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## The Uses of Patient Records by Historians—patterns, possibilities and perplexities<sup>1</sup>

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During the past two decades, more especially the last ten years, the use of patient records by historians has come into vogue. At the end of the 1970s, when I began a dissertation on 19<sup>th</sup>-century medical practice and started to think seriously about using hospital case histories in reconstructing clinical behaviour, models were all but non-existent. In retrospect it's clear that there were a lot of us grappling with what historical questions these records could aid us in answering; how to organise and analyse the potentially overwhelming mounds of information they offered—selecting a meaningful sample, or managing issues of confidentiality when no guidelines were dictated to us. Today, by contrast, I could use up my allotted time reciting an inventory of historical studies that have taken patient records as their cardinal source (which is *not* what I'm going to do).

Clearly one impetus to this transformation was the ascendancy of the 'new social history', with its quest for new types of sources in discovering the social experiences of the past. Another was the historical preoccupation with practice that grew so pronounced in the 1980s. Just as historians of science have turned to laboratory and field notebooks, so historians of medicine have turned to hospital patient records to reconstruct workaday activity at the bedside, autopsy

1. See Günter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient records in Medical History', *Social History of Medicine*, 5 (1992): 183-205 for a fuller discussion.

table, and clinical laboratory. So too, the creation of the clinical chart is increasingly being recognised by historians as itself an important medical practice, a constitutive part of clinical life that invites close attention. The new cultural history has redoubled attention to the patient chart as one resource in integrating a social history of ideas with an intellectual history of experience. And, not least of all, the literary turn in historiography has underscored the ways doctors and patients construct illness by telling stories about it, and patient records as illness narratives have joined the cultural history mainstream.

My task here, as I understand it, is to sketch some of the kinds of questions historians have been seeking to answer using patient records. How is it that they have come to be seen as indispensable to understanding the medical past and the creation of the medical world we live with today? I also want to stress that to extract historical meaning from these sources we have to use them in conjunction with other 'medical records'—some published, but many of them also archival texts, images, or artifacts. And deliberations about their preservation really can't be disentangled from questions about a host of other 'medical records'.

I'm going to skip over studies using 17<sup>th</sup>, 18<sup>th</sup>, and early 19<sup>th</sup> century records, as I'm assuming their archival management is not so problematic as for later periods (or differently problematic, at any rate). One could point to Michael Macdonald's use of Richard Napier's 17<sup>th</sup>-century case records and the compelling way it has illuminated healing, astrology, and contemporary views of madness.<sup>2</sup> Or one can cite the accounts of patient care the 18<sup>th</sup>-century New England midwife Martha Ballard inscribed in her diary, and the brilliant way Laurel Ulrich has used it to retrieve a world of women healers invisible in other records.<sup>3</sup> Offered 18<sup>th</sup>-century patient notes, though, I'm guessing most archivists would tell the donor, yes I do think perhaps I can find a home for them. It's later 19<sup>th</sup> and 20<sup>th</sup> century records, more daunting in their abundance, that, ironically, are more vulnerable to destruction.

Leaving aside demographic and epidemiological studies, the most extensive use historians have made of hospital patient records has been in reconstructing clinical activities. Underlying this labour is a recognition of the disparity that often exists between normative

2. Michael McDonald, *Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth-Century England* (Cambridge and New York, 1981).

3. Laurel Ulrich, *A Midwife's Tale*, (New York, 1990).

statements and actual practices. What textbooks and journal articles said clinicians should do is not a reliable index of what they actually did. By turning to patient records, we have a way of telling. Case reports published in journals are sometimes edited and always selective, but the selection criteria are not always clear: the archival record gives us inscriptions made closer to the bedside (as in an 1891 photograph taken at Bellevue Hospital in New York, showing a physician examining a ward patient and a nurse standing by holding the record book, waiting a daily update).

The questions asked might be simple: Did clinicians at a particular institution in 1837 routinely use the stethoscope in examining patients with pulmonary complaints? Or prescribe antitoxin for all patients diagnosed as having diphtheria in 1897? Or penicillin to febrile patients in 1957? More ambitious use of the records might inform a cross-sectional reconstruction of clinical behavior in 1897 or 1957, or trace the changing treatment of, say, pneumonia across this span of time.

Such research is neatly suited for cliometric analysis. Patient records are already broken up into discrete units or individual cases, each containing specific bits of information, such as age, sex, occupation, diagnosis, medical interventions, and laboratory tests. Coded and statistically evaluated, this information can produce baseline demographic and behavioral profiles, reconstructions of diagnostic and therapeutic behavior to which often the historian has no other access.

As a tool for studying medical culture, these records are proving to have their greatest utility in systematic explorations of the relationship between medical ideas and medical activities, between ideology and behaviour. Knowing what physicians did does not reveal what their behaviour meant. To draw meaning from these accounts of behaviour, they must be interpreted in the light of information from other sources, including published medical literature, lecture notes kept by students, minutes of clinical staff meetings, and so on. When patterns of change predicted by the medical literature and those discovered in patient records significantly fail to match up, that discrepancy invites historical attention.

From my own studies of hospital and general practitioners' records, it's clear that in the United States, physicians most fervently celebrated the importance of therapeutic bloodletting in principle at precisely the moment it was vanishing from practice. Bloodletting had taken on a powerful symbolic significance as an emblem of distinctive

traditions that set the orthodox profession apart from competing alternative healers. Only by comparing the changing status of bloodletting in the literature with its changing use at the bedside can one discern its transformation from being an important therapeutic option to being only a key professional symbol.

Challenges to explanation become even greater when the patient records reveal sharp, unanticipated changes. How to explain a sudden mid-19<sup>th</sup>-century upswing in bloodletting and other heroic therapies at a municipal hospital in Cincinnati, for example? In this case, it represented part of a complex response by physicians to a crisis of orthodox professional power and identity. But such an interpretation must grow from explorations of other archival sources, such as the hospital Board of Trustee Minutes; the diaries, daybooks, and correspondence of physicians practising there; notes their students took on clinical lectures; debates recorded in the minutes of local medical societies; and Faculty Meeting Minutes of the rival orthodox and botanic medical schools in Cincinnati that were vying for control of the wards.

Sometimes we can reconstruct the clinician's decision-making process. Stephen Jacyna, for example, has explored the checkered role of laboratory authority in late-19<sup>th</sup> and early-20<sup>th</sup> century clinical diagnostic and therapeutic decisions by systematically comparing surgical ward books with pathology journals from the Glasgow Western Infirmary.<sup>4</sup>

Representative of a kind of study grown common is Joel Howell's investigation of the introduction of diagnostic technology into the Pennsylvania Hospital and New York Hospital between 1900 and 1925. Focusing on the early use of x-ray machines and electrocardiographs, he demonstrated that what clinicians actually did with these instruments sometimes diverged from what was published in annual reports. By contrasting patterns of urinalysis, blood tests, and x-ray use at the two hospitals, he argues that local political cultures, not consensus about the usefulness of particular technologies for the care of the sick, accounted for the changing use of medical tests.<sup>5</sup>

4. L. S. Jacyna, 'The Laboratory and the Clinic: the Impact of Pathology on Surgical Diagnosis in the Glasgow Western Infirmary, 1875-1910', *Bulletin of the History of Medicine*, 62, (1988), 384-406.

5. Joel D. Howell, 'Early Use of X-Ray Machines and Electrocardiographs at the Pennsylvania Hospital', *Journal of the American Medical Association*, 255 (1986), 2320-3.

Howell used systematic sampling and never needed to look at the cases that fell outside his sample population. Sometimes, however, the researcher requires access to the entire run of records. Jack Pressman's book, *Last Resort*, which analyses the use of psychosurgery (or lobotomy) at a mental asylum in the 1940s offers one illustration. Pressman's research soon revealed that it is not enough simply to describe statistically the 'average' psychosurgery patient, for no insight can be found into the reasons why a particular patient was selected for this specific treatment. Closer inspection reveals differences in the patterns of psychosurgery use within each psychiatric diagnosis: in the schizophrenic population, surgery was performed on younger patients, while in the manic-depressive group, psychosurgery was performed preferentially on older patients. It is only by scrutinizing the daily entries of nurses' notes, however, that Pressman finds clues as to why doctors selected any given patient to receive a lobotomy.<sup>6</sup>

Because patient records document the behavior of physicians dealing with large and varied patient populations, they offer singularly rich access to knowledge about how such variables as ethnicity, race, class, gender, and geography shaped clinical behavior. Were certain ethnic immigrant minorities treated differently when they came to 19th and 20th – century dispensaries and hospitals? It's not surprising that in the American context they were, but clinical records help us define what this actually meant. Martin Pernick's study of the early use of anaesthesia in surgery revealed that at the Massachusetts General, doctors discriminated according to ethnicity, gender, and age. As Pernick perceptively observes, differences in treatment reflected the views of physicians who took pride in individuating their therapies. Surgeons articulated a social hierarchy of sensitivity to pain that decreed a middle-class, native-born, white woman should receive anaesthesia for the same operation that an Irish-born, male labourer would be better off enduring fully sentient, avoiding the risks of being anaesthetized. And such ideas were carried out in practice to the extent that at the Pennsylvania Hospital, during the decade after surgical anesthesia was introduced, while two-thirds of the

6. Jack Pressman, *Last Resort: psychosurgery and the limits of medicine*, (Cambridge and New York, 1998).

7. Martin Pernick, *A Calculus of Suffering: pain, professionalism and anaesthesia in nineteenth century America*, (New York, 1985)

immigrant labourer was a prime candidate) underwent amputation with no anaesthesia whatsoever.<sup>7</sup>

We can also learn about the broader experiences of sick or injured men and women. In a set of Melbourne hospital admission records, incidents that led the patient to the institution were consistently recorded in the first person narrative voice. In the instance of a man admitted in 1857, for example, his own account of the injury he incurred when, attempting to fix gas lamp, he slipped off the porter barrel on which he was standing, is followed only by the prescriptions ordered—a mercurial purgative on the 16<sup>th</sup> and a milder one on the 17<sup>th</sup>—and the notation that he was discharged cured. In other more discursive hospital records, we hear patients' stories about what brought them to the hospital (which often said less about physical symptoms than social circumstances) and about what they had done for themselves therapeutically (such records offer a splendid wedge into working-class health beliefs, notions of disease causation, and medical self-help practices). Equally, we can learn about how hospital inmates were regarded by clinicians, who often made their subjective, judgmental, sometimes disturbing reactions part of the clinical history.

Patient records also provide a window into the wider conditions of social life. The way in which Janet McCalman is now using birth weight data from Melbourne's Women's Hospital records which reveal staggering levels of malnutrition among women in Victoria during times of economic depression, is an elegant example of how patient charts can help recapture otherwise elusive realities of daily life.<sup>8</sup> Diana Wylie has used mid-20<sup>th</sup>-century patient records at a rural South African hospital to reveal seasonal variations in the admission of infants for malnutrition. Taking this as a starting point, she goes on to show how disruptions in infant feeding indicated more fundamental disruptions in traditional farming practices and living arrangements that changed the nature of women's work.<sup>9</sup>

Perhaps the least explored use of patient records is to elucidate the process of clinical creativity. How, out of the protean signs and symptoms patients displayed, did clinicians actually select those deemed 'significant' in making diagnostic distinctions, such as separating typhus

8. Janet McCalman, *Sex and Suffering*, (Melbourne and Baltimore 1998, 1999).

9. Diana Wylie, "The Ignorance of Mothers" and the Health of Children in Twentieth Century Pondoland", paper for discussion at University of London Institute of Commonwealth Studies, postgraduate seminar on 'The Societies of South Africa in the 19th and 20th Centuries, London, 4 May 1989.

and typhoid fever? The published record tells us much, but clinical case histories can give new clues about the production of clinical knowledge as in Jacalyn Duffin's study of clinical epistemology that traces how Rene Laennec's medical ideas grew from his bedside experience.<sup>10</sup>

While the patient records historians most often have studied come from institutional sources (hospitals, asylums, outpatient clinics) those kept by individual general practitioners equally warrant attention and preservation. Hospital case books represent a collaborative endeavour, whereas those from home or office practice document the work of a single practitioner, sometimes making it easier to discern consistent patterns. Jacalyn Duffin has used the exceptionally complete set of daybooks and account books kept by one general practitioner near Toronto between 1847 and 1875 to trace through over 26 000 doctor-patient encounters his changing work-load and income, the composition of his clientele, the diseases he confronted, and the therapies he prescribed.<sup>11</sup> Another study, by Paul Weindling, based on the working-class practice of a Berlin physician between 1896 and 1906, illuminates the everyday actions of a young 'scientific' physician, his hospital referrals, treatments, and fees. In contrast to the case book, one type of private-practice record that has survived in abundance is the financial record.<sup>12</sup> General practitioners ran small businesses, and even those who did not have time or take the trouble to record case histories usually kept some kind of day book. Such records help us understand the workaday business of medicine, as Irvine Loudon has shown by reconstructing the economy of an English general practice during the 1830s.<sup>13</sup> In the past as at present, the sorts of behaviour most closely documented were billable procedures. Therefore a surgical procedure like venesection was invariably recorded, along with the fee; and it's for this reason we can learn more about how the use of venesection in 19<sup>th</sup>-century domiciliary practice changed over time and varied geographically than about any other important therapy.

I'm not going to talk about the uses cultural anthropologists and literary critics have been making of patient records, or the ways a

10. Jacalyn Duffin, *To see with a better eye: a life of R. T. H. Laennec* (Princeton, 1998).

11. Jacalyn Duffin, *Langstaff: a nineteenth century medical life*. (Toronto, 1993).

12. Paul Weindling, 'Medical Practice in Imperial Berlin: the Casebook of Alfred Grotjahn', *Bulletin of the History of Medicine*, 61 (1987), 391-410.

13. I. S. L. Loudon, 'A Doctor's Cash Book: the Economy of General Practice in the 1830s', *Medical History*, 27 (1983), 249-68.

cultural studies' preoccupation with representation has drawn attention to the changing visual practices we can trace in them. Yet such work has been important in encouraging historical exploration of patient charts as a record of clinical narrative. And just as historians have been giving more and more attention to scientific writing as a constitutive part of scientific enterprise, historians of medicine increasingly have come to recognize the practice of writing as one of the practices of clinical medicine. This has prompted us to ask new questions and to look at patient records through new eyes. And let me just give you one concrete example from my own work.

When around 1979 I first looked at patient records from 19<sup>th</sup> century American hospitals, I saw a page—about a 28-year-old stone cutter admitted to a US hospital in 1823—principally as a source of information for reconstructing therapeutic practice. Sampling around 4000 cases from Massachusetts General Hospital in Boston and the Commercial Hospital in Cincinnati for my book *The Therapeutic Perspective*, I coded information for computer analysis about the patients, their ailments, the therapies administered, and so on.<sup>14</sup> I then used this data in reconstructing things like the changing use over time of purgative calomel; changes in calomel dosage; the declining use of depletive therapies; the rising use of stimulant therapies and supportive diet; and the changing language of use (as in the shift from describing patients in terms of what was 'natural' to what was 'normal', which I found to be a telling indicator of shifting perceptions of the body in sickness and in health). I went on to use such reconstructions to get at larger issues, such as changes in professional identity; but the point is, I looked at patient records chiefly as a source of data which I could code and analyse.

Having been away from these archives for more than a decade (working on quite unrelated projects), recently I've been drawn back to them. But what I now see in a record like the 1823 patient history I described is that above all, what we have in front of us is a page full of words—true of all the twelve pages that make up this dense case history. And my interest now is in the processes through which that kind of record was transformed into the much more terse document which was the typical 1880 patient chart of American hospitals by the

14. John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-1885*, (Cambridge, Mass., and London: 1986), how has been published in paperback with a new preface by Princeton University Press (Princeton, 1997).

end of the century. Compared with the earlier records from the 1820s, the overall visual impression of the opening page begins to be one of standardisation, regimentation, and streamlining, even more so in the quantification, visualisation, and freedom from patient's words in the second and final page, recounting the labourer's forty day stay—namely, a form printed with a grid for plotting pulse rates, respiration rates and temperature, and diagrams of the human body that enabled the clinician with a motion of the pen to locate precisely the seat of the pathological disorder.

For this new study, what I want from the archive is a way to follow the *formal* transformation of the patient record. What becomes crucial to me here is tracing in clinical narrative, the emergence and consolidation of a new epistemological and aesthetic sensibility, expressed as a narrative preference for what was universal and precise over what was individual and discursive. So I need to know for a variety of hospitals when printed forms replaced blank sheets; not only when but under what circumstances graphing became common, and when hand-drawn grids were replaced by standardised printed forms; to know when clusters of hand-drawn grids appeared, and when they were replaced by forms (at one major north eastern hospital in 1866, within a few months); and to know when hand-drawn diagrams of the body were supplanted by printed figures or by a rubber stamp that at some institutions came into common use by the 1890s. (And of course these were hardly just American changes: something clear, for example, in the records of late-19<sup>th</sup>-century British hospital ward books I've only begun to explore, such as those of the Bristol Royal Infirmary, the Glasgow Royal Infirmary, and St Bartholomew's in London.)

Part of what I expect to argue in a book tentatively titled 'Bedside Stories: Clinical Narrative and the Making of Modern American Medicine' is that changes in scientific knowledge and medical technology were not as responsible as we've assumed, or in the ways we've assumed, for transformations in how clinicians depicted and thought about the sick, that fixed in place one cornerstone of modern medicine. The point here, though, is that such a study—which looks at patient records with an agenda very different from my earlier work—relies utterly on being able to reconstruct the precise timing of change, something that can only be retrieved by using full runs of hospital records.

I'd just add that while I've focused on the history of medicine, I can't think of a better example of how this work is reaching beyond that field than Elizabeth Lunbeck's recent book *The Psychiatric*

*Persuasion*, in which, as she states bluntly, 'Boston Psychopathic Hospital case records form the most important source for this study'. Her early-20<sup>th</sup>-century 'case records' include psychiatrists' notes, transcripts of staff meetings, ward notes, letters written by and to patients, and, in many instances, extensive social service notes. And it's a token of the wider value of such records that this study has won prizes as the best book in intellectual history, the best book in American Studies, and (from the History of Science Society) the best work on Women and Science.<sup>15</sup>

There's much more I could say but no time to about issues like confidentiality and access; issues very much in flux and in some ways remarkably dependent on relationships between particular health care systems and the state. In the United States, the absence of uniform policies often leaves the management of confidentiality up the individual historian in ways I find sometimes disturbing (though with rising use of patient records, archives and the lawyers retained by hospitals are paying vastly more attention than they did a decade ago to conditions of use). On the one hand, some historians like Barbara Bates and Jacalyn Duffin have cogently pointed out that by keeping patients anonymous while naming physicians, historians can display an element of arrogant disrespect, of dismissal, privileging the physician as historian actor over the nameless patient.<sup>16</sup> It certainly runs counter to the movement to rewrite medical history from the patient's perspective. On the other hand, using the names of patients even from 19<sup>th</sup>-century records runs risks of invading family privacy and offending descendants; and what worries me is that a single challenged instance of abuse by an insensitive historian might be enough to bring a backlash restricting access. And my own practice has been to consistently mask patient names, at least encountered in institutional records. But since I opened by saying that the use of patient records has come into vogue, I'd emphasize in closing that this is no mere passing fashion.

How such records will be used in the future will surely change, and it is impossible to predict the questions future historians will have in mind as they approach the archive. That these records have become

15. Elizabeth Lunbeck, *The Psychiatric Persuasion: knowledge, gender and power in modern America*, (Princeton, 1994).

16. Barbara Bates, *Bargaining for Life: a social history of tuberculosis, 1876-1938*, (Philadelphia, 1992) and Duffin, *Langstaff*, op. cit.. Both Bates and Duffin are physician/historians.

established as an indispensable source in historical investigation, however, is absolutely clear. And one of the points I've tried to stress is that the 'medical records' that urgently need archival protection are scarcely limited to patient records. We all know horror stories about unique collections that have been destroyed, but we also realize (sad to say) that it's impossible to save everything. What we do need is an ongoing collaboration between archivists and historians (among other researchers) in approaching the increasingly pressing issues of selection and preservation.

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