⁴⁹ PR: *Percy Fravio*, Roughton Men December 1907, p. 1005, PR: *Elizabeth Vincent*, Berry Women July 1907, p. 376

⁵⁰ PR: *Ada Cook*, Carr Women December 1912, p. 413 and 424, PR: *Ernest Marini*, Sainsbury Men December 1912, p. 709

⁵¹ PR: *Arthur F. James*, Berry Men July 1907, p. 595

in order to receive the best and most convenient care. The twenty-six-year-old patient Annie Stercks had seen a Dr Mansell of Hastings during 1897, and a Dr Tom Robinson in 1900, both for the same condition (adenoma of the thyroid gland) which ultimately led her to the RFH in 1902.⁵² Kate Odds was treated by Dr Bland Sutton and Dr Feely for ulcers of the mouth six years before her current visit to the hospital.⁵³ Patients often sought specific medical advice as a result of another doctor's recommendation (reasons for why patients came to the hospital are discussed later in this chapter). Dr E. Henry of Long Sutton treated five-year-old Herbert Ward for renal calculus before the patient was brought to the RFH and Robert Braybrook was seen by Dr Pattison for pain in his abdomen before his parents took him to the hospital.⁵⁴ Female medical professionals were also seen by patients for past complaints, such as in the case of Eliza Batchelor, who had been treated by Dr Allen of Bethnal Green, and by Miss Chubb MB. BS.⁵⁵ Alice Aldridge had also consulted a medical woman for her current complaint, a Miss Morrell M. B., who advised her to go to the hospital.⁵⁶ Some patients had been treated previously by specialist physicians or those eminent in their field, as they sought the very best treatment for their condition. The patient Millie Thompson, who suffered from the tropical disease Sprue after having visited the Malay States, was treated by Sir Patrick Manson on her return to England in 1905 until at least her admission to the RFH in 1907.⁵⁷

Many patient histories, however, refer to treatment from an unnamed 'private doctor' who was not referred to as being the patients' usual practitioner.⁵⁸ The patient may have sought treatment from an unfamiliar practitioner out of convenience or because they

⁵² PR: *Annie Stercks*, Berry Women July 1902, p. 468

⁵³ PR: *Kate Odds*, Carr Women July 1907, p. 337

⁵⁴ PR: *Robert Braybrook*, Berry Men December 1912, p. 943, PR: *Herbert H. Ward*, Berry Men December 1907, p. 924

⁵⁵ PR: *Eliza Batchelor*, Sainsbury Women December 1912, p. 692

⁵⁶ PR: *Alice Aldridge*, Carr Women December 1903, p. 548

⁵⁷ PR: *Millie Thompson*, Sainsbury Women July 1907, p. 536

⁵⁸ Examples include: PR: *Kate Barnes*, Sainsbury Women December 1907, p. 856; PR: *Ivy Chambers*, Sainsbury Women July 1902, p. 268, PR: *Elizabeth Malin*, Sainsbury Women December 1907, p. 863; PR: *Sarah Mansfield*, Sainsbury Women July 1902, p. 261, PR: *Lucy Alice Prior*, Sainsbury Women December 1907, p. 845

charged a low fee. Either way, such practitioners cannot have been well known to the patient or their immediate family or community network as the patient could not remember their name. This suggests that the patient did not always stick to being treated by doctors known to them or their family and friends, but chose to seek medical advice from further afield at certain times of ill-health. In 1902 a private doctor treated the young child James Albert Cox who suffered from measles and bronchitis.⁵⁹ Henry Crow had previously been treated for 'bronchial catarrh' by an unnamed private doctor for six months.⁶⁰ In the case of Emily Oliver, who suffered an appendicitis, a doctor was called and treated her for four days before advising that she go to a hospital.⁶¹ Similarly, fourteen weeks before attending the RFH, Joseph Voyles went to an unnamed doctor on Drury Lane, who gave him some medicine, and since September 1903 was attended in bed by a doctor before coming to the hospital in the December.⁶² The use of male and female practitioners, as well as specialist consultants, demonstrates the variety of professionals available to patients of the metropolis during the early twentieth century, and the extent to which they were utilized.

It is often impossible to know from the health histories if these doctors (both named and unnamed) were the patients regular or family physicians, except in cases where practitioners were referred to as 'his' or 'her' doctor. The case record of Margaret Blachic states that she was treated with medicine by 'her own doctor', and Edward Sullivan's notes that he saw 'his doctor' three times before he was advised to come to the hospital.⁶³ Such patients were in the position to have had a family doctor, or general practitioner, from whom they felt comfortable seeking medical advice and who knew their personal and family health histories. Of course the cases in which practitioners were not recorded as being 'his' or 'her' doctors may have simply been the result of how the medical staff at the

⁵⁹ PR: *James Albert Cox*, Sainsbury Men December 1902, p. 472

⁶⁰ PR: *Henry Crow*, Sainsbury Men December 1912, p. 715

⁶¹ PR: *Emily Oliver*, Sainsbury Women December 1902, p. 28

⁶² PR: *Joseph Voyles*, Carr Men December 1903, p. 945

⁶³ PR: *Margaret Blachic*, Carr Women July 1903, p. 313, PR: *Edward Sullivan*, Carr Men July 1903, p. 500

RFH recorded the information. That said, it would appear that patients often did not remember the details of treatment received from doctors other than those recorded as their own. In such instances it would appear that patients were often unsure as to what medicines they were being given or of the procedures they underwent. Others may have been deliberately vague when recalling previous treatments. The patient Ada Basket was examined without anaesthetic by an unnamed private doctor with 'an instrument', and subsequently had 'something removed' (most likely an abortion).⁶⁴ In this case, the patient had a moral and legal imperative not to provide the practitioners name or the exact treatment she underwent.⁶⁵ Overall, the popularity of private practitioners (both named and unnamed) indicates that during some past periods of ill-health patients and their families were in the financial position to pay for medical treatment. Their use of the RFH highlights the variable financial circumstances of the patients, who as explained in the previous chapter, were often employed in unstable labouring positions.

The cost of seeking medical advice and treatment from a private doctor, however, was not one which patients could always afford outright. Instead, patients made use of those provided through friendly societies or sick clubs, and dispensaries to which they would have made weekly contributions.⁶⁶ In 1902 Mary Heale was visited at home by a dispensary doctor for severe pain in the back of her thigh, which was treated with blisters and iodine but 'all to no purpose'.⁶⁷ Dispensaries provided home visits to the 'deserving poor', which Granshaw has explained to be a method of care 'more in keeping with contemporary ideas about disease (that illness was unique to the individual in his or her setting, and could not be easily understood outside that setting) than hospital treatment

⁶⁴ PR: *Ada Basket*, Sainsbury Women December 1912, p. 702

⁶⁵ See: M. Jackson, *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000*, (Ashgate Publishing, Aldershot, 2002)

⁶⁶ M. Gorsky, 'Friendly society health insurance in nineteenth-century England', in M. Gorsky and S. Sheard (Eds.), *Financing Medicine: The British experience since 1750*, (Routledge, Abingdon, 2006), pp. 147-164

⁶⁷ PR: *Mary Heale*, Sainsbury Women July 1902, p. 285

could be said to be'.⁶⁸ The patient history of Percy Beale reported that he had previously been treated by a club doctor after having had an operation on his foot.⁶⁹ Given that free medical treatment was available at voluntary hospitals like the RFH, it is interesting to see examples of patients who were willing to contribute towards the cost of a club doctor. Indeed, the 'Almoners Record Book' details the struggle the almoner and her team underwent in trying to persuade patients (and their families) of the hospital to join friendly societies when they were already in receipt of free medical care.⁷⁰ Other patients were in occupations which had a company doctor on hand. The patient William Roberts worked as an Inspector for the Great Northern Railway Company, and had been treated by the company doctor's for inflammation of the lungs, influenza, and pharyngitis.⁷¹ Similarly, Frederick Cox, a police officer who suffered from acute rheumatism, was attended by the police surgeon for previous joint pain, and the Postman Arthur Saris was given ointment for haemorrhoids by the Post Office doctor.⁷² For many patients, dispensary, club, and company doctors were vital aspects of the mixed economy of health and welfare, as they provided treatment without having required any payment upfront.

Professional practitioners, however, were not the only individuals from which patients had previously sought treatment. The patient histories of both George Sinkett and Walter Feusham include the use of chemists, although in the case of Feusham, the chemist stopped giving the patient bromides after he considered that the patient was taking too much.⁷³ According to Berridge, medical advice came more often from the chemist than from the doctor.⁷⁴ Nursing care was also often recalled in patient histories, such as in the

⁶⁸ Granshaw, 'The rise', p. 206

⁶⁹ PR: *Percy Beale*, Berry Men July 1912, p. 683

⁷⁰ RFHA: *Almoners Record Book*, (RFH/6/A/1)

⁷¹ PR: *William J. Roberts*, Berry Men July 1907, p. 583

⁷² PR: *Frederick Cox*, Carr Men July 1903, p. 547, PR: *Arthur G. Saris*, Berry Men December 1912, p. 946

⁷³ PR: *Walter Feusham*, Berry Men December 1907, p. 939, PR: *George Sinkett*, Carr Men July 1907, pp. 636 and 637

⁷⁴ Berridge, 'Health and medicine', p. 186

case of Elizabeth Pample, who had applied for the services of the district nurse.⁷⁵ Other patients were reported to have been nursed at home for previous complaints, including Ruth Marriott, who was nursed for typhoid fever.⁷⁶ Similarly, Millie Thompson had daily enemas at home before having come to the hospital.⁷⁷ The identity of home nurses, however, frequently went unrecorded. Home nursing care could have been performed by a trained nurse or by an amateur care giver, such as a family member or friend. In either case, it would appear that the name of the individual ‘nurse’ was not worth reporting. Likewise, Amelia Weaver was treated by an unnamed ‘Sister’ with some medicine and a light diet for her current illness, visceroptosis, before being advised by a doctor to go to the RFH.⁷⁸ Albert Cufford, a seven-year-old patient who suffered from a swelling in his neck was previously taken to a ‘medical man’, who lanced the swelling.⁷⁹ The fact that this ‘medical man’ was not referred to as a doctor suggests that he was some form of unqualified ‘quack’ or barber. The use of such individuals at times of ill-health suggests that for some patients, a professional qualification was not considered to be an essential asset when deciding where to seek medical treatment. Unqualified medical men, along with home nurses, were likely to have charged less for their services than certified professionals, making them an attractive alternative to private practitioners. Patients treated by such means would also have been able to receive treatment in the comfort of their own homes, surrounded by friends and family, instead of having to enter an institution. Overall, self medication methods, private practitioners, and other medical individuals, had been popular options to the patients of the RFH at previous times of ill-health.

Hospitals

⁷⁵ PR: *Elizabeth Pample*, Roughton Women July 1902, p. 845

⁷⁶ PR: *Ruth Marriott*, Sainsbury Women July 1907, p. 547

⁷⁷ PR: *Millie Thompson*, Sainsbury Women July 1907, p. 536

⁷⁸ PR: *Amelia Weaver*, Carr Women July 1912, p. 231

⁷⁹ PR: *Albert Cufford*, Roughton Women July 1902, p. 433

Healthcare options provided through means of self-help and by medical individuals, however, were not the only route by which the patients had previously sought treatment for ill-health. The patient health histories also include the medical advice and treatment provided in the hospital setting. As discussed in Chapter One, hospital treatment was becoming more popular by the Edwardian era, as it was recognised as being a safe place to receive many medical and surgical treatments. According to Howell, the hospital of the twentieth century was also becoming a more sociable institution.⁸⁰ As the organisation of the hospital became more complex, it strived to fill the gaps in teaching once filled by the family.⁸¹ For example, women were once taught how to breast feed from their mother or another female family member or friend, but by this period they were offered formal classes on child rearing in the hospital setting.⁸²

The use of hospitals varied patient-to-patient, ranging from those who appear to have attended hospitals frequently and readily, to those who had rarely made use of them. Patients often sought medical advice or treatment from a hospital out-patient department before being admitted if their condition was deemed of a serious enough nature. Working-class patients would have been used to the out-patient system of healthcare, as that is how they had received help at dispensaries and infirmaries (including those connected to workhouses). The patient Florence Chubb had been an out-patient at the Victoria Hospital for four months receiving treatment for a heart condition, whilst Elizabeth Jordan had been an out-patient at St John's Wood Hospital for paralysis and epilepsy treatment.⁸³ At the RFH, Dorothy Dreevey had previously attended the out-patient department for sickness

⁸⁰ J. D. Howell, 'Hospitals', in R. Cooter and J. Pickstone (Eds.), *Companion to Medicine in the Twentieth Century*, (Routledge, London and New York, 2003), pp. 510-11

⁸¹ Ibid

⁸² Ibid

⁸³ PR: *Florence Chubb*, Berry Women July 1902, p. 464, PR: *Elizabeth Jordan*, Roughton Women July 1902, p. 849

and diarrhoea, whilst Annie Alliston was treated as an out-patient for tuberculous meningitis for a few days before having been admitted.⁸⁴ Out-patient treatment allowed patients to receive medical attention without their lives being disrupted to the extent that having to stay in the hospital for long periods of time would have done. That said, the RFH out-patient departments were often only open for a limited time each day. In 1907 it was open daily (except Sundays) from 12.30 p.m. to 1 p.m. for new general medical and surgical cases, and 1.30 p.m. to 2 p.m. for old cases.⁸⁵ Patients therefore only had a half hour window in which to be at the hospital each day if they required treatment. Moreover, as of 1903 children under the age of thirteen years had to be accompanied by an adult, meaning that working parents would have had to take their children to the hospital in their lunch hours or would have had to take time off.⁸⁶ Although the opening hours of the RFH were limited, however, other hospitals offered very large out-patient departments which the patients may have frequented previously. St Bartholomew's, for example, treated nearly 121,000 new out-patients in 1907, whilst the RFH only treated approximately 36,200.⁸⁷

Patients who had made regular use of hospital in-patient treatment throughout their lives can be divided into those who made use of multiple hospitals and those who had a preferred hospital which they regularly attended at periods of ill-health. The patient records contain many examples of patients who made use of multiple hospitals throughout their lives. For some, hospitals were their first choice of medical care, and those who made use

⁸⁴ PR: *Annie Alliston*, Carr Women July 1903, p. 336, PR: *Dorothy Dreevey*, Sainsbury women December 1902, p. 503

⁸⁵ RFHA: *The Eightieth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1907*: Annual Reports 1905-10 : Book A13 (RFH/1/2/2), p. 47

⁸⁶ 'Notice to Out-Patients', December 16th 1903, in RFHA: *Rules and Regulations, 1904-1914*, (RFH/1/3/6/2), p. 83

⁸⁷ Statistics on hospital services were downloaded from the Voluntary Hospitals Database at <http://www.hospitalsdatabase.lshtm.ac.uk>. This is an online version of a database initially constructed at the University of Portsmouth as part of a research project funded by the Leverhulme trust. Creation of the online version was made possible by a grant from the Wellcome Trust. I am grateful to Martin Gorsky and John Mohan for permission to reproduce this material.

of multiple hospitals depending on the nature and timing of ill-health were actively controlling the terms of their hospital healthcare. The thirty-seven-year-old patient Alice Bray had previously been treated at University College Hospital for typhoid fever and dropsy, at the Chest Hospital on City Road for chest trouble, and at the New Hospital for Women for swelling of the knees and ankles.⁸⁸ Bertha Lent had previously been treated at the Brompton Hospital for a cough and haemoptysis, had undergone a double oophorectomy operation at the New Hospital, and had an abscess operated on by Mr Roughton.⁸⁹ The case records also contain examples of families who made use of multiple hospitals across the metropolis, such as that of William Turner, who as a child had been a patient at the Tottenham Hospital but whose mother had been treated at the RFH Gate (the emergency department) and father had been an out-patient of the Brompton Hospital.⁹⁰ The many reasons why patients chose to be treated in the hospital setting will be discussed shortly, although it is worth noting at this point that it would appear that often, patients who made use of different hospitals at periods of ill-health made consumer choices about the most appropriate hospital based on medical specialties. This was particularly the case for many child patients, whose parents often took them to specialist hospitals or children's hospitals such as Great Ormond Street instead of general institutions like the RFH.⁹¹ The patient Edwin Lucas had previously been treated at the Ophthalmic Hospital for his eye condition, whilst Patrick Martin had been treated at the Hampstead Fever Hospital for diphtheria.⁹² Such patients even sought treatment from more than one hospital at once, such as Eliza McNeill, a six-year-old whose parents brought her to the RFH to be treated for acute pneumonia whilst she was already attending the Eye Hospital.⁹³ Other patients who had previously received treatment at multiple hospitals had done so due to their home

⁸⁸ PR: *Alice Bray*, Carr Women July 1907, p. 367

⁸⁹ PR: *Bertha Lent*, Carr women July 1902, p. 384

⁹⁰ PR: *William Turner*, Berry Men December 1902, p. 43

⁹¹ PR: *Elsie Eke*, Sainsbury Women July 1912, p. 476

⁹² PR: *Edwin Lucas*, Sainsbury Men December 1902, p. 453, PR: *Patrick Martin*, Carr Men July 1907, p. 966

⁹³ PR: *Eliza McNeill*, Sainsbury Women July 1912, p. 440

parish having been outside of the capital. Ellen Silver was first treated at the Oxford Hospital for an eye condition, before having gone to the City Road Eye Hospital and subsequently being sent to a Hospital at Holden Square, and eventually to see Mr Roughton.⁹⁴ Similarly, Elizabeth Hardman had previously been treated for a variety of conditions at the RFH, the Queen's Square Hospital, and the Brompton Hospital, but had also received treatment at the Brighton Hospital.⁹⁵ Even if the patient had been referred from an institution outside of the capital, however, it was still ultimately their choice whether they followed the recommendation and moved to the next institution.

Other patients appear to have had a preferred hospital to which they and their families returned at times of ill-health.⁹⁶ Elizabeth Osborne had previously been treated at University College Hospital on five separate occasions, whilst Louisa Nash had been repeatedly treated at the Great Northern Hospital (later the Royal Northern Hospital) and Beatrice Stiles at the Homeopathic Hospital.⁹⁷ Unsurprisingly, the RFH was the hospital of choice for many of the patients in the case records. The patients Lucy Forscutt and Christopher Wren had both been treated at the hospital on three occasions at the end of the nineteenth century and had frequently attended the out-patient department.⁹⁸ George Farley was aged only seven years in 1902, but had been an in-patient at the hospital five times in eighteen months.⁹⁹ The nine-year-old William Taylor had been treated in 1905 for pneumonia, in 1906 for heart problems, and in 1907 for his current condition, mitral regurgitation and stenosis.¹⁰⁰ The patient health histories provide an insight into why patients came to be treated at the RFH, although many of the reasons equally apply to why patients chose to be treated at any other hospital. The cost of long-term private medical

⁹⁴ PR: *Ellen Silver*, Roughton Women July 1907, p. 330

⁹⁵ PR: *Elizabeth Hardman*, Carr Women December 1903, p. 516

⁹⁶ PR: *Robert Williams*, Sainsbury Men July 1907, p. 714

⁹⁷ PR: *Louisa Nash*, Berry Women July 1907, p. 393, PR: *Elizabeth Osborne*, Carr Women December 1903, p. 530, PR: *Beatrice Stiles*, Roughton Women July 1907, p. 315

⁹⁸ PR: *Lucy Forscutt*, Carr Women July 1903, p. 351, PR: *Christopher Wren*, Carr Men July 1903, p. 523

⁹⁹ PR: *George Farley*, Sainsbury Men July 1902, p. 18

¹⁰⁰ PR: *William Taylor*, Sainsbury Men July 1907, p. 732

care would have been a strong stimulus for many patients to seek treatment at a voluntary hospital. The patient records do not include financial details of the patients, nor do they indicate whether or not the patient contributed towards the cost of their care. Reports from the Almoner's Office, however, show that most patients were considered eligible for free medical treatment.¹⁰¹ Moreover, the location of a hospital would have determined whether a patient was likely to attend. As was discussed in Chapter Three of this study, most of the patients in the sample records lived within a three mile radius of the hospital, meaning that they were still close to their family and community networks, who they relied upon to visit, and to provide domestic and emotional support (both to the patient and their families) whilst they were in the hospital. In other instances, patients appear to have decided to attend a particular hospital after having been dissatisfied with the treatment they received elsewhere, as in the case of James Albert Cox, whose mother was not satisfied with the treatment provided by her son's doctor and so decided to bring him to the hospital.¹⁰² The use of multiple or preferred hospitals on the part of the patient demonstrates the diversity of the hospital setting of early twentieth century London, and shows that even very poor patients could act as consumers with medical agency to pick and choose their treatment preferences. Moreover, the majority of hospital treatment would not have been paid for by the patients, meaning that the specialist treatments which were developing in the hospital setting would have benefited all classes of society.

In terms of the RFH, it has already been determined in the discussion above that it was common for patients to have been admitted after having been advised to go to the hospital or recommended for admission by private practitioners or other medical professionals in the wider community. In 1907 the patient Annie Sinkins was sent to the hospital by Dr Woodwark of Shoot up Hill, whilst Arthur James was admitted after Dr

¹⁰¹ *Almoner Report Book*

¹⁰² PR: *James Albert Cox*, Sainsbury Men December 1902, p. 472

Jefferson of Shanklin wrote to Mr Berry and asked for the patient to be treated.¹⁰³ Both Mary Ann Maynard and Frederick Howard were also sent to the hospital by their doctors, whilst Elizabeth Wells had gained admission after the Union Doctor at East Grinstead wrote to the hospital asking that she be treated.¹⁰⁴ Not all patients were advised to go specifically to the RFH, however, such as in the case of Daniel O'Neil, who had been advised by Dr Bodkin of Chelsford to attend any London hospital.¹⁰⁵ In this instance the patient may well have decided to seek treatment at any other general hospital in the metropolis, but for reasons unrecorded in the case history, he at some stage chose the RFH. This decision may have been based on the medical staff of the hospital, as many patients attended in order to be treated by a specific physician or surgeon. It is unsurprising, given that Mr Roughton was the 'Surgeon for Diseases of Throat, Nose, and Ear' and that he also worked at the Dental Hospital, that the patients advised to seek treatment from him at the hospital were primarily those suffering from related complaints. For example, Brenda Chyraens, who suffered from discharge from her nose, was sent to Roughton by Miss Glanville of Tunbridge Wells.¹⁰⁶ Berry was renowned for his work in the fields of cleft palate and hare lip surgery and thus it is not unusual to find patients (usually children) suffering from these complaints treated by him at the hospital, such as two-and-a-half year-old Charles Foster and four-and-a-half year-old Arthur Killby.¹⁰⁷ Both of these patients, however, had undergone cleft palate operations elsewhere; Killby by Mr Stewart at Guy's Hospital and Foster by Mr D'Arcy at the Victoria Hospital.¹⁰⁸ The parents of these children

¹⁰³ PR: *Arthur F. James*, Berry Men July 1907, p. 595, PR: *Annie Sinkins*, Carr Women December 1907, p. 711

¹⁰⁴ PR: *Frederick Howard*, Carr Men July 1903, p. 520, PR: *Mary Ann Maynard*, Sainsbury Women July 1907, p. 507, PR: *Elizabeth Wells*, Berry Women July 1902, p. 443

¹⁰⁵ PR: *Daniel O'Neil*, Roughton Men July 1902, p. 424

¹⁰⁶ Anon, 'Obituary: Edmund Wilkinson Roughton', *The Lancet*, Vol. 181, Issue 4686, (21 June 1912), pp. 1775-6, PR: *Brenda Chyraens*, Roughton women December 1907, p. 528, RFHA: *The Seventy-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1902: Annual Reports 1900-04 : Book A12 (RFH/1/2/2)*, p. 9

¹⁰⁷ PR: *Charles Foster*, Berry Men December 1907, p. 958, PR: *Arthur Killby*, Berry Men July 1907, p. 568

¹⁰⁸ *Ibid*

were clearly seeking the best cleft palate surgeons available. They may have been either dissatisfied with previous treatment or their previous surgeon was unavailable, and so had chosen to see Berry. Patients and other family members were constantly re-evaluating the healthcare options of their children in order to provide them with the best care.

Patients were also advised to see Berry for a variety of other complaints, such as Eva Padney who suffered from exophthalmic goitre, or Elizabeth Vincent who had a ruptured semi-lunar cartilage.¹⁰⁹ Both of these patients were advised by their doctors to see Berry at the RFH, although it was not only medical professionals who had advised patients to seek treatment from a specific doctor or hospital. The fifty-six-year-old patient Mary Fernie was advised to see Berry for sarcoma of the neck not by a doctor, but by her neighbour.¹¹⁰ The identity of the neighbour is unknown, but their recommendation suggests that either they or someone they knew had been treated by Berry in the past with positive results. This highlights the importance of community networks in the medical market. The reputation of medical individuals was clearly not restricted to medical circles, as patients shared their experiences with their families, friends, and the wider community, and formed their own judgements on medical professionals and institutions. Indeed, some patients preferred the treatment of a particular medical professional so much that they sought them out at different institutions. Daisy Hailstone and Alfred Alabaster had both been treated by Berry at the Alexandria Hospital before their parents brought them to see him at the RFH.¹¹¹ Other patients had been treated at the Dental Hospital before having seen Roughton at the RFH.¹¹²

The fact that the physicians and surgeons who staffed many of the hospitals in one particular community or city, such as London, had worked at a number of other hospitals

¹⁰⁹ PR: *Eva Padney*, Berry Women July 1902, p. 447, PR: *Elizabeth Vincent*, Berry Women July 1907, p. 376

¹¹⁰ PR: *Mary E. Fernie*, Berry Women December 1912, p. 686

¹¹¹ PR: *Alfred Alabaster*, Berry Men December 1902, p. 29, PR: *Daisy Hailstone*, Berry Women December 1902, p. 819

¹¹² PR: *Mabel Mitchell*, Roughton Women December 1907, p. 555

during their career meant that they would have developed a network of contacts to call upon when needed. This highlights a further reason behind how patients had come to be treated at the hospital; they had been sent from staff at other institutions in order that they receive the most appropriate and immediate care. Alice Carter was only six-months-old when she was sent to the hospital from Great Ormond Street Children's Hospital.¹¹³ In 1912, Elizabeth Smyth was sent from University College Hospital to the RFH, and John Kenny was sent from the Temperance Hospital.¹¹⁴ This practice demonstrates that a network existed between hospitals which allowed them to communicate and co-operate with each other. Moreover, many staff members of charitable hospitals volunteered to work at more than one hospital simultaneously. Most medical staff at the RFH during the early twentieth century also worked at other hospitals at the same time: Mr Berry and Mr Roughton, but also Dr Phear, who worked at the City Road Hospital and sent Charles Head to the RFH in 1902.¹¹⁵ Dr Crawford worked both at the RFH and at Kings College Hospital, from which he sent Robert Williams in 1907 due to the lack of available beds.¹¹⁶ Lack of space at a different hospital was another reason why some patients ended up having received treatment at the RFH, such as the patients Louisa Mallett and Henry Knight, who were both sent from University College Hospital as they needed a bed.¹¹⁷

Whilst the reasons behind how and why patients came to be treated in a hospital setting are important, analysing the length of time between the start of the patient's symptoms and their arrival at a hospital is of equal value. In some cases, patients waited years before seeking treatment for serious complaints. The sixty-four-year-old tool-grinder Daniel Diamond suffered from a strangulated hernia for eight years before seeking hospital treatment after he was no longer able to reduce it himself, and the clerk Mary Turner

¹¹³ PR: *Alice Carter*, Carr Women July 1907, p. 734

¹¹⁴ PR: *John Kenny*, Roughton Men July 1912, p. 681; PR: *Elizabeth Smyth*, Roughton Women December 1912, p. 627

¹¹⁵ PR: *Charles Head*, Sainsbury men December 1902, p. 486

¹¹⁶ PR: *Robert Williams*, Sainsbury Men July 1907, p. 714

¹¹⁷ PR: *Henry Knight*, Berry Men July 1907, p. 590, PR: *Louisa Mallett*, Sainsbury Women December 1902, p. 472

waited four years before seeking treatment for the nausea and sickness she experienced after food.¹¹⁸ Such complaints would have made the patients lives extremely uncomfortable, and so the fact they endured these conditions for years without seeking medical assistance provides an insight into how patients judged the seriousness of their own ill-health in relation to the cost of missing work or disrupting their family lives to receive treatment. Patients would not have wanted to miss work for fear of being laid-off, particularly older patients who would have found it harder to find new employment. The reluctance of older patients such as Diamond to seek hospital treatment, however, may also have stemmed from the stigma attached to Victorian hospitals as having been places of death rather than healing, which would have influenced their opinion of hospital treatment from a young age.¹¹⁹ Indeed, some patients had never visited a hospital prior to their current sojourn in the RFH. The forty-two-year-old patient Stephen John Maffey had never been to a hospital before, despite having suffered from typhoid as a child and having spent the ten years prior to his admission to the hospital suffering with phlegm.¹²⁰ Maffey had also experienced six months of wasting before he came to the hospital and was diagnosed with chronic pulmonary tuberculosis and haemoptysis.¹²¹ Other patients were fortunate enough never to have suffered from ill-health serious enough to warrant seeking any form of professional medical care. The health history of fifty-nine-year-old William Walker claims that apart from the occasional head cold he had suffered no other illnesses in his life until in 1912 he fell unconscious in the street and was brought to the RFH, where he was diagnosed with Stroke Adams disease.¹²²

In other cases, patients attempted to self-diagnose the cause of their conditions and convince themselves that they were not in need of hospital care. For example, Flavie

¹¹⁸ PR: *Daniel Dimond*, Roughton men July 1912, p. 668, PR: *Mary Turner*, Carr Women December 1912, p. 428

¹¹⁹ Porter, *The Greatest*, p. 375

¹²⁰ PR: *Stephen John Maffey*, Sainsbury Men July 1912, p. 406

¹²¹ Ibid

¹²² PR: *William Walker*, Carr Men July 1912, p. 959

Febore believed that when her abdominal pain began two years before admission it was due to worry, causing her not to seek medical treatment until it became more acute a month before coming to the RFH.¹²³ Whilst some patients may have been unaware of the seriousness of their complaints, others had been advised to seek hospital treatment for their conditions but still waited until they attended a hospital. The patient May Wilder, who suffered from a swelling in her neck, was advised by Dr South in 1907 to go to a hospital but waited two months before going to the RFH.¹²⁴ Similarly, the sixty-seven-year-old patient Margaret Whitton had been treated as an out-patient for over eight months for pain and vomiting after food, and was told to enter the hospital as an in-patient a fortnight before having been admitted, but claimed that 'she was not able to come in then'.¹²⁵ These examples highlight the choice and control exercised by patients. For many, medical care provided in the home would have been the standard healthcare option of their family for generations, which left the hospital as a last resort.

In most cases the parents or guardians of the younger patients ensured that they received medical attention as soon as they showed signs of ill-health or injured themselves, but there are some examples in the case records of parents waiting days or even weeks before bringing the child to hospital. The mother of Dorothy Dreevey waited eight days before seeking treatment for the four-year-old, who was suffering from diarrhoea and vomiting, whilst the parents of one-year-old Louisa Fawke waited five days before bringing her to casualty suffering from broncho-pneumonia.¹²⁶ In both of these instances, the parents of the patients chose to wait until the condition of their children was dire and their outlook bleak before taking them to the hospital. In the case of Louisa Fawke, by the

¹²³ PR: *Flavie Febore*, Berry Women July 1907, p. 381

¹²⁴ PR: *May Wilder*, Berry Women December 1907, p. 783

¹²⁵ PR: *Margaret Whitton*, Carr Women December 1907, p. 727

¹²⁶ PR: *Dorothy Dreevey*, Sainsbury Women December 1902, p. 503, PR: *Louisa Fawke*, Sainsbury Women December 1912, p. 654

time she was admitted her body was in a state of collapse, and she died two days later.¹²⁷ Perhaps the parents of patients such as Dreevey and Fawke were unaware of the dangers of childhood disease, or at least unable to recognise the signs of serious ill-health until they became extreme. Whilst the high levels of infant mortality which occurred during the nineteenth century should have made people aware of childhood diseases, perhaps the fatal reputation of such diseases had caused parents to assume the worst when their child got sick. In another case, the health history of the twenty-one-month-old Dorothy Seaton stated that when she was only four-months she fell out of a chair and hurt her head, but instead of immediately seeking medical aid, her mother reported that after the accident the patient lived in a neglected condition and had very little to eat for six weeks.¹²⁸ Exactly what constitutes child neglect is a complex issue, but clearly in this instance the parents recognised that the child was not sufficiently provided for. The patient's mother added that since that time the patient was 'well cared for and looked after', which suggests that the family were experiencing financial problems at the time of the child's accident which they later overcame. Another explanation, however, could have been that the parents did not seek medical aid for the child as they believed she was already unlikely to survive, as in her health history the patients mother claimed that the child had 'always been ailing more or less'.¹²⁹ Either way, as children could not act as solo agents or consumers in the medical market, they relied on their parents or guardians to fairly represent them.

In most instances of accidents and emergencies, however, patients or their guardians did not wait to seek treatment, having chosen or been brought to a hospital in close proximity. The ten-month-old James Allen suffered from scalds on his abdomen and was brought to Gate where his wounds were dressed with picric acid.¹³⁰ The nine-year-old Maud Herring was also brought to Gate with injuries to her face, which were stitched

¹²⁷ PR: *Louisa Fawke*, Sainsbury Women December 1912, p. 654

¹²⁸ PR: *Dorothy Seaton*, Sainsbury Women December 1902, p. 499

¹²⁹ Ibid

¹³⁰ PR: *James Allen*, Berry Men July 1902, p. 644

before her admission.¹³¹ Child patients would not have had a say in where they received treatment. They were brought to the hospital by their guardians. Some adult patients were also brought to the RFH as they were not in a condition to decide for themselves where to receive medical attention. The patient Richard Dyes was brought to the hospital by a policeman after having vomited in the street, whilst Harry Handford was brought by an unidentified individual after falling from a ten-foot high wall and suffering a concussion.¹³² Indeed, if they had suffered a very serious or painful accident, it should be assumed that patients attended one of the nearest emergency departments. Such patients might include Herbert Moules, who broke his leg whilst laying timber under the railway at Finsbury Park Station by catching his heel in a roller and being knocked down.¹³³ Arthur Stanghton also suffered a railway related injury, with his little finger having been crushed by a railway carriage so badly that it was removed at Gate under gas, and a skin graft was needed for the wound left on his hand.¹³⁴ It is not surprising to see that railway related injuries were treated at the RFH, given that it was located close to one of the major hubs of the network at Kings Cross. Though many adult patients did not chose themselves to come to the RFH, however, they did act as agents of their own healthcare by choosing to stay.

It has to be remembered, however, that whilst a patient may have decided to attend the RFH for treatment, they were not automatically admitted. Space at the hospital was in constant demand and caused patients like Christine Bensley to be told by the staff at the Gate that they would not be admitted unless their condition worsened (which incidentally, is exactly what happened in Bensley's case).¹³⁵ Others would have been admitted if the wards were not already full. The patient Florence Brown (who was suffering from a heart condition) was told to stay in bed until space became available in the hospital, whilst

¹³¹ PR: *Maud Herring*, Berry Women December 1912, p. 694

¹³² PR: *Richard Dyes*, Carr Men December 1903, p. 963, PR: *Harry Handford*, Roughton Men December 1907, p. 1028

¹³³ PR: *Herbert Moules*, Berry Men December 1902, p. 5

¹³⁴ PR: *Arthur Stanghton*, Berry Men July 1902, p. 647

¹³⁵ PR: *Christine Bensley*, Sainsbury Women July 1912, p. 429

Thomas Allen (who had carcinoma of the stomach and liver) was asked to return after a week as a bed might have opened up.¹³⁶ The parents of twenty-three-month-old Howard Foess (who was suffering from broncho-pneumonia) were also told that their son could not be admitted until a bed was free.¹³⁷ These patients were all suffering from serious health complaints which required hospital treatment, but the RFH was simply not a large enough institution to accommodate all those patients seeking care. It is surprising that the medical staff did not send such patients to other hospitals, given that we have discussed examples of patients having been sent to the RFH from other institutions. We must assume that if a patient was in dire need of medical attention that they would have sought hospital treatment at another institution or the Poor Law, and not waited for a bed. As we have seen, however, some patients required the treatment of a specific staff member at the RFH and so may well have been prepared to wait in order to be seen by them.

Whilst the patient case records have shown how patients could make use a number of hospitals throughout their lives, they also provide a unique insight into how hospitals worked together in order to provide the patient with the most appropriate treatment. This is a point which has received little, if any, consideration in the current literature. In many cases the health history provided by the patient was supplemented with old case records obtained from other hospitals. The file records of Ethel Norris contained an extract from papers at the Miller Hospital, whilst that of Emma Cole included notes from the patient's previous treatment at the Royal Hospital for Diseases of the Chest on City Road.¹³⁸ Equally, the case records of Nellie Farrier and Rose Tyson included notes from the New Hospital and St Bartholomew's respectively.¹³⁹ The practice of the medical staff at the RFH having had case notes from another hospital at the time of the patients' admission

¹³⁶ PR: *Thomas Allen*, Carr Women July 1907, p. 959, PR: *Florence Brown*, Sainsbury Women December 1907, pp. 811, 818, 828

¹³⁷ PR: *Howard Foess*, Sainsbury Men December 1907, p. 1138

¹³⁸ PR: *Emma Cole*, Sainsbury Women December 1912, p. 663, PR: *Ethel Norris*, Sainsbury Women December 1902, p. 481

¹³⁹ PR: *Nellie Farrier*, Carr Women December 1907, p. 706, PR: *Rose Tyson*, Berry Women July 1907, p. 401

implies that either the hospital requested the records from the other institutions or the patients brought them to the hospital personally on admission. Typically patient records were stored at a hospital until patient discharge and eventually bound. Once a patient's records had been requested from another hospital, it was the task of the administrative staff at that hospital to search back through potentially hundreds or thousands of records in order to find the one in question and either have it taken to the RFH, or if it was already bound, to have it copied in order not to remove the binding. This was an expensive and time-consuming process, little understood by the current historiography. Moreover, if a patient only revealed on admission that they had previously received treatment at a different hospital, the staff at the RFH would not have any previous records until they had been requested, located, and transferred, which may have taken days. This system demonstrates how medical health care providers contributed to the expansion of the Victorian information state at a personal and institutional level.¹⁴⁰ Regardless of the practicalities, however, it is likely that the practice of record sharing was developed as a result of patients making use of numerous hospitals throughout their lives, and is an example of the network which existed between hospitals in order that the medical staff might have as detailed a treatment history as possible.

Aftercare

Hospitals like the RFH were not, however, the final or ultimate means of medical care through which patients could expect to recuperate from ill-health. Whilst the hospital treated patient's immediate health complaints, they were usually discharged with advice, medicine, or medical instruments. Patients were often advised to rest and allow themselves to recuperate, as in the cases of Frederick Cox and Emily Luck, who were both told to rest

¹⁴⁰ See: E. Higgs, *The Information State in England: the central collection of information on citizens, 1500-2000*, (Palgrave, London, 2004)

for a fortnight.¹⁴¹ This was not always a practical option for patients who had families and jobs to get back to after a period of ill-health, and so the help of family and community networks would have pivotal to their recuperation. Some were advised to lead healthier lives, such as Thomas J. Thomas, who was advised by Berry to give up beer and spirits for at least three months.¹⁴² Patients were also often encouraged to lead ‘outdoor lives’, and to take trips or holidays to the country in order to improve their general health by escaping the smog and fumes of the metropolis.¹⁴³ Many were discharged with prescriptions, such as Ellen Wilson, who was to use a heroin and cocaine throat spray.¹⁴⁴ The use of medical instruments or equipment was also often a condition of the patients discharge, such as it was for Lizzie Holmes, who was to wear a back splint to limit her knee movement.¹⁴⁵ Others were discharged wearing suspenders to support the scrotum, colostomy belts, trusses, and flannel binders.¹⁴⁶ Often, patients were only discharged on the condition that they returned to the hospital for follow-up treatment. Patients returned to the Outpatient Department to have minor treatment, such as getting stitches removed and dressings changed.¹⁴⁷ Albert Smart and Emily Moore were required to come up to the hospital for daily massage treatment.¹⁴⁸ Some needed to return for more major care, such as Henry Cordery, who was to receive gonorrhoea treatment, or George Horner and Lily Draper, who both needed to come to the hospital frequently for electrical treatment.¹⁴⁹

¹⁴¹ PR: *Frederick Cox*, Carr Men July 1903, p. 547, PR: *Emily Luck*, Berry Women December 1902, p. 802

¹⁴² PR: *Thomas J. Thomas*, Berry Men December 1907, p. 963

¹⁴³ PR: *William Bear*, Sainsbury Men July 1902, p. 4, PR: *Claude Flower*, Roughton Men December 1902, p. 587, PR: *Eva Padney*, Berry Women July 1902, p. 447

¹⁴⁴ PR: *Elizabeth Pample*, Roughton Women July 1902, p. 845, PR: *Mary Walker*, Sainsbury Women July 1907, p. 498, PR: *Ellen Wilson*, Roughton Women December 1902, p. 956

¹⁴⁵ PR: *Lizzie A. Holmes*, Berry Women July 1902, p. 472

¹⁴⁶ PR: *Debby Bore*, Roughton Women December 1912, p. 616, PR: *Matilda Collins*, Sainsbury Women December 1902, p. 485, PR: *John McFadden*, Berry Men July 1902, p. 623, PR: *James Edward Mitson*, Berry Men July 1902, p. 626

¹⁴⁷ PR: *Amy Abbott*, Berry Women December 1907, p. 778, PR: *James Allen*, Berry Men July 1902, p. 644, PR: *Violet M. Risley*, Berry Women July 1902, p. 482

¹⁴⁸ PR: *Emily Moore*, Berry Women July 1907, p. 420, PR: *Albert Smart*, Roughton Men December 1907, p. 992

¹⁴⁹ PR: *Henry Cordery*, Berry Men December 1912, p. 960, PR: *Lily Draper*, Berry Women July 1912, p. 489, PR: *George Horner*, Berry Men December 1907, p. 950

Frequently, patients were discharged to other medical professionals or institutions. Patients including William Godding were discharged into the care of their usual doctor, who was generally the family's General Practitioner.¹⁵⁰ Nathan Moses was removed from the RFH by his parents in order to be taken to the Orthopaedic Hospital, Daisy Hailstone was sent to the Alexandria Hospital, and Elizabeth Hardman to the National Hospital for Paralysis.¹⁵¹ More often, patients were transferred to the Fever Hospital, also referred to as 'the Infirmary', in order to limit contagion at the RFH.¹⁵² Howard Foess was sent to the Infirmary with measles, Jack Winch with diphtheria, and both Annie Jeal and Harry Lock with scarlet fever.¹⁵³ An important aspect of medical care provided by the RFH was to ensure that patients in need of recuperation or convalescent aftercare were moved to a suitable home or facility. It was the role of the medical staff and the team of almoners to ensure that patients were discharged only when they had other means of medical care or respite help to rely upon, and to which they were willing to attend. The most common aftercare organised for patients through the hospital was placement at a convalescent home. The Dresden Assistance Fund (discussed in Chapter Two) spent approximately £740 on convalescent treatment for outpatients during 1912 alone.¹⁵⁴ Patients including Ruby Lincoln, George Harvey, and Bertie Shan, were all discharged to Eastbourne Convalescent Home.¹⁵⁵ Many were discharged to convalescent homes at Bexhill, Broadstairs, Hale, Weston-Super-Mare.¹⁵⁶ Others were sent to homes at St. Sermades-on-Sea, Bognor,

¹⁵⁰ PR: *William Godding*, Berry Men July 1912, p. 701

¹⁵¹ PR: *Daisy Hailstone*, Berry Women December 1902, p. 819, PR: *Elizabeth Hardman*, Carr Women December 1903, p. 516, PR: *Nathan Moses*, Roughton Men July 1907, p. 611

¹⁵² PR: *Frederick Davis*, Carr Men July 1912, p. 613, PR: *Rose Meyers*, Carr Women July 1912, p. 250, PR: *Grace Nye*, Carr Women December 1907, p. 703

¹⁵³ PR: *Howard Foess*, Sainsbury Men December 1907, p. 1138, PR: *Annie Jeal*, Berry Women December 1907, p. 770, PR: *Harry Lock*, Roughton Men July 1907, p. 608, PR: *Jack Winch*, Carr Men December 1907, p. 975

¹⁵⁴ RFHA: *The Eighty-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1912*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), p. 33

¹⁵⁵ PR: *George Harvey*, Sainsbury Men December 1902, p. 463, PR: *Ruby Lincoln*, Sainsbury Women December 1902, p. 454, PR: *Bertie Shan*, Berry Men December 1902, p. 23

¹⁵⁶ PR: *Kate Barnes*, Sainsbury Women December 1907, p. 856, PR: *James Dent*, Carr Men December 1912, p. 1004, PR: *Nellie Farrier*, Carr Women December 1907, p. 706, PR: *Alfred Herring*, Roughton Men July

Ventor, Folkstone, Otham, and Alton.¹⁵⁷ Placements were usually organised for periods up to three weeks.¹⁵⁸ Convalescent homes were not, however, the only aftercare facility to which the RFH transferred patients. Maud Sartain and Henry Crow were moved to sanatoriums, whilst Millie Thompson was sent to a Sisters Nursing Home in the country.¹⁵⁹ Patients were also discharged to a Salvation Army Home, a Merchant Taylor Home at Bognor, and to a long-term home at Hurstpierpoint.¹⁶⁰

Aftercare treatment was therefore diverse, and deemed a necessary part of long-term patient care. Clearly, the RFH did not consider itself a place of respite or recuperation, but was instead focused on treating the immediate health concerns of the patients before ensuring they had a bed at a convalescent home or other centre of rehabilitation.

Conclusion

Overall, the case records of the RFH have shown that patients acted as ‘agents’ to their own healthcare by making conscious, consumer-like decisions as to where and when it was best to seek medical advice and treatment at different periods of ill-health. Whilst historians including Porter and Digby have shown that patients controlled a degree of their healthcare, the case records of the RFH have demonstrated the extent of that control.¹⁶¹ Self medication techniques were common, particularly as an initial response to the onset of

1912, p. 644, PR: *Henry Knight*, Berry Men July 1907, p. 590, PR: *Ivy Lee*, Carr Women December 1912, p. 449,

¹⁵⁷ PR: *George Davis*, Carr Men December 1912, p. 976, PR: *Ernest Felix*, Roughton Men December 1912, p. 1094, PR: *Charles John Guy*, Sainsbury Men July 1912, p. 413, PR: *Herbert Moules*, Berry Men December 1902, p. 5, PR: *Lucy Alice Prior*, Women December 1907, p. 845, PR: *Beatrice Stiles*, Roughton Women July 1907, p. 315

¹⁵⁸ PR: *George Harvey*, Sainsbury Men December 1902, p. 463, PR: *Bertie Shan*, Berry Men December 1902, p. 23

¹⁵⁹ PR: *Henry Crow*, Sainsbury Men December 1912, p. 715, PR: *Maud Sartain*, Sainsbury Women July 1912, p. 461, PR: *Millie Thompson*, Sainsbury Women July 1907, p. 536

¹⁶⁰ PR: *Edith Burrows*, Sainsbury Women July 1912, p. 433, PR: *William Holloway*, Sainsbury Men July 1912, p. 380, PR: *Lily Keep*, Sainsbury Women December 1912, pp. 706 and 709

¹⁶¹ Digby, *The Evolution*, p. 224, Porter, ‘The patient’, p. 91

ill-health, and family and community networks were crucial. This reinforces Berridge's view that the early twentieth century was a transitional period, in which patients used self-medication alongside medical professionals.¹⁶² Moreover, patients often turned to private practitioners before attempting to gain admission to a hospital, both in hope that they would be prescribed medicine to take in the comfort of their own homes, but also in order that if they did require hospital treatment they might have a professional recommendation for admission. Though Digby has discussed the doctor's personality as a factor patients considered when choosing their preferred method of healthcare, the records have demonstrated that there were many other important factors to consider when deciding on the most suitable method of medical treatment. The reputation of the individual or institution, recommendations made by family, friends or other medical professionals, dissatisfaction with previous healthcare providers, and the availability and location of treatment options were all variables.

Many patients made use of multiple hospitals throughout their lives, suggesting that the constellation of deciding factors changed depending on the nature of the ill-health from which they suffered. Others had a preferred hospital to which they returned at times of ill-health throughout their lives, either for practical reasons or as they preferred to seek treatment at an institution which was familiar to themselves and their family. Patients of the RFH were able to make use of multiple or preferred hospitals thanks to the practice of record sharing between institutions, which was an important aspect of how the hospital system of Britain developed prior to the NHS. It was also possible for patients to choose between multiple hospitals due to the fact that so many were located in central London. According to Prochaska, in the 1880s ninety per cent of all hospital beds in London were within walking distance of Charing Cross, and in the 1890s there were eight general and

¹⁶² Berridge, 'Health and medicine', p. 186

twenty-six special hospitals within a mile of the Middlesex Hospital.¹⁶³ Moreover, the practice at the RFH of organising aftercare treatment helps to place the hospital in the wider medical market. It was not a centre of rehabilitation, but understood the importance of such, and took it upon itself to ensure that patients had access to long-term healthcare.

The records have also shown that patients made use of different means of medical assistance simultaneously. There was not, however, one universal pattern of medical treatment to which patients adhered at times of ill-health. For some patients, all self-help methods were exhausted before they sought treatment advice from independent medical professionals, after which they were left with little choice but to enter a hospital. Although most medical professionals practiced independently, a network existed between these individuals that often saw patients referred between them, such as in the case of Alice Se Good, who was sent from a Miss Stepney to Mr Berry, and subsequently to Mr Buzzard.¹⁶⁴ Other patients appear not to have attempted to self-medicate or seek advice from a private practitioner before being admitted to a hospital. It may have been the case that these patients had no family or community networks to turn to at times of ill-health, or perhaps by the late nineteenth century patients were comfortable enough with hospital care that they did not need to actively avoid it. It is important to note, however, that whilst patients made use of a variety of medical treatment options there were other means available which do not appear in the patient health histories, such as workhouse infirmaries. Moreover, many of the medical options listed in the case records appear only rarely, such as the dispensary doctor or the club doctor. The typical patients of the hospital were those who were not destitute and reliant on the workhouse, but were also not in the position to contribute towards medical insurance. Whilst the records have proved that patients acted as consumers in the medical market, it must be remembered that not all means of medical

¹⁶³ Prochaska, *Philanthropy*, p. 7

¹⁶⁴ PR: *Alice Se Good*, Carr Women July 1907, p. 361

assistance were viable options. Indeed, not all patients could seek treatment at voluntary hospitals such as the RFH, as they refused to treat infectious or dangerous conditions.¹⁶⁵

The RFH was therefore an important location in the ‘mixed-economy’ of healthcare in London by 1900. Patients made use of the hospital as a part of the wider medical market for a variety of reasons, which would have altered at each period of ill-health. The following chapters will examine the ailments from which the patients suffered and the treatments they received at the RFH, which in turn will provide an even greater insight into how and why patients chose to attend the hospital.

¹⁶⁵; PR: *Annie Jeal*, *Berry Women* December 1907, p. 770, PR: *Harry Lock*, *Roughton Men* July 1907, p. 608, PR: *Jack Winch*, *Carr Men* July 1907, p. 975

CHAPTER FIVE

PATIENT HEALTH

We know little about the health of the general population during the early twentieth century, as the most detailed perspectives often derive from those works which primarily consider the late nineteenth century and the period of the First World War. The key historiography for this study relating to the health and disease of this period is that relating to the epidemiological transition. Debate has centred on the work of McKeown and his interpretation of changing mortality levels between the eighteenth and early twentieth centuries. McKeown and his supporters claimed that ‘preventative or curative measures had no significant influence on mortality before the twentieth century’.¹ Instead, mortality levels were argued to have been reduced due to an improved environment in which there resulted less incidence and fatality of infectious diseases.² He claimed that a rising standard of living (and diet), better hygiene as introduced by sanitary reformers, and favourable trends in the relationship between the infectious agent and the human host all contributed to reduced mortality levels throughout the nineteenth century.³ Improved nutrition influenced the decline of air-borne infections and reduced exposure was occasioned by better hygiene, reducing water- and food-borne infections. The influence of immunization and therapy was less certain.⁴

Historians have been divided over the accuracy of McKeown’s hypothesis. Hardy and Harris have both supported some aspects of his argument, but have disagreed with others. Harris agreed that nutrition was an important factor in the mortality decline from the eighteenth century, but believed that it has to be regarded as ‘one of a battery of

¹ T. McKeown and R. G. Record, ‘Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century’, *Population Studies*, Vol. 16, No. 2 (Nov., 1962), p. 94

² *Ibid.*, pp. 95-6

³ *Ibid.*, pp. 120-21

⁴ T. McKeown, R. G. Record, R. D. Turner, ‘An Interpretation of the Decline of Mortality in England and Wales during the Twentieth Century’, *Population Studies*, Vol. 29, No. 3 (Nov., 1975), p. 422

factors, often interacting' on Britain's mortality transition.⁵ Although infection and nutrition are interrelated, he highlighted the difficulty in distinguishing between the two, as it was often those individuals who suffered from poor diets that lived in insanitary and overcrowded environments, making them most susceptible to infectious outbreaks.⁶ Harris believed that McKeown should have paid more attention to the effects urbanization would have had on the nature of the disease environment, and to how the increase in the value of real wages enabled people to secure improved housing.⁷ According to Hardy, however, the rise in real incomes had little effect on improving the national dietary standards in Britain.⁸ Her work reiterates the importance placed on the decline of infectious diseases by McKeown in the mortality decline since the eighteenth century. To date, Hardy remains the only historian to have comprehensively considered the prevalent infectious diseases of the nineteenth century, with particular focus on the eight major endemic and periodically epidemic infections which McKeown claimed contributed to the mortality decline.⁹ These diseases were whooping cough, measles, scarlet fever, diphtheria, smallpox, typhoid, typhus, and tuberculosis. She claimed that during the 1860s 'these diseases as a group contributed nearly thirty per cent of the total annual deaths' in England and Wales.¹⁰ By 1900 nearly all of these had declined as causes of death, and their share of annual mortality had dropped to under twenty per cent.¹¹ Hardy believed that sanitary reform made a positive contribution to reduced mortality rates, but in contrast to the ideas of McKeown,

⁵ B. Harris, 'Public Health, Nutrition, and the Decline of Mortality: The McKeown Thesis Revisited', *Social History of Medicine*, Vol. 17 No.3 (2004), p. 379 - 80

⁶ *Ibid*, p. 381

⁷ *Ibid*, p. 406

⁸ A. Hardy, *Health and Medicine in Britain since 1860* (Palgrave, Basingstoke, 2001), p. 38

⁹ A. Hardy, *The Epidemic Streets; Infectious Disease and the Rise of Preventive Medicine 1856-1900*, (Clarendon Press, Oxford, 1993), p. 3

¹⁰ *Ibid*

¹¹ *Ibid*

has also claimed that medical intervention made a positive contribution in London during the nineteenth century.¹²

Mooney has agreed that the ‘great killing infections’ declined over the course of the nineteenth century, but claimed that more importance should be placed on chronic degenerative diseases such as cancer and heart disease, and the influences that acted upon them.¹³ Whilst improved living standards and diet played their part in diminishing the mortality risks associated with urban living, he suggests that it was the success of sanitary reforms that had a large influence on ameliorating the problem.¹⁴ Mooney and Luckin claimed that in London, ‘significant innovations in public health, the provision of private and charitable medicine, and elementary systems of environmental control’ were collectively one explanation for the consistently higher levels of life expectancy at birth in the city than in other areas over the course of the nineteenth and early twentieth century.¹⁵ This view of the McKeown thesis is similar to that of Woods and Hinde, who claimed that ‘McKeown overstates the case for mortality decline caused by improvements in nutrition’, and that it was improvements in sanitation and water supply, and better local administration that in fact had the most influence on life expectancy.¹⁶ Szreter also believed that increasing momentum in public health measures from the 1860s had more impact on the mortality decline than improvements in nutrition.¹⁷ Guha, on the other hand, argues that it was the changing nature of the population’s resistance to infectious diseases which was the primary cause of mortality decline over the course of the nineteenth century,

¹² A. Hardy, ‘Diagnosis, Death, and Diet: The Case of London, 1750-1909’, *Journal of Interdisciplinary History*, Vol. 18, No. 3 (Winter, 1988), p. 400, Hardy, *The Epidemic*, pp. 293-4

¹³ B. Luckin and G. Mooney, ‘Urban history and historical epidemiology: the case of London, 1860-1920’, *Urban History*, Vol. 24, Pt. 2, (1997), p. 38

¹⁴ G. Mooney, ‘Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England and Wales’, *Social History of Medicine*, Vol. 10, No. 1 (1997), p. 54

¹⁵ *Ibid*, p. 45

¹⁶ R. Woods and P. R. A. Hinde, ‘Mortality in Victorian England: Models and Patterns’, *Journal of Interdisciplinary History*, XVIII: I (Summer 1987), p. 53

¹⁷ S. Guha, ‘The Importance of Social Intervention in England’s Mortality Decline: The Evidence Reviewed’, *Social History of Medicine*, Vol. 7, (1994), p. 102, and S. Szreter, ‘Mortality in England in the Eighteenth and the Nineteenth Centuries: A Reply to Sumit Guha’, *Social History of Medicine*, Vol. 8, (1994), pp. 269 and 274

though increased resistance on the part of the female population against tuberculosis he attributed to improvements in nutrition.¹⁸

The debates over the epidemiological transition and the causes of the mortality decline are ongoing, but notwithstanding, we can observe that the debate has only touched lightly on the Edwardian period and on the experience of health and mortality in London.¹⁹ This chapter aims to contribute to these debates and to the historiography of health and disease more widely, by examining the life-cycle of ill-health experienced by the patients of the Royal Free Hospital (henceforth RFH) in order to identify the prevalence of various conditions amongst the population as opposed to instances of mortality. Difficulties will arise when taking up the task of moving from and between the analysis of the patient case histories collectively and the stories of individuals, and more widely from the sample to the general population.

The resolution in this instance will be to employ case studies that seem to exemplify the main characteristics of the disease profile of the RFH patients at point of entry and over their life-cycle. We will see that such case studies not only represent the ill-health experienced by patients of the RFH, but allude to the health and medical practice of the wider community during the early twentieth century. Patient case records are an excellent and unique means of identifying the types of ill-health patients suffered throughout their lives, but such records are rarely used as an historical source. The chapter consists firstly of an examination of patient case records as a source, in this particular endeavour, followed by a short but essential note on the changing nature of ill-health classification over the course of the late nineteenth and early twentieth century. The remaining text is divided into two major sections that examine the current health of the patients, and the previous and family health contained in the case records. The first of these

¹⁸ Guha, 'The Importance', pp. 100, 102, and 113

¹⁹ P. Weindling, 'From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries', in A. Wear (Ed.), *Medicine in Society; Historical Essays*, (Cambridge University Press, Cambridge, 1992), pp. 303 – 316

sections (and the main focus of this chapter) examines the current ailments for which the patients sought treatment at the hospital and considers the causes of those ailments. Never before have patient case records been used to identify the ill-health suffered by a section of the population on this scale. This section will focus on the most prevalent specific ailments suffered by the patients, the most prevalent classification of ailments, and will explore the physical condition of the patients, including their weight and the condition of their teeth, providing incidental insight into the wider health of the population during this period. The second section considers the previous health histories of the patients. In the case of the older patients, this allows for the health of the patients to be identified from the mid-nineteenth century as a representation of how the wider population suffered ill-health throughout their lifetimes. Such analysis will provide a unique and valuable contribution towards ongoing debates regarding the epidemiological transition by tracing the real longitudinal experiences of trends in ill-health.

The family health histories included in the records allow us to further expand our knowledge of the health of the population during the period between the mid-nineteenth century and the onset of the First World War, as the ill-health of potentially over double the number of individuals sampled can be assessed. By examining the health of the patient's families, this study reflects on the collective experience of ill-health and not simply on the health of isolated individuals. Family health histories often include contagious ill-health, which would often have been suffered by many members of the same family living in close proximity, and hereditary ill-health issues passed down through generations. The histories contained in the records reflect current ailments suffered by various family members, previous ailments from which those members suffered, and causes of death in the family. The broad themes of ill-health causation will be discussed throughout the chapter based on the ailments recalled in the patient records. Occupational health hazards, accidents and self-harm, public health concerns, and the habits of patients

will be examined in relation to the ill-health reported. The habits of the patients recalled in the records reflect wider health concerns over the consumption of such substances as alcohol, tea, coffee, and tobacco, while the practice of recording the previous travel habits of the patients demonstrates the sensitivity of medical staff to the prospect of foreign health hazards. The attitudes and beliefs of both the patients and the medical staff in regards to what constitutes a healthy lifestyle will also be discussed.

Patient Case Records

Before examining the health of the patients and their families recorded in the case histories, it is important to discuss the structure and content of the patient case records themselves in order to understand the information drawn from them, and judge their reliability as a source of health information. Each case record is made up of a front cover page, which contains pre-printed boxes for such information as the medical staff associated with the case, the patients name, age, sex, marital status, and occupation, along with their admission and discharge dates, the diagnosis, a clinical abstract, and the result of their treatment. The remainder of the record is made up of blank pages in which the medical staff took note of the patients' condition on admission, the history of the current complaint from which they suffered, relevant health histories, treatment information, daily notes, and diagnosis. In most instances, the health histories include a history of the current complaint from which the patient was suffering, a history of the patient's previous ill-health, and a history of the health of the patient's family. The images on the following pages show a typical patient case record of the surgeon Mr. Roughton, from the year 1907.²⁰ In order to understand how the patient case records were compiled, and judge how accurate and

²⁰ Royal Free Hospital Patient Case Record (henceforth PR): *John Dale*: Roughton Men December 1907, pp. 1008-1009:1

reliable their conclusions were likely to be, it is important to explain the principles behind the process of diagnosis. According to the surgeon James Berry, the correctness of the diagnosis depended both on the ‘fullness and the accuracy of the information obtained’ from the patient, and on the ‘experience and knowledge’ possessed by the medical staff.²¹ The professional histories of the physicians and surgeons compiled in the second chapter of this study strongly suggest that these medical men held sufficient knowledge in their respective fields, and so the accuracy of their diagnosis should theoretically have depended on the information they obtained of the patient’s illness. Questions such as “Have you, or have you ever had, anything else the matter with you?” were suggested by Berry as a useful means of revealing ‘some obscure or unnoticed feature in the condition of the patient or in the history of the case’.²²

Although such questions were considered useful, Berry advised the recorder to induce the patient to ‘tell his story in his own way’.²³ If the patient was not able to recall their health history themselves, information should then have been sought from family and friends, or anyone else who had opportunity to observe the symptoms of the patient’s present condition.²⁴ The practice of taking three part patient health histories was not unique to the RFH, but a crucial aspect of the process of diagnosis in the wider medical community, notwithstanding suggestions that the patient narrative became unimportant in the nineteenth century. A full history of the patient’s health ought to have included;

1. The history of the disease, illness or injury from which the patient is at present suffering.
2. The past history, relating to any disease, illness, or injury antecedent to the commencement of the present trouble.
3. The family history, relating to diseases whether of a similar kind or not, that may have occurred in other members of the patient’s family.²⁵

²¹ J. Berry, *A Manual of Surgical Diagnosis*, (J. & A. Churchill, London, 1904), p. 1

²² *Ibid*, p. 5

²³ *Ibid*, p. 13

²⁴ *Ibid*, p. 14

²⁵ *Ibid*, p. 1

The practice of recording the patient's health history was followed by a physical examination of the patient by the physician or surgeon. While this chapter must address some of the issues surrounding the process of diagnosis in order to determine the reliability and accuracy of the patient records, the practical methods of the physical examination will not be examined until the following chapters, specifically in relation to the treatment the patients underwent at the hospital and their experience of the process of diagnosis.

As with any historical source, when using patient case records we must remain aware of how they were compiled in order to assess what information may be missing. When taking the patients previous health history, it may have only been the information regarded as relevant to the current case that was recorded, and so it has to be remembered that many ailments or conditions may have been omitted.²⁶ In some cases no patient health history was recorded, as nothing was considered relevant to the current complaint, as in the case of Walter Wilson, who himself suffered from an undecended testicle, and whose family history listed only those family members suffering from the same.²⁷ In the case of Alexander Morland, who was treated for bronchitis, his family history focused on the other family members who had suffered or died from bronchitis or related chest complaints.²⁸ On other occasions, the staff member sought relevant information on the current patients complaint, but found 'nothing bearing on case', such as in the cases of Millie Thompson who suffered from Sprue (a tropical disease), Ernest Mitchell who suffered Pyrexia (fever), and John McFadden, who was operated on for varicocele.²⁹ According to Berry, family history was rarely of any real importance in diagnosis, except in the cases of the few diseases which 'show a marked tendency to be transmitted from one generation to

²⁶ Ibid, p. 16

²⁷ PR: *Walter Wilson*, Roughton Men December 1912, pp. 1072-3

²⁸ PR: *Alexander Morland*, Sainsbury Men December 1907, pp. 1151 and 1153:1

²⁹ PR: *Millie Thompson*, Sainsbury Women July 1907, pp. 536 and 538:1, PR: *Ernest Mitchell*, Sainsbury Men July 1907, pp. 728 and 729:1, and PR: *John McFadden*, Berry Men July 1902, pp. 623-4

another'.³⁰ Family histories also acted to highlight 'some common influence' to which all members had been exposed.³¹ Such influences could have been infectious conditions, but also 'some common source of the disease' from which the patient was exposed to in early life, such as 'having lived in a goitrous district and drunk goitriiferous waters'.³² Family members were likely to have been brought up together in the same household, and so it was believed that they were likely to develop similar diseases based on insanitary living conditions, bad water supply, bad ventilation, or improper feeding.³³ In such cases, diseases may have had the 'epidemiological appearance of hereditary maladies', when in fact the nature of family ailments would have been due to the environment in which they lived.³⁴

While some information regarding the health history of the patients and their families may be missing from the patient records, the huge amount of health data they do contain justifies their use as an insight into the health of the population during the late nineteenth and early twentieth centuries. Major previous and family health complaints appear to always have been recorded. The majority of instances where 'nothing bearing on case' was reported relate to surgical accident cases, and thus the general health of the patient and their family had no relevance, such as in the case of John Dale, whose record is included above. Nonetheless we face further technical problems. Thus, in those cases where a patient history was recorded, it was rare for each previous complaint to be recorded by date, or by age. In cases where no more information was given than 'has had measles', or 'suffered as a child', we cannot cross examine the ailments suffered by year, season, or patient age as can be done with the current ailments. Overall, the information

³⁰ Berry, *A Manual*, p. 18. For further reading on the risk of hereditary ill-health, see: P. Jasen, 'Breast Cancer and the Language of Risk, 1750-1950', *Social History of Medicine*, Vol. 15, No. 1, (2002), pp. 17-43

³¹ *Ibid*

³² *Ibid*, pp. 18-19

³³ *Ibid*, p. 19

³⁴ J. C. Waller, 'The Illusion of an Explanation': The Concept of Hereditary Disease, 1770-1870', *Journal of the History of Medicine and Allied Sciences*, Vol. 57, No. 4, (Oct 2002), p. 413

contained in the family histories can be divided into the complaints from which family members were currently suffering in the sample years, those which family members had previously suffered, and those from which family members had died as a result. The family health section of this chapter will therefore use these categories.

A further consideration when using patient histories is that they can usually only represent ill-health that has been recalled from the patients memories. Many complaints may have been forgotten, especially those suffered in infancy. It would have been important for people to be aware of their own personal health histories, and presumably to make sure that their parents or other family members made sure they knew all of the ill-health they suffered earlier than their memory could serve. It was imperative that parents or other older family members could recall the health histories of child patients. In instances of adult patients who were too ill to recall their own health history however, it was the responsibility of family or friends to recall this information as best they could. Unless the patient was still close to individuals who would have known them all their lives and known their full medical history, it was probably unlikely that anyone but the patient would have known of all complaints previously suffered. That said, the length and detail of many of the health histories contained in the patient records indicates that the population were very good at remembering ill-health. The information they did recall represents that which was regarded as worth remembering.

Overall, patient records provide as comprehensive a snapshot as is possible and available of the life-cycles of ill-health and probably represent the types of complaints suffered by the wider population during this period. Such information is important for advancing a historiography which predominantly focuses on the impact of various health complaints on mortality levels, and not on the complaints suffered by the population throughout their lifetimes. The majority of the patients lived (as we have seen in Chapter Three) in and around central London, and were deemed eligible to receive medical

treatment at a free hospital. These patients were therefore dominantly members of the lower working class, including labourers and domestic servants, for whom large medical expenses meant poverty. In all senses, then, they were representative of the population at large.

Ill-Health Classification

Though the main individual complaints suffered by the patients in the sample will be examined in this chapter, a broader understanding of ill-health during this period can be gained from grouping the complaints suffered into categories or classifications. The various classifications of disease adopted by both contemporary medical minds and historians demonstrate that there was no standard division of ill-health during the late nineteenth and early twentieth centuries, and in a system that allowed for individual tastes and knowledge, the adoption of one particular form of classification for this study is problematic. The most obvious manner of achieving this is classifying ill-health by the system of the body affected, such as respiratory or digestive complaints. There are, however, numerous overlapping disorders, such as cancers or tuberculosis, which can occur frequently in many systems of the body. The method of classification which would best suit epidemiological transition debates is that which divides complaints into infectious or chronic. Given that the RFH admission policy excluded patients who suffered from infectious conditions, however, this system would hardly provide an accurate representation of the ill-health suffered by the wider population during the early twentieth century (although as we will see in the current complaints section of this chapter, some infectious cases were admitted to the wards of the RFH). Furthermore, the records do not always specify whether a diagnosis was chronic or acute in nature. Whilst conditions including cancers or heart disease can be identified broadly as chronic, the nature of

respiratory complaints such as bronchitis cannot be known unless specified. The diagnosis of bronchitis in the cases of Alexander Morland and William Wrigfield, who had both suffered coughs and chest trouble for years, suggests that it referred to the chronic version of the complaints, but we cannot assume that all such diagnosis reflected the same.³⁵

Moreover, we must balance both contemporary and modern epidemiological knowledge. Contemporary medical textbooks are an excellent source of disease classification, as they contain the system of ill-health division that was taught to the profession. Examination of such textbooks soon proves problematic. Each adopted and advocated different divisions of ill-health and disease. In 1907 Caillé divided ill-health into groups based primarily on the part of the body affected.³⁶ His divisions were those of paediatrics; the digestive system; circulatory system; respiratory system; genitourinary system; the osseous, muscular, and articular system; infectious and contagious fevers; diseases due to faulty metabolism, internal secretions, and defragments of the ductless glands; nervous system; dermatological; and otic and ophthalmic diseases.³⁷ In the work of R. Wilcox (also of 1907), however, ill-health was classified according to: infectious diseases; constitutional diseases; the intoxications; diseases of the digestive system and peritonaeum; of the blood; of the ductless glands; of the heart and blood-vessels; of the respiratory system; urinary system; nervous system; muscular system; and parasitic diseases.³⁸ Berry assigned diseases for the purpose of diagnosis into further categories still; congenital malformations; atrophy; hypertrophy; inflammation; extravasations, accumulations, concretions; parasites; new growths; deformities; nervous and hysterical affections; and injuries.³⁹ These classifications were suggested for the purpose of making a

³⁵ PR: *Alexander Morland*, Sainsbury Men December 1907, p. 1151, PR: *William Wrigfield*, Sainsbury Men December 1907, p. 1158

³⁶ A. Caillé, *Differential Diagnosis and Treatment of Disease: A Text-Book for Practitioners and Advanced Students*, (D. Appleton and Company, New York and London, 1907), Contents, pp. vii-xxiv

³⁷ *Ibid*

³⁸ R. Webb Wilcox, *The Treatment of Disease: A Manual of Practical Medicine*, (P. Blakiston's Son & Co., Philadelphia, 1907), Contents, pp. ix-xxii

³⁹ Berry, *A Manual*, p. 10

diagnosis by excluding all other possible causes of ill-health. Berry left the classifications open to be modified or altered 'according to individual taste'.⁴⁰ This highlights one of the main issues when trying to retrieve and assess ideas about disease groupings during the early twentieth century, in that standardised concepts of disease appear to have taken second place to individual practitioner's beliefs about causes of ill-health.

Beyond the issues surrounding the collective classification of disease, the changing names of individual diseases over the course of the late nineteenth and early twentieth centuries must be considered, as this would have affected the diagnosis reached and recorded. Inconsistencies arose on the part of the medical staff when diagnosing patients during this period through the practice of using different names for the same complaint, such as 'Chorea' and 'St Vitus' Dance'.⁴¹ This practice demonstrates the changing nature of the medical profession during the early twentieth century, as old terminology gradually made way to clinical terms for disease. It was not, however, only the medical profession who adopted changing medical terminology. In some instances the patients' recollection of their previous ill-health may not have taken into consideration the developing understanding of many complaints which occurred between the patients having been previously diagnosed and the period from which the patient records were sampled. In some instances the patient may have recalled being diagnosed with a 'winter cough' in the latter half of the nineteenth century, which by the twentieth century would have been better understood as a case of bronchitis.⁴² Similarly, the work of Condrau and Worboys, Mooney, Luckin, and Tanner, all claim that phthisis was a major cause of death between the 1850s and the late nineteenth century, though the patients and their families were

⁴⁰ Ibid

⁴¹ PR: *Kathleen Bardell*, Sainsbury Women December 1912, p. 657

⁴² A. G. Auld, 'A Clinical Lecture on Chronic Bronchitis', *The British Medical Journal*, Vol. 1, No. 2459 (Feb. 15, 1908), p. 368

rarely recorded as previously suffering the complaint.⁴³ One explanation could be that cases of ‘phthisis’ were diagnosed more frequently as bronchitis or pneumonia.

Hardy has explained that the terms ‘consumption’ and ‘phthisis’ derived from the Greek for ‘wasting’, and were therefore used throughout the eighteenth and much of the nineteenth century as the diagnosis for a wide range of diseases beyond pulmonary consumption alone.⁴⁴ According to Appleton, consumption, tuberculous broncho-pneumonia, and phthisis were all considered essentially the same condition by 1905.⁴⁵ However, while broncho-pneumonia and phthisis were terms used largely in the current diagnosis of the patients in the sample, consumption was largely a condition reported to have been previously suffered by either the patient or their family members. If the conditions were considered to be the same, the changing terminology demonstrates the shift from the archaic and very general term of ‘consumption’ to the much more scientific and specific term of ‘broncho-pneumonia’. The fact that the old terminology was recalled by patients is important. It demonstrates that they continued to consider this the illness suffered, even though they would refer to the same complaints as phthisis or broncho-pneumonia if diagnosed in the early twentieth century. Furthermore, the term ‘consumption’ clearly survived into the second half of the nineteenth century, when many of the patients and their families would have suffered the complaint, meaning that Hardy’s timeframe for the use of the term may need to be extended to the later century.

This being so, historians have turned to more complex disease classifications. In their joint work, Mooney, Luckin and Tanner present a table of cause-specific standardised mortality rates in hospitals and workhouses of London during 1861.⁴⁶ Causes of death are divided into diseases which were Zymotic (those considered to be infectious,

⁴³ Mooney, Luckin, and Tanner, ‘Patient Pathways’, p. 267

⁴⁴ Hardy, ‘Diagnosis’, p. 392

⁴⁵ S. Appleton, “*The Doctor Says*” – *What does the Doctor Say?*, (Sidney Appleton, 25 Bedford Street, London, 1905), p. 185

⁴⁶ G. Mooney, B. Luckin, and A. Tanner, ‘Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century’, *Social History of Medicine*, Vol. 12, No. 2 (1999), p. 243

including smallpox, measles, scarlatina, diphtheria, whooping cough, typhus, erysipelas, metria, dysentery, and diarrhoea), cancer and tuberculous conditions including phthisis, diseases of the nervous system, respiratory diseases, diseases of the urinary system, of the joints, and of the circulatory system.⁴⁷ Other causes of death were those relating to childbirth, premature birth, atrophy and debility, old age, fractures and contusions, burns and scalds, other violent causes, and all other causes.⁴⁸ In a later article by Mooney, diseases are again divided for the purpose of identifying their cause of death distribution.⁴⁹ He presents disease classifications including gastro-enteric diseases (cholera, diarrhoea, and dysentery), infectious diseases (smallpox, measles, scarlatina, diphtheria, whooping cough, typhus, scrofula, tables mesenterica, hydrocephalus), respiratory diseases (bronchitis, laryngitis, pleurisy, pneumonia, asthma), respiratory TB (phthisis, consumption, pulmonary tuberculosis), and other causes, including disease of the heart, brain, stomach, kidneys, generative organs, joints and skin, and childbirth.⁵⁰ The source of the corresponding mortality figures to each of these classifications was the Registrar-General's *Decennial Supplement* of 1851-60.⁵¹

This chapter will adopt different classification systems of disease in order to best represent the overlapping nature of ill-health. It will primarily focus on the dominant individual complaints suffered by the patients in the sample in order that the clearest representation of the ill-health experienced by patients and their families throughout their lifetimes are portrayed. That said, ailments will sometimes be grouped in terms of the area of the body they affected in (such as chest complaints) in order to focus on the broad causes of ill-health. By examining the ailments as they were recorded, this study can fairly

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ G. Mooney, 'Second Opinions: Infectious Diseases and Epidemiological Transition in Victorian Britain? Definitely', *Social History of Medicine*, Vol. 20, No. 3 (2007), pp. 595-606

⁵⁰ Ibid, p. 600

⁵¹ Ibid

represent the names of individual conditions and collective classifications used by contemporary medical professionals.

Current Ailments

Whilst previous studies of voluntary hospitals have discussed admission policies they have rarely examined the types of ailments from which the patients on the wards actually suffered. A total of 480 patient case records have been sampled for this study, meaning that there are at least that many current diagnosis to count and examine. Given the nature of the sample it is not possible for this chapter to form a statistical examination of the wide range of ailments that were diagnosed and treated at the RFH. Indeed, such an analysis was never the purpose of this study. Instead, this section will begin by considering the current diagnosis in relation to the four tiered sample divisions (staff member, year, season, and sex), and according to the patient age groups discussed in Chapter Three. This form of analysis will help us to understand how patients were admitted to hospitals like the RFH based on the specialties and interests of the staff. It will also provide an insight into the causes and changing nature of ailments by year and season, and to the differences in the conditions suffered between the sexes and between age groups.

The most common complaints will then be discussed as a collective in order to gain a broad representation of the conditions treated at the hospital and of the health of the wider population. Qualitative analysis of individual cases will be conducted throughout this section. The knowledge of the medical staff as to the influences on health and well being will also be discussed. Public health concerns, occupational health risks, accidental injury, self harm, and poor nutrition are just some of the issues highlighted in the case records. As this is the first time patient records have been used to identify ill-health on such a scale there are no previous studies from which to draw information regarding

practice or techniques of sample analysis. For this reason, decisions regarding the practice of counting diagnoses in this study should be identified before examining the results. Whilst every diagnosis reported in the sample records has been counted, it must be remembered that there are some records in which a current diagnosis is not included. On other occasions a patient may have been suffering from more than one complaint, meaning that more than one diagnosis was counted. We must also recognise that some patients appear more than once in the sample (as explained in Chapter Three), either for the same ailment or a different complaint.⁵² In these instances, even though the patient was returning, the ailments have been counted separately as they were the subject of separate case records and separate diagnoses.

Sample Divisions

Before we can analyse the frequency and cause of the main ailments in the records we must identify the patterns of ill-health according to the sample divisions. The staff member, year, season, patient sex or age could each have been influenced by the types of ailments most prevalent in the capital or those cases admitted to the hospital. It is crucial therefore that we identify patterns of ill-health by these divisions before we can discuss the overall sample. Firstly, it is important to examine the ailments according to the physicians and surgeons whom the patients were admitted under, since the position, interests, and specialties of each staff member may have had a bearing on the cases they admitted. Leff has claimed that voluntary hospitals often only admitted interesting cases in order that the medical staff had opportunity to broaden their knowledge and practice their skills.⁵³ Having been a teaching institution it could also be argued that cases admitted to the RFH might have reflected the interests of the medical students. It must be remembered,

⁵² Chapter Three: footnote 21

⁵³ S. Leff, *The Health of the People*, (Victor Gollancz, London, 1950), p. 100

however, that the patients themselves often chose to attend the hospital due to the specialties or reputation of individual staff members (as has been discussed in the previous chapter).

The largest numbers of diseases treated by Dr Sainsbury were bronchitis, mitral regurgitation, and pneumonia. As explained in Chapter Two, while working at the RFH, Sainsbury was also physician to the City of London Hospital for Diseases of the Chest, Victoria Park, and to the Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.⁵⁴ These positions show that he was interested and well educated in chest complaints, and suggest that the relatively high numbers of such conditions he treated at the hospital was the result of either his own professional interest, or due to his reputation in the field. It has also already been discussed that Sainsbury was well renowned for his work in the field of cardiology, which would help explain the number of patients he treated suffering from the heart condition mitral regurgitation. Moreover, he worked for a time during his early career as a Clinical-Assistant at Great Ormond Street Children's Hospital, and treated the highest number of patients aged under the age of nine years in the sample from the RFH. Dr Carr treated a wide variety of ailments, but his main foci were those of pneumonia, rheumatism, and bronchitis. As was the case with Sainsbury, Carr had a history of treating chest complaints, having worked under Douglas Powell at the Brompton Hospital, and with children, having previously been employed at the Victoria Hospital. Since children and chest conditions appear to have been the largest groups of patients and ailments treated respectively in the sample, Carr's experience made him well equipped to deal with such cases.

The surgeon Mr Berry treated the largest number of tuberculous body parts and fractures. The majority were hip complaints, with which he would have had experience though his position at the Alexandra Hospital for Diseases of the Hip. Berry was also the

⁵⁴ 'Obituary: Harrington Sainsbury', *Tubercle*, Vol. 18, Issue 6, (March 1937), p. 279

only one of the four staff members to treat cases of cleft palates, which is not surprising given that he was known internationally as a pioneer of surgery for cleft palate and hare lip. It is perhaps more surprising that larger numbers of such cases were not found in the sample records. What is clear, however, is that in some instances patients receiving treatment for cleft palates had repeated treatment from Berry, such as Violet Risley, who at only aged three years had already been operated on twice by him for cleft palate before seeing him again in 1902.⁵⁵ Experience he gained in these procedures at the RFH no doubt contributed towards his 1912 work 'Harelip and Cleft Palate'.⁵⁶ Mr Roughton treated mostly hernias and fractures. Given that he specialised in ear, nose, and throat conditions, it is surprising to find that the main ailments he treated in the sample were unrelated. That said, upon appointment as surgeon in charge of in-patients in 1904, he would have had to treat countless conditions beyond the remits of his specialist knowledge.⁵⁷

Overall, if we examine the classifications of disease by staff member, we find that in those records sampled from the physicians Sainsbury and Carr, the most common were respiratory complaints. In the cases of the surgeons Berry and Roughton, the most common classification of diseases was those caused by injury. Whilst it is clear that many of the cases in the sample reflected the specialist knowledge of the medical staff at the RFH, it is unclear whether this was due principally to the interests of the staff or to the preference of the patients. It was likely a combination of the two, as many of the patients who sought admission would have done so in order to receive specialist treatment, and the staff could only have chosen which cases to treat from those who came forward. Regardless, we must remain aware that if patients in the sample came to the hospital in

⁵⁵ PR: *Violet M. Risley*, Berry Women July 1902, p. 482

⁵⁶ Amidon, *An Illustrated History*, p. 120

⁵⁷ RFHA: *The Seventy-Seventh Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1904*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 19

order to receive specialist treatment, they may not represent the ill-health of the wider population.

When examining the differences in the ailments suffered by each sex of patient at the RFH, we must remember that equal numbers of male and female cases were sampled. Although pneumonia and bronchitis were common complaints in both male and female patients, other conditions appear to have affected one sex more than the other. The most prevalent conditions in male patients were pneumonia, bronchitis, and hernias, while those of female patients were pneumonia, gastric ulcers, bronchitis, rheumatism, and tuberculous body parts. Pneumonia and bronchial complaints were suffered in large numbers by both male and female patients, but their instance was higher in males. This reflects the guidance of both Carr and Appleton who stated in their respective works that pneumonia and bronchitis were more common in men.⁵⁸ The work of James Grant Andrew compliments these findings. He found that after examining over 42,000 patient records of the Western Infirmary Glasgow over the course of ten years at the turn of the twentieth century, that lung diseases were more frequent in males.⁵⁹ It was believed that male occupations made them more likely to suffer pneumonia or bronchitis than women, as they often worked outside and were exposed to the elements and industrial fumes (more discussion of which will take place later in this chapter).⁶⁰ Hernia's appeared twice as often in male patients as in female and corresponded with Carr's divisions of hernias by sex, in that inguinal hernias were more common in men, and femoral in women.⁶¹ Carr also claimed that acute rheumatism was found equally in men and women, though more women in the sample

⁵⁸ Appleton, "The Doctor Says", p. 183, and J. W. Carr, T. P. Pick, A. H. G. Doran, A. Duncan, *The Practitioners Guide*, (Longmans, Green, and Co., New York and Bombay, 1902), pp. 162 and 787

⁵⁹ J. G. Andrew, *Age Incidence, Sex, and Comparative Frequency in Disease*, (Bailliere, Tindall and Cox, London, 1909), p. xv: Andrew recorded the disease, age, and sex of 42,603 cases over a ten year period. He classified disease by the organ afflicted.

⁶⁰ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 162

⁶¹ *Ibid*, p. 469

suffered the complaint.⁶² Overall, it would appear that the sex divisions of disease in the sample largely correspond with contemporary understanding of disease prevalence.

Collectively, bronchitis, pneumonia, and broncho-pneumonia were always the highest number of diagnoses during each sample year, but other ailments often outnumbered them individually in the yearly totals. During 1902-3 the most common complaint was phthisis, closely followed by bronchitis and pneumonia. In 1907, mitral regurgitation, bronchitis, and pneumonia were the most common ailments. By 1912, hernias were the most common diagnosis, followed by pneumonia, and pulmonary tuberculosis. If we consider the most common diagnosis by season, those records sampled from the summer months of each year contained proportionately higher numbers of patients suffering from pneumonia, fractures, and phthisis. Seasonal work may explain why fractures were more common in the summer months, as an increase in outdoor labour would have led to more accidents. The records sampled from the winter months of each year contained significant numbers of patients diagnosed with bronchitis, pneumonia, and hernias. The high number of pneumonia cases in both the summer and winter months suggest that this was a condition which affected the population all year round. According to Carr, pneumonia was most frequent in the spring months of March to May, which means that the high numbers of pneumonia cases in the sample months of December and July may not even have been the peak months for treatment of the condition at the hospital.⁶³ Carr also claimed that bronchitis was met with mostly in the winter and spring months as it was a condition which favoured 'humid variable climates and cold winds', which corresponds with the high numbers of the condition treated in the winter months at the RFH.⁶⁴

⁶² Ibid, p. 836

⁶³ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 787

⁶⁴ Ibid, p. 162

When we compare the main ailments contained in the sample with the age groups discussed in the previous chapter, we begin to understand which ailments patients were likely to suffer from at different stages in their lifetimes. As explained in Chapter Three, the main age groups in the sample were those patients aged under nine years (if we count together those patients aged under one year to those aged between one and nine years) and those aged twenty to twenty-nine years. The high number of children at the hospital is not surprising when we consider the wide range of ill-health to which they were susceptible. The sample records show that children aged between one and nine years made up the majority of patients who suffered from pneumonia and bronchitis. Of the twenty patients suffering pneumonia in the sample, eleven were in this age group. This corresponds with the findings of Andrew's at the Western Infirmary in Glasgow during the early twentieth century. He found that acute pneumonia was the most frequent infection of the lungs met with, and was common in early life.⁶⁵ In the case of bronchitis, seven of the nineteen patients who suffered the complaint were aged one to nine years, with an additional four aged under one year. Dowse and Appleton both concur that bronchitis was most common and dangerous in the young and the old.⁶⁶ Notably, all of the patients suffering with broncho-pneumonia in the sample were aged nine years and under. Andrew, Carr, Dowse, and Appleton all discuss broncho-pneumonia as a condition which predominantly affected children.⁶⁷ It was believed to be almost as fatal as infantile diarrhoea, and was in the majority of cases a secondary disease to bronchitis, measles, whooping-cough, diphtheria, or influenza.⁶⁸ This suggests that while children were not dying of infectious conditions, they were still contracting them and suffering broncho-pneumonia as a result. Though it

⁶⁵ Andrew, *Age Incidence*, p. xviii

⁶⁶ Andrew, *Age Incidence*, p. viii, Appleton, "The Doctor Says", p. 177, T. S. Dowse, *The Pocket Therapist: A Dictionary of Disease and its Treatment*, 3rd Edition (John Wright & Co., Bristol: Simpkin, Marshall, Hamilton, Kent & Co. LD, London, 1903), p. 66

⁶⁷ Appleton, "The Doctor Says", p. 183, Carr, Pick, Doran, Duncan, *The Practitioners*, p. 791, Dowse, *The Pocket*, p. 66

⁶⁸ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 791, Dowse, *The Pocket*, p. 66

might be assumed that children would have been particularly susceptible to chest complaints in the cold winter months, living in overcrowded and unsanitary conditions during the warm summer months, especially with the combination of humid temperatures and dusty industrial London air, would have meant chest conditions posed a constant threat all year round. The infant mortality rate may have been dropping by the turn of the twentieth century, but infectious chest complaints remained the serious health threat.

Patients seeking aid for various tuberculous body parts, the third most common ailment in the sample, were predominantly those aged ten to nineteen years. According to Cheyne in 1911, tuberculous disease of the hip was considered to be a disease of early life which seldom commenced after puberty.⁶⁹ Andrew also found that at the Western Infirmary, tuberculosis of the hip was most common in patients aged ten years and under.⁷⁰ At the RFH, however, the ages of the nine patients who suffered the condition ranged from four to nineteen years, with seven of those patients being over eleven years of age. Tuberculous hip disease was clearly suffered by patients after puberty more often than was believed. Patients suffering from gastric ulcers were commonly in their twenties. Of the twelve patients suffering the complaint in the sample, seven were aged twenty to twenty-nine years. Even though patients in their twenties made up one of the largest groups of patients at the RFH, of the other major complaints in the sample, patients in their twenties made up one of the minorities. Hardly any patients in their twenties suffered pneumonia, bronchitis, hernias, rheumatism or fractures, and none whatsoever suffered from tuberculous body parts, broncho-pneumonia, or carcinomas. Analogously, patients of this age group suffered from a wide range of less common complaints, such as varicose veins,

⁶⁹ Sir W. Watson Cheyne, *Tuberculous Diseases of Bones and Joints: Their Pathology, Symptoms, and Treatment*, (Henry Frowde, Oxford University Press, Hodder & Stoughton, Warwick Square, E. C, London, 1911), p. 181

⁷⁰ Andrew, *Age Incidence*, p. viii

which corresponds with Andrew's findings that varicose veins were a common complaint of patients in their twenties at the Western Infirmary.⁷¹

Of the main ailments in the sample, patients aged thirty to thirty-nine suffered mainly from hernias and fractures. We might speculate that this was due to people of this age group having worked in manual labour jobs for many years, making them susceptible to such injuries. At the Western Infirmary, Andrew's study also found that fractures of the leg bones were common in patients in their thirties.⁷² Those patients aged over forty years were particularly susceptible to carcinomas. Carr claimed that cancer was a disease which appeared in the latter half of life, and was uncommon before the age of thirty five.⁷³ As no patient in the sample aged under forty-years suffered carcinoma Carr appears to have been accurate. Andrew's study also found that cancers were common in patients aged over forty years.⁷⁴ Unlike carcinomas, contemporary texts suggest that rheumatism was mainly suffered in the earlier years of life. Caillé claimed that acute rheumatism was a disease of early adolescence, which coincides with the finding at the RFH, that the patients who suffered the condition were all aged under nineteen years.⁷⁵ The only complaint in the top ten which appears to have been relatively evenly spread amongst the patient age groups was the heart condition, mitral regurgitation. This supports the theories of Hardy and Matassian, who as explained previously, believed that chronic complaints including heart disease were becoming more prevalent and more deadly by the turn of the twentieth century.⁷⁶

⁷¹ Ibid, p. x

⁷² Ibid, p. xi

⁷³ Caillé, *Differential Diagnosis*, p. 548

⁷⁴ Andrew, *Age Incidence*, pp. xii-xiii

⁷⁵ Carr, Pick, Doran, Duncan, *The Practitioners*, pp. 836 and 840

⁷⁶ F. Condrau and M. Worboys, 'Second Opinions: Epidemics and Infections in Nineteenth-Century Britain', *Social History of Medicine*, Vol. 20, No. 1, (2007), p. 148, M. Kilbourne Matassian, 'Death in London, 1750-1909', *Journal of Interdisciplinary History*, Vol. XVI, No. 2, (Autumn 1985), pp. 188-189

Main Ailments

Overall, examination of the current ailments according to the sample divisions provides us with a breakdown of who suffered what and when, and has shown that child patients suffering from pneumonia and bronchitis were the most frequent type of patient to be treated at the RFH, regardless of year, season, or sex. This form of examination, however, cannot provide us with a broad, collective picture of ill-health suffered during the early twentieth century. For this reason, the main ailments suffered in the sample overall need to be considered and their causes investigated. The ten most common current ailments found in the case records are shown in Table 5.1. The individual totals represent quite small proportions of the sample, but as a collective of 144 diagnoses they represent approximately one third of the patients. As explained in the previous section, the records do not always specify as to whether a condition was acute or chronic in nature. Whilst it is important to recognise that the RFH treated both, the presence of unspecified cases makes it impractical to divide the relevant complaints by their nature. The table therefore represents the collective totals of each condition.

The most immediate conclusions to draw from the table are that whilst a wide range of ill-health was being treated at the RFH respiratory complaints were the most common, and both chronic and infectious conditions were amongst those treated. It is not surprising to find the prevalence of chest complaints when we consider the poor air quality and living conditions of the capital. Contemporary medical texts largely associate the respiratory conditions pneumonia, bronchitis, empyema, and tuberculosis with public health concerns. According to Appleton, the main cause of pneumonia was the inhalation of dust and microbes when the patient's vitality was 'depressed by exposure to cold and damp'.⁷⁷ This

⁷⁷ Appleton, "*The Doctor Says*", p. 183

Table 5.1: *Top Ten Ailments*

Diagnosed Ailment	Number of cases in sample
Pneumonia	20
Bronchitis	19
Tuberculous body part	16
Hernia	16
Rheumatism	13
Fracture	13
Gastric Ulcer	12
Carcinoma	12
Mitral Regurgitation	12
Empyema	11
TOTAL	144

corresponds with the definition of pneumonia given by Carr in 1902, which claimed that it usually followed from a chill, which lowered the patients vitality and meant that all ‘depressing and unhygienic’ conditions such as fatigue, injury, mental depression, insufficient food, alcoholism, were greatly predisposed to it, as were the diseases nephritis, diabetes, and cancer.⁷⁸ Appleton claimed that that predisposing causes of bronchitis were ‘weakly health, insufficient nourishment, exhausting occupations, and bad sanitary conditions’.⁷⁹ Other causes which could start an attack included ‘Irritating vapours, coal, flour, or other forms of dust’, as they were thought to congest the air tubes when inhaled.⁸⁰ People were also believed to be liable to bronchitis if they were used to ‘luxurious habits, confinement in hot stuffy rooms, and undue wrapping up’.⁸¹

⁷⁸ Carr, Pick, Doran, Duncan, *The Practitioners*, pp. 786-7

⁷⁹ Appleton, “*The Doctor Says*”, p. 177

⁸⁰ Ibid

⁸¹ Ibid

One specific cause of the high rate of chest complaints during the sample years was the London fog. In *The Practitioner's Guide*, Carr claimed that bronchitis was caused by the inhalation of irritation fumes, gases, particles, or impure air, and therefore a few hours exposure to a fog may have been sufficient to determine an attack.⁸² It was thus a serious health hazard throughout the nineteenth and early twentieth centuries. In the article 'London Fog and Health' published in *The Observer* in 1905, the 'impure and dusty' London air, especially at times of fog, was said to have had 'a most deleterious effect on the respiratory functions, producing bronchitis, pneumonia, and kindred diseases'.⁸³ The 1902 article 'The Campaign Against Fog' published in the *British Medical Journal*, warned that the air was extremely impure due largely to the chemicals derived from the combustion of fuel coal.⁸⁴ The article claimed that in a bad fog the proportion of carbolic acid in the air was found to rise to sixteen volumes per 10,000, when the ordinary acceptable limit was thought to be only two.⁸⁵ This 'old enemy' was said to be 'impregnated with carbolic acid in sufficient quantity not only to make life inconvenient and uncomfortable, but even to endanger its very continuance'.⁸⁶ Although it was a serious health concern throughout the period of this study, it would appear that 1912 was a particularly bad year. *The Times* newspaper reported on October 16th 1912 that its prevalence that month was 'remarkable'.⁸⁷ During the early hours of October 11th 1912 the capital was reportedly visited by the densest fog that had been experienced for some years.⁸⁸ It continued over the following days, and was reported to be so thick during the evening of October 12th that 'it was impossible to distinguish an approaching vehicle at

⁸² Carr, Pick, Doran, Duncan, *The Practitioners*, p. 162

⁸³ Anon, 'London Fogs and Health', *The Observer*, (November 12, 1905), p. 5

⁸⁴ Anon, 'The Campaign Against Fog', *The British Medical Journal*, Vol.1, No. 2162 (Jun. 7, 1902), p. 1431

⁸⁵ Ibid

⁸⁶ Ibid

⁸⁷ Anon, 'The Prevalence of Fog', *The Times*, (Wednesday October 16, 1912), p. 4

⁸⁸ Anon, 'Dense Fog in London', *The Times*, (Saturday, October 12, 1912), p. 4

more than a foot distance'.⁸⁹ This would have been the cause of various accidents and many chest complaints.

The appearance of chest complaints of an acute nature in the records is significant given that they were understood to be infectious.⁹⁰ Annual Reports of the RFH throughout this period stated that persons suffering from 'infectious and eruptive complaints, being dangerous to other patients, are not eligible for admission'.⁹¹ Nonetheless, the case records show that the hospital did in fact treat chest complaints which contemporaries considered to be infectious, such as tuberculosis, acute pneumonia, and bronchopneumonia.⁹² It was only the identification of the tubercle bacillus by Koch in 1882 that tuberculosis began to be seen as a modern communicable disease instead of an inherited affliction.⁹³ In 1905 it was moved in the Registrar General's Report from the category of constitutional diseases (along with cancer) to the infectious.⁹⁴ Therefore, prior to 1905 the RFH was acting within its admission policy by treating patients who suffered from tuberculosis, as it was not considered to be infectious. After this date it was acting against its general policy. According to Condrau and Worboys, belief in the inherited nature of tuberculosis continued into the twentieth century, causing most people to believe that it was prevalent in those with vulnerable bodies.⁹⁵ Indeed, even as late as 1937 the work of Ross claimed that some races were more inherently prone to the disease, namely 'negroes, North

⁸⁹ Anon, 'The Fog in London. Interference with Shipping', *The Times*, (Monday, October 14, 1912), p. 8

⁹⁰ Dowse, *The Pocket*, p. 297

⁹¹ For examples, see: RFHA: *The Seventy-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1902*: Annual Reports 1900-1904 : Book A12 (RFH/1/2/2), p. 32, and RFHA: *The Eighty-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1912*: Annual Reports 1911-15 : Book A13 (RFH/1/2/2), p. 49. This was also the admissions policy at other voluntary hospitals, see: F. F. Cartwright, *A Social History of Medicine*, (Longman, London, 1977), p. 158, S. Cherry, *Medical services and the hospitals in Britain 1860-1939*, (Cambridge University Press, Cambridge, 1996), p. 45, J. Mohan and M. Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain Past and Present*, (Office of Health Economics and Association of Chartered Certified Accountants, London, July 2001), pp. 36-7

⁹² Wilcox, *The Treatment*, pp. 105, 179, 187

⁹³ Condrau and Worboys, 'Second Opinions', p. 152, Hardy, 'Diagnosis', p. 395

⁹⁴ *Ibid*

⁹⁵ *Ibid*

American Indians, and Irish'.⁹⁶ Other infectious cases, however, were refused treatment at the hospital or were transferred if they developed whilst the patient was already on the ward. The patients Annie Jeal and Harry Lock were transferred to the Fever Hospital as they developed scarlet fever whilst at the RFH, as were Edith Burrows with measles, Harry Sprules with whooping cough, and Jack Winch with diphtheria.⁹⁷ The difference between those infectious conditions admitted to the hospital and those refused was that unlike the former complaints, the latter group were understood to be highly contagious or communicable. The admission policy of the RFH during the early twentieth century remained the same as when the hospital was founded, but medical knowledge of disease had changed dramatically over the course of the nineteenth century with the development of germ theory.⁹⁸ The medical staff at the RFH and those in the wider community understood that there was a difference in communicable nature between them and admitted patients accordingly.

The medical staff at the RFH had to remain alive to public health concerns relating to conditions understood to pose a threat of contagion.⁹⁹ In the record of Ada Poston, who in 1907 was suffering from acute nephritis (inflammation of the kidney), the history of the present illness stated that there was no history of 'headache, vomiting, or of scarlet fever in the neighbourhood'.¹⁰⁰ As a process of eliminating other possible diagnosis, it was important for the medical staff to know if the neighbourhood from which the patient derived was suffering outbreaks of particular diseases or symptoms. Similarly, it was important to know if the patient had put themselves at risk of ill-health by drinking the

⁹⁶ J. M. Ross, *Post-Mortem Appearances*, Third Edition, (Humphrey Milford, Oxford University Press, London, 1937), p. 69

⁹⁷ PR: *Edith Burrows*, Sainsbury Women July 1912, p. 433, PR: *Howard Foess*, Sainsbury Men December 1907, p. 1138, PR: *Annie Jeal*, Berry Women December 1907, p. 770, PR: *Harry Lock*, Roughton Women July 1907, p. 608, PR: *Harry Sprules*, Sainsbury Men July 1912, p. 404, PR: *Jack Winch*, Carr Men December 1907, p. 975

⁹⁸ R. Porter, *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present*, (Fontana Press, London, 1999), pp. 431-35

⁹⁹ C. Hamlin, 'Predisposing causes and public health in early nineteenth-century medical thought'. *Social History of Medicine*, Vol. 5 (1992), pp. 43-70

¹⁰⁰ PR: *Ada Poston*, Carr Women July 1907, pp. 352-3

water of certain neighbourhoods or of specific supplies. It was reported in the patient history of Eva Padney that she had drunk well water in the past, and in the record of Mabel Brown it was stated that the 'drinking water at pt's home in Putney is taken from a well and not from the public water supply'.¹⁰¹ After the cholera epidemics of the nineteenth century it was vital for the medical profession to remain alert to potential threats to the water supply of the metropolis. The patient records also provide an insight into more unusual ailments suffered by members of the population that would have raised public health concerns in the wider world. In April 1907 the patient Millie Thompson was admitted to the RFH suffering from the tropical disease Sprue.¹⁰² The patient had lived in the Malay States between 1901 and 1903 where Sprue was endemic, and has spent much for the following few years travelling via the west coast of Africa back to England.¹⁰³

Occupational health hazards associated with infectious complaints and accidental injuries can also be identified in the case records. As mentioned above, respiratory complaints were often caused by poor working conditions. Carr claimed that bronchitis was caused by occupations 'which involve exposure to marked changes in temperature, or to the inhalation of irritating fumes, gases, particles, or impure air'.¹⁰⁴ In the case of Edward Hounslow, a forty-five-year-old treated for bronchitis in 1907, his occupation of coal porter would have exposed him to such causes.¹⁰⁵ The flower seller Harry Cox, treated in 1912 would have also been exposed through working outside in the fumes of the city.¹⁰⁶ There were a number of patients, however, who suffered bronchitis whose occupations would appear not to have posed them such a direct threat. Ellen Spencer worked for the food company Cross and Blackwell when treated for the condition in 1902, and Frederick

¹⁰¹ PR: *Eva Padney*, Berry Women July 1902, p. 449, PR: *Mabel Brown*, Berry Women December 1902, p. 836

¹⁰² PR: *Millie Thompson*, Sainsbury Women July 1907, p. 536

¹⁰³ PR: *Millie Thompson*, Sainsbury Women July 1907, p. 537, and Wilcox, *The Treatment*, p. 73

¹⁰⁴ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 162

¹⁰⁵ PR: *Edward Hounslow*, Carr Men July 1907, p. 599

¹⁰⁶ PR: *Harry Cox*, Carr Men December 1912, p. 996

Hull was a clerk when treated in 1912.¹⁰⁷ Of course many of the patients suffering from bronchitis were children who were in school, as were many of those who suffered pneumonia. These patients were not exposed to work related causes of their ailments, but were more likely to have developed the condition through generally poor living conditions. There are also examples of other health risks in the case records which were caused by the patient's occupations. In 1902 the domestic servant Lizzie Holmes was treated by Mr Berry after running a needle into her knee whilst carrying out her work.¹⁰⁸ In 1903 another domestic servant Annie Day sought treatment for a varicose ulcer which was at least partly blamed in her patient history on the 'good many stairs to go up and down in the course of her work'.¹⁰⁹ The policeman Frederick Cox sought treatment for pain in his joints in June 1903 and was diagnosed with acute rheumatism.¹¹⁰ The history of this illness is dated back to September 1902 when Cox 'jumped into a canal to save a boy and remained in his wet clothes for about an hour'.¹¹¹ The history reports that two days later 'patient began to have a cold and had shooting pains in his knees, ankles and right elbow'.¹¹² A further example is that of the box maker Alice Lierke, who was diagnosed with influenza in 1907 after being put on 'bronzing' work and inhaling metallic dust.¹¹³ By making the connection between the patient's occupations and their current ill-health, it is clear that the health hazards associated with many occupations were well understood by the medical staff.

In other cases the complaints suffered by the patients were the result of accidents unrelated to their occupation. Fractured bones were usually the result of patients falling over or having been knocked down. Mary Lee tripped on a curb-stone and broke her leg,

¹⁰⁷ PR: *Ellen Spencer*, Sainsbury Women December 1902, p. 495, PR: *Frederick Hull*, Carr Men December 1912, p. 982

¹⁰⁸ PR: *Lizzie A. Holmes*, Berry Women July 1902, pp. 478 and 479

¹⁰⁹ PR: *Annie Day*, Carr Women December 1903, pp. 552 and 553:1

¹¹⁰ PR: *Frederick Cox*, Carr Men July 1903, p. 547

¹¹¹ *Ibid*, p. 548

¹¹² *Ibid*

¹¹³ PR: *Alice Lierke*, Sainsbury Women July 1907, pp. 484 and 486:1

whilst John Dale slipped (somewhat ironically) on a banana skin and broke his elbow.¹¹⁴ Robert Storey was knocked down in a crowd and fractured his patella (knee-cap), and Henry Knight suffered fractured ribs after he was knocked down and run over by a motor-omnibus.¹¹⁵ Accidental self-poisoning also appears in the records, such as in the case of the three-year-old Edward Lake, who suffered ammonia poisoning in 1902 after swallowing some liniment.¹¹⁶ In 1903, the seventy-two-year-old joiner Thomas Mitchell drank some caustic potash mistaking it for water and suffered the effects of poisoning.¹¹⁷ In 1912, the labourer William Bourdice noticed a rash after having fish for supper the night before, and was subsequently diagnosed with food poisoning.¹¹⁸ Accident and emergency cases were the most likely to seek unplanned hospital treatment for immediate specialist advice and treatment, and so we have to remember that the high numbers of such cases at the RFH might over-represent them in the wider community. Other complaints suffered by the patients appear not to have been caused by accidental injury, but instead were the result of deliberate self-harm. Elizabeth Harlow was found unconscious in the street and brought to the hospital by a policeman, where her condition was identified as that of alcoholism.¹¹⁹ Of course in this case the patient's drunken state need not have been more than accidental. In other cases patients appear to have aimed to cause serious self-harm. In 1907 Margaret Roberts died from hydrochloric acid poisoning which was reportedly 'self administered'.¹²⁰ Albert Clark cut his own throat in an apparently delirious state.¹²¹ In other instances, while self-harm was not the aim, it appears to have been a risk the patient was willing to take in order to achieve some other ends. In 1912 Phoebe Porter was treated

¹¹⁴ PR: *John Dale*, Roughton Men July 1907, p. 1008, PR: *Mary Lee*, Roughton Women July 1902, p. 843

¹¹⁵ PR: *Henry Knight*, Berry Men July 1907, p. 590, PR: *Robert Storey*, Berry Men July 1902, p. 640

¹¹⁶ PR: *Edward Albert Lake*, Sainsbury Men July 1902, pp. 1-3

¹¹⁷ PR: *Thomas Mitchell*, Carr Men December 1903, pp. 970-971

¹¹⁸ PR: *William Bourdice*, Carr Men July 1912, pp. 590-591

¹¹⁹ PR: *Elizabeth Harlow*, Carr Women July 1903, pp. 309-10

¹²⁰ PR: *Margaret Roberts*, Carr Women December 1907, p. 739

¹²¹ PR: *Albert Clark*, Berry Men December 1902, p. 37

for quinine poisoning after taking the substance in order to induce abortion.¹²² According to the work of Knight, despite abortion being illegal in the period before 1914 back-street abortion was widespread and ‘probably the most prevalent form of contraception for working-class women’.¹²³ Knight claims that knowledge of how to induce an abortion was passed down through generations of women, and methods included not only the use of quinine, but ‘gin and salts, irons and aloes, caraway seeds, turpentine, washing soda’ and the consumption of lead pills’.¹²⁴

The main ailments treated at the RFH were not, however, limited to infectious conditions and injury cases. Chronic conditions including carcinoma (cancer), mitral regurgitation (a heart condition) and gastric ulcers, along with chronic types of rheumatism, tuberculosis, and bronchitis, collectively dominate the main ailments observed. The causes of chronic conditions such as these are challenging even today, and contemporaries found their increasing appearance difficult to explain. The cause of cancer, for example, was suggested by Caillé in 1907 to be ‘of parasitic origin, but we have as yet no proofs to that effect’, whilst Wilcox stated in the same year that the ‘direct aetiology of cancer is unknown’.¹²⁵ Unhealthy habits such as smoking tobacco and drinking alcohol would have contributed to increasing levels of chronic disease, particularly as the average age of the population began to rise and the body was subjected to them for longer. The amount of alcohol and cigarettes patients consumed was recorded as they were understood to contribute towards certain conditions of ill-health. The patient George Haynes was reported to have smoked heavily, ‘about 30 cigarettes daily’.¹²⁶ Carr stated in his work that two ounces of tobacco a week was a moderate quantity, and ‘the smoking of which is not likely to do any harm to average individuals’, whilst larger quantities were believed to

¹²² PR: *Phoebe Porter*, Carr Women July 1912, p. 224

¹²³ P. Knight, ‘Women and Abortion in Victorian and Edwardian England’, *History Workshop*, No. 4 (Autumn, 1977), p. 57

¹²⁴ *Ibid.*, p. 60

¹²⁵ Caillé, *Differential Diagnosis*, p. 280, Wilcox, *The Treatment*, p. 356

¹²⁶ PR: *George Haynes*, Carr Men December 1912, p. 972:1

cause irritation to the throat, functional derangements of the heart, and occasionally impairment of vision.¹²⁷ The full extent of the danger smoking caused to long-term health, however, was clearly not yet fully recognised, as contemporaries made no mention of the increased risk of developing the cancer or chest complaints we now know it to pose.

Whilst chronic conditions collectively dominated the main ailments suffered at the RFH, infectious chest complaints were still the single most common group of ailment treated. This pattern is reflected in the mortality results of the sample records, which are both noteworthy and significant when examining the records in relation debates over the epidemiological transition. Overall, of the 468 patients treated in the sample, forty-three cases resulted in death.¹²⁸ This gives a death rate of approximately nine percent.¹²⁹ The most common cause of death at the RFH was respiratory complaints, followed by heart conditions and cancers. The fact that respiratory complaints were suffered in the largest number and most frequently resulted in death shows that they were still the primary health and mortality threat during the early twentieth century. The high death rates of chronic complaints, however, supports Mooney's argument that chronic ill-health was becoming more of a threat during this period. The case records suggest that the epidemiological transition was occurring later than has been argued by historians in the current historiography.

The Wider Health of the Patients

The current conditions of the patients listed in the sample records provide a unique insight into not only the ill-health for which the patients sought treatment, but of the patient's general health upon entering the RFH. Even though the condition of the patient on

¹²⁷ J. W. Carr, *How to Live Long*, (Methuen & Co. Ltd, London, 1916), p. 78

¹²⁸ After deducting the second or third records of the patients whom appeared on more than one occasion in the sample of 480 case records, we are left with 468.

¹²⁹ 8.9% of 480 case records, or 9.1% of 468 patients

admission may not appear to have had any direct relevance to the diagnosis, it was nevertheless important for the staff to note such information in order that they understood the overall health of the patient and could identify any other health complaints. Whilst epidemiological transition debates centred on mortality levels indicate what was killing the population, and the current complaints in the sample records provide an insight into the ill-health people suffered but did not necessarily die of, general health information gives an even more detailed picture of the physical and mental condition of the population.

McKeown claimed that improved diets and nutrition enabled the population to become better at fighting off infectious diseases. The weight of the patients gives us an indication as to how well nourished members of the patient base were, and alludes to the condition of the wider population. Stephen Maffey, a forty-two-year-old man suffering pulmonary tuberculosis weighed only 6st 13 ¼ lbs during his stay at the RFH during 1912, although this did increase to 7st 3 ½ lbs over the course of his treatment.¹³⁰ Other than noting the gain, the case record of Maffey makes no comment on the patient's weight, even though he would surely have been considered seriously underweight. There are also examples of underweight women and children in the sample records. Twenty-nine-year-old Elizabeth Dickes was reported at 6st 4lbs as being 'very thin but looks pretty well'.¹³¹ Similarly, in 1907 Alice Se Good entered the RFH weighing only 5st 12 ¼ oz and was reported as 'rather thin'.¹³² If women who weighed this little were considered to be very thin, Stephen Maffey must have been considered dangerously underweight. The one-year-old Fanny Munding weighed only 8lbs 12oz when treated at the hospital in 1903 for marasmus, or progressive emaciation.¹³³ In such cases the patient's condition was likely the cause for their low weight, but the little attention paid to the weight of patients more generally suggests that these low figures were not unusual. In other instances, however, the

¹³⁰ PR: *Stephen John Maffey*, Sainsbury Men July 1912, pp. 406 and 412

¹³¹ PR: *Elizabeth Dickes*, Carr Women July 1903, pp. 303 and 305

¹³² PR: *Alice Se Good*, Carr Women July 1907, p. 363

¹³³ PR: *Fanny Munding*, Carr Women July 1903, pp. 347 and 349

extent of the patient's malnourished condition was well recognised. Edward Fulit, a boy of nearly three years also suffering from marasmus was described as an 'excessively emaciated child', weighing only 14lbs 4oz.¹³⁴ Included in Fulit's patient record is a photograph of the child (on the following page), presumably taken as proof of his serious condition. The historian Leff claimed that 'malnutrition at the opening of the twentieth century was more rife than since the great dearths of medieval times', with the rejection of up to sixty per cent of recruits for the Boer War.¹³⁵ While the population was known to be malnourished at this time, the extent and details of the physical condition of individual patients has not been adequately discussed. That said, there are also examples of patients who were far from underweight. In 1912 the fifty-four-year-old Maria Springer weighed 20st, but had weighed 22st at her heaviest.¹³⁶ Clearly not the entire patient base of the RFH or the wider population, was suffering from malnutrition. The prevalence of underweight individuals, however, indicates that the population was not benefiting from improved nutrition as McKeown claimed.

In many instances the condition of the patient's fingers and toes were commented upon, especially in relation to whether they were 'clubbed' in nature. The case record of Mary Heale stated that her finger ends were clubbed, and that of Esther Lockwood claimed there was some 'slight clubbing of fingers and rounding of nails'.¹³⁷ In other cases the lack of such symptoms was noted.¹³⁸ Wilcox identified clubbing as a symptom of hypertropic pulmonary osteoarthropathy, a condition characterised by the enlargement of the bones of the hands and feet, usually caused by some pulmonary lesion 'such as chronic bronchitis, emphysema, tuberculosis, empyaema, fibroid phthisis or neoplasm'.¹³⁹ By reporting on the

¹³⁴ PR: *Edward Fulit*, Carr Men July 1907, pp. 627-629

¹³⁵ Leff, *The Health*, p. 82

¹³⁶ PR: *Maria Springer*, Carr Women December 1912, pp. 392-393

¹³⁷ PR: *Mary Heale*, Sainsbury Women July 1902, p. 286:1, PR: *Esther Lockwood*, Sainsbury Women December 1902, p. 469:1

¹³⁸ PR: *Winifred Graham*, Sainsbury Women July 1907, p. 447:1, PR: *Mary Ann Maynard*, Sainsbury Women July 1907, p. 510

¹³⁹ Wilcox, *The Treatment*, pp. 842-3

Figure 5.4: The Royal Free Hospital Archive: Photograph included in Patient Case Record:
Edward Fulit, Carr Men July 1907, p. 631

presence of clubbing of either the fingers or toes, the staff at the RFH appear to have been inadvertently judging the probability of the patient having suffered from an infectious pulmonary complaint. The fact that the medical staff were actively searching for signs of such conditions in the patients indicates that they were aware of a continuing threat. Regardless of the stage of any epidemiological transition in real terms, the medical staff at the RFH must have believed that pulmonary conditions were still rife in the wider population of the capital.

The general health of the patients was also judged by any unhealthy habits they undertook. Patients were often questioned as to their alcohol, coffee, tea, and cigarette consumption on admission to the hospital, as we have seen. In many cases these habits may not have appeared to have had any direct relevance to the patient's illness, but the risks to health they posed independently made their use important to note. Cigarette consumption (and its links to cancer) has been discussed in the previous section, but the amount of alcohol patients consumed was one of the habits most often recalled in the patient records. Dangers associated with the habitual consumption of alcohol were well known, and so it was important to record how much the patient drank in order to diagnose their complaint. In Carr's *How to Live Long*, the consequences of alcohol consumption were explained.¹⁴⁰ Those who habitually took more alcohol than they could oxidise in their bodies were labelled as 'chronic tipplers', and risked premature degeneration and loss of resistive power to disease producing germs.¹⁴¹ He claimed it was not 'wise or safe' to drink more than an ounce and a half of absolute alcohol per day, which was the equivalent of a pint and a half of beer or cider, or a small bottle of light wine.¹⁴² Many of the patients at the RFH appear to have been verging on consuming dangerous amounts of alcohol, such as Elizabeth Crew who took '3 or 4 glasses of ginger wine or port in the day', and Ruth Marriott who drank 'one or two glasses of beer a day, and has had brandy nearly every day lately'.¹⁴³ The consumption of tea, coffee and tobacco was also often recorded in the patient histories. According to Carr, the influences of these substances on the health of the body 'is probably quite slight' provided that they were taken in moderation and only in small quantities by those who had a 'special susceptibility for one or other of them'.¹⁴⁴ Tea and coffee were known to stimulate the heart and nervous system, and in some individual's

¹⁴⁰ Carr, *How to Live Long*, pp. 68 - 76

¹⁴¹ Ibid, pp. 68-9

¹⁴² Ibid, 70-1

¹⁴³ PR: *Elizabeth Crew*, Roughton Women July 1907, p. 350, PR: *Ruth Marriott*, Sainsbury Women July 1907, p. 549:1

¹⁴⁴ Carr, *How to Live Long*, p. 76

tea was known to cause 'indigestion, general nervousness, palpitations, giddiness, and insomnia'.¹⁴⁵ Some patients consumed large amounts of tea, such as Maria Springer used to drink 'about 8-10 cups of tea a day', and George Haynes who drank 'about 2 ½ pints of tea per day'.¹⁴⁶

All of these habits would have had a damaging effect on the patients' teeth and it would appear from the frequent reference to dental health in the records that the medical staff at the RFH were well aware of the risks. During this period dental hygiene products were not widely available, and it would appear from the case notes that many patients suffered poor dental health. In many instances the lack of dental health, or indeed the lack of teeth, was met after the physical examination of the patient with little more than a brief comment. In 1912 the fifty-eight-year-old Emma Cole was admitted to the RFH suffering from abdominal pain, and it was found that her teeth were 'absent'.¹⁴⁷ In 1907, the thirty-four-year-old Sarah Woods was found to have 'no teeth in either jaw'.¹⁴⁸ Only a passing comment on the poor dental health of the patients suggests that such conditions were not uncommon at the hospital or in the wider population.

Previous and Family Ill-Health

The previous diagnoses and the family health histories contained in the sample records provide a wider indication of the ill-health suffered by the London population beyond the current condition of the patients and over their life-times. Ailments suffered earlier in the

¹⁴⁵Ibid, p. 77

¹⁴⁶ PR: *George Haynes*, Carr Men December 1912, p. 972:1, PR: *Maria Springer*, Carr Women December 1912, p. 393:1

¹⁴⁷ PR: *Emma Cole*, Sainsbury Women December 1912, pp. 665 and 667:1

¹⁴⁸ PR: *Sarah Woods*, Roughton Women December 1907, pp. 538 and 539:1

Table 5.2: *The Most Frequent Previous Ailments.*¹⁴⁹

Ailment	Number of patients who previously suffered the complaint	
	Sub-total	Total
Measles	74	74
Cough and Whooping Cough	38	67
Rheumatism	29	60
Rheumatic Fever	27	
Rheumatic Pains	26	
Scarlet Fever/ Scarletina	7	
Bronchitis	35	35
Influenza	34	34
	29	29

patient's lifetime and those suffered by their family members also include many which were theoretically excluded in the admissions policies of voluntary hospitals including the RFH. The histories therefore provide an insight into how ill-health accumulated, and how families collectively experienced ill-health. This section will draw on examples which represent broad regularities in the absence and impossibility of a statistical sample of previous and family health. Although the health histories contained in the records cannot necessarily be examined as thoroughly as the current diagnosis, they are still very telling as to the wider health of the population prior to the period of the sample.

Table 5.2 shows the most common ailments previously suffered by the patients of the RFH. Two immediate observations can be made. The first is that the complaints previously suffered were different to those currently suffered by the patients. The second is that the numbers of patients who suffered these conditions were much higher than those who suffered from the most common current complaints in the sample. It has to be remembered, however, that the current complaints reflected only those for which patients

¹⁴⁹ Some ailments have been counted together as they likely referred to the same condition.

could receive treatment at the RFH. What is apparent from the high numbers of each ailment in Table 5.2 is that regardless of their current condition, many of the patients in the sample had similar experiences of ill-health in their pasts.

All of the previous ailments recorded in Table 5.2 were considered infectious, and the top two previously suffered by both male and female patients were measles and coughs. Measles was considered extremely infectious and spread mainly by direct contact, occasionally carried by clothes or other items.¹⁵⁰ Along with whooping cough, measles was endemic, epidemic, and pandemic, and in Britain was thought to occur approximately every two years (whooping cough mainly in the spring months).¹⁵¹ Rheumatism was an ‘acute infectious febrile disease characterized by inflammation of one or more of the joints’.¹⁵² Scarlet fever was a disease endemic in most temperate climates, and according to Carr usually became epidemic in Britain during the autumn months.¹⁵³ Bronchitis has been described in some detail in the current complaint section of this chapter, being as it was evidently prevalent both prior to and during the sample years. Influenza was known to be an acute infectious disease which usually occurred in epidemics.¹⁵⁴ Wilcox claimed in his 1907 work that the last widespread epidemic was in 1889, which would explain why so many of the patients of the early twentieth century had previously suffered the complaint.¹⁵⁵ If the epidemiological conclusions of historians such as Hardy are accurate, the prevalence of infectious diseases should have been declining by the end of the nineteenth century, yet infectious complaints dominate those previously suffered by the patients in the sample. The fact that these conditions were previously suffered, but not fatal, however, may indicate that patterns in mortality were shifting during this period, and that infectious complaints were no longer necessarily life-threatening.

¹⁵⁰ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 636

¹⁵¹ *Ibid.*, pp. 636, 1075

¹⁵² Wilcox, *The Treatment*, p. 105

¹⁵³ Carr, Pick, Doran, Duncan, *The Practitioners*, p. 851

¹⁵⁴ Caillé, *Differential Diagnosis*, p. 625

¹⁵⁵ Wilcox, *The Treatment*, p. 38

The fact that the majority of patients previously accumulated complaints throughout their lives, often interchangeably, overlapping, and long term, is a crucial aspect of the history of health and disease that is often overlooked by historians. It is not sufficient to examine the prevalence of individual complaints, when ill-health was an ongoing experience. Whilst debates centre on complaints which killed, those which the patients experienced at other points in their lives are often omitted from history, quite probably due to the lack of related and relevant source material. The previous complaints noted in the case records provide, therefore, a valuable reminder of the complex nature and experience of ill-health within the broader epidemiological transition debates. Some patients were unlucky enough to have previously suffered from a large number of ailments. William Bear, a thirty-six-year-old picture fitter was treated in 1902 for phthisis, was one such.¹⁵⁶ His history claims that he was ‘delicate as a child’, having suffered from chicken pox, measles, whooping cough, and an abscess in the temporal region.¹⁵⁷ He had also suffered pleurisy, influenza on two separate occasions, and haemorrhoids.¹⁵⁸ In another case, at the age of only three years Bert Chevalier had already suffered bronchitis, congestion of lungs, and whooping cough.¹⁵⁹ Young children were susceptible to chest complaints, but to have suffered three serious complaints by the age of three made Chevalier lucky to be alive. Some patients suffered long term complaints, such as Mary Walker, a forty-four-year-old treated in 1907 for cystitis, who had suffered from similar abdominal pains to her current complaint for ten years.¹⁶⁰ No previous treatment for this pain was recorded, meaning that it took Walker a decade to seek professional medical aid at a hospital for her condition. Even more drastic was the case of Louisa Pakes, who suffered with ‘her digestion for the last twenty years at least, having pain after food and

¹⁵⁶ PR: *William Bear*, Sainsbury Men July 1902, p. 4

¹⁵⁷ Ibid, p. 5:1

¹⁵⁸ Ibid

¹⁵⁹ PR: *Bert Chevalier*, Carr Men July 1903, p. 508:1

¹⁶⁰ PR: *Mary Walker*, Sainsbury Women July 1907, pp. 498 and 500

being frequently sick'.¹⁶¹ Such cases are telling as to the attitudes to both personal healthcare and to hospital treatment. Patients were willing to risk their long-term health, or indeed their lives, by not seeking professional medical aid.

The health history of the patients may also have coincided with their travel history, which, as discussed in Chapter Three, provides us with an insight into the types of people being treated at the RFH. Male patients had previously suffered from a wide range of fevers from which female patients had not. Excluding scarlet, rheumatic, and typhoid fevers, from which both sexes previously suffered, male patients experience many others. Malta, Maltese, and Black fevers were among those previously suffered. These conditions were often caught when the patient was overseas serving in the military. In other cases the case notes specify that the patient had never been abroad, effectively eliminating the possibility that the patient had ever suffered from a 'disease that is unknown or uncommon in the place in which the patient comes under observation'.¹⁶² Such is the case of George Blogden, the twenty-one-year-old dining-car attendant treated in 1907 for phthisis.¹⁶³ It was also common practice for the patient histories to contain details of ailments the patient had never experienced. Alice Lierke previously had measles and whooping cough. Her patient history, however, contained a long list of ailments from which she had never suffered, including chorea, rheumatism, growing pains, scarlet fever, diphtheria, and chest trouble.¹⁶⁴ It would appear that the medical staff were judging her susceptibility to infectious conditions. There are some conditions which we might have expected to see more often in the patient histories, such as phthisis. The work of Condrau and Worboys shows that it was a major cause of death consistently throughout the 1850s to the 1880s.¹⁶⁵ However, the patients in the sample were rarely recorded as having previously contracting

¹⁶¹ PR: *Louisa Pakes*, Sainsbury Women July 1907, p. 527

¹⁶² Berry, *A Manual*, p. 17

¹⁶³ PR: *George Blogden*, Carr Men July 1907, pp. 642 and 643:1

¹⁶⁴ PR: *Alice Lierke*, Sainsbury Women July 1907, pp. 484 and 486:1

¹⁶⁵ Condrau and Worboys, 'Second Opinions', p. 151

the condition, even though many of them would have lived through this era. Condrau and Worboys also claim that the typical ‘epidemic’ experience of the nineteenth century was of ‘local, short-lived outbreaks of diseases such as typhoid fever and typhus’.¹⁶⁶ In the sample records, typhoid appears to have been previously suffered by ten patients, while typhus by only one. Smallpox was previously contracted by nine patients. These low numbers may support Condrau and Worboys claims, or they could simply represent the diminishing nature of these complaints by the latter years of the nineteenth century.

Contemporary ideas about what constituted health can also be ascertained from the patient histories, such as in the case of Mary Grande, a fifty-year-old charwoman who was treated in 1912.¹⁶⁷ Despite previously having had rheumatic fever on five occasions throughout her lifetime, pins and needles and stiffness constantly for two years, breathlessness and palpitations after very slight exertion, as well as pleurisy, influenza, and a winter cough for some years, her history claims that as a rule, she was ‘fairly healthy’.¹⁶⁸ To have suffered such a long list of previous ailments, some of which relapsing or long term conditions, and to be considered a healthy person by the medical profession of the early twentieth century likely reflects the poor condition of the wider population. On the other hand we must remember, however, that some patient histories were either left blank, or stated that the patient had suffered no previous illness. Provided this was true of all ailments and not just those relevant to the patient’s current condition, many of the patients lived very healthy lives.

When the current complaints suffered by family members are examined, it quickly becomes apparent that those experienced each year were largely similar. Family members mainly had chest complaints, such as bronchitis, consumption, and coughs, or rheumatism. In 1902, parents of patients including Ivy Chambers and Esther Lockwood had

¹⁶⁶ Ibid, p. 150

¹⁶⁷ PR: *Mary Grande*, Carr Women July 1912, p. 240

¹⁶⁸ Ibid, p. 241:1

consumption, as did the cousins of Florence Child in 1912.¹⁶⁹ In 1907, two sisters of Mary Creeth were ill with rheumatism, as was the father of Alexander Sutcliffe and the child of Charlotte Vandersteen in 1912.¹⁷⁰ This is not surprising given that chest complaints and rheumatism were some of the main ailments experienced by the patients themselves. The presence of infectious chest complaints in the patient's families demonstrates that such conditions were prevalent in the population beyond the patients of the RFH, and raises questions as to the extent to which the epidemiological transition was underway. We must remember, however, that often it was only conditions related to the patients current complaint that were recorded in a family history, meaning that a disproportionate number of chest complaints may have been recalled, and unrelated health complaints may have gone unrecorded. In terms of previous family health, miscarriages were frequent, which is not surprising given the lack of prenatal care available during the late nineteenth century. It was also quite probable that many instances of miscarriage were in fact abortions. However, the majority of miscarriages reported in the family histories were not those suffered by relatives, but those of the patient themselves. Patients had often suffered more than one miscarriage in their lifetime, such as Elizabeth Hardman and Elizabeth Malin, who had both experienced two miscarriages prior to their visit to the RFH.¹⁷¹ The fact that miscarriages were recalled not in the previous health history, but in the family history, shows that the focus was not on the health of the patient but on the loss of a family member.

The family histories contained in the records also recalled complaints from which family members had died. Consumption, bronchitis, and cancer were some of the main

¹⁶⁹ PR: *Ivy Chambers*, Sainsbury Women July 1902, p. 269:1, PR: *Esther Lockwood*, Sainsbury Women December 1902, p. 469, PR: *Florence Child*, Roughton Women December 1912, p. 631

¹⁷⁰ PR: *Mary Creeth*, Roughton Women December 1907, p. 550, PR: *Alexander Sutcliffe*, Sainsbury Men December 1912, p. 692:1, PR: *Charlotte Vandersteen*, Sainsbury Women December 1912, p. 677

¹⁷¹ PR: *Elizabeth Hardman*, Carr Women December 1903, p. 518, PR: *Elizabeth Malin*, Sainsbury Women December 1907, p. 865:1

causes of death.¹⁷² Cancer killed mainly adult women, whilst chest complaints claimed the lives of mostly young children. The parents of Eliza Batchelor died of bronchitis, while Edward Hounslow lost thirteen children to the complaint.¹⁷³ Many parents had to cope with the loss of their children, as can be seen in the case histories of Charles Head, who was one of twelve children, six of whom were dead, or William Bear, who was one of nine children, five of whom were dead.¹⁷⁴ Often a variety of complaints took the lives of children in the patient's family, such as in the case of Susannah Turlow, who had twenty children, of whom fifteen had died of complaints including scarlet fever, bronchitis, exhaustion, or were stillborn.¹⁷⁵ Instances of stillbirths were common in family histories, such as in the case of Florence Child, who gave birth to seven stillborn children.¹⁷⁶

Collectively, families often contained numerous members simultaneously suffering from various ailments, and would have had to deal emotionally, physically, and financially with such circumstances. The case record of Ethel Norris highlights such collective suffering, with the patient herself having previously had measles, whooping cough, and scarlet fever, and having had three sisters with bronchitis, one sister who died of pneumonia, a father who had suffered rheumatic fever five times, and grandparents who had both died of consumption of the lungs aged thirty-nine and forty-four years.¹⁷⁷ The patient herself died at the RFH aged only thirteen years, after having been treated for rheumatism and pericarditis.¹⁷⁸ A further example is the case of Alice France, who had previously contracted whooping cough, measles, and chickenpox, whilst her mother had previously experienced a miscarriage, and father had suffered with asthma, a cough, gout,

¹⁷² See: PR: *Annie Clayton*, Berry Women December 1902, p. 830, PR: *George Harvey*, Sainsbury Men December 1902, p. 464, PR, *Bertha Lent*, Carr Women July 1907, p. 386, PR: *Mary Anne Maynard*, Sainsbury Women July 1907, p. 510

¹⁷³ PR: *Eliza Batchelor*, Sainsbury Women December 1912, p. 695:1, PR: *Edward Hounslow*, Carr Men July 1907, p. 600:1

¹⁷⁴ PR: *William Bear*, Sainsbury Men July 1902, p. 5:1, PR: *Charles Head*, Sainsbury Men December 1902, p. 488:1

¹⁷⁵ PR: *Susannah Turlow*, Carr Women December 1903, p. 537

¹⁷⁶ PR: *Florence Child*, Roughton Women December 1912, p. 631

¹⁷⁷ PR: *Ethel Norris*, Sainsbury Women December 1902, p. 483:1

¹⁷⁸ *Ibid*

and rheumatism.¹⁷⁹ Her father's brother, her mother's sister, and two nieces died of consumption, and four siblings two died of convulsions and diarrhoea, one of measles and pneumonia, and one of diphtheria.¹⁸⁰ Two other brothers had suffered pleurisy and pneumonia, from which they recovered.¹⁸¹ Such examples demonstrate the accumulation of suffering family units endured over the lifetimes of various generations. It was also important for the family histories to state those ailments from which the family did not suffer in order that the 'hereditary predisposition' of the family was understood.¹⁸² According to Waller, hereditarians believed that individuals did not necessarily inherit afflictions directly from their parents, but instead inherited the potential to develop them.¹⁸³ Many records stated that the family had no history of rheumatism, consumption, tuberculosis, or cancer, which were considered by contemporaries such as Appleton, Carr, and Berry to be hereditary complaints.¹⁸⁴ In other cases, the family history reported that the family had no history of complaints that had no connection to the patient's current complaint, such as in the case of Herbert Brookes, who was suffering sciatica in 1902, and whose family history recalled that there was no history of consumption.¹⁸⁵ It is important to note the good health of family members alongside the bad. Edwin Lucas was one of eight children, and all were reported as being healthy, whilst in the case of Alice Zambra the patient's entire living family were reported to be in good health.¹⁸⁶ The fact that it was felt necessary, however, to report the good health of family members suggests that perhaps it was considered rare.

¹⁷⁹ PR: *Alice France*, Carr Women July 1903, p. 320:1

¹⁸⁰ Ibid, pp. 320:1-321

¹⁸¹ Ibid, p. 321

¹⁸² Waller, 'The Illusion', p. 420

¹⁸³ Ibid

¹⁸⁴ Appleton, "*The Doctor Says*", p. 185, Berry, *A Manual*, p. 18, and Carr, Pick, Doran, Duncan, *The Practitioners*, p. 836

¹⁸⁵ PR: *Herbert Brookes*, Sainsbury Men December 1902, p. 460:1

¹⁸⁶ PR: *Alice Zambra*, Carr Women July 1907, p. 358:1, PR: *Edwin Lucas*, Sainsbury Men December 1902, p. 455, PR: *Elizabeth Weyell*, Sainsbury Women December 1907, p. 842:1

Conclusion

The current, previous, and family histories included in the patient case records provide us with a unique insight into the health of the population during the early twentieth century. The current historiography has depended on the use of mortality figures to examine ill-health, but the methodology behind the use of patient records has allowed for the complaints which were suffered throughout the early twentieth century but did not result in death to be highlighted and examined. This form of analysis is novel and significant to broadening debates and understanding of the history of ill-health. Patients sought treatment at the RFH for a wide range of complaints, both infectious and chronic, and those brought on by accidental injury or deliberate self harm. What is clear from the ailments and complaints contained in the records is that these patients living through the later nineteenth and early twentieth century had to balance their everyday lives with the constant threat of ill-health. The current and previous complaints suffered by the patients themselves together provide a valuable insight into the complex life-cycle of ill-health typically suffered during this period. Moreover, many family members often simultaneously suffered various health complaints and had to deal with losing many loved ones to disease. The accumulation of ill-health in the records provides a novel insight into the collective suffering experienced by patients and their families.

As discussed in the introduction to this chapter, historians have debated the cause of mortality decline over the course of the nineteenth century, based largely on the hypothesis of McKeown. Given that infectious complaints were the most common combined current and previous ailments suffered by the patients themselves, and were also the most common suffered by the patient's families, it is clear that contrary to beliefs that this period witnessed a transition from the dominance of infectious to chronic complaints, infectious diseases remained the major health threat. The high number of infectious

diseases present in the previous health histories of the patients in the sample shows, however, the frequency with which they were suffered and did not kill. This suggests that the population were somehow better at protecting themselves against infectious complaints. According to McKeown and Hardy, better nutrition was one of the factors which helped the population fight off infectious diseases. As we have seen from the condition of the patients on admission, however, many patients were underweight and suffered from bad dental conditions. Szreter claimed that public health improvements were the more likely cause of improved health and the ability to fight off infectious complaints. The constant high levels of respiratory complaints, as caused by bad air quality and poor living conditions, however, suggests that public health measures were also not the most likely cause of better resistance to infections. As discussed in Chapter Three, the majority of the patients in the sample lived in close proximity to the RFH, in areas well known to be overcrowded and unsanitary. The sample suggests, therefore, that the reason high numbers of patients in the sample survived infectious complaints was the changing nature of the infections themselves and favourable trends between such conditions and the human host. The dominance of chronic complaints in the current diagnosis of the patients shows that by the early twentieth century these conditions had become a serious health (and death) risk to the population. The continued prevalence of infectious conditions, however, challenges the current debate by suggesting that the epidemiological transition was occurring later than historians have previously estimated.

Whilst the health information contained in the case records has demonstrated the variety of complaints people suffered throughout their lives, there are some absent complaints which we might have expected to find. One such complaint was rickets, which according to Leff was suffered by one-third of the poor children in large cities by the late

century.¹⁸⁷ Given that the largest age group treated at the hospital was children, it is surprising that it was not evident in either the current or previous complaints of the patients themselves, or in their family histories. Either it was so common in the wider population that it was not deemed noteworthy by the staff at the RFH, or its prevalence has been overestimated in the current historiography.

Overall, this chapter has established the ailments from which the patients in the sample suffered during the late nineteenth and early twentieth centuries. The following chapter will examine the treatments these patients received at the RFH in order to better understand why patients came to be treated on its wards and place it in the setting of the wider medical marketplace of the early twentieth century. By reconstructing aspects of hospital treatment, this study can also consider the experience of patients at the RFH, and in turn, the experience of voluntary hospitals more generally.

¹⁸⁷ Leff, *The Health*, p. 81

CHAPTER SIX

TREATMENT AND ITS RESULTS

The current historiography lacks any comprehensive examination of hospital treatment and patient experience. As will be discussed, medical and surgical procedures were developing and their safety improving throughout the late nineteenth and early twentieth centuries, but there are few empirical studies to trace this in the hospital setting. Previous chapters have considered how patients made use of the Royal Free Hospital (henceforth RFH) in the wider medical market and have examined the ailments from which patients suffered. By considering the treatments patients received and by reconstructing aspects of their experience, this chapter will contribute towards our knowledge of hospital medicine and further our understanding of how and why patients made use of the RFH.

There are two strands of the historiography important to this chapter. The first is that which has considered developments in medicine and surgery over the course of the late nineteenth and early twentieth centuries. As explained in the Introduction to this study, developments in hospital medicine and surgery were influenced by many internal and external factors, including the preferences of the medical staff and the cost of new technologies. General histories of medicine and surgery, including those of Porter, Bynum, and Duffin, have traced developments and transitions in treatment techniques by laying focus on influential individuals, inventions, and discoveries from classical times to the present day.¹ Histories which have considered the period between the late nineteenth century and the First World War have broadly examined developments including

¹ For examples, see; W. F. Bynum and R. Porter (Eds.), *Companion Encyclopedia of the History of Medicine, Volume 2*, (Routledge, London and New York, 1993), A. Dally, *Women Under the Knife: A History of Surgery*, (Hutchinson Radius, London, 1991), J. Duffin, *History of Medicine: A Scandalously Short Introduction*, (Macmillan, Basingstoke, 2000), H. Ellis, *A History of Surgery*, (Greenwich Medical Media Limited, London, 2001), A. Hardy, *Health and Medicine in Britain since 1860*, (Palgrave, Basingstoke, 2001), C. Lawrence, *Medical Theory, Surgical Practice: Studies in the History of Surgery*, (Routledge, London, 1992), R. Porter, *Blood and Guts: A Short History of Medicine*, (The Penguin Press, London, 2002), R. Porter (Ed.) *The Cambridge History of Medicine*, (Cambridge University Press, Cambridge, 2006), R. Porter, *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present*, (Fontana Press, London, 1999)

anaesthetic and antisepsis techniques, vaccinations, and the discovery of the Rontgen Rays (though incidentally, few works have focused on any of these topics individually).² Bynum and Porter's consideration of the main principles of physical diagnosis, Courtwright's study of cocaine, and Ellis' work on surgery are some of the limited number of works which have focused on specific treatments and medicines that patients would have experienced in early twentieth century voluntary institutions.³ The countless other hospital medicines and treatments experienced by patients during this period, however, have been overlooked. The second aspect of the historiography is that which has examined the growth of hospital medicine. By the early twentieth century, medical advice and treatment was provided through a range of institutional settings.⁴ Debate and discussion, however, has primarily focused on the birth of clinical medicine, with the shift away from ancient humoral beliefs, and the resulting scientific and technological breakthroughs encountered in the new setting of modern, professional medicine, the hospital.⁵ Cherry, Porter, and Waddington have all discussed aspects of the British hospital systems, both voluntary and endowed, of the nineteenth and twentieth centuries, including administration, finance, and

² A. Hessenbruch, 'Calibration and Work in the X-Ray Economy, 1896-1928', *Social Studies of Science*, Vol. 30, No. 3 (Jun., 2000), pp. 397-420, G. Mooney, 'A Tissue of the most Flagrant Anomalies': Smallpox Vaccination and the Centralization of Sanitary Administration in Nineteenth-Century London', *Medical History*, Vol. 41 (Wellcome Institute for the History of Medicine, 1997), pp. 261-90, S. J. Snow, *Operations Without Pain: The Practice and Science of Anaesthesia in Victorian Britain*, (Palgrave Macmillan, Basingstoke and New York, 2006)

³ W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge University Press, Cambridge, 1994), pp. 33-42, D. T. Courtwright, 'The Rise and Fall and Rise of Cocaine in the United States', in J. Goodman, P. E. Lovejoy, and A. Sherratt (Eds.), *Consumer Habits: Drugs in History and Anthropology*, (Routledge, London and New York, 1995), pp. 206-228, Ellis, *A History*, R. Porter, 'The rise of physical examination', in W. F. Bynum and R. Porter (Eds.), *Medicine and the Five Senses*, (Cambridge University Press, 1993), p. 179

⁴ Important examples include: S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St. Andrew's Hospital, 1810-1998* (Boydell, Woodbridge, 2003), M. A. Crowther, *The Workhouse System 1834-1929: The history of an English social institution*, (Batsford Academic and Educational Ltd, London, 1981), R. G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871*, (The Wellcome Historical Medical Library, London, 1967), I. Loudon, *Medical Care and the General Practitioner, 1750-1850*, (Clarendon Press, Oxford, 1986), A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900*, (Yale University Press, New Haven, 1993), K. Waddington, *Charity and the London Hospitals 1850-98*, (Boydell Press, Woodbridge, 2000)

⁵ The most important include; E. H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848*, (John Hopkins Press, Baltimore, 1967), Bynum, *Science*, W. F. Bynum and R. Porter (Eds.), *Medicine and the five senses*, (Cambridge University Press, Cambridge, 1993), A. Digby, *The Evolution of the British General Practice 1850-1948*, (Oxford University Press, Oxford, 1999), M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, Translated from French by A. M. Sheridan, (Tavistock Publications, London, 1973), R. French and A. Wear (Eds.) *British Medicine in an Age of Reform*, (Routledge, London, 1991)

education.⁶ However, hospital doctoring and the relationship held between the doctor and the hospital patient have all been relatively neglected. The problem with these historiographies for the purposes of this study is that they have rarely overlapped, which has meant that medicine and surgery of the late nineteenth and early twentieth centuries has not been considered in the hospital setting. The work of Ellis is one of the few to have considered medical practice in the hospital, as the operating theatre became the centre of modern surgery.⁷ More often, medicine and surgery of the early twentieth century has been neglected by historians, who have instead focused on expansion and improvements which resulted from wartime experience.⁸ As a result, we know very little about changes and developments of medical and surgical treatments in the hospital during this period, and surprisingly little from an empirical perspective on the place of hospital medicine and practice in the wider medical market.

Through the use of qualitative analysis, this chapter will draw examples of the main and collective treatments patients underwent at the RFH in order that the patient experience of the hospital can be better understood. The treatments in question relate to all aspects of the medical and surgical care afforded the patients from their admission to discharge, including any practice, procedure, drug or medicine aimed at diagnosing, easing, healing, or curing the patient's ailment. In the first section, the patient case records will be discussed as a source of hospital treatment and experience. This will be followed by an examination of the diagnostic treatment procedures the patients underwent upon entering the hospital. Physical examination techniques developed throughout the nineteenth century are one of the hallmarks of diagnosis in modern medicine, yet the current historiography contains little evidence of their practical application. Thirdly, the

⁶ S. Cherry, *Medical services and the hospitals in Britain 1860-1939*, (Cambridge University Press, Cambridge, 1996) R. Porter, 'Hospitals and Surgery' in R. Porter (Ed.) *The Cambridge History of Medicine*, (Cambridge University Press, 2006), pp. 176- 210, K. Waddington, *Medical Education at St. Bartholomew's 1123-1995*, (Boydell Press, Woodbridge, 2003)

⁷ Ellis, *A History of Surgery*

⁸ An example of which is: Cherry, *Medical services*, p. 19

general treatment the patients experienced on the wards will be explored, including the contact they would have had with medical staff, the duration of their care, and the rules they were to follow whilst staying at the hospital. Medical treatment will then be considered, including specialist diets, skin applications, and x-rays. Fourthly, the specific medicines and drugs used at the RFH will be surveyed, including those used as anaesthetics. Surgical treatment will then be discussed, along with the instruments used in operative procedures. By examining the medical and surgical treatments in the case records we can establish whether the RFH provided up-to-date care, and if it reflected that given across the wider hospital setting of the metropolis. Whilst scientific, clinical medicine, is widely accepted to have dominated hospital treatment by the early twentieth century, we will see that humoral medical beliefs still influenced patient care. Finally, the treatment results will be analysed in order that we can begin to consider the effectiveness of the medicines and surgery afforded to the patients. The condition in which the patient was discharged indicates how the hospital viewed its role as a health care provider, and demonstrates the level of health required before removing the patient from the wards. The task of judging the success of various medical treatments has rarely been discussed in the historiography, and the collective effectiveness of numerous treatments has often been neglected.

Patient Case Records

As in previous chapters, it is important that before examining the treatments recalled in the patient case records, we consider the manner in which information was recorded in order to judge its reliability. Patient records are an excellent means of identifying hospital treatments of the early twentieth century as they contain details of treatment history, diagnostic, medical, and surgical procedures, treatment results, and of aftercare organised

for many of the patients discharged. Whilst the records sampled for this study number a respectable 480, they do not represent a statistical sample of patient hospital treatments. Instead, the sample will be used to draw individual examples of patient treatment and experience that seem to represent broad tendencies. It is important to recognise and understand, however, that as with any historical source, patient records pose potential problems.

The most important issue to address for the purposes of this study is that the case records cannot possibly contain every detail of patient treatment. The daily notes contained in the records did not always recall treatment information for every day the patient was on the wards. The image on the following page shows some of the daily notes of Edith Burrows, a patient of Dr Sainsbury during the summer of 1912.⁹ The page recalls the treatments Burrows received every four-to-nine days, with additional notable medicines administered recorded in the margin. Instead of regular daily notes, records often only contained information regarding a significant change in the patient's condition, or when they had been treated with a medicine deemed noteworthy. This meant that case records could contain gaps in daily notes of days or even weeks, such as in the record of John Wedley, who spent approximately 230 nights on the wards of the RFH between November 1902 and July 1903, for which gaps in the daily notes ranged from a single day to around three weeks.¹⁰ Gaps often made up the last days of a patients stay at the hospital, such as in the cases of Thomas Sessions or Benjamin Clarke, whose last ten days and last two weeks of treatment were respectively not recorded.¹¹ Of course, this does not mean that the patient had no contact with medical staff during these missing days, or that they received

⁹ Royal Free Hospital Patient Case Record (Henceforth PR): *Edith Burrows*, Sainsbury Women July 1912, p. 438:1

¹⁰ PR: *John Wedley*, Carr Men July 1903, p. 537, for further examples see: PR: *Lilian Dunn*, Carr Women July 1903, p. 342, PR: *Ruby Lincoln*, Sainsbury Women December 1902, p. 454, PR: *Arthur M. Sutton*, Berry Men December 1907, p. 936

¹¹ PR: *Benjamin Clarke*, Carr Men December 1903, p. 974, PR: *Thomas Sessions*, Sainsbury Men July 1907, p. 702, or for other examples see; PR: *Maud Brandwood*, Carr Women July 1907, p. 330, PR: *Dolly Stevens*, Carr Women July 1912, p. 252, PR: *Alice Lierke*, Sainsbury Women July 1907, p. 484

no medical treatment during periods when no notes were taken. In other instances, parts of a patient record may be missing or incomplete, such as in the records of Marion Watson, whose last two days at the RFH (including her discharge information) are missing, or the notes of William Wrigfield, whose notes stop mid-sentence.¹² Unlike gaps in daily notes, these instances of missing information were probably the result of a mistake or distraction on the part of the medical staff member completing the record, or of the accidental loss of part of the record prior to storage.

We must also be aware that the treatments noted in the case records were not always described at the time they were performed, which raises issues of accuracy and reliability. Daily notes often recalled treatment administered or contact with medical staff that occurred ‘yesterday’ or a couple of days previous, such as in the notes of Daisy Price and Stephen John Maffey.¹³ Other records contained conflicting information, the most frequent instances of which are those relating to admission and discharge dates. In the case record of Herbert Bouffler, the front cover stated he was admitted on October 31st 1907, but the daily notes reported that he was actually admitted on October 19th, and consultations were performed on October 23rd.¹⁴ Similarly, the front cover of the record of Alice Carter claimed she died on December 22nd 1907, but the daily notes stated death occurred on December 23rd.¹⁵ These examples reflect accidental misreporting, and whilst they may only relate to dates and not to treatment specifics, the presence of such mistakes in the records provokes a level of uncertainty as to the reliability of the information contained in the records more widely. That said, it must be remembered that the staff at the

¹² PR: *Marion Watson*, Sainsbury Women July 1912, p. 454, PR: *William Wrigfield*, Sainsbury Men December 1907, p. 1158

¹³ PR: *Daisy Price*, Sainsbury Women July 1907, p. 555, PR: *Stephen John Maffey*, Sainsbury Men July 1912, p. 406

¹⁴ PR: *Herbert Bouffler*, Berry Men December 1907, p. 931, further examples are that of: PR: *Lilla Norris*, Carr Women December 1907, p. 742, the front cover stated the date of discharge was December 26th 1907, but the daily notes state December 27th, and PR: *Charlotte Rutt*, Carr Women July 1903, p. 328, the front cover stated that she was discharged on July 19th 1903, whilst the daily notes claimed she was discharged on July 18th.

¹⁵ PR: *Alice Carter*, Carr Women December 1907, p. 734

RFH were, of course, only human, and simple mistakes would have been made occasionally whilst working in a busy hospital environment. Although the historian must be aware of the possibility of occasional misreporting, such mistakes do not undermine the broad reliability of the records as a source of treatment information.

It is also important to recognise that the staff member whose name was printed on the cover page may not have been the physician or surgeon who treated the patient. Frank Bone was admitted under the surgeon Mr Legg, but his case record is one labelled Mr Berry, whilst the patients Florence James and Jane Limer were both treated by Mr Barrow even though their records are those of Mr Roughton.¹⁶ It is important to identify the primary staff member treating the patient in order to consider the nature of the doctor-patient relationship formed during the patients stay at the hospital. Whilst it may have been the case that the physician or surgeon whose name was printed on the record was the managing team member ultimately responsible for the patient, they were often not the primary staff member overlooking the patients' treatment. More than one physician or surgeon treated each patient at various periods during their treatment at the RFH, and this would have contributed to the overall experience of hospital medical care the patients received. We should be aware that the standard of treatment each patient received may have differed depending on factors regarding the patient themselves, such as their class or sex, or on the ailment from which they suffered, or on the staff members providing their care. It is difficult, however, to differentiate between real differences in treatment standards contained in the records, and those which reflect the style and attention to detail of the staff member whom completed the record.

When using the case records to reconstruct the experience of the hospital patient, it has to be remembered that they were compiled by hospital staff members and rarely included the voice of the patient. That said it is not the purpose of this study to focus on the

¹⁶ PR: *Florence James*, Roughton Women December 1902, p. 947, PR: *Frank Bone*, Berry Men July 1912, p. 680, PR: *Jane Limer*, Roughton Women December 1902, p. 952

emotions and feelings of the hospital patient. Rather, the patient 'experience' to which the study refers deals with the daily routine of the typical hospital patient. With this in mind, the information contained in the records regarding the treatment, including details of the medicine and diet provided, allows us to identify many aspects of their experience of the hospital setting. In order to reconstruct a more representative picture of the hospital experience, patient records must be used alongside other hospital records, such as the 'Rules and Regulations', which detail how the patients on the wards were expected to behave.

Overall, whilst it is important to remain aware of the potential issues that arise when using patient records as an historical source, the wealth of hospital treatment information they provide is unparalleled. No other source can provide as detailed an insight into the practical treatments patients received. The examination of such records in this study is unique to the historiography, which as explained earlier in this chapter, currently bases discussion regarding hospital treatment on major medical discoveries, or on the content of contemporary medical textbooks and journals which state the methods of medical and surgical treatment which were theoretically performed.¹⁷ Given that the RFH was a general voluntary hospital, situated in central London and staffed by physicians and surgeons who also worked at other institutions and held private practices, it is not unreasonable to assume that the treatments it provided reflect those provided by the wider hospital network of London during the early twentieth century. That said, the fact that the hospital was funded predominantly by charitable donations might lead us to hypothesise that treatment options it could afford may not have been as advanced as the larger hospitals, such as St Bartholomew's.

Diagnostic Treatment

¹⁷ A point made in: G. Risse and J. H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, Vol. 5, No. 2, (1992), pp. 183-205

The process of diagnosis began as soon as the patient entered the RFH and continued throughout their time on the wards as their health was continually re-evaluated. As discussed in the previous chapter, obtaining a patient history was one of the first stages of diagnosis and thus one of the first aspects of hospital treatment the patients experienced. Historians have debated the prominence of the patient narrative against the physical examination in the diagnostic process, often concluding that the patient narrative dwindled in importance as physical examinations became more thorough and socially accepted. Fissell has claimed that ‘the patient’s narrative of illness was made utterly redundant’ during the era which saw hospital medicine focus on signs and symptoms.¹⁸ Although the patient narrative did not disappear quickly or completely during this period, Fissell believes that its ‘erosion’ was very much underway by the start of the nineteenth century, and was replaced by physical diagnosis as the disease became the focus of the physical gaze, ‘not the patient’s version’ of their illness.¹⁹

Whilst this may have been the general trend, the patient records of the RFH demonstrate the continued importance of the patient narrative in the early twentieth century. Whilst practitioners must have seen the benefit of listening to the patient narrative, patients would likely have still expected to have been asked questions relating to their ill-health. Patients were questioned as to the history of their current illness, as well as to their wider health histories and that of their family. Patient narrative was a vital aspect of diagnosing the current complaint by providing an insight into the symptoms patients had experienced and of any pain they were suffering, such as in the case of Esther Lockwood, who complained of pain in her side and irregular bowels for months.²⁰ Rare examples of the patient’s voice can be gained from quotes included in the records, such as Charlotte Aldridge who described having suffered from shivering fits ‘like electric shocks’, and

¹⁸ M. E. Fissell, ‘The disappearance of the patient’s narrative and the invention of hospital medicine’, in R. French and A. Wear (Eds.) *British Medicine in an Age of Reform*, (Routledge, London, 1991), p. 93

¹⁹ Fissell, ‘The disappearance’, pp. 93 and 100

²⁰ PR: *Esther Lockwood*, Sainsbury Women December 1902, p. 467

Charlotte Vandersteen who ‘brought up blood’ prior to coming to the hospital.²¹ Such examples reflect the conclusions of Digby, who has claimed that the importance of the patient narrative ‘continued to outweigh the physical examination, or the laboratory test that might follow it’.²² As the medical staff of the RFH also worked at other hospitals, it stands to reason that the use and importance of patient narrative was recognised in the diagnostic procedures of other hospitals across the capital and beyond.

The continued importance of the patient narrative, however, does not act to discount the value of physical examination techniques used in the process of diagnosis. Their presence in the case notes indicates that the two approaches had equal place and worth in diagnostic procedure as they each gained valuable health information that the other could not. Whilst the patient narrative provided a health history and the symptoms of the current complaint, a comprehensive physical examination would have allowed the staff to determine the nature and complexity of the patients’ condition. Contemporaries have described an examination as consisting of ‘the four cardinal arts’ of inspection, palpation, percussion, and auscultation, or ‘looking, feeling, thumping, and listening’.²³ Inspection refers to the examination of the exterior of the body, and palpation was the technique of examining the outside of the body based on the knowledge of the inside.²⁴ Percussion consisted of ‘striking sharply the body with slightly curved fingers’, and auscultation meant to listen to the sounds of the body, such as with a stethoscope.²⁵ These ‘cardinal arts’ were a regular part of patient examination at the RFH, demonstrating that the hospital was providing up-to-date medical care similar to the wider profession. The performance of these acts, however, was not always discussed in the case records under their four

²¹ PR: *Charlotte Aldridge*, Sainsbury, Women December 1907, p. 801, PR: *Charlotte Vandersteen*, Sainsbury Women December 1912, pp. 674 and 681

²² Digby, *The Evolution*, p. 235

²³ J. Berry, *A Manual of Surgical Diagnosis*, (J. & A. Churchill, London, 1904), p. 20, Bynum, *Science*, p. 33

²⁴ R. Porter, ‘The rise’, p. 179, E. Shorter, *Doctors and Their Patients: A Social History*, (Transaction Publishers, London, 1993), pp. 84-5

²⁵ Bynum, *Science*, p. 35, Shorter, *Doctors*, pp. 84-5, PR: *Lucy Alice Prior*, Sainsbury Women December 1907, p. 845

headings. In the record of Thomas Camp, his temperature, pulse, and respiratory condition were regularly recorded in the daily notes under no headings.²⁶ Testing the blood count of the patients was also important. Berry claimed that healthy blood should contain five million red corpuscles and eight thousand white.²⁷ William Holloway was found to have had only 2,600,000 red blood cells and 6,900 white.²⁸ The patients' senses were also checked, such as Patrick Hinchon, who had his sense of smell tested with peppermint, and Albert Smart, who had his hearing examined through the use of the Rinne's test.²⁹ Eye examinations were also performed, as in the case of Bertha Lent, whose vision chart was included in her case record.³⁰ Overall, the records indicate that regardless of the region of pain or discomfort, or of any suspected diagnosis, a thorough physical examination of the entire body was routinely conducted. This is significant, given that medical research had conceptually separated the body into separate organs and systems through the nineteenth century. Patients at the RFH underwent broad physical exams of seemingly unrelated parts, such as in the case of Mary Russell, who complained of an itchy vulva but was tested for knee jerks.³¹

A range of medical equipment and tools were used to perform diagnostic treatment at the RFH, including various non-invasive tools such as microscopes and flash lights. A Laryngoscope was used by Roughton when examining the throat of Arthur Hill, and by Berry when examining that of Eva Padney.³² Likewise, an Ophthalmoscope was used by Carr to examine the eye of Edward Sullivan.³³ Invasive tools were those which entered the

²⁶ PR: *Thomas Camp*, Sainsbury Men July 1907, p. 749

²⁷ Berry, *A Manual*, p. 30

²⁸ PR: *William Holloway*, Sainsbury Men July 1912, p. 380. For a further example see: PR: *Albert Eames*, Sainsbury Men July 1912, p. 429

²⁹ PR: *Patrick Hinchon*, Sainsbury Men July 1907, p. 722, PR: *Albert Smart*, Roughton Men December 1907, p. 992: Rinne's Test involved a tuning fork being placed on the temporal bone behind the ear. If a vibration was not heard, an obstruction existed. See: H. Morten (revised by Florence Taylor), *The Nurses Dictionary*, (Faber and Faber, London, 1942), p. 300

³⁰ PR: *Bertha Lent*, Carr Women July 1903, p. 384

³¹ PR: *Mary Russell*, Sainsbury Women July 1902, p. 303

³² PR: *Arthur Hill*, Roughton Men July 1912, p. 676, PR: *Eva Padney*, Berry Women July 1902, p. 447

³³ PR: *Edward Sullivan*, Carr Men July 1903, p. 500

patient's body in order for the physician or surgeon to examine suspected internal disease, such as the cystoscope, a long tube used to examine the bladder via the urethra.³⁴ Some tools might only have been considered mildly invasive, such as the nasal speculum (an instrument comprised of two relatively flat blades hinged to two handles, which when placed in the patients' nostril and squeezed together spread the blades and widened the nostril to allow the physician a better view of the nasal passage).³⁵ Larger versions of this instrument, however, were used in diagnostic procedures considered much more invasive and uncomfortable. At the RFH, both rectal and vaginal examinations appear in the case records of all four staff members, although it was not always these men who performed the procedures, such as in the case Arthur Bewell, a patient of Carr who was examined per rectum by Mr Roberts.³⁶ Details of these examinations included no mention of anaesthetics having been given to the patients.³⁷ Sainsbury performed a rectal exam on Mary Anne Maynard which caused her so much pain that anaesthetic was administered in her follow up inspections.³⁸ Vaginal examinations were most often carried out by the resident female gynaecologist. As of the year 1902, the RFH became the first general hospital to appoint a female physician to a consulting post by hiring Mrs Scharlieb as Physician for Diseases of Women and Miss Vaughan (Vaughan-Sawyer as of 1907) as assistant physician to the post.³⁹ Whilst it would not appear from the records that the female staff treated the patients any differently from the male physicians and surgeons, their presence would likely have made female patients more comfortable when undergoing intrusive gynaecological procedures.

³⁴ For example see: PR: *Lucy Cumming*, Berry Women December 1912, p. 672

³⁵ For example see: PR: *George Davis*, Carr men December 1912, p. 976

³⁶ PR: *Arthur Bewell*, Carr Men July 1903, p. 529

³⁷ No anaesthetic was used in the case of: PR: *Clara Stringer*, Berry Women July 1912, p. 479

³⁸ PR: *Mary Anne Maynard*, Sainsbury Women July 1907, p. 507 and 515, PR: *John Wedley*, Carr Men July 1903, p. 537

³⁹ RFHA: *The Seventy-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1902*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 8

Treatment

Once the patient had been diagnosed, their treatment could begin. The contact and relationship between the patients and the medical staff at the RFH would have had a decisive effect on the treatment received and the patient experience of the hospital. As discussed in the patient case records section of this chapter, the patient treatment was often not solely decided by the physician or surgeon to whom they were registered on admission.⁴⁰ In complex cases, patients were seen by numerous consulting staff members during their rounds in order that the most precise diagnosis and treatment could be agreed.⁴¹ Such a case was that of Emma Cole in 1912, who was being treated under Sainsbury for ‘malignant disease of the caecum’ (disease of the large intestine), and was seen at consultations by Berry, Carr, Mr Evans, and Dr Langmead.⁴² Each of these staff members would have performed a physical examination of Cole in order to collectively decide on a course of treatment, which although presumably would have been an intimidating experience, would also have reassured her that she was receiving the utmost attention and care. It was subsequently decided that the growth felt in the intestine be surgically explored, which led to Cole to be transferred into the care of Berry.⁴³ Internal transfers were frequent at the RFH, particularly from the medical to the surgical side, and for female patients, to the gynaecological department.⁴⁴ Having become familiar with one department and its staff, the experience of being transferred to another ward or department

⁴⁰ PR: *Albert Clark*, Berry Men December 1902, p. 37, PR: *Florence Deller*, Sainsbury Women July 1902, p. 299, PR: *Mary Heale*, Sainsbury Women July 1902, p. 285, PR: *Henry Keleger*, Berry Men December 1902, p. 34, PR: *William Mears*, Berry Men December 1902, p. 40, PR: *Mary Russell*, Sainsbury Women July 1902, p. 303

⁴¹ PR: *Herbert Bouffler*, Berry Men December 1907, p. 931, PR: *Louisa Nash*, Berry Women July 1907, p. 393, PR: *Susannah Turlow*, Carr, Women December 1903, p. 535, PR: *Amelia Weaver*, Carr Women July 1912, p. 231

⁴² Morten, *The Nurses*, p. 63, PR: *Emma Cole*, Sainsbury Women December 1912, p. 663

⁴³ PR: *Emma Cole*, Sainsbury Women December 1912, p. 663

⁴⁴ Internal Transfer examples: PR: *George Blogden*, Carr Men July 1907, p. 642, PR: *Mary Creeth*, Roughton Women December 1907, p. 549, PR: *Emily Oliver*, Sainsbury Women December 1902, p. 476, PR: *Dorothy Ruff*, Carr Women July 1907, p. 379, PR: *Alice Sinfield*, Sainsbury Women July 1902, p. 272, PR: *Maria Springer*, Carr Women December 1912, p. 392, PR: *Florence Wilson*, Carr Women December 1903, p. 526

of the hospital would have been stressful for many patients, not only due to the change in surroundings but through the realisation that they were to undergo a change in treatment.

It must be remembered, however, that hospital patients were not solely treated by consulting staff. House physicians and surgeons were those who lived on the premises of the hospital (as explained in Chapter Two) and by the early twentieth century were often (though not exclusively) newly qualified female medical professionals who had studied at the London Medical School for Women and had been appointed on short term contracts. In addition, the presence of many other female staff members including the gynaecologists Mrs Scharlieb and Miss Vaughan, and medical students gaining practical experience of clinical medicine, would have been a frequent sight on the wards of the hospital. Patients would have been treated by medical students often, particularly as they were required to act as dressers.⁴⁵ The presence of female medical staff and students made the RFH unique, as no other general voluntary hospital employed or taught female medical professionals on such a scale during this period. Patient experience would also have depended on their daily contact with the Matron and her nursing team, who collectively would have attended to the patient more than any other staff member in order to administer general care and medicine. The case record of Kathleen Bardell states that she had a nurse by her 'night and day' during her stay at the hospital in 1912.⁴⁶ The wards and corridors of the RFH would also have been busy with staff that ensured that the patients were being treated appropriately, such as the Medical Officer and Registrar.⁴⁷ These staff members have been neglected in the current historiography, along with the countless other individuals who were essential to the successful running of voluntary hospitals.⁴⁸ It is not hard to imagine

⁴⁵ 'Regulations for Casualty Dressers' and 'Directions for Dressers and Regulations for Students', in RFHA: *Rules and Regulations, 1904-1914*, (RFH/1/3/6/2), pp. 22 and 28

⁴⁶ PR: *Kathleen Bardell*, Sainsbury Women December 1912, p. 657

⁴⁷ 'Notes for Medical Officers' and 'Rules for the Registrars', in *Rules and Regulations*, pp. 20, 101, and 108

⁴⁸ Such as: The Steward, Housekeeper, Chaplain, Collector, Dispenser, Pharmacist, Pathologist, and Medical Electrician, to name only a few. More work is needed on the history of hospital staff in order to fully appreciate how hospitals like the RFH were administered, and how patients would have experienced hospital treatment.

that on admission, the number and variety of staff may well have made the hospital environment appear intimidating and somewhat hectic. It was the strict organisation and team work of the staff, however, that ensured that the patients were treated in an orderly setting.

The length of the patients stay at the hospital would have also had an important effect on their overall experience of hospital life. Most patients spent no more than a month at the RFH, which although must have been an inconvenience in regards to family life, keeping employment, or attending school, there were those who spent much longer at the hospital. James Mitson spent 138 nights on the wards, and John Wedley who was an in-patient for a lengthy 230 nights.⁴⁹ Irrespective of the length of time patients spent at the hospital, they were all required to follow the 'Rules and Regulations' regarding their behaviour, which if broken made them liable for dismissal.⁵⁰ Patients were to conduct themselves 'quietly and respectfully' and were not to 'get up from bed nor leave the ward without permission'.⁵¹ Males and females were kept on separate wards and were not allowed to go into that of the opposite sex without special permission of a Medical Officer.⁵² The official 'hour for retirement' was 8 p.m. and no conversation was allowed in the wards after 8.30 p.m. or before 6 a.m., unless that is, some form of entertainment was being conducted on the wards, which was to last until no later than 9 p.m.⁵³ Although we cannot tell from the case records how strictly some of these rules were adhered to, the records do include other details of general day-to-day life on the wards, such as how children played with toys and that patients were visited by family and friends.⁵⁴ Visitors would have been a welcome distraction for patients, but they were also the subject of strict hospital rules. On admission, each patient was supplied with two Visitors' Cards, and only

⁴⁹ PR: *James Edward Mitson*, Berry Men July 1902, p. 626, PR: *John Wedley*, Carr Men July 1903, p. 537

⁵⁰ 'Regulations for In-Patients' 1906, in *Rules and Regulations*, p. 70

⁵¹ *Ibid*

⁵² *Ibid*

⁵³ *Ibid*, p. 75

⁵⁴ PR: *Elizabeth Crew*, Roughton Women July 1907, p. 349, PR: *Margaret Lee*, Carr Women July 1903, p. 357

the two visitors holding those cards would be allowed to see the patient at one time.⁵⁵ Visiting hours changed only slightly over the years 1902 to 1912, having always comprised of no more than two hours on a Sunday (and most public holidays) and one hour on a Thursday afternoon.⁵⁶ In cases of a very serious nature, however, visitors were admitted at all hours.⁵⁷ It was not permitted for guests to bring any provisions or liquors to patients, which was a rule enforced by the nurses on the wards and the Gate Porter, who inspected any parcels brought into the hospital.⁵⁸ One visitor who was allowed on the wards daily was the hospital Chaplain, who gave a short service on each of the wards every Sunday morning, administered the Sacrament when deemed advisable, and reported back to the Hospital Board any matters believed of importance.⁵⁹ This is significant, given that Snell has claimed that religious obedience in Britain was declining throughout this period.⁶⁰ Nevertheless, the presence of the Chaplain on the wards would have been a great comfort to many of the patients, having been a familiar face and someone to talk to other than the medical staff.

Whilst the rules of the wards and the contact held between the patients and the medical staff would have had instrumental effects on the patients' experience, the medical and surgical treatment they received would surely have been the deciding factor in their overall opinion of the RFH. The patient records contain an abundance of information regarding the treatment procedures performed at the hospital, though it is not the purpose of this chapter to consider each of the individual medical and surgical treatments provided for the hundreds of individual complaints admitted. Instead, the remainder of this section will examine the main treatments that appear throughout the records and establish whether

⁵⁵ *Seventy-Fifth Annual Report 1902*, p. 32

⁵⁶ *Ibid*, and RFHA: *The Eighty-Fifth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1912*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), pp. 49-50

⁵⁷ *Seventy-Fifth Annual Report 1902*, p. 32

⁵⁸ *Rules and Regulations*, p. 70

⁵⁹ *Ibid*, p. 81

⁶⁰ K. Snell, *Church and Chapel in the North Midlands: Religious Observance in the Nineteenth Century*, (Leicester University Press, Leicester, 1991)

the hospital provided usual or novel patient care. There are no comparative studies, but we can set out which treatments were usual or unusual in relation to those which could have been performed elsewhere in the medical market, either at other institutions, by private practitioners, or by the patients in their own homes. Treatments ranged from those considered reasonably simple and gentle on the body, such as massages, hot and cold packs, fresh air, and specialist dietary remedies, to include the modern technologies of x-rays and radiography.

One key component of hospital treatment was shaping the diet of the patients to best suit their recovery. Provided the patient was conscious and able to eat and drink, their diet was an opportunity for the staff to improve their health. In 1907, Margaret Whitton was treated by Carr for carcinoma of the stomach, and was fed a varied diet which included milk, weak tea, coffee, beef-tea, lightly boiled eggs, toast, fish, chicken, mince, bread, grapes, nuts, bacon, cocoa, cream, and chocolate.⁶¹ Barley water was given to the patient Charles John Guy who suffered from acute pneumonia in 1912, along with Bovril and Brands Beef-Essence.⁶² Barley water, having been produced by placing barley in cold water and left to reduce, and Beef-Essence, being the result of minced beef being placed in a jar, and slow boiled in a saucepan before being strained, were designed to be high in nutrients and easy for the patient to digest.⁶³ Apart from offering essential nutrients, the natural medical properties of various foods such as rhubarb (a purge) or arrowroot (a nutrient rich starch food) were well known, and were an important aspect of patient treatment.⁶⁴ Specialist diets were also common at the hospital, such as ‘Lenhartz Diet’, which consisted of ‘granulated quantities of egg and milk with sugar’, and was

⁶¹ PR: *Margaret Whitton*, Carr Women December 1907, p. 727

⁶² PR: *Charles John Guy*, Sainsbury Men July 1912, p. 413

⁶³ Morten, *The Nurses*, p. 404

⁶⁴ PR: *Eliza Sweet*, Sainsbury Women July 1912, p. 449, PR: *Florence Brown*, Sainsbury Women December 1907, p. 828

recommended to those suffering from gastric ulcers.⁶⁵ Partially pre-digested foodstuffs known as ‘peptonised food’ were frequently provided to patients who suffered from gastric conditions.⁶⁶ These foods included milk, beef-tea, or other simple fluid foods.⁶⁷ Lucy Forscutt was treated in 1903 by Carr for a gastric ulcer, and was initially fed a liquid diet of milk, soda water, beef-tea, and custard, before gradually being allowed to eat solid foods which had been pre-minced, such as pounded fish and minced chicken.⁶⁸ Margaret Blachic was also treated in 1903 by Carr for the same condition, and was fed a diet of peptonised milk and beef tea, before being moved onto Benger’s food.⁶⁹ Annie Evans was also fed Benger’s food, a ‘self-digestive farinaceous preparation containing trypsin and amylopsin: used with fresh milk’.⁷⁰ Patent food products made up a further aspect of the hospital diet. These included ‘Mellin’s baby food’ and ‘Valentine’s meat-juice’, made through a process of extracting the juice of meat and prepared by dissolving one teaspoon of the juice in water, which claimed to quiet the irritable stomach.⁷¹ The patients’ diet was as important a part of their hospital treatment, but knowledge of the medical properties of food was not limited to the profession. The health benefits of many foods were well known throughout the wider community and patent remedies would have been available to buy from local chemists. However, patients may not have been in the position to source or afford many of the foods they were provided in the hospital. Though not unique to the RFH, the varied and specialist diets available to patients would have made hospital treatment more appealing for many individuals.

⁶⁵ Morten, *The Nurses*, p. 265

⁶⁵ *Ibid*, p. 207

⁶⁶ *Ibid*, p. 265

⁶⁷ *Ibid*, p. 265

⁶⁸ PR: *Lucy Forscutt*, Carr Women July 1903, p. 351

⁶⁹ PR: *Margaret Blachic*, Carr Women July 1903, p. 313

⁷⁰ PR: *Annie Evans*, Sainsbury Women July 1907, p. 490, PR: *Ruby Lincoln*, Sainsbury Women December 1907, p. 454, and Morten, *The Nurses*, pp. 17, 45 and 352: Both trypsin and amylopsin are ferments of the pancreatic juice and have a digestive action on proteins and carbohydrates respectively.

⁷¹ Morten, *The Nurses*, pp. 219, 257-8, PR: *Mary Anne Maynard*, Sainsbury Women July 1907, p. 507 and 515, PR: *Fanny Meending*, Carr Women July 1903, p. 347, and ‘Valentine’s Meat-Juice’, Advertisement in *The British Medical Journal*, (July 23 1927), p. 151

A further aspect of the treatment provided at the RFH was ensuring that the patients exercised and spent time outdoors. When able, patients were to move around the wards or go outside to the hospital square or roof.⁷² Mary Morianty, who was being treated for a fractured leg, was noted to have walked around the ward on crutches, which was not only her daily exercise but part of her rehabilitation.⁷³ Both Sidney Thompson, who was being treated for appendicitis, and Mrs Mortimer, who had diabetes, went out into the square, whilst John Hinton, who suffered with gastric pain, spent time on the roof.⁷⁴ It may appear somewhat ironic that the patients sought ‘fresh air’ outside a hospital situated in central London. The belief, however, that spending time outdoors was essential to good health meant that getting out of bed and off of the hospital wards was one of the principle features of treatment at the RFH, and would have been the same at other hospitals across the country. For the patients who found it more difficult to move around the hospital, massage treatment was a common aspect of their care. Albert Smart suffered from an injury to his shoulder after having fallen from a scaffold, and was subsequently treated with daily massages at the hospital.⁷⁵ Massages were also provided to the patients Edith Burrows and Louisa Rew, who were both treated by Sainsbury in 1912 for Chorea (also known as St. Vitus’ Dance), which caused involuntary twitching of the muscles.⁷⁶ As discussed in Chapter Two of this study, massage treatment was becoming a more prominent feature of hospital care during the early twentieth century, and its presence in the records shows that the RFH was keen to provide up-to-date treatment.

Other external treatments were also provided to the patients at the RFH, many of which were considered by some members of the medical community to be out-dated and

⁷² For examples, see PR: *Charlotte Rutt*, Carr Women July 1903, p. 328, PR: *John Hinton*, Sainsbury Men July 1907, p. 740, PR: *Mrs Mortimer*, Sainsbury Women July 1902, p. 293, PR: *Sidney Thompson*, Roughton Men July 1907, p. 634

⁷³ PR: *Mary Morianty*, Roughton Women December 1907, p. 534

⁷⁴ PR: *John Hinton*, Sainsbury Women July 1907, p. 740, PR: *Mrs Mortimer*, Sainsbury Women July 1902, p. 293, PR: *Sidney Thompson*, Roughton Men July 1907, p. 634

⁷⁵ PR: *Albert Smart*, Roughton Men December 1907, p. 992

⁷⁶ Morten, *The Nurses*, p. 80, PR: *Edith Burrows*, Sainsbury Women July 1912, p. 433, PR: *Louisa Rew*, Sainsbury Women December 1912, p. 684

dangerous. Hot packs were used to treat chorea, such as in the case of Kathleen Bardell, who was treated for the condition in 1912.⁷⁷ Similarly, ice bags were applied to patients suffering from muscle or joint pains, as in the cases of Robert Storey, who was treated in 1902 for a fractured patella, or Olive Meade, also treated in 1902 for arthritis.⁷⁸ The purpose of other external treatments was to irritate the skin in order to treat internal conditions, a practice which dated back to antiquity.⁷⁹ It was believed that ‘disease was a malignant entity or humor, which might be drawn from the deeper organs to the surface by means of irritation of the skin’.⁸⁰ By the nineteenth century the general explanation for the use of skin irritation had developed, believing that congested organs would benefit from the withdrawal of fluids such irritation caused.⁸¹ Fomentations consisted usually of ‘lint or flannel wrung out in some boiling fluid and applied for the alleviation of pain’.⁸² Turpentine fomentations, which were known for their great penetrating power, appear in many of the patient case records, including that of Thomas Allen, to whom it was applied to his right shoulder.⁸³ Fomentations of glycerine and belladonna were also used at hospital, such as in the cases of Robert Finnie and Elizabeth Osborne.⁸⁴ Glycerine was used for its soothing properties in skin preparations, whilst belladonna, a poisonous drug obtained from the deadly nightshade, was used for its paralytic properties.⁸⁵ The dangers of belladonna were well known, and unsurprisingly some patients had reactions after being treated with the drug, such as Lucy Forscutt, who developed a rash from belladonna fomentations.⁸⁶ Various plasters also appear in the case records, including Scott’s plasters,

⁷⁷ PR: *Kathleen Bardell*, Sainsbury Women December 1912, p. 657

⁷⁸ PR: *Olive Meade*, Roughton Women December 1902, p. 922, PR: *Robert Storey*, Berry Men July 1902, p. 640

⁷⁹ A. R. Cushny, *A Textbook of Pharmacology and therapeutics or the Action of Drugs in Health and Disease*, (LEA Brothers & Co., Philadelphia and New York, 1899), p. 76

⁸⁰ *Ibid*

⁸¹ *Ibid*

⁸² Morten, *The Nurses*, p. 143

⁸³ Cushny, *A Textbook*, p. 84, PR: *Thomas Allen*, Carr Men December 1907, p. 959

⁸⁴ PR: *Elizabeth Osborne*, Carr Women December 1903, p. 530, PR: *Robert Finnie*, Sainsbury Men December 1902, p. 476

⁸⁵ Morten, *The Nurses*, pp.34, 44, 157

⁸⁶ PR: *Lucy Forscutt*, Carr Women July 1903, p. 351

which were applied to patient including George Dowford and Michael Clarke.⁸⁷ Scott's plasters were strips of lint spread with compound mercurial ointment, which were prescribed for various skin afflictions.⁸⁸ Mustard plasters and baths were also used to treat patients at the RFH (mustard acted as a penetrating skin irritant much like turpentine), such as in the case of George Haynes.⁸⁹

According to Cushny, the use of skin irritation treatment had fallen into 'a certain disrepute' by the late nineteenth century due to scepticism in modern medicine as to its purpose and effectiveness.⁹⁰ This was particularly true of belladonna and other poisonous applications. Their continued use at the RFH, however, may be explained by the physicians' reluctance to abandon old techniques in the face of new emerging medical knowledge. This may have been due to the fact that these treatments were cheap and that patients were comfortable being treated with familiar remedies. It must also be remembered that the medical staff on which this study is based were all aged in their forties and fifties in the early twentieth century, meaning that they would have been taught their trades decades earlier by men who themselves had been practicing medicine in the middle of the nineteenth century. This meant that their opinions and preferences as to the best course of treatments may well have been out-dated. Reinartz has claimed that many such practitioners would also have donated their old medical equipment to the hospital on their retirement, which in turn would have encouraged the use of old techniques.⁹¹ Crucially, this also means that practitioners were most likely teaching these out-dated methods to medical students of the early twentieth century, which would in turn have continued their use in the face of more modern medicine. Moreover, the fact that these

⁸⁷ PR: *George Dowford*, Roughton Men December 1902, p. 556, PR: *Michael Clarke*, Roughton Men December 1912, p. 1082

⁸⁸ Morten, *The Nurses*, pp. 225, 309

⁸⁹ PR: *George Haynes*, Carr Men December 1912, p. 971

⁹⁰ Cushny, *A Textbook*, p. 76

⁹¹ J. Reinartz, 'Mechanizing Medicine: Medical Innovations and the Birmingham Voluntary Hospitals in the Nineteenth Century', in C. Timmerman and J. Anderson (Eds.), *Devices and Designs: Medical Technologies in Historical Perspective*, (Palgrave Macmillan, Basingstoke and New York, 2006), pp. 46-7

techniques were part of the clinical student training at the RFH medical school indicates that the practices were still used in the wider profession. These treatments were not unique to the hospital setting, however, as plasters and fomentation equipment could have been purchased from a chemist and performed in the comfort of the patients own home.

Whilst patients were treated with a variety of external skin applications, the patient records also contain examples of invasive treatments. Enemas were regularly performed at the hospital in order to clean out the patients' bowels. The ideal purgative was that which had no effect on the body save the intestine, making the bland, non-irritant castor oil perfect.⁹² An enema procedure consisted of an injection being given slowly into the bowel through a rectal tube or syringe, and funnel. The patients Thomas Murphy, Robert Williams, and Isabel West were all treated with different forms of enemas during their time at the RFH.⁹³ The most common types of enemas were soap (made by dissolving an ounce of yellow soap in water), castor oil (made by adding an ounce of castor oil to the soap enema mixture), and turpentine, (made by adding an ounce of turpentine and twelve ounces of thin starch to the soap mixture).⁹⁴ Whilst enemas acted to empty the bowels, catheters were regularly needed to withdraw fluid from the patients' bladder. Catheters could be made from either silver, India-rubber, gum elastic, or glass, as it was in the case of James Edward Mitson in 1902.⁹⁵ Procedures to draw fluids from other parts of the patients' body were also performed, such in as the cases of the six-year-old Alice France and eleven-year-old Margaret Lee, who both suffered from chest conditions and had an exploring needle inserted into their chests to see if any fluid could be withdrawn.⁹⁶ Similarly, tapping fluids from pleural effusions or abscesses was common practice. In the case of Ruth Marriott, ten pints of fluids were drawn off through the tapping of the

⁹² Cushny, *A Textbook*, pp. 92, 96

⁹³ PR: *Isabel West*, Roughton Men December 1912, p. 619, PR: *Robert Williams*, Sainsbury Men July 1907, p. 714, PR: *Thomas Murphy*, Sainsbury Men July 1907, p. 696

⁹⁴ Morten, *The Nurses*, p. 125

⁹⁵ PR: *James Edward Mitson*, Berry Men July 1902, p. 626, other examples include: PR: *William Carter*, Berry Men July 1912, p. 696, PR: *William Godding*, Berry Men July 1912, p. 701

⁹⁶ PR: *Alice France*, Carr Women July 1903, p. 318, PR: *Margaret Lee*, Carr Women July 1903, p. 357

abdomen.⁹⁷ In other instances, the fluid being drawn from the patient's body was their blood. Ancient humoral medicine practiced the use of leeches for this purpose, and leeching had been common during the first half of the nineteenth century.⁹⁸ The work of Caillé still advocated the use of leeches in 1907, however, and the patient records of the RFH show that leeches was still considered appropriate in cases including those of Emily Oliver in 1902, and or Ada Cook in 1912.⁹⁹ This demonstrates that profession still relied on humoral beliefs and practices during the early twentieth century. As with the continued use of skin irritation methods, the continued use of leeches at the RFH was likely due to a combination of factors relating to their low cost, and institutional, professional, and patient familiarity to their use.

The ancient medical use of leeches stands in stark contrast to the modern technologies and discoveries that had appeared in the hospital setting by the early twentieth century. Whilst the RFH clearly continued to use older, traditional, medical methods and techniques, it was also keen to appear up-to-date by using modern remedies. Discovered by Marie Skłodowska-Curie and her husband Pierre in 1898, Radium was found to be a disintegration product of uranium.¹⁰⁰ The therapeutic effects of radium were quickly recognized, and it became known for its ability to destroy malignant growths.¹⁰¹ The RFH made use of radium for such purposes, as in the case of Constance Ives, a patient of Berry in 1912 who suffered from an inoperable carcinoma of the rectum and was treated by having radium introduced to the rectum and left for twelve hours.¹⁰² Radium was not, however, the only major medical discovery to be made in 1890s. Wilhelm Röntgen discovered x-rays (or Rontgen rays) in 1895 and their medical promise and technical

⁹⁷ PR: *Ruth Marriott*, Sainsbury Women July 1907, p. 547

⁹⁸ Bynum, *Science*, , pp. 45-6, Porter, *The Greatest*, pp. 313-4

⁹⁹ A. Caillé, *Differential Diagnosis and Treatment of Disease: A Text-Book for Practitioners and Advanced Students*, (D. Appleton and Company, New York and London, 1907), p. 79, PR: *Ada Cook*, Carr Women December 1912, pp. 413 and 424, PR: *Emily Oliver*, Sainsbury Women December 1902, p. 476

¹⁰⁰ Porter, *The Greatest*, p. 607

¹⁰¹ Morten, *The Nurses*, p. 292

¹⁰² PR: *Constance Ives*, Berry Women December 1912, p. 659

capabilities were immediately apparent, with a radiograph taken for clinical purposes within months of the discovery.¹⁰³ Both the Rontgen Ray and Electrical Departments were founded at the RFH in 1904 (as discussed in Chapter Two).¹⁰⁴ The hospital did treat patients with electrical equipment prior to the departments having been built, such as Florence Deller, who underwent a battery powered muscle test, and Edwin Lucas who was treated with x-rays on three occasions in 1902.¹⁰⁵ The availability of such treatments, however, increased dramatically once the departments were up and running. The Electrical Department treated over 800 patients during its first year, with an additional 500 patients having been examined with the Rontgen Ray screen, and over 180 cases photographed.¹⁰⁶ Given the excitement surrounding x-rays from the onset and the size of the machine determining that it be used in the hospital setting, the fact that it took the RFH nine years to establish a specialist department reflects its dependence on financial donations, and the need to raise enough money to build and fund such an expensive new technology.

X-rays and other electrical procedures became a regular feature of both diagnosis (particularly for suspected chest complaints) and therapeutic treatment (for their effects on body tissue).¹⁰⁷ In 1907, Walter Feusham was treated therapeutically with x-rays in order to kill a keloid, or scar tissue, and in 1912 Lily Draper was treated with electrical currents for facial paralysis.¹⁰⁸ Numerous patients underwent x-rays in order to help diagnose chest conditions, (particularly tuberculosis) such as Edward Powell in 1912.¹⁰⁹ It is not surprising to see high numbers of chest x-rays in the records given that chest conditions

¹⁰³ Duffin, *History of Medicine*, p. 202, J. Reinartz, 'Mechanizing Medicine', pp. 103-32, Porter, *The Greatest*, pp. 605-6

¹⁰⁴ RFHA: *The Seventy-Seventh Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1904*: Annual Reports 1900-04 : Book A12 (RFH/1/2/2), p. 15

¹⁰⁵ PR: *Florence Deller*, Sainsbury Women July 1902, p. 299, PR: *Edwin Lucas*, Sainsbury Men December 1902, p. 453

¹⁰⁶ *Seventy-Seventh Annual Report 1904*, p. 15

¹⁰⁷ Reinartz, 'Mechanizing Medicine', pp. 103-32

¹⁰⁸ PR: *Lily Draper*, Berry Women July 1912, p. 489, PR: *Walter Feusham*, Berry Men December 1907, p. 39

¹⁰⁹ PR: *Edward Powell*, Sainsbury Men December 1912, p. 684

were the most common form of complaint amongst the sample patients.¹¹⁰ According to Porter, however, early chest radiographs were ‘unsatisfactory, since exposure times needed to be long (initially at least twenty minutes) and contrasts were poor’.¹¹¹ The frequent use of x-rays at the RFH in spite of this drawback was likely due to the still relatively novel nature of the technology and the hospital’s intent on securing recognition as a centre for the treatment of tuberculosis under the National Insurance Act of 1911 (for which it underwent negotiations in 1913).¹¹² Alternately, the high number of chest x-rays performed could indicate that the quality of early radiographs was not as poor as Porter believed. Prior to being x-rayed patients were often fed a ‘bismuth meal’, as the salts of bismuth (a metal) appeared opaque in x-ray images and allowed for the diagnosis of blockages in the stomach and intestines.¹¹³ In 1912, Amelia Weaver was fed bismuth and x-rayed in order to diagnose her gastric trouble.¹¹⁴ The properties of bismuth for the purposes of x-ray diagnosis were well known, and thus their use would not have been unique to the RFH. It is interesting, however, that according to Porter, by 1904 bismuth had been substituted in for the safer barium sulphate, or ‘Barium swallows’.¹¹⁵ This was clearly not the case at the RFH, which continued to use bismuth, even though it was considered to be more dangerous than barium and more expensive.¹¹⁶

Whilst financial restrictions may have hindered the RFH from regularly updating their medical technology, the hospitals’ rejection of a cheaper and safer alternative in this instance is an example of its reluctance to change. Along with the fact that it took the hospital nearly a decade to establish a specialist x-ray department, the continued use of

¹¹⁰ Chest x-ray examples: PR: *Alice Bray*, Carr Women July 1907, p. 367, PR: *Maud Sartain*, Sainsbury Women July 1912, p. 461

¹¹¹ Porter, *The Greatest*, p. 606

¹¹² RFHA: *The Eighty-Sixth Annual Report of the Committee of Management to the Governors of the Hospital, With Financial Statements, Medical Reports, and List of Governors and Subscribers, etc., For the Year Ending December 31st, 1913*: Annual Reports 1911-15 : Book A14 (RFH/1/2/2), p. 18-19

¹¹³ Morten, *The Nurses*, p. 48

¹¹⁴ PR: *Amelia Weaver*, Carr Women July 1912, p. 231

¹¹⁵ Porter, *The Greatest*, p. 606

¹¹⁶ Morten, *The Nurses*, p. 42

bismuth indicates that it was not only slow to take up new technology, but was also poor at keeping on-top of related developments. Whilst it is easy to point to the reluctance of the medical staff in adopting new techniques, however, the patients themselves would also have had an impact on the speed with which the hospital changed its medical approaches. X-rays were still a new technology in the early twentieth century, and whilst on the one hand they were considered exciting by the general public, the speed at which they were adopted may also have made many patients uneasy. This feeling would have only intensified by the constant updating of related treatment methods. Thus, in order to continue to attract patients to the hospital, its staff may have restricted its uptake of new treatment methods relating to x-rays until they had become more firmly established in everyday medical and surgical care.

Once an x-ray had been performed on a suspected broken or fractured bone, the medical staff were able to determine if a splint or plaster cast was required. The splint applied to the patient depended on the nature of their injury. Back splints were often applied to those who suffered from knee injuries in order that the knee could be bandaged and kept straight. Robert Storey was put on a back splint in 1902, having suffered a fractured patella after being knocked down in a crowd, as was Elizabeth Vincent in 1907 after suffering a long-term rupture of the semi-lunar cartilage.¹¹⁷ McIntyre's splints, used to immobilise the knee and ankle joint, were also applied to patients such as to Herbert Bouffler, whose knee gave way due to tubercular disease.¹¹⁸ In this case, the patient also received a poroplastic splint, which was constructed with poroplastic sheets made of felt having been cut and moulded with steam into the splint structure.¹¹⁹ The use of Thomas's knee splints used to immobilise a fractured femur or tibia and fibula can also be seen in the case records. This splint was constructed of two sidepieces of metal with a crosspiece at

¹¹⁷ PR: *Elizabeth Vincent*, Berry Women July 1907, p. 376, PR: *Robert Storey*, Berry Men July 1902, p. 640

¹¹⁸ PR: *Herbert Bouffler*, Berry Men December 1907, p. 931

¹¹⁹ Morten, *The Nurses*, p. 279

the foot, kept in position by pieces of material slung between the sidepieces. In the case of Alice Christopher the reference to the splint in the records most likely refers to a Thomas's hip splint, used in tubercular disease of the hip, from which she suffered.¹²⁰ In the case of Arthur Sutton, who suffered hip injuries after being kicked by a horse in 1907, a wooden hip splint known as a Liston's splint was applied.¹²¹ Broken limbs were also often placed in Plaster of Paris in order to hold them in the correct position to heal. Mary Lee suffered a broken leg in 1902, which was put in plaster under anaesthetic, and put up in splints.¹²² In 1907, Emily Moore was treated for 'Talipes Equinus' of both feet, a form of club foot in which the heel lifted from the ground, which were corrected and both feet held in place with Plaster of Paris.¹²³

In some instances, joints were held in place not in order to heal, but in order to allow them to change. The most frequent example of such treatment was leg lengthening techniques, commonly applied to patients who had suffered from leg shortening due to tubercular disease. Alice Christopher, discussed above for wearing a Thomas's splint, had suffered shortening due to tubercular disease of the hip, and so her leg was held in place and extensions weighing 8lbs attached.¹²⁴ This treatment was also applied to patients including Emily Luck, who had her legs put up in gallows for eight days in 1902, and to Florence Child and Ernest Felix in 1912, who both had extensions of 4lbs attached to their legs.¹²⁵ Whilst the application of general splints and plasters would have been common at other institutions, the practice of leg lengthening seems unusual for this period, which suggests that this is a further example of the RFH using outdated treatment techniques.

Dental work also appeared in the records as part of the wider multiple treatments the patients received. Roughton also held a position at the Dental Hospital (as explained in

¹²⁰ Morten, *The Nurses*, p. 343, PR: *Alice Christopher*, Roughton Women July 1912, p. 377

¹²¹ Morten, *The Nurses*, p. 211, PR: *Arthur M. Sutton*, Berry Men December 1907, p. 936

¹²² PR: *Mary Lee*, Roughton Women July 1902, p. 843

¹²³ Morten, *The Nurses*, pp. 337-8, PR: *Emily Moore*, Berry Women July 1907, p. 420

¹²⁴ PR: *Alice Christopher*, Roughton Women July 1912, p. 377

¹²⁵ PR: *Emily Luck*, Berry Women December 1902, p. 802, PR: *Ernest Felix*, Roughton Men December 1912, p. 1094, PR: *Florence Child*, Roughton Men December 1912, p. 630

Chapter Two) and had treated some of the patients in the sample previously for dental conditions.¹²⁶ As one of his specialties, Roughton was clearly in the position to help patients suffering from dental complaints even though such conditions were often not the purpose of the patients' visit to the RFH. It was not only Roughton who was concerned with the dental condition of the patients, however, as the patients' teeth were reported on as standard by all of the medical staff. Rotten teeth were extracted frequently at the hospital and false ones fitted.¹²⁷ Patients found on arrival to have bad, carious teeth often had them extracted under gas or novocaine, such as Emma White in 1907, and George Haynes in 1912.¹²⁸ Even young children such as Patrick Sullivan aged nearly five years had stumps removed.¹²⁹ In many instances large numbers of teeth were taken out, such as in the case of Florence Moor who lost eight.¹³⁰ The patient Emma Cole was reported to have her 'teeth absent' on admission, whilst others were found to already have artificials.¹³¹ As patients could have false teeth fitted at other institutions, the RFH was not unique in the attention it paid to dental hygiene. The evidence suggests that the state of dental health in the population was bad, but whilst the medical profession showed concern, it could only ease the suffering of individuals by removing diseased teeth. There is no mention in the records of any dental hygiene measures having been performed by the patients, nor of any dental health advice having been provided by the medical staff.

Overall, although aspects of patient treatment have been discussed here individually, patients would have experienced a combination of medical treatments during their time at the RFH. The patient Alice Christopher, who has been previously discussed

¹²⁶ 'Obituary: Edmund Wilkinson Roughton', *The Lancet*, Vol. 181, Issue 4686, (21 June 1912), p. 1775, PR: *Elsie Cook*, Roughton Women December 1902, p. 940

¹²⁷ PR: *William Armsley*, Carr Men July 1907, p. 594

¹²⁸ PR: *George Haynes*, Carr Men December 1912, p. 971, PR: *Emma White*, Roughton Women July 1907, p. 353

¹²⁹ PR: *Patrick Sullivan*, Carr Men December 1903, p. 950

¹³⁰ PR: *Florence Moor*, Sainsbury Women July 1912, p. 444

¹³¹ PR: *Emma Cole*, Sainsbury Women December 1912, p. 663, Examples of artificial teeth: PR: *Herbert Alcock*, Sainsbury Men December 1907, p. 1184, PR: *John Hinton*, Sainsbury Men July 1907, p. 740, PR: *Maria Springer*, Carr Women December 1912, p. 392

for wearing a Thomas's splint and having 8lb extensions placed on her leg, also had a tubercular abscess on her hip operated on, had red ointment (an astringent containing zinc) applied to the wound, and had seven teeth extracted.¹³² The contact and relationship between the patient and the medical staff would have developed in a busy hospital setting, under the strict rules and regulations of the wards. Simultaneously, the time patients were allowed to spend away from their beds and the diet they were fed would have contributed to their overall opinion and experience of the hospital. The nature of the hospital environment was an important factor in keeping the patients calm and comfortable as they underwent multiple treatments for their conditions. The range of treatments provided at the RFH suggests that the early twentieth century was a period of transition, when traditional remedies including leeches and skin irritation were used alongside new technologies such as x-rays. With no comparative studies, we cannot know how rapidly other hospitals adopted distinctively modern treatment techniques, but it would appear that the RFH was reluctant in discarding old treatments, even though their safety and cost had been questioned in the wider medical community. It is important to remember that the medicines and drugs administered to the patients would have also had a profound effect on their overall experience of the hospital. Many aspects of the procedures discussed above would not have been possible without the use of pain killers, whilst most surgical practices (examined later in this chapter) could not have been performed safely without the use of anaesthetics and anaesthesia.

Medicines and Drugs

Medicines and drugs in the form of countless pills, powders, gases, and injections, were used to treat the patients at the RFH. Cardiac conditions were often eased with branded or

¹³² PR: *Alice Christopher*, Roughton Women July 1912, p. 377

patent asthma powders including Himrod's, which was burned and the fumes inhaled, and 'digitalis', a foxglove cardiac tonic.¹³³ Bromides, which in large doses were valuable hypnotics, but in small doses lessened cerebral excitement, were given to Howard Foess to treat broncho-pneumonia and to Kathleen Bardell, to treat chorea.¹³⁴ Iron tablets known as Blaud's pills, were used in cases where the patient showed signs of anaemia and Sodium Bicarbonate was given to the patient William Ward to treat stomach acid.¹³⁵ Amelia Weaver was diagnosed with visceroptosis (the prolapse of internal organs) for which the laxatives Aloes and Cascara were provided to her to make her more comfortable.¹³⁶ Various other medical purges were given to patients at the hospital, including Sodium Sulphate, Calomel, and Senna.¹³⁷ All of these medical treatments, however, could have been taken or administered outside of the hospital setting. Dangerous medicines which needed to be (or at least should have been) administered under the supervision of medical professionals were also used at the RFH. Arsenic, a poison frequently used to treat skin diseases, syphilis, or overdose cases, was given to the patient Mary Anne Maynard to act as a check for her Hodgkin's disease.¹³⁸ Carbolic acid, a powerful antiseptic but highly poisonous substance was taken by Thomas Allen to treat flatulence.¹³⁹ William Beasley and Harry Larratt were treated with Strychnine, a poisonous nerve stimulant.¹⁴⁰ In other instances, medicines and antidotes for the patients' own use of dangerous substances were required. Ergot, a drug found in a fungus which grows on rye, was used on female patients

¹³³ Morten, *The Nurses*, p. 110, PR: *Alfred Carter*, Carr Men December 1903, p. 979, PR: *Charles Head*, Sainsbury Men December 1902, p. 486

¹³⁴ Morten, *The Nurses*, p. 59, PR: *Kathleen Bardell*, Sainsbury Women December 1912, p. 657, PR: *Howard Foess*, Sainsbury Men December 1907, p. 1138

¹³⁵ Morten, *The Nurses*, pp. 49 and 317, PR: *Margaret Blachic*, Carr Women July 1903, p. 313, PR: *Rosa Chandler*, Carr Women December 1912, p. 396, PR: *William Ward*, Carr Men December 1912, p. 968

¹³⁶ Morten, *The Nurses*, pp. 14 and 70, PR: *Amelia Weaver*, Carr Women July 1912, p. 231

¹³⁷ Morten, *The Nurses*, pp. 65, 311, and 317, PR: *Ellen Maud Carr*, Carr Women December 1912, p. 440, PR: *William Beasley*, Carr Men July 1912, p. 599, PR: *William Ward*, Carr Men December 1912, p. 968

¹³⁸ Morten, *The Nurses*, pp. 29 and 215, PR: *Mary Anne Maynard*, Sainsbury Women July 1907, p. 507

¹³⁹ Morten, *The Nurses*, p. 67, PR: *Thomas Allen*, Carr Men December 1907, p. 959

¹⁴⁰ Morten, *The Nurses*, p. 330, PR: *Harry Larratt*, Carr Men July 1903, p. 517, PR: *William Beasley*, Carr Men July 1912, p. 599

to contract the uterus after labour or abortion, as in the case of Phoebe Porter, who suffered an abortion after taking quinine.¹⁴¹

Whilst many medicines acted to help heal or relieve the patient's symptoms, the purpose of others was to induce pain relief, such as alcohol, morphine, and oxygen. Historians including Porter have discussed the long history of alcohol as a method of pain relief dating back to ancient times, and it was still an important medical tool at the turn of the twentieth century.¹⁴² Brandy was the most frequent alcohol given to patients including young children. The two-month-old Harry Larratt, the six-month-old Alice Carter, and the one-year-old Louisa Fawke were all treated with brandy.¹⁴³ Other alcohols were also used for medical purposes at the hospital, such as in the case of William Taylor who was treated with white wine whey, a mixture of milk and sherry, which was boiled and left to stand until it curdled, then sweetened with sugar, strained and served.¹⁴⁴ Caffeine was used to counteract the effects of alcohol, such as it was to nine-year-old Arthur Fielder in 1902.¹⁴⁵ Morphine also appeared in the patient records frequently, having been used as a pain killer and sedative.¹⁴⁶ Derived from opium, morphine, like alcohol, had its roots in ancient medicine.¹⁴⁷ It was often used alongside other pain relief substances, such as in the case of the patient Nurse Barmer, who was injected with morphine whilst also being treated with cocaine.¹⁴⁸ The dangers of morphine use were well known, as can be seen through the example of Walter Feusham, a twenty-nine-year-old patient of Berry in 1907.¹⁴⁹ Feusham murdered his step-mother two weeks after being discharged from the RFH and was

¹⁴¹ Morten, *The Nurses*, p. 129, PR: *Phoebe Porter*, Carr Women July 1912, p. 224

¹⁴² Porter, *The Greatest* p. 365

¹⁴³ PR: *Alice Carter*, Carr Women December 1907, p. 734, PR: *Louisa Fawke*, Sainsbury Women December 1912, p. 654, PR: *Harry Larratt*, Carr Men July 1903, p. 517. Other examples include: PR: *Frederick Crutchley*, Sainsbury Men December 1907, p. 1197, PR: *Edith Foot*, Berry Women December 1902, p. 812, PR: *Lucy Alice Prior*, Sainsbury Women December 1907, p. 845

¹⁴⁴ Morten, *The Nurses*, p. 410, PR: *William Taylor*, Sainsbury Men July 1907, p. 732

¹⁴⁵ PR: *Arthur Fielder*, Sainsbury Men December 1902, p. 505

¹⁴⁶ Morten, *The Nurses*, p. 232

¹⁴⁷ Porter, *The Greatest*, p. 365

¹⁴⁸ PR: *Nurse Barmer*, Roughton Women December 1902, p. 950

¹⁴⁹ PR: *Walter Feusham*, Berry Men December 1907, p. 939

sentenced to death, only to be reprieved after consideration of his health history and the fact that he had been taking morphine to relieve his pain.¹⁵⁰

More often, morphine was given to patients alongside oxygen, as in the cases of Edward Young in 1902 and Robert Hughes in 1907.¹⁵¹ Both Young and Hughes suffered from heart conditions, and the use of morphine and oxygen would have acted to calm their heart rates. Hughes was also given the drug atropine.¹⁵² Snow has discussed the pre-operative administration of morphine and atropine, a cardiac stimulant, as common practice during the late nineteenth century for the purpose of diminishing vomiting and pain.¹⁵³ This combination also acted to calm frightened patients.¹⁵⁴ Snow has claimed that by 1900, the administration of morphine and scopolamine (a derivative of atropine) was common amongst London specialists.¹⁵⁵ Heart conditions, however, were not the only ailments treated with oxygen. In 1907 the patients Thomas Camp and Ismail Housane were treated with oxygen for rheumatic fever and an aneurysm respectively, whilst Louisa Fawke was given it alongside brandy in 1912 to treat broncho-pneumonia.¹⁵⁶ Oxygen would have also helped to protect the patients from developing cyanosis, a blue appearance caused from lack of oxygen in the blood.¹⁵⁷ Whilst these methods of pain relief were not unique to the RFH, the collective use of ancient methods such as alcohol alongside new drugs is a further indication that the early twentieth century was a period of medical transition.

For those patients undergoing surgery, specialist anaesthetics enabled a huge variety of treatments and procedures to be carried out which before would have been

¹⁵⁰ Ibid

¹⁵¹ PR: *Robert Hughes*, Sainsbury Men July 1907, p. 759, PR: *Edward Young*, Sainsbury Men December 1902, p. 500

¹⁵² PR: *Robert Hughes*, Sainsbury Men July 1907, p. 759

¹⁵³ Snow, *Operations*, p. 167

¹⁵⁴ Ibid

¹⁵⁵ Ibid

¹⁵⁶ PR: *Thomas Camp*, Sainsbury Men July 1907, p. 749, PR: *Louisa Fawke*, Sainsbury Women December 1912, p. 654, PR: *Ismail Housane*, Sainsbury Men December 1907, p. 1144

¹⁵⁷ Morten, *The Nurses*, pp. 99-100, 254-5

considered far too painful. Pioneered in the Victorian era and well established by the early twentieth century, anaesthetics including gas, ether, chloroform, novocaine, and cocaine were some of the most common methods of pain relief used at the RFH to perform surgical procedures. The use of such substances was not unusual, as by 1890s designated anaesthesia tables were common place in the hospitals of London.¹⁵⁸ Snow has reflected on the contents of average anaesthetist's table as including chloroform, ether, alcohol for mixing with ether, and various apparatus to administer these anaesthetics, such as a Clover or Junkers' ether inhaler.¹⁵⁹ Reference to gas as an anaesthetic appeared frequently in the patient records, but the specific gas was never noted. The most apparent to which the records refer is nitrous oxide, or laughing gas. As explained by Porter, Duffin, and Ellis, the use of this gas for its euphoric effects at social gatherings, or 'frolics', dated from the late eighteenth century.¹⁶⁰ The earliest recorded advocate of the anaesthetic properties of nitrous oxide was the English chemist Humphrey Davy, who in 1799 mixed the gas with oxygen to find that it induced reversible unconsciousness.¹⁶¹ It was not until late 1844 that the dentist Horace Wells carried out a painless tooth extraction on a patient who had been administered with nitrous oxide, after which the use of the gas gradually became standard in nineteenth century dental and medical practice.¹⁶² At the RFH, gas was used for a variety of operative procedures, such as in the case of John Knight, who had a small operation on the ward under gas to remove part of a growth on his tongue for microscopic examination.¹⁶³

Ether was first discovered in 1540 by the German botanist Valerius Cordus (1515 - 44), though it was known as the 'sweet oil of vitriol' until it was re-named in 1730.¹⁶⁴ It shared many of properties of nitrous oxide, and 'ether parties', much like the laughing gas

¹⁵⁸ Snow, *Operations*, p. 167

¹⁵⁹ Ibid

¹⁶⁰ Duffin, *History of Medicine*, p. 226, Ellis, *A History*, p. 81, Porter, *The Greatest*, pp. 365-6

¹⁶¹ Ibid

¹⁶² Ibid

¹⁶³ PR: *John Knight*, Roughton Men December 1902, p. 601

¹⁶⁴ Porter, *The Greatest*, p. 365

frolics, became popular in America and Europe.¹⁶⁵ It was not until 1842 that the American chemist and dentist William E. Clarke performed a tooth extraction on a patient under ether.¹⁶⁶ This procedure was followed two months later by the American doctor Crawford Long, who used the substance to removed cysts from the neck of a patient.¹⁶⁷ At the RFH, ether was used to anaesthetise patients undergoing a variety of surgeries, including Mabel Hensley, who underwent an operation for piles in 1902, and Arthur F. James, who had surgery to remove kidney stones in 1907.¹⁶⁸ In the cases of Emily Puke, who had varicose veins removed, and May Wright, who underwent an operation for inguinal hernia, ether was used alongside gas.¹⁶⁹ The substance also appears in soap form, as in the case of Frederick Syvett, who used it to clean his circumcision wound.¹⁷⁰ Whilst ether became an accepted anaesthetic agent, Ellis has explained that it required a long time to induce the patient, caused nausea and vomiting, and was highly flammable when mixed with oxygen.¹⁷¹ Porter has claimed that due to the vomiting and irritation of the lungs it caused the patient, it was soon displaced by chloroform.¹⁷² Discovered in 1831, chloroform (CHCL₃) was introduced to surgical practice in 1847 by the Scottish surgeon James Young Simpson.¹⁷³ It was considered powerful and easy to administer, but it was associated with ‘very occasional incidents of sudden death from cardiac irregularities’.¹⁷⁴ It was only after Queen Victoria took chloroform for the birth of Prince Leopold in 1853 that it gradually became an accepted anaesthetic option.¹⁷⁵ At the RFH, it was the choice anaesthetic for

¹⁶⁵ Duffin, *History of Medicine*, p. 228, Ellis, *A History*, p. 81, Porter, *The Greatest*, p. 365

¹⁶⁶ Porter, *The Greatest*, p. 366

¹⁶⁷ Ellis, *A History*, p. 81, Porter, *The Greatest*, p. 366

¹⁶⁸ PR: *Mabel Hensley*, Berry Women December 1902, p. 809, PR: *Arthur F. James*, Berry Men July 1907, p. 595

¹⁶⁹ PR: *Emily Puke*, Roughton Women December 1907, p. 544, PR: *May Wright*, Berry Women December 1912, p. 696

¹⁷⁰ PR: *Frederick Syvett*, Roughton Men December 1907, p. 996

¹⁷¹ Ellis, *A History*, p. 88

¹⁷² Porter, *The Greatest*, p. 367

¹⁷³ Duffin, *History of Medicine*, p. 229, Porter, *The Greatest*, p. 367

¹⁷⁴ Ellis, *A History*, p. 88, Porter, *The Greatest*, p. 367

¹⁷⁵ Porter, *The Greatest*, p. 367

operations including those to treat carcinoma of the pharynx on Henry Holland, and adenoma of the thyroid gland in the case of May Wilder.¹⁷⁶

Whilst it has been argued that chloroform replaced ether as the preferred anaesthetic, their simultaneous use at the RFH during operations of the early twentieth century demonstrates the unwillingness of the hospital to commit to either substance. A combination of both anaesthetics was used in cases including those of Lucy Cumming, who underwent an operation to remove a kidney stone, and Herbert Ward, who underwent a circumcision.¹⁷⁷ The likely explanation for the use of both agents was that neither had proved itself to be totally safe in the wider medical market. Although chloroform became more popular in Europe and America by the late nineteenth century due to the previously explained dangers associated with ether, Cushny claimed in 1899 that an increased number of accidents in chloroform anaesthesia caused ether to regain favour amongst some of the medical community.¹⁷⁸ The compromise reached at the RFH appears to have been the use of the anaesthetic mixture of ether, chloroform, and alcohol known as A. C. E. This combination was made up of one part alcohol, two parts chloroform, and three parts ether.¹⁷⁹ It was used to anaesthetise patients for a variety of operative procedures, such as in the cases of William Mackessock, on whom Berry performed a three-minute operation to remove pus from an abscess, or Bertie Shan, who underwent a more complex operation for tuberculous disease of the hip joint.¹⁸⁰ The fact that the RFH used A. C. E., instead of committing fully to chloroform, shows that it was reserved when it came to the uptake of a new medicine or drug. This is not surprising given that its reputation was at stake if it made the wrong choice. Moreover, confidence in a new medicine could not be gained overnight,

¹⁷⁶ PR: *Henry Holland*, Berry Men July 1907, p. 587, PR: *May Wilder*, Berry Women December 1907, p. 783

¹⁷⁷ PR: *Lucy Cumming*, Berry Women December 1912, p. 672, PR: *Herbert H. Ward*, Berry Men December 1907, p. 924

¹⁷⁸ Cushny, *A Textbook*, p. 149

¹⁷⁹ Morten, *The Nurses*, p. 4

¹⁸⁰ PR: *William Mackessock*, Berry Men December 1902, p. 16, PR: *Bertie Shan*, Berry Men December 1902, p. 23

and so whilst the RFH may appear reluctant to abandon old remedies, it was also sensible to prioritise the health and welfare of its patients.

The controversial drug cocaine was also used for the purpose of pain relief at the RFH. Having been isolated from the coca leaf in 1859-60, its pharmacological possibilities were becoming better understood by the 1880s.¹⁸¹ In 1884, the ophthalmologist Carl Koller used cocaine eye drops as a local anaesthetic for an operation on a patient's eye.¹⁸² Whilst articles began to recommend its use as a stimulant for a variety of conditions, it came to revolutionize eye, nose and mouth surgery in particular.¹⁸³ According to Courtwright, 'Operations that had been exceedingly difficult or painful were made routine by the 'tropical application or injection of cocaine solution'.¹⁸⁴ The patients Sidney Taylor and Dora Green both had their noses plugged with gauze soaked in cocaine and adrenalin before undergoing operations on their respective septums.¹⁸⁵ The cocaine acted as an anaesthetic whilst adrenalin, an astringent, was used to contract blood-vessels and inhibit secretion.¹⁸⁶ Whilst cocaine at twenty per cent was given to Dora Green to numb her nose, cocaine at four per cent was given to Ellen Wilson in the form of a throat spray in order to help ease the pain she experienced when eating caused by the cancer at the top of her windpipe.¹⁸⁷ In other cases, Elizabeth Jordan was given cocaine before undergoing a throat examination with a laryogscope, and Nurse Barmer was treated with soluble cocaine after having had the fangs of an old tooth removed.¹⁸⁸ Cocaine was also used in cases other than nose, mouth and throat surgery, such as to tap the abdomen of Daisy Price in 1907.¹⁸⁹ The RFH was not unique in its use of the drug, as can be seen through the records of Lizzie

¹⁸¹ Courtwright, 'The Rise and Fall', p. 206, Porter, *The Greatest*, p. 368

¹⁸² Ellis, *A History*, p. 89

¹⁸³ Courtwright, 'The Rise and Fall', pp. 206-7

¹⁸⁴ *Ibid*, p. 207

¹⁸⁵ PR: *Dora Green*, Roughton Women July 1912, p. 374, PR: *Sidney Taylor*, Roughton Men December 1907, p. 1010

¹⁸⁶ Morten, *The Nurses*, pp. 9-10, 33, 85

¹⁸⁷ PR: *Ellen Wilson*, Roughton Women December 1902, p. 956

¹⁸⁸ PR: *Nurse Barmer*, Roughton Women December 1902, p. 950, PR: *Elizabeth Jordan*, Roughton Women July 1902, p. 849

¹⁸⁹ PR: *Daisy Price*, Sainsbury Women July 1907, p. 555

Holmes who was treated with cocaine by a Dr Long during an attempt to remove a sewing needle from her knee.¹⁹⁰

It is important to remember, however, that by the 1880s warnings about the possibility of addiction and dangers regarding the use of cocaine had begun to appear.¹⁹¹ Courtwright has claimed that some physicians recommended its use too indiscriminately.¹⁹² Substitutes were available by the turn of the twentieth century, including novocaine and eucaine. Developed in 1905, novocaine was less poisonous than cocaine.¹⁹³ At the RFH the use of novocaine appeared in cases such as that of Frances Lewis, who had a tumour removed in 1912.¹⁹⁴ Whilst the use of cocaine appears to have been more restricted to eye, nose, and throat surgeries, novocaine could be used for larger procedures. Eucaine was a synthetic form of the drug which was not habit forming. In 1907 Ruth Marriott was treated with eucaine in order to reduce a stomach swelling caused by cirrhosis of the liver.¹⁹⁵ Regardless of the concerns over the use of cocaine, the RFH continued to prescribe the drug to its patients even when substitutes were becoming available. As has already been discussed, the continued use of out-dated remedies at the RFH can be attributed to be many factors, though in the case of cocaine it suggests that the hospital staff were reluctant to abandon the use of a drug with which they had become familiar. Whilst patients may also have demanded the use of a familiar drug, it is perhaps more likely that they would have wanted to be given the option of a safer alternative. Ultimately, however, whilst the dangers of cocaine were becoming known to the public, its continued use at the RFH and at other institutions may well have calmed any concerns the public had with its use, as they trusted the overall judgement of the medical profession.

¹⁹⁰ PR: *Lizzie A. Holmes*, Berry Women July 1902, p. 472

¹⁹¹ Courtwright, 'The Rise and Fall', pp. 207-8

¹⁹² *Ibid.*, p. 207

¹⁹³ Ellis, *A History*, p. 89, Morten, *The Nurses*, p. 243

¹⁹⁴ PR: *Frances Lewis*, Berry Women July 1912, p. 499

¹⁹⁵ Morten, *The Nurses*, p. 131, PR: *Ruth Marriott*, Sainsbury Women July 1907, p. 547

Whilst anaesthetics helped to get the patient through a surgical procedure more comfortably, it was antiseptics and asepsis understanding and techniques which would ensure that they did not develop a life threatening infection after surgery. As explained by Ellis, ‘surgeons were able to operate untroubled by the need for speed, undisturbed by the screams of their patients and without the high risks of often fatal post-operative infection’.¹⁹⁶ One of the earliest antiseptics precautions recorded is that carried out by Ignaz Semmelweis in 1847, which introduced the washing of hands and instruments in chlorine water, but Semmelweis did not publish his findings until 1860.¹⁹⁷ Joseph Lister experimented with carbolic acid as an antiseptic in open fractures and announced his results in 1867.¹⁹⁸ In Lister’s opinion, infections were caused by bacteria, but others believed that wounds were ‘clean’ from the outset.¹⁹⁹ Introduced by Ernst von Bergmann in 1877, preventative asepsis to avoid wound contamination became the accepted method of preventing infection by the late nineteenth century.²⁰⁰

At the RFH, antiseptic and asepsis techniques and medicines were used. Antiseptics recalled in the case records of the early twentieth century included iodine, per chloride solution, Condy’s fluid, and silver nitrate. Iodine was a ‘poisonous element obtained from the ashes of seaweed’, and was used as an antiseptic for the skin.²⁰¹ Patients including Ellen Rowles, Isabel West, and Alfred Charlton all had wounds ‘painted with iodine’ in 1912.²⁰² Perchloride was considered a very powerful and poisonous antiseptic, and was used to dress the wounds of patients such as Emma Barwick and Henry Knight in 1907.²⁰³ Violet Vince had her wound pencilled with silver nitrate, which as a weak solution was

¹⁹⁶ Ellis, *A History*, p. 101

¹⁹⁷ Duffin, *History of Medicine*, p. 229

¹⁹⁸ *Ibid*

¹⁹⁹ *Ibid*

²⁰⁰ *Ibid*, p. 229-30

²⁰¹ Morten, *The Nurses*, p. 195

²⁰² PR: *Alfred Charlton*, Roughton Men July 1912, p. 660, PR: *Ellen Rowles*, Roughton Women July 1912, p. 382, PR: *Isabel West*, Roughton Women December 1912, p. 619

²⁰³ Morten, *The Nurses*, p. 95, PR: *Emma Barwick*, Berry Women July 1907, p. 389, PR: *Henry Knight*, Berry Men July 1907, p. 590

used as an antiseptic known particularly for the prevention of ophthalmia neonatorum (severe inflammation of the eyes in the newly born, due to gonorrhoeal or septic infection during childbirth).²⁰⁴ Condy's fluid was another form of antiseptic used at the hospital, as in the case of Rosa Chandler in 1912.²⁰⁵ Condy's was the popular name given to permanganate of potash that took the form of purple crystals which when mixed with water, formed an odourless and colourless disinfectant and antiseptic solution.²⁰⁶ The practice of skin irritation, discussed earlier in this chapter, required antiseptic substances to be left on the skin in order that it did not become infected. Turpentine was often sprinkled on a fomentation when counter-irritation was required as it both caused the skin to become inflamed and acted as an antiseptic.²⁰⁷ Another antiseptic used with fomentations was Boracic acid, which was a milder antiseptic and often used on burns, such as in the case of Edna Griffiths in 1907.²⁰⁸ In this case, the patient was also treated with eucalyptus ointment, another antiseptic solution made by mixing eucalyptus with paraffin.²⁰⁹ Whilst antiseptics were frequently recalled in the operative notes, asepsis techniques were not recorded. The 'Rules and Regulations' inform us, however, that asepsis techniques were considered essential at the RFH, though were imperfect.²¹⁰ Sisters and nurses employed in the operating theatres were to wear sterilised overalls and caps, but if the Sister came from the same ward as the patient, she was not required to change her cap.²¹¹ All persons, however, were to wear 'rubber over their shoes, or special boots or shoes previously cleaned and prepared and kept in a proper place'.²¹² As staff were often trained at other hospitals, the shortcomings of asepsis methods were likely to have been common across

²⁰⁴ Morten, *The Nurses*, pp. 249 and 314, PR: *Violet Vince*, Roughton Women July 1912, p. 356

²⁰⁵ PR: *Rosa Chandler*, Carr Women December 1912, p. 396

²⁰⁶ Morten, *The Nurses*, p. 91

²⁰⁷ *Ibid*, p. 354

²⁰⁸ *Ibid*, p. 56, PR: *Edna Griffiths*, Berry Women December 1907, p. 794

²⁰⁹ Morten, *The Nurses*, p. 131

²¹⁰ 'Regulations for the Guidance of the Staff Employed in the Operating Theatres', in *Rules and Regulations*, p. 100

²¹¹ *Ibid*

²¹² *Ibid*

the hospitals of London during the early twentieth century, and thus was not a problem exclusive to the RFH.

Surgery

Nevertheless, by the early twentieth century, advances in surgical safety meant that an increasing number of procedures had become routine.²¹³ At the RFH, small surgical interventions were carried out on the wards, such as in the case of William Mackessock, for whom Berry made an incision over the scrotum in order to release trapped pus.²¹⁴ More often, the operating theatre was the site of surgical procedures, as complex, dangerous, or time consuming operations could be performed in a sterile environment with sterile surgical instruments and equipment. Surgery was common in cases of accident and emergency, hare lip and cleft palate, and for the removal of cyst, tumours, or swellings (often of a gynaecological nature). Some of the accident and emergency cases that appear in the patient records were relatively minor. In the case of the domestic servant Lizzie Holmes the needles lodged in her hand and knee took Berry twenty-five minutes to remove.²¹⁵ Robert Storey suffered a fractured knee after having been knocked down in a crowd, which Berry also took twenty-five minutes to repair.²¹⁶ Other accidents were more severe, such as that of Herbert Moules, who had to have his broken leg put up in splints after suffering an accident whilst laying railway timber at Finsbury Park Station.²¹⁷ Arthur Stanghton had his little finger crushed between two railway carriages and subsequently removed.²¹⁸ A skin graft was then needed, for which skin was taken from the left arm.²¹⁹

As the RFH did not have a large accident and emergency department (or Gate), patients

²¹³ Ellis, *A History*, p. 101

²¹⁴ PR: *William Mackessock*, Berry Men December 1902, p. 16

²¹⁵ PR: *Lizzie A. Holmes*, Berry Women July 1902, p. 472

²¹⁶ PR: *Robert Storey*, Berry Men July 1902, p. 640

²¹⁷ PR: *Herbert Moules*, Berry Men December 1902, p. 5

²¹⁸ PR: *Arthur Stanghton*, Berry Men July 1902, p. 647

²¹⁹ Ibid

were likely to have made use of the department at bigger hospitals more frequently, such as St Bartholomew's. Operations to correct hare lip and cleft palates, however, were surgical specialties which would have set the RFH apart from other general institutions in the capital. These operations appear in the records of Berry, which is not surprising given that he was known internationally to be a pioneer in the fields and published *Harelip and Cleft Palate* in 1912.²²⁰ Berry was performing these procedures over a decade prior to this publication, however, as can be seen in the record of Violet Risley, which states in the history that Berry operated on the patients' harelip in 1901, and operated on her cleft palate in 1902.²²¹ The cleft palate operations of Montague Hayward and Arthur Killby took twenty and thirty-five minutes respectively, whilst that of Charles Foster for cleft palate and a hare lip scar took eighty minutes.²²²

Surgery to remove growths from the body became safer with the advent of anaesthesia and antiseptic techniques (discussed in the previous section), as they allowed surgeons to performed removals slowly, calmly, and in a more precise manner. It took Berry twenty-five minutes to remove a swelling from the breast of Florence Chubb, and twenty-minutes to operate on a swelling in the neck of Annie Stercks.²²³ Disproportionately large growths became non-life threatening once their removal could be performed safely. In 1902, the patient Elizabeth Wells had a cyst which weighed 77oz removed.²²⁴ Operations to safely remove kidney stones also became possible, as in the case of Charles Hanson, who had a stone the size of an almond removed.²²⁵ One of the most common types of cysts removed at the RFH was the ovarian. In 1912, Annie Stewart underwent an operation to remove an ovarian cyst, which resulted in her also have to lose

²²⁰ L. A. Amidon, *An Illustrated History of the Royal Free Hospital*, (Published by the Special Trustees for the Royal Free Hospital, London, 1996), p. 120

²²¹ PR: *Violet M. Risley*, Berry Women July 1902, p. 482

²²² PR: *Charles Foster*, Berry Men December 1907, p. 958, PR: *Montague Hayward*, Berry Men July 1907, p. 579, PR: *Arthur Killby*, Berry Men July 1907, p. 568

²²³ PR: *Florence Chubb*, Berry Women July 1902, p. 464, PR: *Annie Stercks*, Berry Women July 1912, p. 468

²²⁴ PR: *Elizabeth Wells*, Berry Women July 1902, p. 443

²²⁵ PR: *Charles Hanson*, Roughton Men December 1902, p. 580

the attached ovary and fallopian tube.²²⁶ In some cases surgery allowed for previous diagnosis to be proved wrong, as it did in the case of Mabel Risley who was diagnosed with a tumour believed to be ovarian, but which was found on the advent to surgery not to be gynaecological in nature.²²⁷ Equally, in other cases surgery enabled a diagnosis to be expanded, as in the case of Maria Springer, who underwent an ovariectomy (an operation to remove the ovaries), during which an ovarian cyst was also found.²²⁸ Mrs Scharlieb (the Physician for the Diseases of Women) often performed gynaecological operations after patients were transferred to her department.

Whilst their appointment were ground breaking, Mrs Scharlieb and her assistant Miss Vaughan were not the only female staff members to work on surgical cases. The House Surgeon Miss Turnbull operated in cases including that of Emily Luck, a two-and-a-half year old patient of Berry, who underwent surgery on a fractured femur.²²⁹ The patient case records also include details of female medical staff that assisted in surgeries but did not appear in the hospital annual reports. In the case of Emily Luck, Miss Turnbull was assisted by Miss Coultald, as was Mr Cunning (the Assistant Surgeon) in the surgery of Mr Roughton's patient Ellen Wilson.²³⁰ In the case record of Wilson, Miss Coultald is stated as administering chloroform during surgery.²³¹ In the hernia surgery of George Thomas Collins, Mr Roughton was assisted by Miss Seekings.²³² Although not stated, it is probable that Coultald and Seekings were medical students at the RFH Medical School for Women, and were assisting as part of their training.²³³ As discussed previously in this chapter, the volume of female medical staff at the RFH made the hospital unique. For many patients, having been operated upon by a female surgeon would have been a new and

²²⁶ PR: *Annie Steward*, Roughton Women July 1912, p. 361

²²⁷ PR: *Mabel Risley*, Berry Women July 1912, p. 473

²²⁸ PR: *Maria Springer*, Carr Women December 1912, p. 392

²²⁹ PR: *Emily Luck*, Berry Women December 1902, p. 802

²³⁰ PR: *Emily Luck*, Berry Women December 1902, p. 802, PR: *Ellen Wilson*, Roughton Women December 1902, p. 956

²³¹ PR: *Ellen Wilson*, Roughton Women December 1902, p. 956

²³² PR: *George Thomas Collins*, Roughton Men December 1902, p. 559

²³³ Amidon, *An Illustrated History*, p. 32

perhaps worrying experience, given that the profession had long labelled women incapable of such tasks.

The current historiography focuses on a selection of discoveries and developments in surgery over the course of the nineteenth century, but has overlooked the importance of the general apparatus and equipment used alongside developments in surgical approaches and techniques. Forceps and scissors were essential surgical instruments which appeared frequently in the sample records of the RFH. There were many types of forceps used for surgery, including sinus forceps to explore the brain in the case of George Collins, and Spencer Wells forceps, used to prevent haemorrhage during surgery, which were used during the operations of Elizabeth Vincent and Florence Piggott.²³⁴ Scissors were used to remove growths from the patient's bodies during surgery. In the case of Kate Purcell, scissors were used to remove bone, whilst in the case of Louisa Willis they were used to remove external piles.²³⁵ Needles were another essential surgical tool, such as the MacEwen's needle used during the hernia operation of George Thomas Collins.²³⁶ The Volkmann's spoon, a sharp spoon needed to scrap out a septic cavity, was used during the surgeries of Mary Mansfield and Arthur Stanghton.²³⁷ Once an operation had been performed, Michel's clips were often required to close the patients wound. In 1912, Mr Roughton used these clips during his surgeries on patient including Lily Chadman, Isabel West, and Richard Cooling.²³⁸ Sutures and stitches were then applied in order to hold the wound together and allow it to heal. Sutures of horsehair, along with silkworm, fishing,

²³⁴ Morten, *The Nurses*, pp. 114, 320, PR: *George Collins*, Roughton Men July 1907, p. 624, PR: *Florence Piggott*, Roughton Men December 1902, p. 931, PR: *Elizabeth Vincent*, Berry Women July 1907, p. 376

²³⁵ PR: *Kate Purcell*, Roughton Women July 1912, p. 365, PR: *Louisa Willis*, Roughton Women July 1902, p. 833

²³⁶ PR: *George Thomas Collins*, Roughton Men December 1902, p. 559

²³⁷ Morten, *The Nurses*, p. 336, PR: *Mary Mansfield*, Roughton Women December 1902, p. 925, PR: *Arthur Stanghton*, Berry Men July 1902, p. 647

²³⁸ PR: *Lily Chadman*, Roughton Women December 1912, p. 613, PR: *Richard Cooling*, Roughton Men December 1912, p. 1085, PR: *Isabel West*, Roughton Women December 1912, p. 619

and cat guts, all appear in the case records.²³⁹ Silkworm gut was very strong, not absorbed, and could be sterilized by boiling without destroying the qualities.²⁴⁰ As has been discussed, once the patient was out of surgery, many forms of dressings and antiseptic procedures would have been applied in order to keep the wound clean. Collodion dressings, which formed a false skin over the patients wound, were used in the cases of Emily Puke and Henry Wyatt.²⁴¹

Overall, the presence of female surgical staff and students, and the specialist operations for cleft palate and hare lip, made the RFH unique. That said, most of the surgery undertaken would have been typical of that available at other general hospitals during this period. This indicates that the surgical instruments used at the RFH were not unusual, and thus represent the complexity and precision of surgical practice both at the hospital and in the wider medical community by the early twentieth century. This is significant, given that the current historiography has neglected to consider the instruments with which modern surgery was performed. For a modest sized hospital, the range of surgeries performed at the hospital was impressive, and suggests that the presence of the medical school may have encouraged the performance of a variety of procedures as a means of teaching the students.

Treatment Results

Once the patients at the RFH had been treated for their complaints, the outcome of that treatment was recorded and they were discharged. The results noted in the case records provide an insight into not only how well the hospital carried out medical treatments, but

²³⁹ PR: *Albert Clark*, Berry Men December 1902, p. 37, PR *Caroline Grocer*, Berry Women July 1907, p. 411, PR: *Beatrice Stiles*, Roughton Women July 1907, p. 315, PR: *Robert Storey*, Berry Men July 1902, p. 640, PR: *Elizabeth Vincent*, Berry Women July 1907, p. 376

²⁴⁰ Morten, *The Nurses*, p. 314

²⁴¹ PR: *Emily Puke*, Roughton Women December 1907, p. 544, PR: *Henry Wyatt*, Roughton Men December 1907, p. 1001

also into how it perceived its duty as a centre of medicine and healthcare. Some patients were described as having been discharged ‘cured’, such as Christopher Wren and Henry Keleger.²⁴² In both of these cases, however, the patients left the hospital with ill-health issues. Keleger still had trouble passing urine when he was discharged, whilst Wren’s heart condition was described as being ‘not much altered since admission’.²⁴³ Similarly, whilst Alexander Morland was reported as being ‘relieved’, and was ‘much better for his time in hospital’, others were described as ‘relieved’ when still in pain, as in the cases of Arthur Bewell and Mary Walker.²⁴⁴ The condition of Edward Powell was described as being ‘Improved’, even though his cough was still ‘very troublesome’ and he had pain in his left side and epigastric region on being discharged.²⁴⁵ Whilst there are no comparative studies on the results of hospital treatment, the popularity of convalescent homes during this period suggests that it was common practice to discharge patients unwell. At the RFH, if a patient’s condition was improved the hospital appeared to regard that improvement as a success, sometimes even as a cure. It was not the role of the hospital to see the patient back to full health, but instead to attempt to set them on course to improve over time. That said there were some patient whom the hospital considered it impossible to help, and were subsequently reported as being discharged ‘I.S.Q’ (In Status Quo). Patrick Hinchon suffered from Tabes (wasting caused by syphilis) and was discharged I.S.Q, as was Kate Odds, for whom ‘Dr Carr found nothing could be done for her’.²⁴⁶

On some occasions issues relating to hospital administration were the cause for patients having been discharged early. Winifred Graham and Florence Brown were both discharged as the respective wards on which they were being treated were closed.²⁴⁷ Marie

²⁴² PR: *Henry Keleger*, Berry Men December 1902, p. 34, PR: *Christopher Wren*, Carr Men July 1903, p. 523

²⁴³ Ibid

²⁴⁴ PR: *Arthur Bewell*, Carr Men July 1903, p. 529, PR: *Alexander Morland*, Sainsbury Men December 1907, p. 1151, PR: *Mary Walker*, Sainsbury Women July 1907, p. 498

²⁴⁵ PR: *Edward Powell*, Sainsbury Men December 1912, p. 684

²⁴⁶ PR: *Patrick Hinchon*, Sainsbury Men July 1907, p. 722, PR: *Kate Odds*, Carr Women July 1907, p. 337

²⁴⁷ PR: *Florence Brown*, Sainsbury Women December 1907, pp. 811, 818, 828, PR: *Winifred Graham*, Sainsbury Women July 1907, p. 475

Plume was discharged as her cot was needed for another patient.²⁴⁸ Some patients discharged themselves from the hospital, such as Herbert Alcock, who left against the doctor's wishes in order to retain his job at the Post Office.²⁴⁹ John Wedley discharged himself after having spent approximately eight months, or 230 nights at the hospital between November 1902 and July 1903, and being in near the same condition as on admission.²⁵⁰ Elizabeth Gizzi also chose to leave the RFH, and died at home ten days later.²⁵¹ Other patients were discharged in order to receive further treatment from another hospital or to attend a convalescent home (as discussed in Chapter Four).

On some unfortunate occasions, however, the result of the patient's treatment at the RFH was death. Of the 480 patient case records sampled, and of the 468 individual patients in that sample (as discussed in Chapter Five), forty-three cases resulted in death. This indicates that just under ten per cent of patients treated at the hospital died. According to Mooney, Luckin and Tanner, phthisis was 'consistently the largest single cause of death in late nineteenth-century London'.²⁵² This is not evident in the case records, however, as only ten patients suffered phthisis, of which two died.²⁵³ This suggests that the RFH was treating a disproportionately low number of phthisis cases in relation to its prevalence in the wider population. Either patients were seeking help at other institutions for the condition, or these results are an indication that phthisis cases did not typically seek hospital treatment. The most common complaints suffered by those patients who died at the RFH were broncho-pneumonia, heart conditions, carcinomas, and meningitis, (which correspond with the main causes of death listed in the annual reports).²⁵⁴ Of the forty-six

²⁴⁸ PR: *Marie Plume*, Carr Men July 1907, p. 349

²⁴⁹ PR: *Herbert Alcock*, Sainsbury Men December 1907, p. 1184

²⁵⁰ PR: *John Wedley*, Carr Men July 1903, p. 537

²⁵¹ PR: *Mrs Gizzi (Elizabeth)*, Berry Women December 1902, p. 806

²⁵² G. Mooney, B. Luckin, and A. Tanner, 'Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century', *Social History of Medicine*, Vol. 12, No. 2 (1999), p. 267

²⁵³ PR: *Mary Heale*, Sainsbury Women July 1902, p. 285, PR: *Joseph Voyles*, Carr Men December 1903, p. 945

²⁵⁴ *Eighty-Fifth Annual Report 1912*, pp. 45-48

patients who died, thirty-seven were the patients of the physicians Sainsbury and Carr, whilst only nine were surgical patients of Roughton and Berry. The high number of deaths on the medical wards could be a reflection of inadequate medical care or knowledge being practiced at the hospital, or the result of people only attending when their condition was so grave that nothing could have been done for them. The low number of deaths on the surgical wards may be a demonstration the advances in surgery that had occurred by the early twentieth century, or the result of only relatively save surgeries being performed.

Conclusion

This chapter has shown that the collective treatments patients received at the RFH were diverse, and their experience of the hospital depended on a variety of factors. Patient narrative was still a vital aspect of diagnostic treatment at the hospital, and since the consulting staff ran private practices, the importance of the patient voice must have been recognised in the wider medical market. Physical examinations, particularly the invasive (such as gynaecological examinations conducted with a speculum), demonstrate the growing acceptance of patient discomfort (both physically and emotionally) as an inevitable side-effect of clinical medicine. The contact and relationship between the patients and the various hospital staff would have had a strong influence on their opinion of the RFH, not simply their contact with doctors and nurses. Equally, the rules and regulations the patients were required to follow, the visitors they received, the diets they were prescribed, and the time they were allowed off of the wards and outside of the hospital, would have helped to determine their overall experience of hospital life.

The early twentieth century would appear to have been a period of transition at the RFH. On the one hand, it adopted new medical theories and technologies (such as massage treatment and x-rays) when finances allowed, and was progressive in its attitudes towards

the medical education and employment of women, which collectively would propel hospital medicine into a new era. On the other hand, the evidence suggests that it was slow to keep up with the developments associated with new technology which had been recognised in the wider medical market (including the use of barium instead of bismuth prior to x-ray). Moreover, the interchangeable use of different terms for x-ray, Röntgen-ray, Radiograph, or Skiagram in the records indicates that the hospital was struggling to understand the new technology. It was also reluctant to abandon familiar drugs and medicines, including alcohol, morphine, and cocaine, when they had been proven harmful or more effective substitutes had become available. This reluctance, along with its compromise in the use of the combined anaesthetic A.C.E., reflects the hospital's uncertainty about adopting new scientific medical products and abandoning its traditional techniques. The continued use of ancient medical practices at the RFH, including tapping, blood-letting, leeching, and skin irritation, demonstrates the strong influence that humoral beliefs still had on the 'modern' medicine of the hospital during the early twentieth century. The reasons why the RFH continued to favour older treatment regimes and remedies related to institutional, professional, and patient preferences. The hospital itself was often not in the financial position to keep up-to-date with the newest technologies, and older staff members may well have been reluctant to abandoning favoured methods for new approaches, which may have turned out only to be short-term fads or trends. Patient demand would also certainly have had an impact on the treatments made available to them at the RFH, as if the hospital could not attract patients, it would not, in turn, have attracted the benefactors it needed to stay in business.

The surgery performed at the RFH reflects the use of the hospital as both a place of convenience for emergency cases (having been located in central London) and as an institution offering specialist care, particularly in the fields of cleft palate and hare lip surgery and the gynaecological treatment offered by female professionals. The use of

antiseptic substances and practices, along with anaesthetics developed throughout the second half of the nineteenth century, collectively made surgery safer and allowed for more dangerous and complex procedures to be performed with increasingly delicate and specialist instruments. Patients (or their parents on their behalf) travelled hundreds of miles in order to benefit from the excellent reputation of the consulting staff of the hospital, particularly the operative skill of Berry on hare lips and cleft palates. For all the success the surgical and medical departments at the hospital must have seen in order to build such a reputation, it could not always achieve the desired outcome. The results recorded in the case notes reveal that it was not the intention of the hospital to nurse patients back to full health. As previously discussed, patients were often transferred to convalescent homes to recuperate after having been seen out of immediate danger and having spent no more than a month at the hospital. Approximately one in ten of those patients sampled died at the RFH, a number which reflects the prevalence of chest complaints amongst the population of the capital during the early century.

Overall, medical practice and technology was undergoing a period of transition during the early twentieth century. The RFH is an example of an institution that was reluctant to abandon traditional medicine in favour of modern scientific practice. In terms of the developing medical knowledge of drugs and new technologies in the wider profession, the hospital was behind the times. This is surprising, however, given that the physicians and surgeons sampled for this study were highly regarded and at the top of their professions. It is likely that financial restrictions made it difficult for voluntary hospitals like the RFH to adopt new technologies quickly, and they would not have wanted to invest in treatments such as x-rays without knowing first that they had achieved success in the wider medical community. Although there are no comparative studies, we might expect to find similar reluctance at other voluntary institutions, given that they were often staffed by overlapping consultants and limited by similar financial restrictions. It is important to

remember, however, that hospital medical practice could not have changed overnight. New medical knowledge and technologies would have had to spread amongst the profession, be incorporated in medical training, and in the case of large equipment, be physically installed in the hospital building. Moreover, hospitals still needed to be attractive consumer options in the wider medical market, and so suddenly abandoning treatments which would have been preferred and familiar to many patients would not have been an option. In this respect, the patients of the RFH were well catered to, as it could offer them the comfort of the old with the excitement of the new.

CHAPTER SEVEN

CONCLUSION

Through the use of patient case records, this study has contributed towards the current literature of the London hospital system, doctors and patients, and the health of the population in the period between the end of the nineteenth century and the First World War. As discussed in Chapter One, whilst these literatures are substantial, they contain considerable gaps. Firstly, institutional histories of London hospitals are surprisingly few in number. As a result, the Royal Free Hospital (henceforth RFH), an important voluntary institution of nineteenth and twentieth-century London, has never before been the subject of academic study. Secondly, the identity of the hospital patient has remained anonymous, and comprehensive analysis of how patients made consumer choices within the medical market has been minimal. Thirdly, there has been little empirical examination of medical and surgical treatment in the hospital setting, which has subsequently meant that we know next to nothing of the patient experience of hospital care. Fourthly, whilst the birth of modern medicine in the hospital setting has been a dominant theme in the current historiography, the practice of hospital doctoring, and where it fitted into the wider career structure of medical professionals has been relatively neglected. Finally, we know very little about the health of the London population during the early twentieth century, or of the lifecycle of ill-health experienced by individuals and their families. Considerable strides have been made to filling these lacunae.

Firstly, by compiling a history of the RFH, this study has inserted a key institution into the historiography for the first time. Though relatively typical in the means and manner of its foundation and development over the course of the nineteenth century, the RFH was the first voluntary hospital to admit patients without the use of a subscriber's letter of recommendation. Having started life as a small dispensary for cases of venereal

disease, the hospital gradually expanded in size to become a general healthcare institution. Whilst the official admissions policy excluded infectious, incurable, or destitute cases, the evidence has shown that in reality, the hospital accepted many such patients. Cases which would have been considered suitable only for the Poor Law in the nineteenth century were by the period of this study treated alongside those patients considered of a more respectable and deserving nature. By the late nineteenth century, the appointment of the first Lady Almoner at the hospital marked the introduction of the patient means test, which would determine who was able to contribute financially towards their treatment. This is significant, as it demonstrates the changing attitudes towards poverty and charity in the wider community over the turn of the century. The physicians and surgeons of the RFH sampled for this study are examples of distinguished male practitioners at the top of their respective fields. The hospital must therefore, have been considered an institution which only associated itself with highly educated and well respected medical professionals. This is also significant, given that the RFH was the first general institution to practice clinical training to female medical students of the London School of Medicine for Women (henceforth SMW) since the 1870s. The hospital clearly regarded medical women as an important aspect of the future of the profession, and its commitment to this belief was evident from its appointment of the first permanent female physician at a general hospital in 1902 (Mary Scharlieb to the position of Physician for the Diseases of Women).

Secondly, by examining the identity of the RFH patient base, this study has made a novel and significant contribution towards bringing the patient to the forefront of medical history. The evidence has shown that the typical patients were either young boys, who were most commonly treated by physicians in the summer months, or young, single women aged between their early teens and late twenties, treated by surgical staff. Though the hospital had a separate gynaecological ward, it allocated more beds to male patients overall by the period of this study. This is important, as the current historiography contains

very little consideration of male hospital patients, who were not believed to frequent the hospital as often as females. Moreover, just as at King's College Hospital and at the Great Northern Central Hospital, single patients were the most common at the RFH. This indicates that voluntary hospitals were particularly central to the mixed economy of single patients, who most likely did not have a local family network to depend upon at times of ill-health. That said children made up many of the single patients. School children were the largest occupational group, followed by male labourers and porters, and female housewives and domestic servants. The hospital did not, however, exclusively treat the young working class, as patients as old as eighty-years were found in the sample records. Patients differed in means and circumstances from the destitute poor to the respectable working and middle classes. For those who could have afforded to pay for medical treatment, their use of the RFH shows voluntary hospitals had become socially accepted healthcare institutions, and were no longer considered the sites of medical charity.

Having identified the patient base of the RFH, this study has been able to consider patient agency and choice in the mixed economy of healthcare. These themes are crucial to advancing our understanding of the medical marketplace. How and why patients made use of various healthcare options would have determined the manner in which the market developed over the late nineteenth and early twentieth centuries. The patient health histories have demonstrated how patients made consumer choices at times of ill-health that depended on the nature and severity of their condition. Self medication by means of herbal, dietary, or patent remedies were often the patients' first choice of medical aid. Private medical individuals including chemists, club and dispensary doctors, and other practitioners were also popular options at times of ill-health. For those who chose to seek hospital treatment, some repeatedly relied on a preferred institution, whilst others made use of multiple and simultaneous hospital care.

The RFH catered predominantly for its local community; it was the preferred institution for many patients due to its close proximity to their home or workplace. Such patients tended to live in rented accommodation, which has been specifically designed and allocated to the working class poor (the Beaconsfield or Peabody buildings). There are examples in the records, however, of patients who travelled hundreds of miles to seek surgical treatment at the hospital, which demonstrates not only its good reputation beyond the city of London, but also that it was a viable consumer options for those patients who made up the wider medical markets of Britain. Having been surrounded by many other voluntary hospitals in the capital, however, the RFH more often interlinked with the London healthcare network. Patients came to the hospital either on their own accord, or were recommended, sent, or transferred, usually from a private practitioner or other institution. Once the end of their treatment had been determined, aftercare was organised if needed by the almoner and her team. The medical social work conducted by the almoner's office has been overlooked in the current historiography, but the charitable networks it formed would have been crucial to ensuring the patient received the most beneficial aftercare available. The treatment results have shown that the hospital did not consider itself an ultimate centre of healthcare. Instead, it treated the immediate ill-health of the patient before transferring them to a convalescent home (or similar) for long-term recuperation and rehabilitation. The RFH recognised that it was only one part of a wider network of healthcare provision, and worked within that network to provide the most efficient and appropriate care.

Thirdly, this study has undertaken the novel examination of medical and surgical treatments provided in the hospital setting, and the resulting patient experience. Whilst the current historiography has stressed the central role of the physical examination in the process of diagnosis, the patient records have shown the continued importance of the patient narrative during the early twentieth century. The patient experience of hospital

treatment would have been influenced by their diagnostic treatment, but also by the contact and relationship between themselves and hospital staff throughout the duration of their stay. The rules and regulations they were to follow and the visitors they were allowed to see would have also had a profound impact on the overall experience of the patients. Although the wards were single sex, the many children who attended the RFH did not have a separate ward until the opening of the Riddle Wards for Children in 1927.¹ Having been away from their families and treated alongside adults, child patients were likely to have considered the hospital a daunting and perhaps frightening place. This did not go unnoticed by the hospital staff, however, as the evidence has shown that children were allowed to play with toys on the wards to keep them entertained.

The medical and surgical treatments provide to patients at the RFH were diverse. The hospital was undergoing a period of transition between traditional and modern medicine, which we have seen to be a reflection of developments in the wider medical profession of the early twentieth century. Financial restraints caused the hospital to be slow to uptake expensive modern treatments (such as x-rays), but the evidence suggests that it was its reluctance to abandon traditional remedies that hindered its ability to keep up-to-date with developments in medical science. In some instances compromises were made which allowed the hospital staff to use trusted medicines alongside those they held to be suspect (such as the A.C.E. anaesthetic mixture). In other cases, however, traditional humoral remedies were used despite evidence of their dangerous nature. This is significant, as it highlights the debates and disparities in the wider medical community around the use and effectiveness of ancient techniques such as blood-letting, tapping, skin irritation, and leeching. Moreover, whilst the development of antiseptic and asepsis theories and practice has been well charted in the current historiography, there has been little empirical discussion of their practical application in the hospital setting. The RFH

¹ L. A. Amidon, *An Illustrated History of the Royal Free Hospital*, (Published by the Special Trustees for the Royal Free Hospital, London, 1996), p. 44

case records indicate that the measures taken to keep surgical practice sterile were imperfect, which in turn implies that this was also the case elsewhere in the medical community. More work is needed on the use of medical treatments both in the hospital setting and at other means of medical assistance, in order that comparisons can be drawn and developments traced.

Fourthly, hospital doctoring has been analysed in relation to both its place in the broader career structure of medical professionals, and to the doctor-patient relationship. The positions held by the physicians and surgeons at the RFH reflected only one aspect of their careers, which included posts at numerous other hospitals previously, and often simultaneously.² This is important, as networks which developed between the staff at different institutions would have influenced the efficiency of patient transfers and record sharing. Posts at voluntary hospitals like the RFH would also have allowed staff to develop their specialist interests and skills. For example, most working class families could not have afforded to pay for private surgical treatment for a child who suffered from a cleft palate or hare lip. The frequency of such patients who sought free treatment at the RFH would have provided Mr Berry with not only cases on which to exercise his own skill, but also allowed him to teach his methods to the students of the SMW. The presence of female medical students on the wards of the hospital would have symbolised a move towards further gender equality in the profession. Though their practice would have reflected the attitudes and approaches of their male teachers, the patient experience would have been influenced by having female students, and eventually female practitioners, administer hospital treatment. The records have highlighted, however, that patient treatment and experience would have depended on their contact with many members of the hospital staff who have not been considered in the current historiography, such as the Medical Officer

² A. Crowther and M. W. Dupree, 'The invisible general practitioner: the careers of Scottish medical students in the late nineteenth century', *Bulletin of the History of Medicine*, Vol. 70 (1996), pp. 387-413, and A. Digby, *The Evolution of the British General Practice 1850-1948*, (Oxford University Press, Oxford, 1999)

and Registrar. Moreover, the duties and interaction between those staff members who worked away from the wards, including the Pathologist and the Hospital Museum Curator, is also noteworthy to our understanding of developments in medical knowledge and research.

Finally, the health of the London population has been considered through the examination of the current and previous ill-health suffered by the patients of the RFH and their families. Such an examination is novel, as epidemiological transition hypothesis have centred on mortality figures, and not on the lifecycles of ill-health suffered by the population. The records have shown that the RFH treated both chronic and infectious conditions during the early twentieth century, which indicates that the transition was still underway. It must be remembered that concepts of disease causation were changing over this period, and conditions including tuberculosis were officially recognised as infectious and not chronic in nature. Whilst important, this recognition only added to the abundance of other infectious chest complaints in the sample. Bad living and working conditions, coupled with the consistently poor air quality in the capital (especially during a fog) meant that the population was at constant threat from infectious chest complaints. The prevalence of conditions including bronchitis and pneumonia in the case records of the physicians is significant, as it demonstrates that whilst the resulting mortality of these conditions had decreased, they were still widely suffered by the population. Given that the general condition of the patients at the RFH appeared to be poor, the most likely explanation for the decreased mortality of infectious complaints is the changing nature of the complaints themselves. Moreover, the previous and family health histories have demonstrated the variety of conditions people suffered throughout their lives, and has drawn attention to the collective experience of ill-health within the family and the wider community. More work is needed, but this is a major advance towards our understanding of how family networks dealt with simultaneous or collective ill-health within the mixed economy. Having been

members of the working class community, patients at the RFH often suffered from work related complaints or accidents, such as fractures or hernias. The sudden onset of a disease or injury that rendered the patient unable to work could have pushed the family into poverty. Worse still, the death of a family member, particularly the breadwinner, would often have had a profound long-term effect on the financial circumstances of that family.

Beyond contributing towards to the current historiography, this study has been an original working example of how patient case records can be used as an historical source. These records have provided a novel and valuable insight into patient identity, health and disease, medical consumer choices, medical and surgical hospital practice, and patient experience. As with any source, however, they are not without their limitations. Though the 480 records sampled for this study is significantly greater than any previous examination, it is a small number in relation to the tens of thousands of patients who would have been treated at the RFH during the ten year sample period. With this in mind, this study has attempted to draw out broad trends in patient identity, health, and treatment, in order to best represent the patients of the hospital and of the wider community. In terms of the information contained within the records, each chapter of this study has raised similar issues regarding the nature of their completion and overall reliability. Patients may have lied or withheld information regarding their identity, health, or previous treatment. In other instances they may have made honest mistakes when recalling such information from memory. Equally, the staff at the hospital could have made mistakes when recording patient information. The amount of detail noted would also have depended on the staff member completing the record. Often, it was only previous health and treatment information considered relevant to the current case that was included in the record. Similarly, only daily treatment considered important was noted, which meant that the majority of the patients stay at the hospital was not reflected in the records. Furthermore, patient records can only provide us with an insight into patient health and treatment prior

to its completion. Developments in the lifecycle and experience of ill-health and medical treatment beyond the RFH in the early twentieth century cannot be known unless later records of the same patients can be found and accessed.

However, whilst it is imperative that the limitations of patient case records are considered, this study has highlighted their vast potential as an historical source. Their value is increased further when used in conjunction with other contemporary material, such as other hospital records, medical textbooks, journal articles, and newspaper reports. By comparing the information in the records to that contained in these sources, this study has been able to compare the official or published knowledge of the medical profession to the empirical evidence of their practice. Moreover, the language and terminology contained in the records offers a unique opportunity to consider the professionalization of medical practice and the wider accessibility to medical knowledge. Countless references to the size and appearance of a swelling or wound by comparison to common objects are found in the sample records. Lumps the size of ‘a hen’s egg’, ‘a walnut’, or ‘a penny’ were described by both the patients and the medical staff alike.³ This demonstrates the shared lay language of the profession and the wider community. In contrast, the Latin abbreviations contained in the case records for seemingly simple treatment orders (such as ‘aq’ for water, ‘ad’ for ‘up to’, or ‘aa’ for ‘of each’) indicates the distinct efforts by the profession to isolate itself from the public during this period.⁴

Furthermore, whilst this study has touched on the significance of patient case record administration during the early twentieth century, more work is needed into the practicalities of their storage, their availability as a means of reference in later periods of their respective patients’ ill-health, and the practice of record sharing between institutions.

³ Examples include: Royal Free Hospital Patient Case Record (Henceforth PR): *William Beasley*, Carr Men July 1912, p. 599, PR: *Florence Piggott*, Roughton Women December 1902, p. 931, PR: *Charlotte Rutt*, Carr Women July 1903, p. 328, PR: *Marion Watson*, Sainsbury Women July 1912, p. 454

⁴ H. Morten (revised by Florence Taylor), *The Nurses Dictionary*, (Faber and Faber, London, 1942), p. xiv, PR: *Jane Johnson*, Sainsbury Women July 1902, p. 277

As discussed in Chapter Four, in some cases the patient records included old notes or records from either the RFH or other institutions. The time and effort involved in searching through presumably hundreds of thousands of records in order to find old case notes is remarkable. The work then of copying the record and having it sent to the institution at which the patient had decided to receive their current treatment was also impressive. The scale of such tasks would have been enormous for a single case record, let alone for the countless requests which would have been made for old case notes each year at institutions across the capital and beyond, as patients made more frequent use of multiple hospitals throughout their lives.

This study has made a contribution to the current literature of early twentieth century hospitals, health, doctoring, and patients in London, and to the history of medicine more generally. The advances made by this study, however, also have the potential to intersect with several wider topics of literature. Firstly, the findings represent the wider professionalization of nineteenth and early twentieth century Britain. Evidence of professional education and career structures have been discussed throughout this study, along with the importance of specialised networks as a means of sharing knowledge in a developing professional community. The establishment of professional rules of conduct are also evident, which reflect wider issues of accountability that are an inevitable product of professional development. The study has also shown the significance of both the mutual trust between professional peers, and the faith which was needed in the profession by its clientele. These issues are essential to the success and development of any profession, not just the medical. Secondly, whilst patient agency has been considered throughout this study, the findings raise issues of wider agency throughout people's lives. The agency demonstrated by the patients of the RFH would have been influenced by many other factors, particularly the circumstances of their employment. This raises issues as to the amount of control people held over their own lives. If choices were determined by the

means and circumstance of individuals, lower class members of the community could not have exerted the same agency as those who were better off. Thirdly, the findings of this study intersect with broader literature on the development of the Victorian information state. It demonstrates the social acceptance that private information was not only to be shared, but was to be recorded as a matter of routine.

Whilst scientific developments in medicine have been discussed, this work also reflects advancements in scientific knowledge, particularly in the fields of chemistry and physics, during the late nineteenth century. Technology was also developing, and the injuries discussed in this study relating to the railway demonstrate the dangers associated with industrial progression. Fifthly, in contrast to developments in science and technology, the continued importance of the religion in the hospital setting intersects with literature on the increasing secularisation of Britain during this period.⁵ Religious observance may have been in decline, but this study raises debates regarding its place and importance during different periods of people's lives (especially at times of ill-health). Gender debates are the sixth area of literature to which this study contributes. Issues of gender have been raised in regards to the experience of female staff and patients at the hospital, but the limited amount of relevant detail contained in the patient records meant that it was not possible for this study to focus on this topic. Nonetheless, wider issues of women's place in society over the turn of the twentieth century can be addressed through this study. The history of gender difference is extensive, but this study provides an empirical example of women embarking on professional careers decades before they were enfranchised. Lastly, this study can intersect with wider literature on class and poverty during the late nineteenth and early twentieth centuries. Social attitudes towards the poor can be drawn from the findings,

⁵ See: G. Levine, 'Scientific Discourse as an alternative to Faith', in R. J. Helmstadter and B. Lightman (Eds.), *Victorian Faith in Crisis: Essays on Continuity and Change in Nineteenth-Century Religious Belief*, (Stanford University Press, California, 1990), pp. 225-261

along with examples of how members of different classes interacted in the public space of the hospital. Findings also contribute towards the literatures of philanthropy and voluntary action, and to the methods of social investigation which operated to determine who was morally deserving of charitable aid.

Overall, the findings of this study have made a significant contribution towards filling the gaps in the medical history literature, but can also intersect into much broader range of historical work. The use of patient case records in this study has been novel, but more work is needed to compare with these findings, and to expand our understanding of healthcare and patient experience beyond the hospital setting.

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