

AN INTRODUCTORY GUIDE TO HOSPITAL RECORDS

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Introduction

In recent years there has been a steadily growing interest in hospital records. This is shown by the small but increasing number of professional archivists employed within the health service, although these are to be found principally in the Thames Regions. It is also reflected in the archive profession as a whole where there have been concerted efforts both to survey and encourage the deposit of hospital records in local authority record offices and libraries with archive departments.

This article will look at the status and location of hospital records, as well as the types and contents of those records in the context of the history of the hospitals which produced them.

The Public Records Act, 1958, classified hospital records as public records, and the classification was to apply retrospectively, so that records predating the establishment of the National Health Service in 1948 are also deemed to be public records. However, hospital records are regarded as a class which can suitably be deposited locally in recognised places of deposit authorised by the Lord Chancellor through the Keeper of Public Records, therefore few hospital records will be found centrally in the Public Record Office. Their status as public records also means that hospital records are subject to the closure rules of 30 years on administrative records and 100 years on records containing confidential information. The effect of this is to discourage local record offices from accepting deposits of clinical records, which are usually vast in number, bulky and will occupy shelf space for a long period of time before they can be used. So, if clinical records are accepted, almost invariably some form of selection or random sampling will have taken place to reduce them to a manageable quantity.

Locating the sources

Recently the Wellcome Institute and the Public Record Office, with financial support from the King's Fund, have undertaken a Hospital Records Project to record full details of all hospital records held in public repositories. The results of this were computerised, and the database, comprising information on the records of 1,000 hospitals, is held at the Wellcome and the PRO and provides an excellent starting-point for locating hospital records. Other printed sources are the **Hospital and Health Services Yearbook** published annually which gives the names and addresses of all current hospitals, while for the nineteenth

century **Burdett's Hospitals and Charities**, first published in 1890, gives useful potted histories of all the hospitals, including foundation date, number of beds, names of senior staff. Both books are fully indexed and cover England, Scotland and Wales. A further more general source is **British Archives**.¹

If the records are still retained by the hospital, it is necessary to write to either the General Manager or the Director of Patient Services. But be prepared for disappointment. Historical records are not a priority for hospital staff and often they will not know if there are any, or where they are. When the author had been District Archivist to City and Hackney Health Authority for six years, a nailed-up door in the basement of a hospital that was about to be demolished proved to conceal a room full of records dating back to the foundation of the hospital, which literally no-one had known existed. Also, when a hospital moves site its historical records may be left behind, and this is the reason why a luxury hotel at the top of Drury Lane in London has underneath it a basement full of hospital records! However, if the request is successful and you are invited to go along to look at the records, do please inform your local archivist; also don't be discouraged from writing, because if sufficient interest is shown in their records hospitals may be prompted to do something about them.²

Administrative classification

Before the NHS was established in 1948 there were basically two types of hospital. The voluntary hospitals, so-called because they were funded by voluntary contributions or benefactions which were administered by a Board of Governors to generate income. These hospitals tend to be tenacious of their records, notwithstanding the Public Records Act, and regard the records as their own property. For this reason records of voluntary hospitals will more often be found in situ. The other type is what may be loosely termed local authority hospitals. These were principally hospitals which had developed from workhouse infirmaries.

Workhouses began to be established in the later eighteenth century and it was early found necessary to make some provision for sick inmates. This provision developed in an ad hoc manner during the following century, until a scandal involving the death of an inmate of Holborn Workhouse from 'extreme filthiness' led to Florence Nightingale spearheading a campaign for the reform of workhouse infirmaries. The eventual result of this was the Metropolitan Poor Act of 1867 which stipulated that workhouse infirmaries should occupy separate buildings from the main workhouse and should be under the control of a Medical Superintendent, not the workhouse master. This Act produced a plethora of new building during the 1870s and '80s, and often a hospital which developed from such a rebuilt infirmary will take the rebuilding date as its date of foundation; in such a case the records may well pre-date the supposed foundation date.

In 1930 all workhouses and their related hospitals passed to local authorities, and often the records were transferred to the authorities' offices and thence to

the county record office when it was established. Such records will therefore be found among the official records of pre-county or borough authorities. Local authorities also assumed control of fever hospitals, which had been established during the later nineteenth century under the auspices of the Metropolitan Asylums Boards. A further development in the 1880s was the establishment of county mental institutions, and the records of these and the fever hospitals will normally be found in local authority record offices.

The structure and contents of sources

Hospital records can be divided roughly into three categories: administrative, clinical and medical/nursing administrative and personnel records. Administrative records are more likely to form a cohesive body in voluntary hospitals where they have generally been created and kept on site. Local authority hospital administrative records will be scattered through various series of council and pre-council records as indicated above. The voluntary hospital's administrative records will be similar to those of any other large institution and will comprise primarily minutes of the governing body and financial records; through these it should be possible to trace the history of the hospital and some of the people, for example benefactors, governors, senior staff, suppliers, connected with it. If the hospital invested in property there will be the usual estate records, deeds, leases and rentals giving information of use to the local historian.

Medical or clinical records comprise admission/discharge registers; death registers; case histories and supporting records such as post mortem reports. It is possible to find admission and death registers from the eighteenth century onwards, for example Guy's Hospital maintained them from the date of its foundation in 1723. Early registers, however, may not be very informative, the first registers at St Bartholomew's in London in 1818 give only a list of patients' names for each ward every week with no further details. Generally it is not until the mid-1830s that you can be sure of finding more useful information, when the registers were expanded to give the address, diagnosis and outcome.

Death registers are far more rewarding in terms of the information they afford. Usually they will give the date of admission; the patient's full names; age; date of death; ward name (useful for tracing extant case-histories – see below); whether an inquest was held (which can lead on to coroner's records); whether a post mortem was held (again there may be records of this); cause of death (this may simply state fever or carbuncle); civil state; occupation (that of father or husband will be given where appropriate); full address; who removed the body. These, therefore, can provide a wealth of information for the social historian, the genealogist and the epidemiologist. For example, death registers have been used to chart the growing sophistication of diagnosis, and an analysis of ten-yearly samples of the death registers of St Bartholomew's Hospital, London, between 1868 and 1978, for the residential distribution of patients showed a steady increase in non-local patients after the turn of the century.³ This probably reflected the fact that people were more willing to enter hospital and better able to travel to receive specialist treatment, in contrast to

the general nineteenth century abhorrence of hospitals, which were regarded as insanitary and infectious places, so much so that erysipelas, a severe and potentially fatal skin infection, was known as the 'hospital disease' since it rarely occurred elsewhere.

Strictly speaking, these registers are part of the administrative records of the hospital. However, since they contain confidential medical details, they are classified as clinical and therefore governed by the 100 year rule. Nevertheless it can be possible to gain access to the information in them if a reasonable case can be made for doing so to the authority in charge.

Case histories were first kept as teaching aids and so date from the beginnings of formalised teaching in hospitals in the early nineteenth century. Because of their teaching purpose they were very detailed but selective, generally concentrating on the most interesting and instructive cases. They were kept on the wards and written up by the clinical clerks or surgical dressers, the equivalent of today's housemen. Such case histories will give the full life story of the patient and relevant family details. Gradually case histories became more structured, with printed forms which were routinely filled out for every patient, and so the amount of personal detail was much reduced. By the 1870s they were bound in large volumes according to the physician or surgeon in charge of the case, but these volumes were often the victims of patriotic fervour during the paper salvage effort of World War II. The present system of an individual file for each patient developed from the 1920s with the increase in diagnostic tests which necessitated the easy movement of patient notes between departments. Local authority hospitals had similar systems but generally starting later because they were not used as teaching centres until the 1880s.

When using patient records, particularly for genealogy, it should be remembered that in the nineteenth and early twentieth centuries only the poor and destitute would generally go into hospital. If at all possible the sick person would stay at home to be nursed by the family or a paid nurse and the physician or surgeon would visit. An operation on the kitchen table was preferable to running the risks of hospital infection. However, with the discoveries of anaesthetics and antiseptic techniques, which made hospitals less dreadful and more hygienic, and the general increase in medical knowledge, which led to increasing specialisation, people became much more willing to receive treatment in hospital. Again hospital records could be profitably used to study and substantiate these trends.

Subsidiary series of records to the main clinical ones already discussed include post mortem reports and operation books, both of which are likely to be more accessible and more use to historians of modern medicine; for example to trace the development of a particular surgical technique or the incidence of a particular disease and its relative fatality at different periods.

Finally, there are medical and nursing administration and personnel records, which are primarily the records of the medical and nursing schools. Medical schools invariably kept registers which students were obliged to sign. These may also give an address and possibly details of the courses studied. Individual

files may also be kept for each student, but these were not usually started until this century. Schools of nursing began to proliferate in the 1880s and, possibly because these early professional nurses were determined to prove the worth of their enterprises, records were kept systematically and in detail. So there may be a variety of registers detailing probationer and student nurses, giving name, age and next of kin, comments on the different stages of training, including character assessments, what wards were worked on, reasons for non-completion of the course or details of future career. From these much can be learned not only of the training itself but of the conditions of work and the health of the nurses. Many would-be nurses were defeated by the sheer hard work, with bad backs and feet often the cause for leaving, whilst those who did not live up to the high moral code might be dismissed for 'light and indiscreet conduct with the patients'.⁴ The matron's reports notice any nurses on sick-leave, with details of any infections contracted while on duty. It should be remembered however that the medical and nursing schools often do not regard their records as forming part of the records of the hospital to which they are attached, and so for access to them it is advisable to write directly to the school and not to the hospital.

Conclusion

In conclusion hospital records may be difficult to find, difficult to gain access to because of the closure rules and time-consuming to use. However, if these obstacles can be overcome, hospital records are a very rich source for a wide range of historical enquiry whose potential has so far not been realised.

NOTES

1. J. Foster and J. Shepherd, **British archives: a guide to archive resources in the U.K.**, (2nd edition), 1989.
2. Since this article was written the Department of Health has issued a circular concerning hospital records (HC (89) 20) which requires health districts to appoint a records officer to identify and arrange for the permanent preservation of historically significant records.
3. T. Forbes, 'Mortality at St Bartholomews Hospital, London, 1839-72', **Journal of Historical, Medical and Allied Sciences**, inc., 38, 1983, pp.432-49. R. Finlayson, 'Ischaemic heart disease, aortic aneurysms and arterosclerosis in London', **The emergence of modern cardiology. Medical History**, supplement no.5, 1985, Table 1.
4. **St Bartholomews Hospital Register of Probationer Nurses, 1877-1903.**