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‘Because of Poverty brought into Hospital: . . .’ A Casenote-Based Analysis of the Changing Role of the Edinburgh Royal Maternity Hospital, 1850-1912

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Summary

Although the shift from a social to a medical function which occurred in nineteenth-century general hospitals has been explored, the occurrence of such a change in maternity hospitals has not been considered. Recent analyses of such institutions have examined particular aspects only, and thus give a somewhat static picture. This paper uses analysis of patient records (themselves an under-exploited resource) to explore the changing function of the Edinburgh Royal Maternity Hospital from a provider of shelter during childbirth to the destitute to a source of skilled medical care. It concludes that, although the Hospital had adopted the outward features of a medical institution by 1890, its casebooks suggest that its purpose only truly changed in the early twentieth century, and thus can perhaps be more appropriately linked with national anxiety regarding the health of babies and their mothers.

Keywords

Edinburgh; maternity hospitals; patients; personal health records; childbirth; casenotes; casebooks; maternal and child welfare

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In 1912, Mrs Henry, a 36 year-old mother of two, was ‘[b]ecause of poverty brought into Hospital ...’.¹ The wife of a painter, and already delivered, she was admitted to the Edinburgh Royal Maternity Hospital (ERMH) not because she had developed a medical problem, but because the attending nurses considered her domestic circumstances were too poor for a puerperal woman and her baby. The house surgeon evidently felt this was unusual, yet 68 years previously, when the Hospital was founded, almost all patients were admitted for social reasons rather than medical treatment. The aim of this paper is to examine the changing function of the ERMH from its foundation as a charity in 1844 until the introduction of National Insurance in 1912, through analysis of its patient records.

Significant developments in the historiography surrounding maternity hospitals have recently taken place. Formerly, studies tended towards the narrowly institutional and medical, the result of reliance on administrative records as sources.² However, by

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¹Lothian Health Services Archive (LHSA), 1912 Indoor Casebook (ICB) [LHB3/16/3], case 28, Professor Halliday Croom’s quarter, Births Register entry (BR) 497 [LHB3/14/7]. Patients’ surnames for the year 1912 have been anonymised.

²See, for example, Browne 1947; Young 1964; Rhodes 1977; Dow 1984; Dewhurst 1990; Farmar 1994. A rare exception to this approach, which examines British maternity hospitals as a whole, is Gunn in Poynter (ed.) 1964.

supplementing these with a wider range of archives, historians have begun to explore the social implications of the establishment of maternity hospitals. Incorporation of the analysis of admission registers has enabled the hospital-patient relationship to be explored through the discrepancy between the declared aims of the institution and its actual practice.³ The addition of contemporary writing on midwifery and of account- and day-books to the repertoire has enabled the changing relationships between attendants, patients and benefactors in eighteenth-century maternity hospitals to be examined, not solely in terms of gender,⁴ but also in relation to medical professionalisation and the medical market-place, and to the development of obstetrics as an academic discipline.⁵

A more subtle interpretation of the apparent link between maternity hospitals and puerperal fever has also resulted, beginning to redeem their poor medical reputation.⁶ A medical narrative has similarly re-emerged from the use of oral history and local government reports (again in combination with hospital administration records) to examine the work of late nineteenth- and early twentieth-century maternity hospitals. However, their use has changed the nature of the narrative: the institution is no longer examined discretely, but is set at the centre of a wider picture, to be seen in relation both to the social and economic life of the local community, and to changes in the nation's health.⁷

Nonetheless, despite a deeper examination of themes in the development of maternity hospitals, what is conveyed is a fairly static picture which, within any particular hospital, fails to communicate the changes over time in its role. This contrasts with general hospitals, whose shift from a social to a therapeutic function has been explored, and closely linked with the development of a separate nursing profession, the introduction of antiseptics, and the associated growth in surgery.⁸ Such a shift in function has not been reflected in any examination of a maternity hospital. Further, despite the widening range of sources, little use has been made of the potential contribution of personal health records to the history of their originating institution, except as a source of local colour.⁹

The aim of this paper is to examine that shift at the ERMH, using personal health records as the principal source to reconstruct its changing purpose from its establishment in 1844 to the introduction of National Insurance in 1912. The paper is divided into three sections. The first contextualises the study and its sources by describing the history of the ERMH until 1912; the second assesses the registers and casebooks used, whilst the third explores the patients themselves. The paper concludes that, although the ERMH had adopted many of the outward features of a medical institution (such as an antiseptic regime and an increased use of instrumental intervention) by 1890, its patient records show that its purpose perhaps only truly changed in the early twentieth century, and thus can be more appropriately linked with increasing national anxiety and awareness of the health of babies and their mothers.

The Edinburgh Royal Maternity Hospital, 1844-1912

The ERMH opened in 1844, replacing the Edinburgh General Lying-In Hospital which had been sold following the death in 1839 of its owner, James Hamilton, Professor of Midwifery before James Young Simpson.¹⁰ The intention was that it would likewise provide relief for

³Quiroga 1989.

⁴Versluysen in Roberts (ed.) 1981; Donnison 1988.

⁵Ross 1986; Croxson 2001; Schlumbohm 2001.

⁶DeLacy 1989; Cody 2004.

⁷Marks in Fildes *et al.* (eds) 1993; McCalman 1998.

⁸Porter 1997, pp. 368-81; Rosenberg 1987, pp. 118-22; Rosner 1982, pp. 1-7.

⁹It could be argued that the exception is Nancy Dye's detailed examination of the New York Midwifery Dispensary, which does analyse medical records to explore changing attitudes to childbirth and medical care among the immigrant poor. However, her work is focused on a dispensary, not a hospital, and on changing approaches to childbirth among patients, not within an institution (Dye 1987).

the poor and the ‘means for the practical study of the obstetric art’.¹¹ Fee-paying ‘Pupils, Midwives, and House Surgeons’ were essential for its financial survival, whilst senior staff embodied its dual charitable and educational role—all occupied honorary posts at the Hospital, but an increasing number taught at either the University or Extra-Mural Medical Schools.

The charitable remit dominated the Hospital’s early years. It was managed by a group of mainly non-medical Ordinary Directors, to whom the Medical Board reported, and who employed a Matron to manage the House. Appeals for support dwelt solely on ‘the helplessness of poverty’, and yielded donations from both individuals and Parochial Boards in Edinburgh and Leith.¹² Although the Professor of Midwifery ‘and the other professional gentlemen composing the medical staff’ were routinely thanked for their role in the Hospital, in early Annual Reports this occurred only in the final paragraph, with the implication that that role was minor.¹³

The Directors interpreted their charitable role widely. Unlike many other maternity institutions,¹⁴ the ERMH accepted both married and un-married women, who were admitted as Indoor patients by the possession of a subscriber’s ticket, by being an enrolled pauper, or privately: those already in labour were always admitted.¹⁵ The ERMH was not the only maternity charity in Edinburgh (in 1870 there were another four at least, rising to eight by 1903), but all other dispensaries provided attendance in the patient’s home only, reflecting the normal childbirth behaviour of the period. Domiciliary deliveries also dominated at the ERMH, constituting about two-thirds of the cases it treated prior to 1914. However, until the end of the nineteenth century, the Hospital was the only provider of in-patient maternity care in the city.

During the early 1860s, there were two significant developments in the Hospital. It ran into financial problems, and, not unconnected, there was a shift in the balance of power between the Directors and doctors. After a promising start, subscription income first levelled off by 1855, and then fell in real terms.¹⁶ The ERMH apparently remained viable only as the result of a loan from Simpson.¹⁷ The Hospital’s financial difficulties continued until the mid-1870s, worsened by the need to repay the loan to Simpson’s estate,¹⁸ but the decision to spend the donations ‘collected to perpetuate the memory of Sir James Simpson’ on custom-built premises at 79 Lauriston Place, which the ERMH occupied from 1879 to 1939, gave it a secure base from which to expand.¹⁹ Subscription income rose, and from 1881 Annual Reports enthused about the work of Auxiliary and Lady Collectors.

Possibly resulting from the debt to Simpson, the doctors became more involved in the running of the Hospital after 1860, sometimes to the irritation of the Directors. Relations between them and the Matron soured, amid accusations of dirty wards: at their first attempt to force her resignation in 1861, she was supported by her employers, the Directors, but in 1863 her departure was negotiated to ‘prevent any unpleasant collision between the

¹⁰Sir James Young Simpson Bt (1811-1870), Professor of Midwifery and the Diseases of Women and Children, University of Edinburgh, 1839-70.

¹¹*First Annual Report* 1845, p. 5.

¹²*First Annual Report* 1845, p. 8.

¹³*First Annual Report* 1845, p. 6.

¹⁴Donnison 1988, p. 38; Dow 1984, p. 31; Young 1964, pp. 7, 53.

¹⁵LHSA, Directors’ Minutes (DMERMH) [LHB3/1/2], 22 February 1862.

¹⁶Subscriptions and donations received in the ERMH’s first year of operation had totalled £493 13s 10d (*First Annual Report* 1845, p. 9); by 1860 subscription income had fallen to £145 11s 10d. (*Seventeenth Annual Report* 1861, p. 8).

¹⁷*Fourteenth Annual Report* 1858, p. 5; LHSA, DMERMH [LHB3/1/2], 2 May 1856.

¹⁸LHSA, DMERMH [LHB3/1/3], 6 March 1871.

¹⁹Simpson in Gibson *et al.* (eds) 1893, pp. 46-7.

Directors and the Medical Board' at the Annual General Meeting.²⁰ In a break from custom, the meeting at which a new Matron was appointed took place at 52 Queen Street, Simpson's home. From 1863, too, doctors began to attend the Directors' meetings, and by 1864 both Simpson and John Moir (Consulting Medical Officer) were Ordinary Directors. However, within a fortnight of Simpson's death, the Directors asserted their right 'to elect to the vacancies which may occur in the Medical Board and staff of the Hospital',²¹ and constitutional changes in the early 1870s emphasised the separateness of the ERMH's medical and charitable managements by excluding the Professor, as a Medical Officer, from the Directors.²² However, Professor Alexander Simpson's²³ plans to connect the Hospital more closely with both medical schools were slowly accepted during the 1880s,²⁴ and by the 1890s any antagonism had largely gone.

The importance of the Hospital as 'a proper school for the instruction in Midwifery . . . to students and nurses' grew:²⁵ by the final quarter of the nineteenth century, it played a prominent part in the education of medical students from both Edinburgh University and the Extra-Mural Medical Schools. Its honorary medical staff expanded from four in 1870 to eight in 1906, all also involved in obstetric teaching. It benefited from the professionalisation of midwifery: in 1904 the ERMH was recognised as a training institution by the Central Midwives' Board (England and Wales), and its Leith branch was established in 1907 specifically to provide more cases for midwives in training as required by the Board.²⁶

This summary of the early history of the ERMH presents a picture of its apparent steady advance as a medical institution, if not from 1861, when its doctors first became actively involved, then from 1879: it remains to be seen whether this is borne out by its patient records. The following section describes those records, and their analysis.

The Birth Registers and Casebooks of the ERMH

The ERMH recorded its administrative activities privately in both Directors' and Medical Board Minutes and publicly in Annual Reports. Detailed records of its patients were kept by the house surgeons in its Casebooks, Indoor and Out, and in the Registers of Births. In the Casebooks are recorded patients' medical data, with additional nursing data for Outdoor patients from 1907.²⁷ The Births Registers contain patients' social data, and are the principal focus of this paper.

With both Hospital funds and the possibility of maternal death (or absconding) in mind, the ERMH Rules and Bye-Laws required all patients to furnish the Hospital Secretary with

correct information in reference to her *age*, place of *birth*, and *parentage*, . . . the various places in which she has resided. . . . If . . . married, she shall be required to give the name and residence of her husband, and . . . similar information regarding the places in which he has resided;—if unmarried, the name and residence of the child's father, and any other information regarding him which may be required.²⁸

²⁰LHSA, DMERMH [LHB3/1/2], 31 March 1863.

²¹LHSA, DMERMH [LHB3/1/3], 18 May 1870.

²²LHSA, DMERMH [LHB3/1/3], 4 July, 10 November 1871.

²³Sir Alexander Russell Simpson (1835-1916), Professor of Midwifery and the Diseases of Women and Children, University of Edinburgh, 1870-1905.

²⁴LHSA, DMERMH [LHB3/1/3], 23 November 1878, 24 January 1879, 14, 21 April 1884.

²⁵LHSA, 26th Annual Report (ARERMH) [LHB3/7/26] 1870, p. 7.

²⁶LHSA, DMERMH [LHB3/1/4], 21 January 1907.

²⁷These are recorded in the Students' External Casebooks [LHB3/18/14-43].

²⁸*Rules and Bye-Laws* n.d., 'Patients', Rule 1.

It is this information which appears in the Register of Births, although a smaller Births Register was introduced in 1877 and maintained by the Matron. The new Registers contain less information: most notably, patients were no longer asked directly if they were married, and the details of the baby's father were omitted if the child were illegitimate. However, the mother's occupation was recorded in place of that of the father when she was unmarried, so marital status can still be deduced. Information on the mother's own family, such as her father's employment, and whether (and where) her parents still lived, was also no longer collected.

This paper is based on whole year analyses of all patient data from the Hospital from four discrete years, approximately 20 years apart.²⁹ Although the Births Registers constitute an almost continuous record from 1847, record-keeping in the Casebooks was less meticulous, and the years for study (1850, 1870, 1890 and 1912) were selected for the completeness of the data they contain, and their proximity to the decennial census, a source of additional information on Outdoor patients in the three earlier years studied. 1912 was the final year of Hospital records before the introduction of Maternity Benefit for the wives of insured persons under the new National Insurance Act began to alter the childbirth behaviour of its working-class patients. All the cases treated by the Hospital in each year were recorded. Indoors, where data from Casebook and Birth Register records were linked, the Casebooks were used as the primary documents, and patients listed in them were identified in the Births Register by name (small variations in spelling and recognised abbreviations were allowed), age, and date of delivery. Only in 1890 was there an absolute correlation between the two records.³⁰ In 1850, 21 patients appear only in the Births Register, whilst in 1870 two women who did so were described as 'not pregnant' after a week's stay.³¹ In 1912, one of the three excluded cases died undelivered, whilst two were admitted post-delivery.³² The data thus collected were subjected to minimal manipulation, classification and coding. When possible, actual numbers are used in the following account, with percentages used for comparisons.

How reliable was the evidence recorded in the Births Registers? The quoted passage from the Hospital Rules suggests that the answers resulted from direct questioning, reducing opportunities for deceit or misinterpretation. Nonetheless, it is evident that not all inmates told the truth in all respects: in every year examined, one or two tried to deceive the Hospital in respect of their married status, and were later detected.³³ In 1850, almost all the single women (153 of the 155 whose records were complete) claimed to be able to identify the baby's father, but the men in question might not have admitted their paternity. However, the real value of the Births Registers lies not in the individual entries, but in the links that can be made with the same patients' medical data, and therefore in the possibilities the ERMH material offers for studying the two together. The following section uses the patients' social and health records from the four selected years as the principal source to reconstruct the changing purpose of the Hospital, relating this to the account of its development given in administrative documents.

Indoor and Outdoor Patients at the ERMH, 1850-1912

As a result of its provision of both in- and out-patient care, the ERMH effectively served two populations, who differed in more than their place of delivery. The main focus of this

²⁹These analyses form the basis of the author's thesis (Nuttall 2003).

³⁰In 1850, delivery records constituted 92.8 per cent of patient records found; in 1870, 97.9 per cent, and in 1912, 99.4 per cent.

³¹Patients Ednie and Ferrier, admitted 2 March 1870 (LHSA, Births Register [LHB3/14/2], entries un-numbered).

³²Evidently considered disqualified from entry in either Casebook or Register, these cases are recorded only in the final form of clinical record, the Special and Ordinary Casebooks (SOCB), which contain narrative accounts of unusual cases. [LHSA, LHB3/17/1-17].

³³For example, LHSA, 1912 ICB [LHB3/16/3], Professor Halliday Croom's quarter, case 134, BR600 [LHB3/14/7].

paper will be on the Indoor patients, the result of the richness of the sources, while the larger proportion of Outdoor patients, more conventional in their decision to deliver at home, serve as a comparison. The principal differences between the two populations were their age distribution, and the proportions of married and single. Changes in these indicate the altering function of the ERMH over the 62 years of this study.

Given that obstetric problems can affect any age from menarche to menopause, if the role of the Hospital had been primarily medical from the outset, one would expect the average age of the patients to conform to the Scottish data on maternal age at delivery (collected in 1855 only), and for Outdoor and Indoor patients to be similar in age distribution.³⁴ This is not the case. If the ages of all Outdoor patients in the four years studied are contrasted with the 1855 data (Figure 1), it can be seen that in 1850 they were younger, their peak child-bearing age being 20-25 years in contrast to a peak at 25-30 years in the national figures. However, in 1870 their age distribution pattern conformed to that of the 1855 census figures, although at a lower level. Thus, whilst Outdoor peak child-bearing age was also 25-30 years, only 24 per cent of 'dispensary' mothers fell into this category. By 1890, 30 per cent did. Such closeness to the norm suggests that by then the 'dispensary' was delivering a typical population of parturient women. This trend was maintained in 1912, when 27 per cent of Outdoor patients were aged between 25 and 30.

When the exercise was repeated for all Indoor patients, it was found that they were consistently younger than the national average. However, this was not just the result of the high proportion of single inmates: married women who used the ERMH between 1850 and 1890 were also younger than average, as shown in Figure 2. Although by 1890 they conformed to the census pattern, peaking at 25-30 years, an excessive number were still younger than the norm.³⁵ Only in 1912 did the age distribution of married patients approach the norm as represented in the census, with the implication that it was only in the twentieth century that the function of the ERMH changed to become a source of medical care for all pregnant women, and not principally a provider of shelter for the poorest and youngest mothers.

Married women dominated the Outdoor Casebooks throughout. In 1850, 64 per cent were recorded as 'Mrs'; by 1912, 100 per cent of those in the 'main dispensary' book, and 97 per cent of those in the Leith Students' External Casebook (hereafter SECB) were so entered, the convention in the Leith SECB of giving both the mother's name and her married title ('Kate Lynch, Mrs Campbell'), suggesting that this was not merely courtesy.³⁶ Indoors, the reverse was the case, and single patients predominated until the twentieth century. In 1850, 58 per cent of patients were unmarried, and in 1870, 74 per cent. However, by 1912, only 48 per cent were unmarried, and this decline in the proportion of single in-patients, with its corresponding rise in married in-patients, is a major indicator of a change in the Hospital's function.

Despite their minority status for much of the period under consideration, this paper focuses on the changing experiences of married Indoor patients in the four years surveyed. During the nineteenth century, almost all married women delivered among their family, typically in

³⁴Census of Scotland 1871, Vol. II, pp. lxiii-lxvii, especially Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855 . . . and the percentage at each age'. The amount of information required was reduced in 1856, as local registrars were over-burdened (Sinclair 2000, p. 40). Nonetheless, these are the only nineteenth-century British data on the age of mothers at delivery (Anderson (ed.) 1996, p. 300).

³⁵The census data showed that 19-22 per cent of married mothers were in the age range 20-25 years. At the ERMH in 1890, it was 31.5 per cent. Further, only 2 per cent of married Scottish mothers were aged less than 20, but at the ERMH, the figure was 5 per cent.

³⁶This was done for 353 of the 474 presumed married patients. However, the alternative mode, 'Kate Lynch or Campbell', used on 37 occasions, is less clear. A further 84 had only their married name entered, whilst an additional 17 had no title and have been considered to be single.

their own home: to undergo hospital delivery was so unusual it implies the existence of a definite and identifiable motive for so doing. This paper suggests that such motives indicate patients' expectations of the Hospital and therefore its likely role. In contrast, the motives of single women must always be unclear. Their position in Scottish society became increasingly marginal as the national illegitimacy rate fell, whilst they remained as vulnerable to obstetric problems as any other patient.³⁷

The data on the 93 married women who attended the ERMH in 1850 show that its charitable role was dominant: most came for social reasons. Although half the population of Edinburgh in the 1850s were immigrants, they constituted three-quarters of the Indoor married patients, 82 living in the city at the time of their admission. A quarter were Irish, the wives of 'navigators' unable to return home due to the famine.³⁸ Their presence highlights the accuracy of the Directors' claim that the Hospital's clientele came from the poorest in society, and from those who had no local family support to call on during labour and the puerperium. In contrast, half of the Outdoor patients traced were Edinburgh natives.

Evidence of patients' family background further suggests that lack of family resources and support contributed to their admission. Throughout the entire period studied, patients at the ERMH were almost uniformly poor in origin. Although rare examples such as Jane Grierson, a doctor's daughter who had an illegitimate child in May 1850, stand out, the majority of patients, married and single, were the daughters of labouring men, often, like Dr Grierson, already dead.³⁹ These women married men in similar occupations to their fathers', continuing to be poor and without resources.

In addition to lack of family support, almost half of the married in-patients gave a different address for their husband, whilst five did not know his whereabouts at all. Some were separated by the husband's work: Alexander Mercer, a 'Hardware Merchant', was in 'Kelso, en route for Tranent'; four men were 'at sea'.⁴⁰ Three husbands were absent for other reasons: one was in Calton Prison,⁴¹ whilst two were themselves in-patients.⁴² The overwhelming impression is that married in-patients were prevented from having a conventional lying-in in their own home by broken relationships, family mobility, ill-health and poverty, and that the Hospital met this need. The husbands of traced Outdoor patients had more settled occupations, while three couples lived with other adults, giving them access to additional domestic support. For example, Philip and Margaret Clark, both Edinburgh-born, lived in Scott's Entry with their two children, her sister (a house servant), and a lodger,⁴³ whilst Thomas and Margaret Clifford, from Ireland, lived in Blackfriar's Wynd with their son and her widowed mother.⁴⁴

The domestic circumstances of the married in-patients resident in Edinburgh in 1850 suggest very strongly that their selection of the Hospital was based on their lack of family ties and support, an interpretation reinforced by the low take-up by Edinburgh-born women. It has been observed that using hospital or dispensary care potentially gave poor women free access to the foremost obstetricians in the city, but this does not explain the decision to become an Indoor rather than an Outdoor patient, given that both could call on senior doctors for medical help.⁴⁵ Fears about childbirth may have played a part in the decision to

³⁷Smout 1986, p. 173, Table 7: in 1861-5, 9.79 per cent of live births were illegitimate: by 1911-5, the figure was 7.21 per cent.

³⁸Thorburn 1851, pp. 6-7, Table XV, pp. 40-1.

³⁹LHSA, 1850 ICB [LHB3/16/A], case 2050, BR731 [LHB3/14/1].

⁴⁰LHSA, 1850 ICB [LHB3/16/A], case 2197, BR863 [LHB3/14/1].

⁴¹LHSA, 1850 ICB [LHB3/16/A], case 2062, BR747 [LHB3/14/1].

⁴²For example, LHSA, 1850 ICB [LHB3/16/A], case 2199, BR873 [LHB3/14/1].

⁴³LHSA, 1850 Outdoor Casebook (OCB) [LHB3/18/2], case 3279; *Edinburgh Census 1851*, Volume 723, Enumeration Book 2.

⁴⁴LHSA, 1850 OCB [LHB3/18/2], case 3144; *Edinburgh Census 1851*, Volume 728, Enumeration Book 5.

⁴⁵Quiroga 1989, pp. 44-6; Leavitt 1986, pp. 74-7.

attend the Hospital, but the evidence suggests a minor role for this compared to social circumstances.

11 married in-patients had no recorded Edinburgh connections and seem the group most likely to have come to the ERMH seeking obstetric help. However, even here social need appears dominant. Five women were not living with their husband, while only two had sad obstetric histories. Catherine Linch, a 40 year-old Irish-born collier's wife from New Lanark, had borne one child and miscarried nine: she delivered a live boy after a short labour.⁴⁶ Catherine Seymour, aged 26, from a Newcastle address, but born in Burton-on-Trent, had had three miscarriages before she delivered a stillborn daughter in the Hospital. However, Richard Seymour, printer, was recorded as living in Kingston-upon-Hull, and this separation surely contributed to his wife's use of the ERMH.⁴⁷

Obstetrically, there was little difference between the Indoor and Outdoor married populations. Using the labour classifications employed in the Casebooks, those Indoor patients living outside Edinburgh were least likely to deliver normally (82 per cent).⁴⁸ This is, however, an anomaly, resulting from the ambiguous way data were recorded, rather than a reflection of any search for obstetric care. Indoor patients resident in Edinburgh were most likely to deliver normally (92 per cent), there being a higher rate of preterm births among Outdoor patients. One instrumental delivery took place among the married Indoor patients, in contrast to three Outdoors. Again, the circumstances combined social and medical needs, the mother being the primigravid wife of Thomas Hutchison, himself a Royal Infirmary patient.⁴⁹ Chloroform was recorded as being used twice, both times Indoors. The combined medical and social data of married patients in 1850 overwhelmingly indicates that the Directors were correct to emphasise the Hospital's charitable role: its medical role was minimal.

The troubles that the ERMH underwent during the 1860s, including closure due to puerperal fever in 1869, reduced the number of patients who attended in 1870, and only forty married women were admitted. Immigration was a less noticeable feature. Nonetheless, 23 were born outside the Edinburgh area, with the implication that they lacked local family support. Although the Births Register no longer recorded whether the woman's father was still living, entries show that half the women were separated from their husbands, sometimes through employment: William Reddy, for example, was the House Steward at Lisfallen House, Perthshire.⁵⁰ The whereabouts of four husbands were unknown, the wife of one being admitted from the Canongate Poorhouse.⁵¹ As in 1850, those Outdoor patients traced appear to have had more stable lives: only one spouse had an occupation likely to lead to separation. In addition, six families shared accommodation with other adults or their own older employed children, suggesting access to more domestic support.

In keeping with its continued charitable focus, obvious medical reasons for admission to the ERMH were rare: as in 1850, there was little obstetric difference between Indoor and Outdoor married patients. Labour was more likely to be classified as normal Indoors (94 per cent), although this is largely the result of 20 Outdoor labours being unclassified, and a higher rate of recorded preterm deliveries in the 'dispensary'. As in 1850, there was

⁴⁶LHSA, 1850 ICB [LHB3/16/A], case 2167, BR841 [LHB3/14/1].

⁴⁷LHSA, 1850 ICB [LHB3/16/A], case 2055, BR735 [LHB3/14/1].

⁴⁸These were: 'normal'/'natural' (cephalic presentation, labour completed within 24 hours); 'laborious' (cephalic presentation, labour in excess of 24 hours), subdivided into 'lingering'/'tedious' (ending in a natural birth), and 'instrumental'; 'pretermatural' (breech or trunk presentation); and 'complex' (complications on the part of either the mother or child, including multiple pregnancy).

⁴⁹LHSA, 1850 ICB [LHB3/16/A], case 2024, BR686 [LHB3/14/1].

⁵⁰LHSA, 1870 ICB [LHB3/16/A], case 1706, BR-, admitted 31 May 1870, [LHB3/14/2].

⁵¹LHSA, 1870 ICB [LHB3/16/A], case 1637, BR-, admitted 25 April 1870, [LHB3/14/2].

one death among married women. Three Edinburgh-born Indoor patients had cause for anxiety, such as ante-partum haemorrhage or prematurity, as did a proportionate seven Outdoor cases. Mrs Stewart, born in the Canongate, and admitted in her fourth pregnancy, was 'artificially induced . . . & delivered by turning', which suggests she had a severely contracted pelvis.⁵² Nonetheless, there was little obstetric difference between those Edinburgh residents delivered in their own homes, and those delivered in the ERMH. Most were in-patients for social rather than medical reasons.

In contrast to 1850, only three married women entered who had no Edinburgh connections. One, Mrs Mary Black, a 38 year-old watchmaker's wife from Marykirk, was admitted from Dalkeith Poorhouse, the result of the ERMH's prior arrangements with local poorhouses.⁵³ Nine days later mother and son were sent back, extreme illustrations of the argument that the married patients who used the Hospital were principally the victims of social disruption and poverty that prevented them from delivering at home. However, the other two women living outside Edinburgh had real cause for anxiety, and appear to have sought admission for medical reasons. Both were expecting their fourth child, had no living children, and anticipated problems at delivery. Mrs Boyle, 24, a labourer's wife from Glasgow, had lost three previous children in infancy:⁵⁴ she delivered a live son on 29 April, but at discharge on 6 May the baby was described as 'not expected to survive the day'.⁵⁵ Mrs Airey, 28, an engineer's daughter, came 'from Penrith to be prematurely delivered in consequence of contracted pelvis'. Following induction she laboured for '3 to 4 days', until 'Dr Keiller dilated Os artificially, turned and extracted' a stillborn daughter.⁵⁶ These two women, together with Mrs Stewart, are the only married patients it is possible to identify clearly as being in need of skilled obstetric help and using the Hospital to access it. Despite the involvement of senior medical staff in these cases, the overall impression is that in 1870 the ERMH was still a place of social rather than medical care, and that, for its inmates, 'hospital admission was only one symptom of a more fundamental social ailment'.⁵⁷

Between 1870 and 1890 there were considerable changes in the Hospital. Routine medical involvement was ensured by senior individuals taking responsibility in rotation; an antiseptic regime was adopted in 1881. Its educational role expanded as Edinburgh's medical schools grew: in 1870, 27 medical students had attended cases, but 180 were recorded in 1890; the number of nurses in training doubled over the same period. The 1891 appointment as Matron of Miss Edward, previously a Royal Infirmary staff nurse of 'great and varied Hospital experience',⁵⁸ further indicates the direction the ERMH wished to take. Instrumental intervention in labour was deployed earlier, the result of the development of more effective forceps, and of an increasingly pro-active attitude among doctors,⁵⁹ and this was to the benefit of both mothers and babies. The casenotes indicate that a longer rest after delivery was now encouraged, in keeping with the advice for the puerperium expressed in a series of public health lectures given in 1881.⁶⁰

Despite these organisational changes, there was little alteration in the social circumstances of the Hospital's married in-patients, of whom there were 86 in 1890. 51 were not natives of Edinburgh or Leith, including six living outside the city, and two with no recorded connection. The new Births Registers no longer contain information about the woman's own

⁵²LHSA, 1870 ICB [LHB3/16/A], case 1599, BR-, admitted 5 February 1870 [LHB3/14/2].

⁵³LHSA, 1870 ICB [LHB3/16/A], case 1720, BR-, admitted 3 August 1870, [LHB3/14/2].

⁵⁴She may also have had social problems: her husband's address is 'dashed', and not recorded.

⁵⁵LHSA, 1870 ICB [LHB3/16/A], case 1643, BR-, admitted 29 April 1870, [LHB3/14/2].

⁵⁶LHSA, 1870 ICB [LHB3/16/A], case 1615, BR-, admitted 5 March 1870, [LHB3/14/2].

⁵⁷Rosenberg 1987, p. 118.

⁵⁸LHSA, 47th ARERMH [LHB3/7/47], 1891, p. 7.

⁵⁹Nuttall 2006.

⁶⁰Edinburgh Health Society 1881, pp. 115-38.

family, or a separate address for her husband. However, the husband's occupation was still recorded, and for the first time there was a major difference in the domestic circumstances of women born inside or outside the city. Almost a third of spouses of non-natives were engaged in occupations where accommodating a home delivery might be difficult,⁶¹ in contrast to only three of those married to Edinburgh-born women. As in earlier years, their wives were using Hospital care to replace the family support lost through distance or employment. In contrast, the husbands of families traced from the Outdoor Casebook had more settled employment, while three couples shared their homes with other adults: either a boarder, or their own employed children. Unlike many married women Indoors, Outdoor patients had easy access to adult and family support.

As in 1870, very few married in-patients had no recorded connection with Edinburgh, the women most likely to have an obstetric motive in attending the ERMH. Mrs MacLachlan, 27, born in and living in Linlithgow, came in her sixth pregnancy to be induced prematurely for a known rickety pelvis: her son died.⁶² In contrast, Mrs Bell was an English-born actor's wife, currently living in Dunfermline, who delivered without problems.⁶³

Although Indoor married patients remained atypical of the childbearing population as a whole, an early indication of the shifting role of the Hospital can be seen in the growing number of local-born women clearly admitted on medical grounds. This is apparent when the degree of perceived maternal anxiety shown by Indoor and Outdoor local residents is compared in those cases where the mother and her 'friends' were conscious of possible complications.⁶⁴ In 1890, 11 of the 80 Indoor married inmates resident in Edinburgh or Leith had reason for anxiety (14 per cent), compared with only 3 per cent of married Outdoor patients (17 out of 593). Six were referred to the Hospital by an outside doctor, the first time this practice has been noted. Further evidence of nascent change in local understanding of the purpose of the Hospital can be seen when the Edinburgh-resident Indoor married patients are compared according to their place of birth. Reasons for maternal anxiety were more common among Edinburgh-born Indoor married patients (six instances among 35 women, 17 per cent), than among those born outside Edinburgh but now resident (five instances in 45 women, 11 per cent). Such cases were markedly more common than among Outdoor patients (3 per cent).

Nonetheless, the 'anxious' group was small, and most patients did not see the Hospital as a medical resource. For example, when Mrs Moffat suffered uterine rupture and the attending doctors '[t]ried . . . to get her removal to hospital . . . neither she nor her relatives would allow it'.⁶⁵ There was no differentiation in treatment: more Outdoor patients had serious delivery problems, yet were still treated at home.⁶⁶ Hospital publicity material recognised this continuing suspicion, and, even when fund-raising for separate accommodation for married admissions, stressed the care given to domiciliary cases.⁶⁷ Married women born outside the city, the larger sub-group of in-patient Edinburgh residents, persisted in seeking admission for social reasons. 16 were delivering their first baby (37 per cent), with the husbands of ten potentially employed away from home, but the women's good health indicates that they were using the Hospital as a substitute for the social support of their

⁶¹Eight were soldiers, four in domestic service, two were 'travellers', whilst one was an actor.

⁶²LHSA, 1890 ICB [LHB3/16/2], Dr Berry Hart's quarter, case 38, BR64 [LHB3/14/4].

⁶³LHSA, 1890 ICB [LHB3/16/2], Dr Halliday Croom's quarter, case 35, BR218 [LHB3/14/4].

⁶⁴Typical complications included ante-partum haemorrhage, prematurity, cardiac disease, or eclampsia. The general change in approach to the management of labour which took place between 1870 and 1890 (Nuttall 2006) means that intervention at delivery cannot be used as a reliable indicator of increased medical need.

⁶⁵LHSA, 1890 OCB [LHB3/18/5], Dr Underhill's quarter, case 34; 1890 SOCB [LHB3/17/6] p. 76.

⁶⁶These cases also included two abdominal operations, and a placenta praevia; difficult cases handled Indoors included two placental presentations, and one uterine rupture.

⁶⁷LHSA, 48th ARERMH [LHB3/7/48], 1892, p. 9.

family.⁶⁸ Although by 1890 the ERMH had adopted many of the trappings of a general hospital, its patient records suggest that its role was unchanged, and that most patients still used it as a substitute for family support. Only a small group had begun to turn to it for obstetric assistance and care.

The ERMH continued to develop between 1890 and 1912. All senior staff were associated with either the University or Extra-Mural Medical Schools. Its midwifery training programme was approved by the new Central Midwives' Board for England and Wales, and the numbers of such pupils increased. However, its long-established method of teaching practical midwifery to medical students had been robustly criticised by one of its own assistant physicians, Robert Milne Murray, and by 1912 medical students attended indoors for a month, and then spent two months in one of Edinburgh's many dispensaries, now administratively linked to the ERMH.

In 1908 Milne Murray's widow similarly criticised the in-house care the Hospital gave, claiming that the food was poor, treatment was both grudging and public, and therefore that patients were reluctant to attend.⁶⁹ The Directors responded by declaring their intention to address any problems and to expand the medical aspects of the Hospital.⁷⁰ Mrs Milne Murray's criticisms illustrate the growing public interest in improving the childbirth experience of all poor women. Both local and national government shared her concern, although their primary focus was rather the survival and health of newborn infants: from 1907 the Hospital was required to notify the Edinburgh Public Health Department of all the births its staff attended, to make future health surveillance possible. As a result of notification, in 1912 the Medical Officer of Health could report 6,700 live births in the city, of which 2,200 were attended by charities.⁷¹ The ERMH was a major player, providing almost two-thirds of charitable attendances. Indoors and Out, in 1912 the ERMH recorded 1,442 cases in Edinburgh alone.

The data from 1912 suggest that the medical role of the Hospital was expanding. It has already been shown that the ages of married inmates now conformed to the national data, and that the number of married women using the ERMH had increased to outnumber the single. Married patients were still equally divided between those who were Edinburgh-born and those who were not, but, in contrast to earlier years, approximately a quarter of those who were born outside Edinburgh still lived outside the area. This group suffered an extremely high proportion of obstetric problems. Social reasons for admission had declined markedly, with the husband's occupation becoming a less decisive factor. Only eighteen of those men whose wives were born outside Edinburgh (11 per cent) had occupations where accommodating a confinement might have been difficult, but, in contrast to 1890, thirteen of those whose wives were Edinburgh-born had similar occupations. In 1912, unlike the earlier years studied, there was scant evidence of social distress among married Indoor patients: for Mrs Henry to be admitted by reason of poverty alone was manifestly anachronistic.

There was now differentiation in the treatment of Indoor and Outdoor married patients. Among Edinburgh residents admitted to the Hospital, the intervention rate at delivery was 20 per cent; in the 'main dispensary' it was 3 per cent, whilst in Leith it was 2 per cent. Even more telling, no serious problems were tackled Outdoors, but the patients were transferred to hospital without any recorded objection, and no mother died at home. Maternal ill-health was recorded in only four Outdoor cases. Overall, the Outdoor services were now geared to

⁶⁸Only 11 of those born in Edinburgh were primiparae (31 per cent), three of whose husbands were likely to be absent.

⁶⁹Murray 1908 [LHB3/26/6].

⁷⁰Middleton and Robertson 1908 [LHB3/26/7].

⁷¹Williamson 1913, pp. 17-18.

treating well women in labour and the puerperium, and transferred to in-patient care those patients who did not meet this description.

The change in function of the ERMH is also seen in the increase in married in-patients who were resident outside Edinburgh, the great majority of whom now had serious health problems. In 1912, there were 45 patients in this category, 14 per cent in contrast to 7 per cent in 1890, when only one of the six non-residents had an obvious medical reason for admission. In 1912, only five of the 45 had no recorded problems. Their data are very distinctive, and indicate the obstetric need of the women, and thus their presumed reason for admission. The intervention rate in this group was 71 per cent, compared with 20 per cent among in-patients resident in Edinburgh. Chloroform was used in 29 per cent of their cases, compared with 5 per cent in the case of other inmates, and less than 2 per cent Outdoors. Unsurprisingly, reasons for maternal anxiety can be found in 60 per cent of these women, in contrast to 8 per cent of other in-patients, and less than 4 per cent of Outdoor patients.

Despite the presence in this group of five women for whom the ERMH must have been their last hope of having a live child, more than a quarter were primiparae. However, in contrast to 1890, even these women appear to have sought admission on medical grounds: only two delivered without problems. For example, three were eclamptic, and two suffered from contracted pelvis, Mrs Roberts being admitted from Linlithgow 'after labour had lasted for 3 days'.⁷² Mrs Murdoch of Kinlochleven suffered from chorea gravidarum and died the night after her admission.⁷³ Overall, a quarter of patients resident outside Edinburgh died in the Hospital, when the maternal mortality rate among other in-patients was 3 per cent. Their perinatal mortality rate was 58 per cent, compared with 17.5 per cent among Edinburgh residents Indoors, and approximately 4.5 per cent Outdoors.

The evidence of married patients' backgrounds also suggests a widening social range of patients at the ERMH, compatible with its increasing medical role. Whilst the majority of spouses continued to come from 'the industrial class', 16 per cent were now categorised as 'commercial'. Seven wives of clerks were admitted, all as emergencies. For example, clerk's wife Mrs Gillespie of Morningside was described as 'healthy & athletic. . . . [P]erhaps overdoes (!) golf as a sport. . . . [A]lways jolly . . . leads a regular life'. She had engaged both her family doctor and a 'trained nurse' for her confinement, but when she developed '[f]its associated with pregnancy', Dr Martin arranged her admission.⁷⁴ Her case not only shows that illness was forcing those who would not normally have considered using the ERMH to do so (the result of increasing use of more intensive treatment), but also that it was becoming a resource for health professionals in Edinburgh and beyond.

Until the early twentieth century, the Hospital's purpose had been defined, not by the presence of the poor, but by the almost complete absence of the obstetrically needy. By 1912, this had changed, and medical reasons for admission had increased amongst the married women in-patients. Comments from the casebooks also suggest that the Hospital now had a reputation as a centre of expertise in Scotland to which general practitioners could refer difficult cases routinely. The ERMH had moved from providing shelter for married women unable to organise lying-in for themselves, to supplying a significant minority with necessary medical care that they could not provide independently.

⁷²LHSA, 1912 ICB [LHB3/16/3], Professor Halliday Croom's quarter, case 29, BR485 [LHB3/14/7]; 1912 SOCB [LHB3/17/13], pp. 210-11.

⁷³LHSA, 1912 ICB [LHB3/16/3], Dr Haultain's quarter, case 49, BR122 [LHB3/14/7]; 1912 SOCB [LHB3/17/13], pp. 42-4.

⁷⁴LHSA, 1912 ICB [LHB3/16/3], Dr Haultain's quarter, case 117, BR485 [LHB3/14/7]; 1912 SOCB [LHB3/17/13], pp. 90-2.

Conclusions

The ERMH casebooks are a rich source, and provide clear evidence of the Hospital's changing function between 1844 and 1912. They show that a shift from a social purpose to a medical function occurred in maternity hospitals, just as it had in general hospitals. However, whereas in general hospitals the shift was directly associated with the development of antisepsis, professional nursing and surgery, for the ERMH at least, it was not chronologically linked to advances in technology. Instead the change in function appears to have occurred 20 years after either the beginning of increased intervention, or the introduction of antisepsis: in 1890 the ERMH presented itself as a medical institution, but its patients continued to perceive it as a place of shelter. This discrepancy had gone by 1912.

Clearly this raises the question of what did bring about the actual change in function at the ERMH, if it were not the direct result of improving technology. The new chronology suggested by the casebook data implies that the true development of its medical function should rather be linked with the changes in attitudes to child health and maternity care which occurred in the early twentieth century. Ultimately these attitudes would find public expression in the published research of the Co-operative Women's Guild, and in the introduction nationally of local maternity and child welfare schemes in the years following the Great War.⁷⁵ The change in the role of the ERMH from the beginning of the twentieth century perhaps suggests that it was making an early (and entirely charitably-funded) contribution to the expansion of maternity care which would become so important in the inter-war period, although clearly this is an area which would require further research.

This paper has also sought to employ personal health records as the principal source for the history of the ERMH, and to give them a greater role than merely a source of local colour. Their use undoubtedly restores the importance of its patients to an institution, if not suggesting that their actions can shape its behaviour, at least showing the reality of its care. In addition, they reveal popular attitudes to childbirth, and its persistence as a social rather than a medical event, even in a city famous for its medical associations. However, at the ERMH casebook data have provided much more. They have suggested an alternative chronology for the development of the Hospital, at variance with any conclusions that might be reached about the Hospital's purpose based on its administrative history, the careers of its medical staff, or its location in a city with a long medical tradition and a large medical school.

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⁷⁵See, for example, Llewellyn (ed.) 1915; Lewis 1980; Lewis in Garcia et al. (eds) 1990.

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Fig. 1.

The ages of ERMH outdoor patients, 1850-1912, compared with 1855 data collected from all mothers. *Sources:* ERMH Outdoor Casebooks, 1850, 1870, 1890, 1912; 1871 Census of Scotland, Table XIX, 'Number of Mothers at Each Quinquennial Age . . . '.

Fig. 2.

The ages of ERMH indoor married patients, 1850-1912, compared with 1855 data collected on age at delivery. *Sources:* ERMH Indoor casebooks, 1850, 1870, 1890, 1912; 1871 Census of Scotland, Table XXII, 'Number of Married Women at Different Ages who bore . . . '.