
Writing the Women's—hospital history with medical records

JANET MCCALMAN

In 1992 I was commissioned to write a new history of Australia's oldest specialist women's hospital, the Royal Women's Hospital in Melbourne. The Board of the hospital was conscious of the institution's rich, even notorious history and of the limited public interest usually evoked by hospital histories. Before seeking an historian, the Archives Committee of the Board had resolved that the history should really be a social history of women's reproductive health as seen through the work of the hospital from its founding in 1856 through to 1996.

The project's scholarly potential, however, was determined by the astonishing archive of detailed patient medical records which have survived since the 1850s. Dr James Evans, the hospital's historian, knew the riches of the hospital's archives, especially of the medical records; and the committee, in planning for a history had first commissioned Dr Therese Radic to undertake a feasibility study of the raw material. Therese Radic found herself in gas-mask and veil, or at least surgical gown and mask, being led on to the roof of the services block. There stood a small room, a cubby hole. The door had a generous gap—which probably prevented damp—and leaves and dust and rubbish blew in. Inside, half in bound volumes, half unbound and falling out, were over 14,000 gynaecology case histories, one of the best collections so far found in the English-speaking world. The hospital then appointed an archivist, Robyn Waymouth, who was therefore a part of this project from the beginning.

This archive was remarkable because the records were made in the first place: this was to be an Antipodean Edinburgh Maternity Hospital

and by 1866, a university teaching hospital. Its founders, Richard Tracy and John Maund, were products of the Irish and Scottish teaching hospitals and both had studied *clinical medicine in Paris*. The midwifery records comprise the oldest, largest and most detailed collection in our region and among the oldest in the New World.

Even more remarkable are the detailed gynaecology case records from 1883 to 1936, many giving detailed nursing notes such as have rarely survived elsewhere. Even those which have been preserved, are in very much smaller hospitals than was Melbourne's Women's Hospital, which became a big hospital within two decades of it founding. Finally, there is a wonderful collection of over 3000 records of home births conducted by medical students under the supervision of the District Nursing Society (now the Royal District Nursing Service.) The audience was the student's fellows, the character at the centre of the drama, the student and not the patient, and the genre was mock heroic. They are an astonishingly candid record of the experience of giving medical care rather than of the process; and at a time when a student's examination result in English at Leaving Honours was the best predictor of future academic success in Medicine, they are literary gems. They are also potentially embarrassing for descendants of the working-class families whose intimate lives and personal habits are so graphically revealed.

It was therefore looked possible to write the history of a hospital at work, of the patients and their treatments, of the staff and their practice, of the culture of the hospital, and of the progress of medicine from the dawn of anaesthesia to IVF and HIV AIDS. It was also possible to make this a history of women in Australia, revealing a level of sickness and suffering such as rarely glimpsed in conventional sources. This study had the potential to add a new biological story to the history of women in this country.

Much of the history of this old, and at times, great women's hospital is painful, embarrassing, even shameful. It has been charged with doing the 'dirty work' of women's health which other hospitals shrink from. But a history was not worth doing at all unless it was an exercise in examining the past in order to improve the future. It provided an opportunity for reflection and many staff, both old and new, have participated in this taking stock. In the end, however, it has been the historian who has learnt most.

The hospital and the historian

It needs to be said at once, that this history was only possible because of the vision of the old Board of the Royal Women's Hospital. Its Archives Committee understood what history is about and can achieve. A history was not worth doing if it didn't contribute to public discourse about women's reproductive health and the place of publicly-funded teaching hospitals. The Board was anxious that I wouldn't search only for causes for indignation and frame the history entirely in medico-patriarchal conspiracies. They already had had a taste of that and had been alarmed.

Their concerns about hurting the living and the relatives of the recently dead were not unreasonable, at least to me. I had already written two books about the living in the knowledge that my subjects would be reading about themselves in print. There is no question that when you write about the living, your hands are tied. If critical things have to be said, then they must often be couched in generalities and with courtesy, so as to save the face of the unfortunate held up for public scrutiny. Often, past professional shortcomings—such as rudeness to working-class patients, indifference to patients' feelings and rights to consent—were not considered unprofessional behaviour at the time. More seriously, one becomes aware of practices and individual standards which, if revealed, might cause pain for former patients or give grounds for the contemplation of litigation. Obstetrics is a litigiously fraught area of medicine and discussion of fashions in the use of forceps, for instance, have to be careful—certainly I decided not to use certain oral evidence about high forceps deliveries out of prudence. One difficult issue was the general refusal of senior obstetric staff in the 1950s and early 1960s to perform caesarean sections on unmarried women—lest they have a 'scar' which signified their sinful past or might compromise a fresh start to motherhood and a subsequent vaginal delivery. A couple of informants had no doubt that was an attitude amongst some staff that unmarried women should 'sweat it out' to teach them a lesson. The issue that really bothered me was that there was a period when senior staff competed as to how long they could keep a patient in labour—three, four days—and it was only the consultant anaesthetist who protested that this could be to the detriment of the babies: 'You only had to do the arithmetic' he complained and he was banned from the unit.

All of this was worked through with the Archives Committee which became my support group through thick and thin. Many of them

were involved in the research either as oral informants or in the diagnosing of case histories and discussion of issues both medical and administrative. I did not have to submit drafts for continuous approval, but they did all read the completed manuscript and commented on it. They were clear in what they didn't want and even gave me copies of other hospital histories as examples of what NOT to do. They never wavered in their commitment to history as truth-seeking, even when that truth-seeking might be painful. The history had to examine the past in order to improve the future and I know that the book is now used and discussed within the hospital in policy meetings. The history has become part of the modern hospital's culture: a reminder of what they once achieved, of the value of clinical medicine and accountability and of their continuing mission to women.

Patient confidentiality

If I were to use patient records, then the problems of patient confidentiality were crucial. Unfortunately the law in the State of Victoria is less than helpful. When I began the project, the rule was open access to adults' records after seventy-five years, and to children's after one hundred. However, that rule now seems to have lapsed and access to records has become more ambiguous and difficult. Historians may seek dispensation from restrictions for projects of high scholarly value which are conducted under strict guidelines, just as medical researchers may; but access to patient and client records for both medical and social researchers is now clearly a matter for hospital and university ethics committees. Each case has to be considered on its scholarly merits and guidelines have to be policed. This may well mean submitting all written work from the research for scrutiny.

Even when I believed I was covered by the 75-year rule, I resolved not to use patient names. I have learned from past experience that Melbourne is still a very small town with a relatively stable population by international standards. While many immigrants come, once here, they mostly stay. Your potential readers always include direct descendants of patients and thousands of enthusiastic family historians who trawl every new publication for a mention of an ancestor. Quite rightly, they would not appreciate (and neither would their grandmothers), having intimate gynaecological problems linked to the real name of the patient in the public record, let alone their syphilis or septic abortions. The only exceptions I permitted myself were the first deaths in childbirth and one I couldn't resist, 'Mrs Thunderbolt' from (where else) 'Walhalla'.

These problems become even more serious when you get into the twentieth century. The hospital preserved many of the case histories from the septic wards in the 1920s and early 1930s and this archive is of immense international significance in the history of infection, women's reproductive health, abortion, sexuality and the family. However it will be many years before the descendants of those patients cease to care about such revelations and access to them will need to be tightly policed. There is always a tension in scholarship between the need and right to know, examine and understand, and the individual's right to privacy and the protection of reputation. While we must respect individual rights, were we always do so, the whole process of public scrutiny and scholarly investigation which is essential to the protection of democracy, must not be compromised. There will come a time when historians will need to examine the medical records of the 1990s to evaluate the true impact of Casemix funding on patient care and well-being and here the individual rights of patients, practitioners, administrators and politicians have to be balanced against the community's right to know and judge.

The bad stories

Every worldly Melburnian knows that the 'The Women's' was always somewhat unsavoury. The Queen Victoria Hospital, run by women for women, did well out of its more respectable and genteel image in contrast to the earthy roughness of the Women's. Nurses still say that you hadn't seen life until you went to the Women's. 'The Women's' was 'where all the abortions went' although plenty also went to the Queen Vic. The Women's is where they 'do all the abortions now' even though that is only true of the immediate past and of the public sector. Termination of pregnancy is a service that most, apart from Pro-lifers, believe should be offered to women, but which too few are prepared to provide themselves. Again this was a story that had to be handled carefully: there is till a court injunction banning Right-to-Life movement from crossing Grattan Street to approach the hospital; there are still marches with banners telling the world that 'The Women's Hospital Kills Babies'; there were still members of staff whose identities need to be concealed lest they be harassed.

But most difficult of all was how to handle in print one of the most dramatic stories in the hospital's history: septic abortion in the 1930s and 1940s, and the epidemic of gas gangrene of the uterus caused by the *Clostridium welchii*. This was the hospital's finest and yet most stigmatising hour. It is the single most common form of remembrance

of anyone who worked there as a midwife or doctor, or studied as a pupil midwife or medical student from the early 1930s through to the end of the 1960s. Few of the rememberers actually saw a patient turning bronze, the purple blebs breaking out over her body, her urine port-wine from the haemoglobin blocking her kidneys, while a foul stench emanated from her bubbling insides; but they all feared it. That experience profoundly affected the non-Catholic medical profession in Melbourne, bringing most to support termination of pregnancy for social as well as medical reasons. A number of senior private practitioners were moved by what they had seen at the Women's to take the immense risk of providing non-therapeutic curettes for Victorian women until the *Menhennit* ruling of 1969. One such told me that he estimated that 60 per cent of his respectable middle-class private patients by the end of the 1960s had had a termination of pregnancy at some stage in their reproductive careers—usually for the unplanned fourth or fifth pregnancy in the typical baby-boomer family.

The septic abortion story was also one of the most fascinating and significant clinical science stories in Australian medical history. It had to be told properly and readers had to understand what it had really been like. The patient histories illustrated that more powerfully than mere description—how staff coped and why these cases had the long historical effect they in fact exercised. Here was an opportunity also to make clear what happens when termination of pregnancy is illegal and pushed underground. I did not, by contrast, publish the worst case histories of domestic violence and mutilation against patients, because the book was not about domestic violence: it was about reproductive medicine and the long struggle against puerperal and post-abortal sepsis is a central chapter in the history of women's health. These case histories illustrated the medical practice as well as the human suffering. None the less, I am careful recommending the book to students and warn them that parts are likely to distress them. I wouldn't set the septic abortion sections in class readers for university courses in history, for instance, only for biomedicine and health sciences students.

The audience

I had to write a book that would make a significant scholarly contribution to learning, but which also would communicate with the hospital's own constituency. I couldn't, therefore, write a book which

spoke to only a small community of scholars. Even then, which community of scholars was more important: history of medicine or history of women—they are very different. Should it be a local audience or an international audience?

The archive itself answered many of these questions. The scholarly value of the book had to lie in the use of the case histories: to discover what was happening to women's bodies from the mid-nineteenth century to the present day. The archive was vast: 14 000 gynaecology records from 1883 to 1936; and the total of midwifery records we analysed from 1856 to 1936 was over 70 000. (We are now using those midwifery records for a reconstruction of working-class life courses and social destinies from the 1850s through to the 1980s.) I decided to focus the book first on the medicine and the patients' health, and second on social relations, hospital culture, professional history and public history. My audience over time became clearer: primarily it would be people who worked in biomedicine: nurses, doctors, para-professionals and lay people with a strong interest in women's reproductive health. Historians of medicine would be interested and some others, but it was outside the normal boundaries of women's history, feminist history and even hospital history. I realised also that there was an international audience in the history of medicine, and that in this instance, the chance survival of all those patient records had made this book one which had something to say outside Australia. In other words, that archive has been a gift to posterity not just in this city, but also to the world.

University of Melbourne