

2 The Experiences of Female Surgical Patients at the Royal Free Hospital, 1903–1913

In January 1911, Ethel Vaughan-Sawyer addressed the Royal Free Hospital Medical Society on the topic of ‘The Patient’.¹ Vaughan-Sawyer’s speech encouraged her audience to consider the practical experience of patients, whose reality is far more complicated than a textbook diagnosis will allow. The practice of medicine in the early twentieth century was precise and increased scientific understanding was illuminating the previously obscure; as a consequence, practitioners were more theoretically knowledgeable than ever before. With this superiority, however, came a corresponding distance from the patient’s point of view; an inability to bridge the gap between professional, quotidian routine and the sheer torment of a consultation, operation or prolonged hospital visit. Vaughan-Sawyer’s interests originally lay in psychology, and this was evident from her stress upon the necessity for patient empathy in the formation of a fully-rounded member of the medical profession, who considers the condition of the individual and not just the individual’s condition.² The problem, of course, was that patients were frustratingly anxious or verbose, inarticulate and confused, unable to remember clearly the longevity of their own symptoms or the intricacies of their family history. For Vaughan-Sawyer, however, it was patient incoherence which more accurately resembled medical and surgical practice than textbook neatness. Clinical reality was messy, bloody and painful: patients suffered, noisily.

¹ ‘The Patient’, *London (Royal Free Hospital) School of Medicine for Women Magazine*, 7.48 (March 1911), 350–8. Future references to this periodical will be shortened to *L(RFH)SMWM*.

² See Louisa Garrett Anderson’s letters to her mother, sent in September 1899, from her post at Camberwell Infirmary, about the possibility of taking ‘psychology coaching’ from Miss Vaughan. Vaughan was considered to be ‘100 times better at her work’ than the letter-writer, 15 September, 19 September, 28 September 1899. The quotation is from the letter of 15 September. See *Letters from Louisa Garrett Anderson to Elizabeth Garrett Anderson, 1899–1901*, Elizabeth Garrett Anderson Letters and Papers, HA436/1/3/6, Ipswich Record Office.

This chapter will take Ethel Vaughan-Sawyer's advice and explore a ten-year period at the Royal Free Hospital through the gynaecological case notes of Mary Scharlieb (1903–1909) and Vaughan-Sawyer herself (1904–1913), focusing on the patient's experience from admission to discharge and beyond in some instances. Only one patient-based study of the RFH has been carried out before, but that focused deliberately on both sexes seen by male physicians and surgeons, and excluded the female members of staff.³ By contrast, I want to address a number of fundamental questions about female patients more generally in the early twentieth century, as well as their specific composition at this particular hospital, which had done so much to promote the medical education and employment of women. Who filled the 12 or 13 beds allotted to these two female surgeons?⁴ Why were they admitted and what routes had they taken before seeking hospital assistance? How did they characterise their symptoms, bearing in mind that early pioneers of women's right to enter the medical profession had expressed the untold benefits female patients would receive from discussing their problems with their own sex? What was their attitude to surgical procedures, which could include the modern accoutrements of surgery such as the X-ray, blood counts, pathological reports, and, of course, anaesthetic and aseptic measures? What was life like on the wards and what made some patients discharge themselves before their treatment had ended or even before it had begun? In short, adopting Vaughan-Sawyer's focus will give a unique insight into the female surgical patient's experience of pain, suffering and hospital treatment in the early twentieth century.

It is important to recognise from the outset, however, that case notes are controversial sources of information about medical and surgical care because of their very nature as mediated accounts, written by the practitioner (or would-be practitioner) on behalf of the patient. Ironically, while her lecture asked for attention to the finer points of the patient narrative, it is telling that apart from one personal observation, Vaughan-Sawyer's

³ See Cullen, 'Patient Records'. Cullen excludes the patient notes of female staff; her justification concerns the small numbers of records, which would ensure that it would not be possible to 'conduct a fair and representative comparison': 'Moreover, the study would have had to consider not only the relationship between the male member of staff and male and female patients, but also that of a female member of staff to her patients, which would have proved too broad an examination for this study alone to conduct', p. 38.

In this chapter, I have excluded the notes of Lady Barrett, which are initially small in number and do not begin until autumn 1908.

⁴ In 1902, there were 12 beds (out of a total of 170) allotted specifically to 'the diseases of women'; this increased to 13 a year later (of 165) and again became 12 in 1914. See the 1902 *Seventy-Fifth* (1903), 1903 *Seventy-Sixth* (1904), and 1914 *Eighty-Seventh* (1915) *Annual Reports* respectively.

examples of the trials of the clinical experience came from poetry. While the poems of W.E. Henley (1849–1903) intended to awaken her medical audience to the other side of the doctor–patient encounter, they were, of course, shaped and stylised to meet the demands of their genre. Terrors and torments might beset this patient, ‘waiting – waiting for the knife’, ‘near[ing] / the fateful minute’, but his voice was as precise in its carefully literary organisation of symptoms as any textbook example.⁵ It was not only the poet, however, who moulded patient experience. Two years before Vaughan-Sawyer’s speech, the magazine in which it is printed had mocked the current tendency for overembellishment of the patient record by the note-taker. While the resulting text became more graphic, exciting and thus ‘delightful and entertaining reading’, the patient was lost sight of amongst stylised or lengthy literary passages. Two examples will suffice:

Dr C–r, on approaching the bed, exclaimed with pleasure and surprise at the great improvement manifested since he last saw the patient. He realised, he said, that he had been mistaken in his previous treatment, and confessing this before us all, utilised the case as a theme for a prolonged dissertation on the merits and demerits of the drugs employed, passing a profitable hour before passing on to the next bed, asking me innumerable questions, none of which I was able to answer.

Full post-operative note: Surgeon, Mr L–g; Asst. Surgeon, Miss Bl–r; Anaesthetist, Miss W–tts. Mrs V–gh–n S–wy–r was also present and was asked her opinion of the case. Among others present was a distinguished foreigner, and the House Physician looked in, in the course of the afternoon. Time of operation . . . [No space for more – Ed].

Note next day – P is wonderfully well considering the operation she went through yesterday.⁶

The first extract is novelistic in its approach, composed ornately, but without any attempt at extracting the vital details about how or why the patient was so improved. It is hardly surprising that the writer could not respond to the questions asked about this case or the next. The second account also omitted important surgical information to discuss the operation in the manner of a society event, noting the presence of others, but, in doing so, running out of space to note precisely which procedure was carried out. What the patient ‘went through’ in either case will never be known.

It is this filtered nature of the patient experience which has concerned recent investigations into the value of patient notes as a source for the

⁵ Henley, ‘Before’, ll.1; 6–7, in ‘The Patient’, 353.

⁶ ‘From the Notes’, *L(RFH)SMWM*, 44 (October 1909), 167.

historian of medicine. This is hardly surprising when, to illustrate concerns about the compiling of records, one patient, 20-year-old single servant Mary Roots, who was in the RFH for gonorrhoea and resulting miscarriage, was described as having the all-too-familiar ‘life of a second or third rate London serving girl’.⁷ In 1992, Guenter B. Risse and John Harley Warner extolled the value of the clinical history as key to ‘understanding the discourse and practice of medicine’, but also warned of the care which must be taken when examining collaborative institutional documents whose inconsistency of approach would be only too recognisable both to Vaughan-Sawyer and to the readers of the *LSMW Magazine*.⁸ Jonathan Gillis has drawn attention to the first half of the twentieth century as a point when the patient history was characterised by its dual nature, which comprised both the patient’s faulty account and the physician’s interpretations of and observations upon that narrative.⁹ Such competing voices superseded the dominant format in the second half of the nineteenth century, whereby the physician took control in order skilfully to reveal the facts of the case.¹⁰ The theorisation of surgical case records has received far less attention, but Ortrun Riha has provided a German example from the Göttingen University Hospital, which examines the problems of statistical research when sources are incomplete and advocates a prosopographical approach to patient history.¹¹ Far less evident in current research are case studies of patient records themselves.¹² The problems anticipated by those who have theorised about patient histories and the lack of surviving documents have combined in another way to silence the patient voice and the complexity of the clinical encounter remains underexplored.

If the historian has been unable to hear the patient voice because of professional reinterpretation, then another dimension is added to their silence when the patient is female. Thirty years ago, Mary Poovey, influenced by Foucauldian cultural history, lamented the passivity and

⁷ Mary Roots (MS: 1906; Part I), Dr Scharlieb’s Case Notes: Women, H71/RF/B/02/30/004, Royal Free London NHW Foundation Trust, LMA. Patient records will appear throughout in this shortened format to distinguish surgeon, date and number of box. Scharlieb’s run from 1902–1903: H71/RF/B/02/30/001–1907–1908: H71/RF/B/02/30/006. Dr Vaughan Sawyer’s Case Notes: Women from 1904–1908: H71/RF/B/02/31/001–1919: H71/RF/B/02/31/012.

⁸ Guenter B. Risse and John Harley Warner, ‘Reconstructing Clinical Activities: Patient Records in Medical History’, *SHM*, 5.2 (August 1992), 183–205; 184.

⁹ Jonathan Gillis, ‘The History of the Patient History Since 1850’, *BHM*, 80.3 (Fall 2006), 490–512; 497.

¹⁰ *Ibid.*, 495.

¹¹ Ortrun Riha, ‘Surgical Case Records as an Historical Source: Limits and Perspectives’, *SHM*, 8.2 (August 1995), 271–83.

¹² The notable exception being Cullen’s ‘Patient Records’.

'silencing of the female body', which was at the mercy of the 'superintendence' of the chloroform-wielding male professional.¹³ Poovey concluded that 'the medical representation of woman silenced real women'.¹⁴ In a witty rejoinder to Poovey, Regina Morantz-Sanchez later wondered how the medical men had actually 'g[o]t there', forwarding the possibility that, against type, they had been requested to provide treatment by the female patients themselves.¹⁵ By contrast, Anne Digby has acknowledged the part played by earlier feminist accounts in situating the patient encounter within cultural and sexual politics, but has welcomed instead a more balanced interpretation where *soi-disant* victims and oppressors are not so readily identified along the lines of gender.¹⁶ This latter point is especially important when considering that not all doctors were male and not all patients were female; sometimes, as is largely the case in this book, both were women. In a number of recent articles focusing on surgery in the late nineteenth and early twentieth century, Sally Wilde has advocated reconceptualising clinical encounters in a far more detailed manner than the predictable duality of 'doctor-patient relationship' will allow. Patients were autonomous, made decisions about their treatment, were influenced by a number of factors outside the advice of their practitioners, and gambled upon still faltering procedures working successfully. Professionals, meanwhile, were uncertain about the outcomes of their experimental surgical practice and by no means in control of patients, who requested operative treatment independently of their judgements.¹⁷ While acknowledging that the majority of early twentieth-century female patients had different responsibilities to their male counterparts, an intensive study of case records at the RFH indicates that women were just as capable of being obstinate as far as their health and its maintenance was concerned. They were also choosy about their treatment, whatever the purported medical or surgical benefit. Female patients were willing to listen to advice, but they would not always take it up. In the end, and this is why case histories provide such a frustrating, but also so intriguing a resource, they were more likely to do exactly what suited them as an individual, rather than what succeeded (or not) for the person in the next bed. Rather than flattening out the differences between around 1400 individuals to search for the typical

¹³ Mary Poovey, "Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women', *Representations*, 14 (Spring 1986), 137–78; 154; 146.

¹⁴ *Ibid.*, 156. ¹⁵ Morantz-Sanchez, *Conduct Unbecoming*, p. 139.

¹⁶ Digby, *Making a Medical Living*, p. 259.

¹⁷ See, for example, Sally Wilde, 'The Elephants in the Doctor-Patient Relationship: Patients' Clinical Interactions and the Changing Surgical Landscape of the 1890s', *Health and History*, 9.1 (2007), 2–27 and 'Truth, Trust'.

or the average, this chapter will examine the variety of ways in which female surgical patients, in all their many guises, negotiated their time in the RFH.

The Background of Patients in the Hospital

In order to discover more about the patient base of the RFH, it is necessary to start with an analysis of available statistical records, and continue with an examination of the more narrative details case histories provide so as to situate the patients within a wider institutional framework. Unlike the NHW and other charitable medical ventures, the RFH did not require its patients to possess letters of recommendation. Treatment could be sought by the individual solely, with one exception. Those who were travelling from some distance were required to make written application, stating the details of their case. The hospital was proud to proclaim its usefulness to the 'immediate neighbourhood', some of the poorest areas in the city.¹⁸ It was evident, however, as far as gynaecological patients were concerned, that many would be willing to travel from the other side of the country, and, indeed, from abroad, to be examined by Scharlieb or Vaughan-Sawyer. There was only one fundamental condition of entry: the patient had to be classified as 'sick poor', or 'unable to pay for advice and medicine'.¹⁹ But, in keeping with other voluntary general hospitals keen to attract donations from the wealthy, the RFH regularly insisted upon the worthiness of its patients, who were never admitted simply for rest or refreshment, and the corresponding vigilance of its lady almoner.²⁰ If, after examination, the patient was found to be incurable, they would, in theory, be discharged. In-patients, if able, had to bring 'a change of linen, towel, knife, fork, spoon, comb, brush, soap, and flannel', as well as providing for 'their own personal washing', so a hospital stay was far from gratuitous for those who might not even possess their own basic

¹⁸ See, for example, *The Seventy-Seventh Annual Report for 1905* (London, 1906). This was a particularly interesting year in terms of patient composition, as the number from the local London parishes of St Pancras, Islington and Holborn Union (50) was only one more than the combined number from other London districts and the 'Country' (49). While there were structural improvements being carried out from June 1905, necessitating the closure of 54 beds, it is fascinating to note that, given the insistence on treating the neighbourhood primarily, the RFH was so keen to accommodate its non-local patients, p. 14.

¹⁹ 'Regulations as to the Admission of Patients', *The Seventy-Fifth Annual Report for 1902* (1903), p. 32.

²⁰ For more on the role of the almoner, see Lynsey T. Cullen, 'The First Lady Almoner: The Appointment, Position, and Findings of Miss Mary Stewart at the Royal Free Hospital, 1895-1899', *JHMAS*, 68.4 (October 2013), 551-82.

items for cleanliness and nourishment.²¹ Given the deeply distressing bloody or sanious symptoms experienced by gynaecological patients in particular, the cost of the washing of personal items such as linen must have mounted up, adding another burden to the already weighty nature of their illness.

From 1903, the In-Patient Department of the hospital housed 165 beds and this number remained constant over the decade covered by this chapter.²² Between 1903 and 1913, the beds allotted to the Diseases of Women were 13, or 7.9 per cent of the total. This was the largest number allotted to a specialist department. Diseases of the eye, in contrast, were given 6 (3.6 per cent) and isolation cases provided with 4 (2.4 per cent). Befitting its status as a general hospital the greatest number of beds were reserved for general medical cases (64: 36 for men; 28, or 38.8 per cent, for women) and general surgical cases (62: 33 and 29, respectively, or 37.6 per cent, for women).²³ In her 1924 *Reminiscences*, Scharlieb lamented what she saw as the 'inadequate number of beds allotted to [her] department', which necessitated turning away very many of the 'serious and interesting cases' discovered at Out-Patients.²⁴ Statistics concerning the number of female patients seen at Out-Patients confirms this lack of fit between those seeking treatment and places available in the hospital. Given the beds provided, the number of Out-Patients seen by the Gynaecological Department was enormous. From 541 in 1902, the total leapt to 1069 in 1903, reaching a peak of 1568 in 1905, before falling again to 865 by 1913.²⁵ At its zenith, therefore, there were just over 120 women potentially requiring each bed, revealing the high demand for and use of this special department. The numbers admitted remained fairly constant throughout the decade between 1903 and 1913, as shown in Figure 2.1. From 138 in 1904 to 174 a year later and 159 in Scharlieb's final year at the RFH, numbers averaged out at around 129 for

²¹ 'Regulations as to the Admission of Patients', p. 32. The continued call in *Annual Reports* for 'cast off clothing for the use of poor patients on leaving the Hospital' indicated the genuine poverty experienced by some. See, for example, *The Eightieth Annual Report for 1907* (1908), p. 20.

²² This number was very small compared to other metropolitan hospitals. The London, for example, offered 900 beds after its early twentieth-century expansion. See A.E. Clark-Kennedy, *London Pride* (London: Hutchinson Benham, 1979), p. 159.

²³ Statistics obtained from *Annual Reports*. See, for example, *The Seventy-Sixth Annual Report for 1903* (1904), p. 11. Accident cases were allotted 17 beds from 1903; this was reduced to 16 in 1909 [*The Eighty-Second Annual Report for 1909* (1910)], and raised again to 17 in 1914 [*The Eighty-Seventh Annual Report for 1914* (London, 1915)].

²⁴ Scharlieb, *Reminiscences*, p. 170.

²⁵ See *The Seventy-Sixth Annual Report for 1903* (1904); *The Seventy-Eighth Annual Report for 1905* (1906); and *The Eighty-Sixth Annual Report for 1913* (1914).



Figure 2.1 Total Number of Gynaecological Patients in Relation to the Total Number of In-Patients: RFH, 1904–1913.

the last five years covered by this study, when Vaughan-Sawyer took on Scharlieb's position.²⁶

Given the stated aim of the RFH, namely, to see patients from the immediate metropolitan vicinity and then only from the 'sick poor', it is useful to explore the social and geographical background of those who sought treatment at the hospital (Figure 2.2). Until 1909, the *Annual Reports* listed the residences of only those who were present in the hospital on their census day of 1 January, but from this date it is possible to compare the numbers attending throughout the year. As the statistics reveal, the hospital did indeed serve the immediate neighbourhood more frequently than other parts of London or the rest of the country. When patients from outside the inner metropolitan areas of St Pancras, Islington, Finsbury and Holborn are combined with those from elsewhere in the country, however, the propinquity of the patient base looks less consistent. By 1913, there were only 120 more patients from the areas surrounding the hospital than other London districts and the rest of the country combined. This distribution could point to

²⁶ Numbers of patients are calculated from the number of case notes. Inevitably, some patients appear more than once, but are treated as separate cases for the purpose of this study. 1903 has not been included here as the records are incomplete.

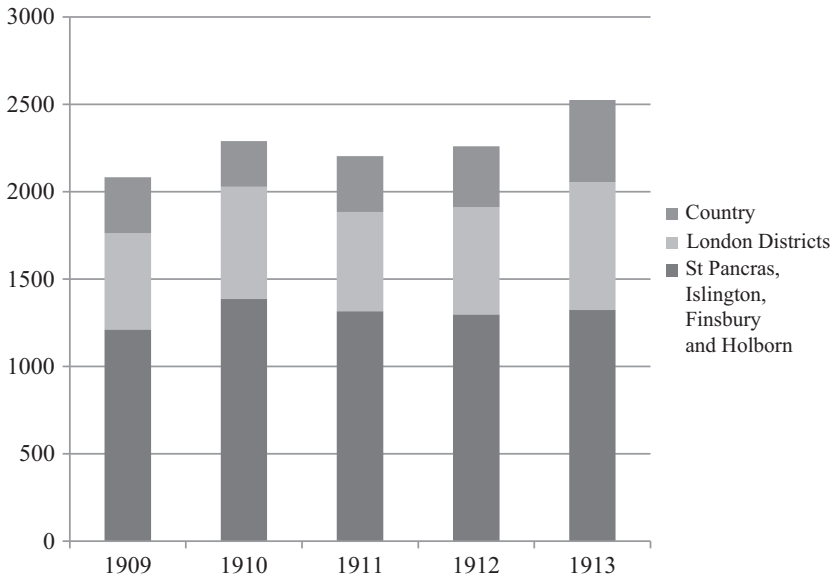


Figure 2.2 Total Number of In-Patients and their Geographical Location, 1909–1913.

the reputation of the RFH and its medical and surgical treatment. As Cullen has noted, surgeons to the hospital, such as Sir James Berry, were internationally renowned for their procedures. Berry's expertise in goitre and in the disfiguring conditions of hare lip and cleft palate would have been particularly welcomed by anyone searching for a surgical solution to these very visible afflictions.²⁷ Of course, a more cynical suggestion would be that the ease of entry to the hospital, without a letter of recommendation, might attract those who had failed to gain admission elsewhere. The very central location of the hospital, on Gray's Inn Road, might also determine its wider popularity. Either way, the RFH, given its small size, proved an attractive option for a large number of patients, who were not necessarily living near the institution.

A comparison with the in-patients of the Gynaecological Department between 1909 and 1913 reveals that women who sought treatment at the RFH for diseases peculiar to their own sex were, by contrast, largely from the metropolis (see Figure 2.3). This is not surprising given the number of outpatients in relation to the few beds available for specialist

²⁷ See Cullen, 'Patient Records', p. 73. Also chapter 1, for Berry's goitre procedure at the NHW.

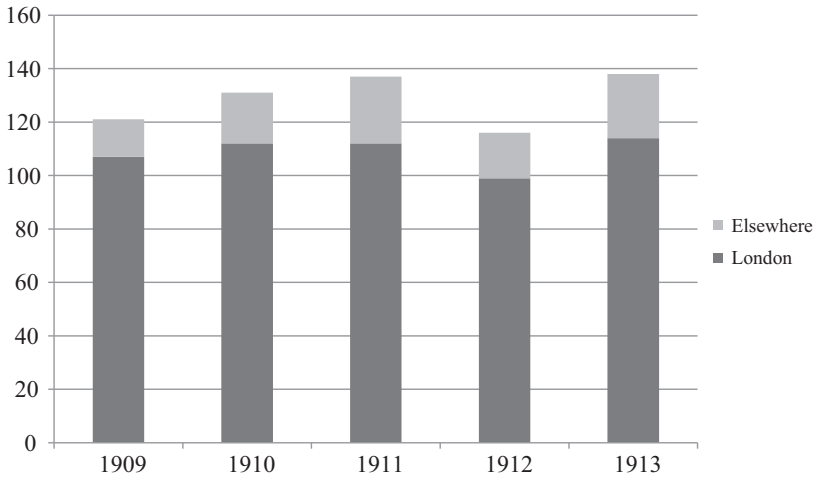


Figure 2.3 Vaughan-Sawyer's Patients: Geographical Location, 1909–1913.

care. Admission to the hospital would require prompt attendance at Gynaecological Out-Patients, which might prove more difficult for those coming from a distance. The large number of metropolitan female patients could also be explained simply by their gender. If the average number of days spent by in-patients in the RFH between 1909 and 1913 was 24.04, this was a long period of time for anyone to be away from employment or family, let alone the large number of children some of the patients had to support, feed and clothe. The recovery time from a serious surgical procedure, as well as any consequences of that operation, such as wound suppuration, the formation of sinuses or reactions to medication, would further delay the return home. Patients were also sent on to Convalescent Homes to complete their treatment through rest and recuperation, and, if operations failed, as they sometimes did, then a further stay in hospital might be the only solution to a final cure. If admission was sought at a nearby hospital then worries about home might be partially alleviated, although proximity to one's troubles could also have the opposite effect, as will be discussed later. Conversely, patient notes from the Gynaecological Department reveal that the RFH attracted women from all four corners of Britain. For example, Florence McClelland came to the hospital from Scotland in 1907; Mary G. Le Brun travelled from Guernsey in 1910 and Elizabeth Cuthbert from Norfolk in the same year; Louie Carren arrived from North Wales in 1913. Others came from even further afield, adding another category to the patient census unrecognised by the *Annual Reports*. Emily Marichean

was from St Vincent, Jennie Blanchard had reached the RFH via South Africa and America, Annie Crowl had been a missionary in China for 15 years, while Katie Sykes had lived in Denmark and South Africa. A number of patients were back from India: Winifred Walden, to use only one example, was 'invalided home' in 1909 from her post as a missionary.²⁸

While a speedy return to family may have been a priority for both male and female patients, it is important to realise that not all women treated at the hospital were married or occupied with looking after their home or children. Neither a patient's age nor employment, for example, can be discerned accurately by looking at *Annual Reports*, because they do not list background in such detail. The 16 beds allotted solely to 'Accidents' suffered by men, however, and the category of 'Injuries', such as burns, fractures, concussions, visceral and multiple injuries, as well as the 'brought in dead' section, recorded in yearly medical and surgical reports give some idea of industrial occupational hazards. Case histories, with the patient's age, address, marital status, next of kin (in some instances) and employment provide much more precise information about each individual, and allow the historian to fill in the silences left by more public documents. The Gynaecological Department dealt with young and old alike: from newborn babies, such as the unnamed 'Baby Hobbs', William J. Roberts, or Arthur James Brumell to three 77-year-olds – Rebecca Bosher, Kate Turner and Susannah Chapman.²⁹ Figure 2.4 shows the age distribution of the in-patients seen by Scharlieb and Vaughan-Sawyer between 1903 and 1913. Of the 1403 patients seen by the two in this decade, women in their twenties (419) and, in particular, their thirties (470) dominate the numbers, followed a little way behind by females aged 40 to 49 (309). This differs from Cullen's findings concerning the patient base of other physicians and surgeons at the RFH, where those in their teenage years and twenties dominated surgical practice.³⁰ The distinction is not surprising, however, as far as the diseases of women were concerned. As obstetrician Thomas Wilson remarked succinctly in 1907, 'women in the full vigour of adult life' were most susceptible to infection and disease: parturition and sexual intercourse still key parts of their everyday lives. Puberty and the climacteric, as indicated by the smaller numbers in their

²⁸ See: Florence McClelland (MS: 1907; Part II); Mary G. Le Brun (EVS: 1910; Part I); Elizabeth Cuthbert (EVS: 1910; Part I); Louie Carren (EVS: 1913; Part I). Emily Marichean (MS: 1908; Part II); Jennie Blanchard (MS: 1904); Annie Crowl (EVS: 1911; Part II); Katie Sykes (MS: 1904); Winifred Walden (EVS: 1908; Part I).

²⁹ See: 'Baby Hobbs' (MS: 1905; Part I); William J. Roberts (MS: 1907; Part II); Arthur James Brummell (MS: 1906; Part II); Rebecca Bosher (MS: 1904); Kate Turner (EVS: 1910; Part II); Susannah Chapman (EVS: 1911; Part I).

³⁰ Cullen, 'Patient Records', p. 89.

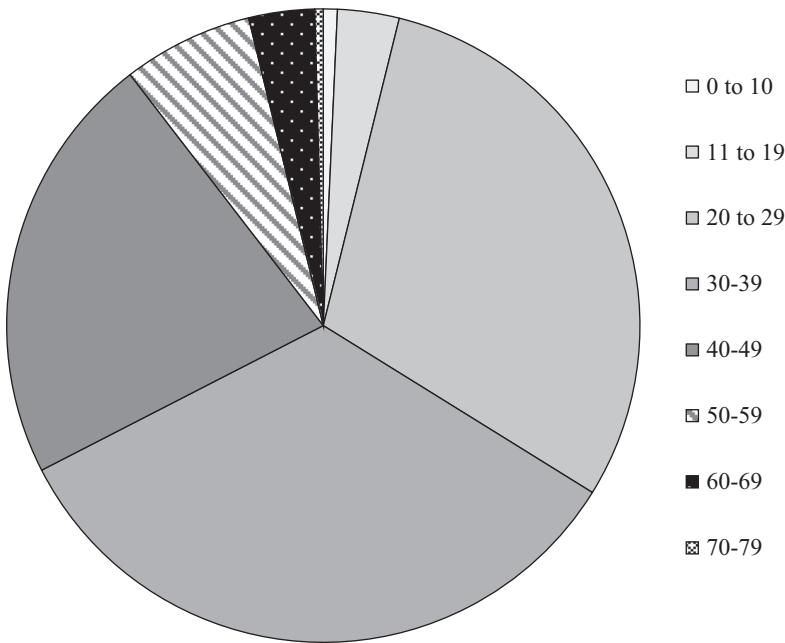


Figure 2.4 Age Distribution of Patients in the Gynaecological Department under Scharlieb and Vaughan-Sawyer, 1903–1913.³¹

teens and fifties, were also stages of potential concern.³² By the early 1900s, developments in bacteriology and pathology had strengthened the understanding that it was not simply the weaknesses of inherent femaleness which caused women's bodies to ache and to bleed, but often the introduction of external forces which then destroyed from within.

Given the predominance of women in their twenties and thirties, it would be easy to assume that the majority of patients treated by the Gynaecological Department were wives and mothers, who may have been employed in the past, but were now dedicating their lives to home and husband. However, the range of occupations, as displayed in Figure 2.5, shows a far greater variety of situation and status than might be expected. 'House', the RFH shorthand for housewife, dominates, to the extent that

³¹ This chart includes 1401 of the 1403 patient records, which comprise all of the patients in the files of both surgeons between 1903 and 1913. Only two patients are excluded as their ages have been spread across too great a range in the notes (one patient, Mary Lake [EVS: 1911; Part I] is noted both as 36 and 40; and one, Edith Lewis [EVS: 1912; Part II] is aged both as 51 and 31).

³² Thomas Wilson, 'On Pelvic Inflammations in the Female', *JOGBE*, 12.1 (July 1907), 3–27; 10.

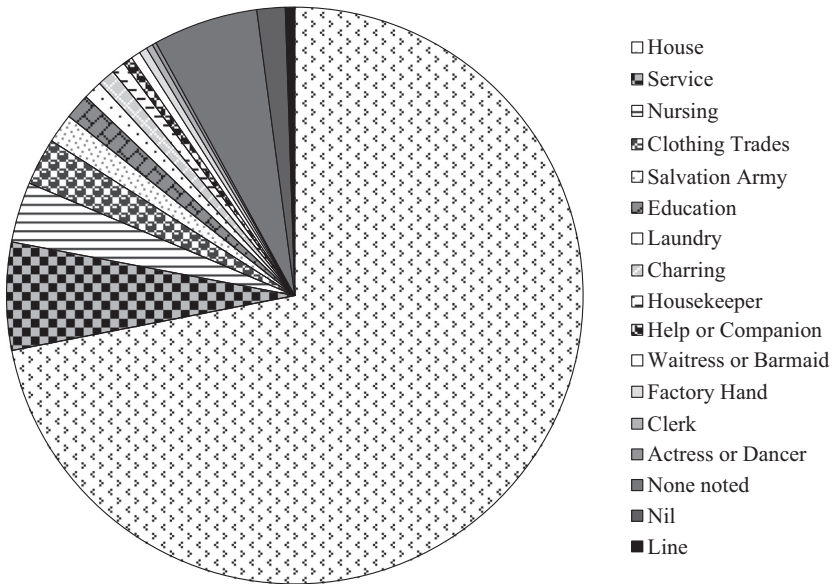


Figure 2.5 Occupations of Female Patients, 1903–1913.

72 per cent of patients were labelled this way. Situations occupied largely by single women or, less frequently, widows, were the next largest categories. Service included a variety of general servants, but also maids such as chamber, lady's, parlour, as well as cooks in private residences or in institutions, such as hotels or clubs. The nurses in the survey were from other hospitals, mental institutions and asylums, and a specialist maternity nurse. Patients from the clothing trades included tailoresses, an embroideress and a corsetière, and were largely comprised, again, of young single women, widows or those who needed to supplement the family income. One woman, Maria Dearman, who worked at home, and, therefore, could be mistaken for a housewife, was, in fact, running a treadle sewing machine in addition to her household chores: work she described as 'hard'.³³ The number of Salvation Army women is interesting, as the home from which they were sent was in Hackney, East London. As some of these patients' notes contained letters from the matron there, addressed directly to Scharlieb or Vaughan-Sawyer, and described symptoms and suffering, informal connections must have been established between the two institutions. In the case of Martha Parker, for example, Alice H. Halls wrote informally to Sister Milner of the RFH

³³ Maria Dearman (EVS: 1911; Part II).

explaining that she ‘had to keep [Parker] in bed, as she was in such pain’ and that this had been constant for ‘seven weeks’.³⁴ The education sector comprised schoolchildren, students (including two medical), as well as teachers, governesses and, in one instance, a London County Council Lecturer.³⁵ Laundresses and charladies, predominantly widows, often aged, revealed the physical hardships of their menial posts. Martha Aldridge, who was 64, remarked that ‘she stands all day’ in the laundry, and it is not surprising that 53-year-old charwoman Eliza Miles looked ‘rather tired’.³⁶ Those who waited on others, whether in restaurants, public houses or in the homes of the lonely or invalids, were again predominantly single women: young in the case of the former, middle-aged in the latter. Despite her previous life in South Africa, for example, Emma Bevan, a 52-year-old spinster, had been recalled to become her mother’s help in Kent.³⁷ Skilled occupations such as clerking and semi-skilled factory work illustrated both the advance of women into posts normally considered male and the influence of technological progress on modern manufacturing. Interestingly, the clerks were in their mid-twenties to mid-thirties, rather than very young, so presumably found their way into their positions after trying others. Kate Davey, who appeared three times in the notes, was first a waitress, then a clerk, and, in her final stay, had returned to service.³⁸ Occupational mobility was evidently more possible, if not necessary, at this point for a single female who had only herself to support. The range of employment held by patients at the RFH, from the very menial to those requiring training and qualifications, offer a different picture to the official representation of the patient base given by the *Annual Reports* of poverty and necessity.

It was not only the single or widowed who were represented in the gynaecological case notes of the RFH as employed. In *Women in Modern Industry*, published in 1915, B.L. Hutchins made the salient point that ‘women’s work is subject to considerable interruption, and is contingent on family circumstances, whence it comes about that women may not always need paid work, but when they do they often want it so badly that they are ready to take anything they can get’.³⁹ Picking up a former

³⁴ Letter from Alice H. Halls to Sister Milner, dated 28 January 1911, attached to the notes of Martha Parker (EVS: 1911; Part I).

³⁵ The medical students are Kathleen Baylis (MS: 1906; Part I) and Mary Atherton (MS: 1907; Part II); Cora Sergeant is the LCC lecturer (MS: 1907; Part II).

³⁶ Martha Aldridge (MS: 1907; Part II); Eliza Miles (EVS: 1913; Part II).

³⁷ Emma Bevan (EVS: 1911; Part II).

³⁸ Kate Davey (MS: 1907; Part I) and (EVS: 1909; Part II; 1911; Part I).

³⁹ B.L. Hutchins, *Women in Modern Industry* (London: G. Bell and Sons Ltd., 1915; republished Wakefield: E.P. Publishing Limited, 1978), p. xiv. Hutchins explains that the analysis was completed before the outbreak of war in the summer of 1914 (v), and so provides a useful source for this pre-war study.

trade or beginning a new one when times were hard is evident from the situations of a number of married women attending as in-patients. Annie Hobbs remarked that her husband had been out of work for six months, compelling her, though heavily pregnant and unwell, to work for Eley's, a firearms manufacturer in Edmonton.⁴⁰ Lizzie Fife was an in-patient twice in 1904. When she was first admitted in April, suffering from haemorrhage following a miscarriage, she was given the occupation 'house'. By August, however, when she was pregnant again and another miscarriage threatened, she had evidently returned to work, as she was now listed as a milliner.⁴¹ Georgiana Mary Hardcastle acknowledged that she had been a waitress only for the last three months, having been married for five years, with two children under four, but did not explain why she had taken up employment at this point.⁴² At 44, Louisa Francis worked as a bookfolder and had to walk five miles to her place of employment; as four of her five children were dead and the survivor was 20, she evidently did not work to support them, but circumstances dictated that she had both to take on employment and walk there.⁴³ A number of women had continued to work since their marriages, whether they had children or not. Again, the range of occupations was wide. Hard or physically demanding employment was carried out by Ada Bowman, who was a laundress, and Emily Burt, a dairy-maid, when she first visited the hospital as a married woman.⁴⁴ Although noted as 'house' on the cover sheet, Elizabeth Smith's work was 'very heavy, with great worry'; hardly surprising given she stated that she was occupied between 7.30am and 12.30 midnight.⁴⁵ Beckish Schwartz, although noted as a housewife, claimed that she had 'been working at washing and cleaning up to the present illness', which had contributed to the premature labour of a dead six-months' child.⁴⁶ Catharine Bennett's dual existence was emphasised by her roles as 'house and char'.⁴⁷ Annie Baddock worked in a factory as a cartridge maker, while Helen Longman, who was yet to have children, had continued her life in service.⁴⁸ Sarah Woods combined keeping her own house with the management of another, while the notes of Louisa Whelan did not elaborate any further upon precisely what she did in 'perfumery'.⁴⁹ Margaret Llewelyn Davies' introduction to a

⁴⁰ Annie Hobbs (MS: 1904). See also (MS: 1906; Part I) and her final visit and death (MS: 1906; Part II).

⁴¹ Lizzie Fife (MS: 1904). ⁴² Georgiana Mary Hardcastle (EVS: 1904–1908; 1904).

⁴³ Louisa Francis (EVS: 1904–1908; 1908).

⁴⁴ Ada Bowman (EVS: 1913; Part II); Emily Burt (MS: 1904); (EVS: 1904–1908; 1905). On her second visit, Emily Burt has 'house' as her occupation.

⁴⁵ Elizabeth Smith (MS: 1908; Part II). ⁴⁶ Beckish Schwartz (MS: 1908; Part II).

⁴⁷ Catharine Bennett (MS: 1906; Part II).

⁴⁸ Annie Baddock (MS: 1907; Part II); Helen Longman (EVS: 1912; Part I).

⁴⁹ Sarah Woods (MS: 1907; Part I); Louisa Whelan (MS: 1907; Part II).

collection of 160 *Letters from Working Women*, published in 1915, offered a salutary consideration of the ‘incessant drudgery’ experienced by the early twentieth-century working-class wife and mother. Those critical of working married women did not consider the double burden faced by those compelled through circumstances to seek employment: housework differed very little from servitude in Llewelyn-Davies’ eyes. She warned: do not ‘forget that the unpaid work of the working woman at the stove, at scrubbing and cleaning, at the washtub, in lifting and carrying heavy weights, is just as severe manual labour as many industrial operations in factories’.⁵⁰ Female patients who were married and who worked offer a rare insight into the juggling of responsibilities many women were forced into to keep their household in order. When coupled with the pain and suffering of illness, this burden was made even heavier.

An examination of the background of female patients at the RFH would not be complete without exploring the family histories of illness given by the patient which allows us to place the individual within a wider social network. The case notes traced keenly any potential patterns in ill-health between the patient and their wider circle of family members. This was in order to establish the possibility of hereditary disease, as well as dangers of the local environment which could constitute future threats to existing good health from infectious friends and relatives. The most popular queries concerned incidences of rheumatic fever, and, perhaps most importantly for a department dealing with the female generative organs, tuberculosis and cancer, two of the most feared diseases of the early twentieth century.⁵¹ Given the secrecy surrounding infectious diseases such as TB, as well as the terror associated with cancer, the pathology of which was still uncertain, as chapter 3 will explore, it is surprising how much was revealed by patients when asked for the history of their family’s health, even if it was not relevant to the current condition. Ada Hanton’s circumstances were particularly extreme. Although she was attending as an in-patient for the incomplete miscarriage of her tenth child, she discussed her background with stark frankness, revealing a willingness to talk about illnesses usually stigmatised. Her

⁵⁰ Margaret Llewelyn Davies, ‘Introduction’ to *Maternity. Letters from Working Women* (London: G. Bell & Sons Ltd, 1915), ed. Gloden Dallas (London: Virago, 1978), p. 6.

⁵¹ For tuberculosis in the early twentieth century, see Linda Bryder, *Below the Magic Mountain* (Oxford: Clarendon Press, 1988). For cancer more generally in the period concerned, see Ornella Moscucci, ‘The British Fight against Cancer: Publicity and Education, 1900–1948’, *SHM*, 23.2 (August 2010), 356–73; on cancer and gender, Moscucci, ‘Gender and Cancer in Britain, 1860–1910: The Emergence of Cancer as a Public Health Concern’, *American Journal of Public Health*, 95.8 (August 2005), 1312–21; and more specifically focusing on cancer of the cervix, Ilana Löwy, *A Woman’s Disease* (Oxford: Oxford University Press, 2011).

father died of bronchitis, four of her brothers had 'consumption' and her mother was in Colney Hatch, vernacular for the lunatic asylum located in that area.⁵² Rachel Watts' mother died in an asylum, where she had been incarcerated for 14 years, and two of her aunts were also inmates. The risky revelation that there was insanity on the female side was obviously brave in an institutional environment.⁵³ Louisa Harrington, also in for a miscarriage, had a 'strong family history of consumption'. Harrington's mother died of pneumonia (from which the current patient had also suffered), her father of cancer; all her father's brothers had died from consumption and five of her sisters and one of her brothers suffered from the disease too. The next generation had not been exempt either: Harrington's youngest child had 'consumption of the bowels' and 'suffers with its chest'; the eldest a 'cough'.⁵⁴ While her mother died, quite rarely, of nothing but 'old age', the rest of Elizabeth Smith's family background was more complicated. Her father and one sibling died of rheumatic fever, the other siblings died from consumption, heart disease, and Bright's disease. One died from blood poisoning. Additionally, an aunt and a cousin had succumbed to cancer.⁵⁵ Rose Law was found to be suffering from inoperable carcinoma of the cervix. Her history showed a remarkable incidence of the disease in the immediate and wider family. Law's mother died of 'cancer of the bladder', her sister at 44 (Law's current age) of 'cancer of the womb', a maternal uncle of 'cancer of the throat', and a paternal aunt of 'cancer of the breast'.⁵⁶ The specificity of detail given by patients permits a wider perspective on the prevalence of ill-health in the early twentieth-century family. Similarly, the willingness of some patients to lay bare a possible 'taint' contradicts received wisdom that many found infectious or life-threatening disease a taboo subject.

If openness to inquiry was evident in patient notes, the opposite was also true. Family breakdown and ongoing dissent were apparent, ensuring that a request to detail the condition of relatives was met with a negative or a tirade. Although Louisa Norfolk was one of 13 children, she now knew 'nothing of [her siblings]' and 'has never been ill in her life'.⁵⁷ Eighteen-year-old housemaid, Trixie Lucrece, lost her parents when she was a child and, therefore, 'knows nothing about her family history'.⁵⁸ Cecilia Chambers was an 'orphan and brought up in an orphanage, so does not know family history'.⁵⁹ The splitting

⁵² Ada Hanton (MS: 1904). ⁵³ Rachel Watts (EVS: 1911; Part II).

⁵⁴ Louisa Harrington (MS: 1905; Part I). ⁵⁵ Elizabeth Smith (MS: 1908; Part II).

⁵⁶ Rose Law (EVS: 1913; Part I). ⁵⁷ Louisa Norfolk (MS: 1904); (MS: 1907; Part I).

⁵⁸ Trixie Lucrece (MS: 1904). ⁵⁹ Cecilia Chambers (MS: 1907; Part II).

up of a family through more violent means occurred a number of times in the notes. Alice Dignum had ‘no relations’ and the only thing known about her parents was that her mother was Jamaican.⁶⁰ Lily Burtles’ husband was in an asylum, and had been there longer than the child she was carrying had been in existence.⁶¹ When Florence Coleman first visited the RFH, her husband was alive, although she was charring for a living and looked ‘distressed’; by 1911, eighteen months later, she was a widow, her husband having been in asylum for a year before his death.⁶² Although married, without any mention of separation noted in her history, Annie Stafford did not want to talk about her spouse and remarked that her husband was healthy ‘as far as she knows’.⁶³ Fanny Backshall dated all her many problems to her marriage, explaining that ‘her health was good until’ this point; now she suffered from a variety of pains, aches and attacks of ‘general debility’, none of which she had experienced before she wed her husband.⁶⁴ Having procured an illegal abortion, Mrs Constance Webb or Mrs Mary Ross, depending upon which name was really hers, falsified information and disguised her background.⁶⁵ Other women sought to defend the awkwardness or embarrassment of their situation. Twenty-four-year-old Rose Nash’s stoicism characterised her history. She could ‘remember no illnesses of any kind’ and ‘has always been well and healthy’. Although ‘circumstances have not been quite so good lately’, she insisted that she ‘always has enough food and has no great cause to worry’. When asked about her paleness, Nash responded by confirming that she ‘always is’, clearly anxious not to concern anyone.⁶⁶ Alice Reynolds, exhausted after nursing one of her seven children with scarlet fever, had a miscarriage in hospital after days of bleeding. The frustration of the note-taker with Mrs Reynolds’ cheery outlook was palpable: ‘patient looks very pale and exhausted but expresses herself as feeling very comfortable; the patient says she feels stronger and better every day – but she looks extremely pale. [...] She still looked exceedingly anaemic and ill, but expressed herself as feeling quite well and gaining strength daily.’⁶⁷ At times, those examining patients were forced to rely solely on the person in front of them, if they were co-operative, to assist in a clinical diagnosis. Risse has expressed concern over the lack of consideration in the history of medical institutions about the ‘isolation from family networks’ which

⁶⁰ Alice Dignum (EVS: 1913; Part II). ⁶¹ Lily Burtles (EVS: 1910; Part II).

⁶² Florence Coleman (EVS: 1909; Part II); (Part 1911; Part I).

⁶³ Annie Stafford (EVS: 1910; Part II). ⁶⁴ Fanny Backshall (EVS: 1904–1908; 1908).

⁶⁵ Constance Webb/Mary Ross (MS; 1908; Part I).

⁶⁶ Rose Nash (EVS: 1908; Part II). ⁶⁷ Alice Reynolds (EVS: 1906; Part II).

resulted from a stay in hospital.⁶⁸ But, as some of the female patients of Scharlieb and Vaughan-Sawyer implied, the family network might be something from which the patient was keen to distance herself. Placing an individual within a family environment in order to determine susceptibility to specific conditions was not as easy as it sounded when patients could obscure, deliberately or otherwise, their connections to others.

Drudgery and ingrained family suffering were not the lot of every woman between 1903 and 1913. There was another category, split into three in the graph of female occupations, which offered further evidence that the 'sick poor' were not the only patients to frequent the hospital. The sections represented 'None noted', 'Nil' or '-' are worth exploring in more detail. 'None noted' was the most unreliable of the three, as it referred to a blank on the cover sheet, where the note-taker failed, deliberately or otherwise, to fill in the question. While some years have very complete records, others, like Vaughan-Sawyer's for May–December 1913, have 29 blank boxes for occupation, out of a total of 71 patients. Of those, some can be ascertained. Marjorie Crittenden was eight months old; Emma Bull was 14, and could have still been at school, but her history noted that she was a bookbinder; and 23-year-old Ethel Tweed's record stated that she was an assistant in a baker's shop. It was harder to guess whether women in their sixties, such as Emily Higham or Mary E. Piddington, were still employed. As previous paragraphs have shown, it was entirely possible that widowed female patients, like both of these, worked to support themselves. Hagar Walker was in the hospital for the fifth time in 1913 and had been an in-patient on and off since 1906. She had previously been described as 'house', but her occupation was now left blank, either through oversight or familiarity.⁶⁹ Some may not have chosen to reveal what they did or the note-taker did not write down 'house', as it was taken as read, given the number seen. More intriguing was 'nil' or '-', which was nearly always attributed to single women and implied that they did not have to work for a living. In some cases this was due to a long-standing medical condition. Elsie Ward, who was 20, had 'some paralysis' since she was a child, and did not walk until she was four.⁷⁰ Twenty-three-year-old Isla Logan, who was said to have previously suffered from 'hysteria', and 'fainted several times a day', appeared to be a

⁶⁸ Guenter B. Risse, 'Hospital History: New Sources and Methods', in *Problems and Methods in the History of Medicine*, eds., Roy Porter and Andrew Wear (London: Routledge, 1987), pp. 175–204; p. 175.

⁶⁹ All patients mentioned in this paragraph, unless stated otherwise, are from (EVS: 1913; Part I). Hagar Walker appears originally in (MS: 1906; Part II), and then in (EVS: 1909; Part I); (EVS: 1911; Part I) and twice in (EVS: 1913; Part II).

⁷⁰ Elsie Ward (MS: 1908; Part II).

chronic invalid.⁷¹ Edith James was a private patient of Vaughan-Sawyer, and, therefore, must have been able to pay something for her initial treatment. While women surgeons, such as May Thorne, held ‘cheap days’ in private practice for less well-off patients, fees were not gratuitous and something was contributed, even if it was offered at a discount.⁷² The leisure time of 21-year-old Ida Gladys Ord, whose occupation was replaced by a line, was more than evident in her personal history, which was characterised by visiting a dubious set of ‘friends’.⁷³ Charitable or religious endeavours also occupied others, such as Amy Drake, whose occupation was recorded as ‘Church Work’ and who resided at Harrow Mission, and the number of Salvation Army officers has already been noted.⁷⁴ Cullen has remarked upon the incidence of patients who were hardly to be categorised as destitute poor in other departments of the hospital, so the Gynaecological Department was clearly not alone in admitting those who could pay for treatment.⁷⁵ The increased aseptic safety of the hospital environment must have overridden any concerns those who did not have to work for a living might have had about life on the ward of an institution largely composed of the sick poor, as we shall see later in chapter 5.

Reasons for Attendance

After exploring the varied backgrounds of female patients who sought treatment in the Gynaecological Department, it is necessary to consider their reasons for attending in the first place. The majority of patients would have been seen at Out-Patients and admitted from there, either immediately, if the case was serious, or when there was a bed free. Others travelled from outside London, having presented a letter from their own practitioner in order to gain admission to a metropolitan institution. Some of these documents were still extant, attached to the case histories, and pointed to the ways in which the profession operated. Correspondence indicated how general practitioners sought the opinion of specialists, or how stumped specialists requested another

⁷¹ Isla Logan (EVS: 1911; Part I). She does state, however, that she has been worn out with ‘nursing’ and ‘worry’ the past six months, but, unfortunately, does not elaborate upon the situation.

⁷² Edith James (EVS: 1912; Part I); widowed housekeeper, Lucy M. Jones, is also directly noted as a private patient of Vaughan Sawyer (EVS: 1912; Part I). For private operations and the woman surgeon, see my ‘Risk, Responsibility and Surgery’, 320.

⁷³ Ida Gladys Ord (EVS: 1910; Part II). ⁷⁴ Amy Drake (EVS: 1911; Part I).

⁷⁵ Cullen, ‘Patient Records’, p. 255.

opinion.⁷⁶ A decade after a laparotomy performed by James Berry, where abdominal adhesions had been broken down, Kent resident Kate Johnson was admitted under Vaughan-Sawyer for a recurrence of pain in her abdomen. Her doctor, W. Batchelor Taylor of Sevenoaks, wrote:

I should be extremely glad if you give this woman, Mrs Johnson, the benefit of your advice. She was an inmate of the Hospital for some abdominal complaint and had a section done in 1901. She has been having attacks on the other side resembling renal colic, but not quite typical. I think her old notes on the case might help. She is a case deserving of Hospital treatment.⁷⁷

Given the contemporary outcry over misuse of voluntary hospitals, Taylor prudently concluded his request with a reassurance that this was a 'deserving' case.⁷⁸ In Devon, Olive M. Goodwin's case confused her local practitioner, who thought she must be seven months pregnant because of the rapid increase in the size of her abdomen and had prepared accordingly. Unsure of his own assessment, he then consulted another medical man in Torquay, who diagnosed an abdominal tumour and sent the patient to the RFH, where she was, indeed, discovered to have an ovarian cyst.⁷⁹ The network of communication between general practitioner and specialist did not only function one way, however. There were also copies of notes from within the RFH addressed to patients' doctors, usually in order to elicit further information about the case or to have medical confirmation of something the patient might have suggested. When Alice E. Howes was admitted she stated that she has been treated previously for 'effusions of blood' under the skin of her arms, legs and face by Dr Mellor of Wood Green and this clearly concerned the hospital. Dr Mellor was subsequently contacted for 'information', which he duly provided. 'Madam', he wrote, 'In reply to yr [*sic*] letter received last night, the statement of Alice Howes is correct. I considered it a case of Purpura. As far as I know there is no history of bleeding in the family.'⁸⁰ In this instance, the RFH, troubled by what a patient suggested about their past history (namely, that they might, without using the term, have haemophilia) and the implications it might have for the success of any future surgical

⁷⁶ For the 'generally good' (p. 294) relationship between general practitioners and hospital specialists or consultants, see Anne Digby, *The Evolution of British General Practice 1850–1948* (Oxford: Oxford University Press, 1999), especially pp. 294–305.

⁷⁷ This letter is actually appended to the wrong set of notes, bound two years before Kate Johnson entered the hospital. See Kate Johnson (EVS: 1911; Part II) and the letter, dated 6 November 1911, which is with the file of Emily Saich (EVS: 1909; Part II).

⁷⁸ See, for example, Keir Waddington, 'Unsuitable Cases: The Debate over Outpatient Admissions, the Medical Profession and late-Victorian London Hospitals', *MH*, 42.1 (January 1998), 26–46.

⁷⁹ Olive M. Goodwin (EVS: 1912; Part I). ⁸⁰ Alice E. Howes (EVS: 1910; Part II).

procedure (the possibility of the patient bleeding to death on the operating table), sought further information from the general practitioner so that they could continue with the patient's treatment appropriately. Communication between different members of the medical profession was vital to ensure that the hospital received lay as well as clinical information about the patient. This meant that the individual's testimony was supported by well-documented medical evidence, but also reveals the sheer importance of listening to patients so extolled by Vaughan-Sawyer.

While such examples showed the necessity of smooth communication between practitioners and between patient, practitioner and specialist, there were also a number of instances in the case histories where failures in these links caused disastrous consequences. Digby has claimed that 'hard-pressed' general practitioners, when faced with 'difficult or time-consuming patients', might utilise the services of a specialist to put an authoritative stamp on the case, either dismissing it as trivial or elucidating the condition for colleague and patient alike.⁸¹ Annie Dryden's general practitioner sent her to the RFH, fearing that she had 'cancer of the lining of the womb'.⁸² Vaughan-Sawyer agreed that the patient's history of menorrhagia and dysmenorrhoea, along with the increase in the size of her abdomen, appeared suspicious of malignancy. However, she believed the condition was more suggestive of fibroids, and this, in fact, was what Annie Dryden was discovered to have. Here, communication between patient, general practitioner and specialist ensured that Mrs Dryden was seen quickly, her condition considered through her own testimony, physical examination and finally decided by operation. Her doctor's fears were unfounded, but an overreaction led to the discovery of a different problem, which was solved through surgery. Likewise, Ellen E. Winborn was sent in for 'carcinoma of the cervix', because she had been bleeding irregularly per vaginam for four months.⁸³ Luckily for Mrs Winborn, 'nothing to suggest' such a diagnosis was found. Too frequently, however, women's fears, especially when the problem was gynaecological, were dismissed by their own doctors, as we shall see later in the chapter. The series 'Heard about Hospital', a regular feature in the *Magazine* of the LSMW from 1910, mocked the patient body for its absurdities, malapropisms and general ignorance. One anecdote shed a more serious light on the gulf between the patient narrative and professional opinion. In the form of a question addressed to a student by an examiner, the dialogue ran as follows: 'What is the difference between *symptoms* and *signs*? Answer: A symptom is what the patient *thinks* is the

⁸¹ Digby, *Evolution*, p. 298. ⁸² Annie Dryden (EVS: 1912; Part II).

⁸³ Ellen E. Winborn (MS: 1908; Part II).

matter with him. A sign is what *really is*.⁸⁴ Symptoms could be described even if they were not felt, but signs were seen, legible only to the medical professional. Symptoms could be ignored; signs never.

'Heard at Hospital' mocked mercilessly the 'symptoms' described by omniscient patients.⁸⁵ One claimed they were suffering from "nervous ability and haricot veins", while 'Medical Knowledge in the Laity' was revealed to be particularly scanty: "Yes, poor girl, she's very ill, her eyes bulge right out". "Why is that?" "She has goitres behind them". Nor did surgical advances bypass some, as one particularly sage comment made clear in a discussion about treatment: "Oh nowadays surgeons never give anaesthetics. They just rub a drop or something on the patient's back and he feels nothing till it's all over". Cullen notes the ways in which patient and professional characterise the physical signs of ill-health, such as the size of wounds or swellings, in similar lay parlance, but it is also noticeable that the former had their own ideas about where or when their problems originated.⁸⁶ Either through sheer ignorance or deliberate obfuscation, Hettie Beck was convinced that abdominal problems caused by gonorrhoea could be attributed to 'a meal of fried fish'.⁸⁷ Margaret Clifford also blamed 'fried fish' for pain, diarrhoea and vomiting.⁸⁸ Alternatively, Mary Pipe pointed to her consumption of strawberries.⁸⁹ Seventeen-year-old Gladys Ward's sister informed the hospital that she had a nose or a mouth bleed every month instead of a period.⁹⁰ Edith Doves blamed her underclothes, in this case having put on damp tights, for causing the cessation of menstruation.⁹¹ In these instances, Sir James Berry's warning in his *Manual of Surgical Diagnosis* (1904) that '[i]t is well to receive with a certain amount of distrust any diagnosis which the patient himself may have made' was only too apt.⁹²

Neither did a number of patients comprehend precisely what previous treatment they had received. This could imply that communication between doctor and patient was not as open or honest as might be assumed, especially when the purpose or consequences of an operation were concerned. Or, potentially, it may mean that the patient did not listen to what they were being told about their condition or understand what

⁸⁴ 'Heard about Hospital', *L(RFH)SMWM*, 8.51 (March 1912), 43; original emphasis.

⁸⁵ All the following examples are from 'Heard at Hospital', *L(RFH)SMWM*, 7.49 (July 1911), 438.

⁸⁶ Cullen, 'Patient Records', p. 261. ⁸⁷ Hettie Beck (MS: 1905; Part I).

⁸⁸ Margaret Clifford (EVS: 1910; Part II). ⁸⁹ Mary Pipe (EVS: 1909; Part II).

⁹⁰ Gladys Ward (MS: 1907; Part I). ⁹¹ Edith Doves (EVS: 1910; Part II).

⁹² James Berry, *A Manual of Surgical Diagnosis* (London: J. and A. Churchill, 1904; Philadelphia: P. Blakiston's Son and Co, 1904), p. 14.

had happened to them. Professional language might perplex a lay person or confusion may result from how the procedure related to their own bodies. Katie Sykes knew she had an anaesthetic at the Soho Hospital and subsequently 'some operation', but she did not know which.⁹³ Henrietta Bray was aware that 'something' had been wrong with both of her children; that one had 'something removed from the back passage' and the other 'something from above the eye', but she was unable to articulate what exactly had been removed from each.⁹⁴ At either the German or the Homeopathic Hospital, Frances Fidler had 'something' 'passed up into lower passage and the stomach became smaller but not as small as it used to be', while Annie Cohen dated her problems from the time she was examined by a doctor 'who did some manipulation with an instrument'; since then she had 'never been well'.⁹⁵ A number of confused accounts were related to conditions surrounding pregnancy. It is not clear whether this was because the female patient evidently had other things to worry about at this point, and, therefore, might not remember in detail what had been said, or because miscarriages and parturition were experienced as an inevitable routine by both doctor and patient. Bessie Barrett knew that 'afterbirth had grown to the womb and had to be taken away', while Martha Aldridge was 'told by a doctor at University College Hospital' that passing clots after going 'beyond your time', which she had done 12 or 14 times, meant a miscarriage.⁹⁶ Margaret Robertson's muddled account of her previous RFH operation was compounded by the fact that her old notes from 1892 could not be found. She was informed, she stated, that there was a tumour in her pelvis as large as an apple, and in the tumour there was an abscess and from this she had 'got blood poisoning'.⁹⁷ By contrast, Louie Barnard remarked that she had been curretted twice at St Mary's Hospital, but when she was opened up, her right ovary and fallopian tube were absent, something which she had not previously mentioned. Vaughan-Sawyer was left to 'surmise' that these had been removed at St Mary's.⁹⁸ Eliza Croft stated categorically that she 'was not told what her previous operation was for' at Marylebone Hospital for Women. It was noted in the margin of her notes that the left ovary had been removed.⁹⁹ The late nineteenth and early twentieth century saw increasing agitation at the way hospital patients were treated, with the formation of organisations such as the Society for the Protection of Hospital

⁹³ Katie Sykes (MS: 1904). ⁹⁴ Henrietta Bray (MS: 1905; Part I).

⁹⁵ Frances Fidler (EVS: 1912; Part I); Annie Cohen (EVS: 1912; Part I).

⁹⁶ Bessie Barrett (MS: 1905; Part II); Martha Aldridge (MS: 1907; Part II).

⁹⁷ Margaret Robertson (EVS: 1913; Part II). ⁹⁸ Louie Barnard (EVS: 1912; Part I).

⁹⁹ Eliza Croft (EVS: 1910; Part I).

Patients.¹⁰⁰ It is easy to see when reading some accounts of past procedures why groups were calling for more clarity in the clinical encounter.

While the language used by patients to describe their symptoms revealed their lack of knowledge about clinical terminology or their imprecision about exactly what was wrong with them, quoted phrases from the notes indicated the extent of the pain suffered. Berry remarked on the patient tendency to compose narratives from reading about a condition rather than experiencing it, especially if the sufferer was middle class: a 'glib' and imaginative line of symptoms resulted.¹⁰¹ Some of the gynaecological patients of Scharlieb and Vaughan-Sawyer were no exception. Edith James, for example, a private patient of the latter, had the 'unhealthy appearance of a chronic invalid' and her narrative was lengthy and extremely detailed, explaining every symptom felt and hospital stay undergone over the past 15 years.¹⁰² Many others, however, were only able to characterise their suffering through bald, visceral description, without attempting to make their vocabulary anything other than understandable to all. These phrases, placed in inverted commas in the patient records, succeeded in drawing the attention of the note-taker to the individual with the condition, rather than the condition itself. The patient voice was not suppressed here, but only too audible. Women utilised familiar, often household analogies or metaphors to discuss the reality of their situation. Knife imagery featured a great deal. Ellen Elliot's sharp abdominal pain was 'like a knife in the womb' and another Edith James described her pain as 'sharp like knives'.¹⁰³ Elizabeth Bennett's pain on defecation was also 'sharp like a knife'.¹⁰⁴ Violent actions, like a kick or a punch, illuminated the ways in which some ached. Annie Bodley's abdomen hurt 'as if she had a blow on her back', for example.¹⁰⁵ The majority of patients, whether they were mothers or not, sought to use the language of childbirth to compare with their present suffering: 'bearing-down pains' characterised many gynaecological cases at the RFH.¹⁰⁶ The sheer unpleasantness of passing clots or heavy bleeding per vaginam reminded some of cuts of meat or offal. Mabel Frost suggested her discharge contained 'thick pieces like liver' and Elizabeth Trehwella

¹⁰⁰ See, for example, my 'Risk, Responsibility and Surgery', 330–2 for the Beatty versus Cullingworth case which led to the formation of this society.

¹⁰¹ Berry, *A Manual*, p. 14. ¹⁰² Edith James (EVS: 1912; Part I).

¹⁰³ Ellen Elliot and Edith James: both (MS: 1904). For a recent exploration of how patients describe pain, see Joanna Bourke, *The Story of Pain* (Oxford: Oxford University Press, 2014), especially pp. 53–87.

¹⁰⁴ Elizabeth Bennett (MS: 1905; Part I). ¹⁰⁵ Annie Bodley (MS: 1908; Part II).

¹⁰⁶ Two of very many examples will suffice: from a single patient, Eva Foster (EVS: 1912; Part II) and a married one, Elizabeth Collett (MS: 1905; Part II).

also found ‘lumps of liver’ within her blood.¹⁰⁷ Graenia M. Johnson compared the mess caused by a miscarriage as like passing ‘brain’. Ruth Barden was less specific, simply noting the ‘pieces of flesh coming away’. The amount of blood lost, whether from coughing or vaginally, was frequently measured in chamber pots. Sarah Handford expressed her loss in half-chamber pots, while Ruth Barden explained an episode whereby she brought up a ‘chamber-full’ of blood from her lungs.¹⁰⁸ By contrast, Amelia Young’s rectal discharge appeared more innocent than the bloodiness of other images: ‘like the white of an egg’.¹⁰⁹ Its innocuous nature belied the seriousness of her condition: carcinoma of the sigmoid. Others were far more idiosyncratic in their choice of description, especially if symptoms or signs were not easily evident on the patient’s body. Elizabeth Mackinney’s example of her abdominal swelling feeling as if there was ‘an egg rolling about in her stomach’ was a particularly individualised way to label what turned out to be an ovarian cyst.¹¹⁰ Caroline Williams’ daily chores provided her with an ideal way to depict the internal trouble she had been having. While using a wringing machine, she felt as if her ‘inside had been twisted’.¹¹¹ Gertrude Figg, by contrast, could only point to a sinking feeling ‘as if her inside was dropping from her’.¹¹² After her first confinement, Emma Storrie explained that her ‘insides were outside’.¹¹³ These patients, the majority uneducated housewives, could not easily replicate lists of symptoms learned from books or have recourse to literary language, as Berry claimed more middle-class persons could. Their examples were illustrated through comparisons with what they knew – the home, cooking, childbirth – but were none the less potent for that familiarity.

Some of the more outlandish reasons for illness so mocked in the ‘Heard at Hospital’ series and the ignorance apparent in the patient records themselves obscured the more precise knowledge which several patients showed regarding their condition. Such a grasp of symptoms and signs tended to stem from experience, which allowed a patient to recognise when there was something wrong with them because they have been through the same process before. Martha Penry’s case provided an excellent example of a patient’s quick thinking in seeking hospital treatment because she was familiar with her condition. Mrs Penry was admitted twice in 15 months.¹¹⁴ The second time she arrived at the

¹⁰⁷ Mabel Frost (EVS: 1913; Part II); Elizabeth Trehwella (MS: 1908; Part II).

¹⁰⁸ Sarah Handford (EVS: 1912; Part I); Ruth Barden (MS: 1908; Part I).

¹⁰⁹ Amelia Young (EVS: 1904–1908; 1907). ¹¹⁰ Elizabeth Mackinney (MS: 1904).

¹¹¹ Caroline Williams (MS: 1905; Part I). ¹¹² Gertrude Figg (MS: 1905; Part II).

¹¹³ Emma Storrie (EVS: 1913; Part I).

¹¹⁴ Martha Penry (EVS: 1911; Part I) and (EVS: 1912; Part II).

hospital she knew what was wrong with her and informed the doctors. Sudden pain and a heavy feeling in her abdomen alerted Mrs Penry to the fact that she was haemorrhaging internally. Although she had not been feeling well for weeks, it was the speed with which the pain came on that told her she had experienced another ruptured ectopic gestation. Similarly, in some instances, a family member's or friend's awareness of particular signals, which pointed to something they recognised or understood, was also evident. Frances Graves' mother told her 'that there was something the matter with the womb'. It turns out that Mrs Graves' mother was correct, as her daughter was discovered to have an eroded cervix.¹¹⁵ Overreaction, especially to bumps and swellings, also suggested that fear of cancer, as already noted, led some women to be more concerned about possible sources of disease. Although she had only a cyst of Bartholini's Gland, Annie Stafford came to the RFH because she was terrified that the lump might turn into a 'tumour'.¹¹⁶ Wider awareness of the potential causes of pain, whether that was from personal experience, family connections, or greater publicity of diseases in the early twentieth century, all prompted some patients to seek treatment as quickly as possible to end both physical and mental suffering.

There were numerous circumstances where both symptoms and signs were ignored by the professional, with consequences only for the patient. If public trust in medicine was increasing at the end of the nineteenth and the beginning of the twentieth century, some patients might have had cause to think the opposite.¹¹⁷ Some were lucky. Vaginal examinations were not performed by the doctors of Julia Randolph and Esther Chapman, but the former's practitioner advised her to go to hospital and the latter was given initially successful medical treatment by hers.¹¹⁸ A few cases in particular showed a more disastrous failure to consider patients seriously enough: all of these were dismissed as instances of the menopause. As American gynaecologist Howard Kelly urged, 'every week of delay in radical treatment [. . .] is precious time lost'. He had no qualms about blaming the general practitioner for 'a fault which makes him responsible year by year for the loss of many lives'.¹¹⁹ In May 1904, Ellen Mead was admitted with extensive, inoperable carcinoma of the cervix. Three months before she had been to a Dr Roberts of Cambridge Gardens, who had given her medicine and told her that the excessive bleeding she was experiencing, her loss of weight and extreme

¹¹⁵ Frances Graves (MS: 1904). ¹¹⁶ Annie Stafford (EVS: 1910; Part II).

¹¹⁷ On trust, see, for example, Wilde, 'Truth, Trust'.

¹¹⁸ Julia Randolph (EVS: 1910; Part I); Esther Chapman (EVS: 1910; Part II).

¹¹⁹ Howard A. Kelly, *Medical Gynecology* (New York: D. Appleton and Company, 1908), p. 155.

weakness were due to ‘the change of life’; her painful, persistent back-ache, he decided, was caused by sciatica.¹²⁰ When Mrs Mead came to Out-Patients, she was admitted at once. Although Scharlieb believed her cancer might be operable, when the patient was opened up, it was discovered to have spread to the iliac vessels and was irremovable. As a note appended to her history reveals, Ellen Mead died ten weeks after leaving hospital. Sarah Timpson, a 46-year-old steam-laundry worker, experienced similar treatment.¹²¹ She had been bleeding for three months and had seen a Dr Wyborn of York Road. He informed Mrs Timpson that it was ‘the change of life’, which he deduced without any examination of his patient. When Sarah Timpson came to Gynaecological Out-Patients malignancy was feared and she was admitted and underwent a panhysterectomy for carcinoma of the fundus uteri. By 1907, there was a recurrence and the cancer became inoperable. A self-confessed ‘very strong’ woman who did hard physical work as a laundress, the last time she appeared in the notes, she was compelled to walk on crutches because of the pain. Mary Hilier was not examined by her doctor, Dr Stokers of the New Kent Road, despite vaginal bleeding. He did give her medicine and told her to stay in bed for two weeks and the bleeding stopped. She went to the RFH, where she was diagnosed as having carcinoma of the fundus uteri; she refused hysterectomy and was discharged.¹²² Jane Thomas also had a detailed history of irregular bleeding.¹²³ She too visited a doctor, who gave her medicine and told her to stay in bed until she was better. When, after a month, she was so weak ‘she felt she could not continue her daily life without help’, she consulted Dr Edith Sargeant, who sent her immediately to the RFH. Mrs Thomas had an abdominal hysterectomy for cervical cancer. There was a recurrence at the beginning of 1907, and she died four days after admission. Agnes Wade had experienced vaginal bleeding for a year and had consulted a doctor, who informed her that she was undergoing ‘the change of life’ and ‘treated her accordingly’. The pain became worse, so she consulted another doctor, who advised her to seek further advice. She was treated at the RFH for carcinoma of the cervix, but, a year later, it had spread, become inoperable, and she died in hospital.¹²⁴ Finally, Florence M. Spanghton was told by her doctor that she had miscarried because of blood loss and passage of large

¹²⁰ Ellen Mead (MS: 1904). She also appears as Emily on the front cover.

¹²¹ Sarah Timpson (MS: 1905; Part I) and for the recurrence (MS: 1907; Part I).

¹²² Mary Hilier (MS: 1905; Part I).

¹²³ Jane Thomas (MS: 1907; Part I); recurrence and death in hospital also (MS: 1907; Part I).

¹²⁴ Agnes Wade (EVS: 1909; Part II); (EVS: 1910; Part I).

clots.¹²⁵ As she informed the RFH, she was very much aware that she was not pregnant, so knew something was wrong. Mrs Spanghton was cachetic, evidently extremely ill, therefore, and was subsequently found to have inoperable carcinoma of the cervix. The failure of these five medical men to provide adequate initial consultation, in spite of patient concerns, ensured that vital symptoms and signs were missed, effective treatment was given too late, and conditions became inoperable.

That there was an obvious gender division here between the reaction of the one medical woman mentioned and the male general practitioner warrants discussion. This is not to suggest that all medical men were unable to spot malignancy or that female doctors were preternaturally aware of such conditions. Maud Davis' male doctor, for example, gave her medicine to stop haemorrhage, but, concerned about her health, encouraged her to seek further advice as soon as possible.¹²⁶ Women doctors treated women; male general practitioners treated both sexes and were perhaps less used to seeing such conditions or hearing similar concerns. Although very few of the gynaecological patient base used the services of medical women, as we shall see, those who did were referred quickly to specialists when anything suspicious arose. This might be because the female medical network was small and therefore particularly tightly interrelated; many women doctors had passed through the LSMW, for example, and maintained connections with it, the RFH, the Association of Registered Medical Women, and other female-run institutions.¹²⁷ The case of Ethel Joud illustrated the extent of international links between medical women. Joud had been married for five years and lived in India for the same length of time. Three years previously, she had seen a male doctor there; later, six months before her admission, she had seen a 'woman doctor', who recommended the RFH. On her return to London, she had visited Scharlieb, who referred her for admission under Vaughan-Sawyer.¹²⁸ Even more fascinating was the number of women who had been sent to the RFH from female general practitioners. The total was surprisingly small. Not all patients named their local doctor, neither did note-takers always write down the first name of the practitioner, and so it was not possible to be precise on the actual figures involved. However, of 1403 patient records examined, only 73 women named a general practitioner of the same sex. Nearly half of those patients mentioned Mary

¹²⁵ Florence M. Spanghton (EVS: 1907; Part I).

¹²⁶ Maud Davis (EVS: 1911; Part II).

¹²⁷ For connections between medical women, institutional or otherwise, see Elston, "Run by Women".

¹²⁸ Ethel Joud (EVS: 1909; Part I).

Scharlieb, who, even after retirement from the hospital in 1908, continued to act as Consultant to the Diseases of Women and regularly sent her own patients there.¹²⁹ Ethel Vaughan-Sawyer had previously seen seven of these women. So, out of the 73, 39 patients had already seen the two female surgeons at the RFH. The relatively few seeking out treatment by medical women may be the result of their lack of prominence in areas where patients lived, or perhaps because there was still a stigma about female doctors. Certainly, while women were willing to see several different general practitioners, they nearly always sought male advice. The only exceptions were teachers. Some 50 per cent of Scharlieb's patients who described themselves as teachers had sought her advice privately beforehand; this was true of a third of Vaughan-Sawyer's cases, who had also been to see Scharlieb.¹³⁰ It could be suggested then that more of the educated and single chose to visit women doctors than their working-class counterparts. Interestingly, though, one patient, Alice M. Turner, first saw a male doctor, and it was he who pointed out that she had a swelling in her abdomen; she only decided to see Scharlieb when the problems became worse.¹³¹ This pattern was similar to many other narratives encountered in the notes of women from all backgrounds. As the case of Harriet Stanford made clear, some female patients had been searching for years for someone to help them, moving from doctor to doctor in the hope that one would eventually and successfully effect a cure.¹³²

Whether through the desire to obtain a male opinion or a decision to go straight to a hospital where women's diseases were treated and bypass a general practitioner, the case notes of the Gynaecological Department revealed that the majority of women patients saw medical men before coming to the hospital. The speed with which female general practitioners sent their patients to the RFH, however, generally exceeded that of their male colleagues. Not one patient, however, of the 1403 seen by Scharlieb or Vaughan-Sawyer between 1903 and 1913 made reference to embarrassment at or feeling uncomfortable by a male practitioner's examination. One of the key arguments women had utilised to claim their suitability to practise medicine was simply not relevant to the RFH's female patients.

¹²⁹ *The Eighty-First Annual Report for 1908* (1909), p. 19.

¹³⁰ Patients of Scharlieb: Alice A. Turner (MS: 1907; Part I); Margaret Barker (EVS: 1909; Part II); Fanny Freeman (EVS: 1911; Part I); not patients: Ellen Kinsey (MS: 1908; Part II); Gypsy Andrews (EVS: 1911; Part I).

¹³¹ Alice A. Turner (MS: 1907; Part II).

¹³² Harriet Stanford (EVS: 1904–1908; 1908). Since the birth of her first child, Mrs Stanford had undergone a number of procedures to repair a perineal tear; none had been successful.

The time it took a patient to seek either male or female medical advice was a vital part of the case history. It allowed the specialist to track the progress of an illness, and determine, especially in gynaecological cases, the likelihood of malignancy even before tests were carried out or laparotomies performed. Cullen has drawn attention to those who wait, dismissing symptoms and allowing the historian an ‘insight into how patients judged the seriousness of their own ill-health in relation to the cost of missing work or disrupting their family lives to receive treatment’.¹³³ Economic considerations were of importance to the female patients who worked, but the majority of housewives would have been concerned primarily with the effect any absence through hospitalisation would have on the family. Women did not always seek treatment as soon as they ‘understood their bodies to be ailing’.¹³⁴ Additionally, due to the very nature of the conditions witnessed, even if a problem had been thought solved, as in the case of Harriet Stanford’s ongoing perineal tear, repeated childbearing could literally reopen old wounds. The patients who waited the longest for treatment were those who had prolapses or torn perineums; neither of which would have made daily life very comfortable. It is possible that both conditions were considered peculiarly female, and, therefore, something which women, by their very nature, had to expect. As one writer began, when dealing her maternal ‘sufferings’ for the 1915 collection of *Letters from Working Women*: ‘I thought, like hundreds of women do to-day, that it was only natural, and you had to bear it.’¹³⁵ ‘Bearing it’, though, was a messy, bloody, often filthy business for the women involved. Edith Abrahams, who was in the RFH four times between 1903 and 1906, had suffered from vaginal haemorrhages since her first and only confinement in 1890.¹³⁶ Although she had sought professional advice several times, including treatment at St George’s Hospital for a decade, Mrs Abrahams’ situation had been worsening, the bleeding coupled with epileptic fits and loss of consciousness. After 20 years of dysmenorrhoea following catamenia at 14, single clerk Ethel Court put into words the suffering many women must have gone through by claiming succinctly that the pain was so bad that she would frequently ‘contemplate suicide’.¹³⁷ Miss Court was the only patient to

¹³³ Cullen, ‘Patient Records’, p. 137.

¹³⁴ Regina Morantz-Sanchez, ‘Negotiating Power at the Bedside: Historical Perspectives on Nineteenth-Century Patients and their Gynaecologists’, *Feminist Studies*, 26.2 (2000), 287–309; 300.

¹³⁵ ‘Letter 21: How a Woman May Suffer’, in *Maternity*, pp. 48–9; p. 48.

¹³⁶ Edith Abrahams (EVS: 1910; Part I); see also twice (MS: 1906; Part I). There is no extant record for her 1903 stay in the hospital.

¹³⁷ Ethel Court (EVS: 1912; Part I).

phrase her suffering in such a shocking tone, but the sentiment would be understood by many. Torn and re-torn perineums were dealt with by Mary Surtees and Eliza Miles for 18 years, Caroline Leggett and Alice Munday for 15 (the latter including four years of 'difficulty in holding the motions'), and Elizabeth Mitchell for 12.¹³⁸ Emma Spooner's perineum was torn seven years before, and again five months previously, but she had incontinence of faeces ever since the first incident.¹³⁹ Similarly, Eliza Skate suffered from faecal incontinence for 12 years following childbirth. Prolapses had been experienced by Louisa Watson for 17 years and Mary Blogg for 15.¹⁴⁰ One of the most disturbing prolapses was that experienced by 43-year-old Lily Langley, who, on admission, was discovered not only to have a misplaced uterus, but also bladder, appendages and coils of intestine.¹⁴¹ Although not as forthright in her description of her feelings as Edith Abrahams, Margaret Gray simply 'hasn't been right' since a miscarriage 18 years before.¹⁴² Emily Ineson's discharge was so profuse that she 'always wears a pad', as did Margaret Dingwall; while Agnes Martin soaked '5 or 6 in half an hour'.¹⁴³ By contrast, when Jane Turner's menstruation became so heavy normal pads would not suffice, she was forced to utilise 'bath towels'.¹⁴⁴ The case histories did indeed give an indication of what women were willing to support before they sought treatment. In doing so, however, they drew attention to the very real, vile, profuse, foul-smelling discharges which needed to be stanching and the physical discomfort which must have dogged the lives of already hardworking, hard-pressed women.

As Jane Turner's case revealed, women patients were not averse to controlling their conditions by doing something about it themselves. The cost involved in seeing a doctor, the time wasted sitting in hospital outpatient departments, or even the distress at the possibility of hospitalisation may have been preferable to seeking professional advice. Additionally, the sheer unpleasantness of a situation they would rather keep to themselves or, in some instances, illegal measures, could also prevent medical consultation. Women who suffered from prolapse were quite used to

¹³⁸ Mary Surtees (MS: 1904); Eliza Miles (EVS: 1913; Part I); Caroline Leggett (MS: 1907; Part I); Alice Munday (MS: 1908; Part II); and Elizabeth Mitchell (EVS: 1912; Part II).

¹³⁹ Emma Spooner (MS: 1906; Part II).

¹⁴⁰ Louisa Watson (MS: 1905; Part I); Mary Blogg (MS: 1904).

¹⁴¹ Lily Langley (MS: 1905; Part I).

¹⁴² Margaret Gray (MS: 1908; Part I), and later (EVS: 1913; Part I).

¹⁴³ Emily Ineson (EVS: 1911; Part II); Agnes Martin (EVS: 1904–1908; 1908); Margaret Dingwall (EVS: 1912; Part II).

¹⁴⁴ Jane Turner (EVS: 1913; Part I). This was misfiled, as Mrs Turner actually attended as an in-patient between 12 August and 13 September 1912.

replacing their own uterus; indeed, for many, the easiness of this rendered treatment worthless. Lily Langley had successfully returned her womb for five and a half years; it was only once she was unable to do so that she sought outside help.¹⁴⁵ Similarly, Prudence Cooper, who had to carry out very heavy work in a laundry, had suffered from prolapse for 15 years. It has ‘never caused any pain; the only trouble is the continual discomfort and inconvenience’, made worse, of course, by her employment. Only recently had she been unable to replace it properly. Three weeks before her admission, Mrs Cooper finally admitted defeat and went to Clapham Maternity Hospital; as they were unable to replace it, she was sent to the RFH, where her womb was with difficulty replaced. She was later admitted as an in-patient under Vaughan-Sawyer. For 15 years, Prudence Cooper ‘never had any treatment’.¹⁴⁶ Less physically demanding self-treatment included measures so ‘bowels open regularly’. Most women guarded themselves against constipation, utilising innocent aperients such as senna or liquorice powder; something which Cullen has similarly noted of patients in her study.¹⁴⁷ Piles were also a problem experienced by a number of women; most were ignored until they became intolerable, but Rebecca Shopin stated that she used ‘Vaseline’ for internal ones.¹⁴⁸ Clara Hughes treated herself with ‘Turps’, rubbed on to her abdomen in order to ease the abdominal pains she had been experiencing; unfortunately, all that resulted were sores and blisters.¹⁴⁹ Alcohol or drugs were other measures to which some turned in order to numb the pain. Miriam Silverston, a nurse, was a morphomane, and, despite several attempts at treatment, was still addicted to the drug.¹⁵⁰ Interestingly, she also gave her address as Hammond Lodge: a home for female alcoholics.¹⁵¹ Dorothy Temblett, formerly a popular stage actress (see Illustration 2.1), had drunk regularly for five years, mostly whisky, and had also been taking morphia, ‘off and on’, since an accident in which she suffered bad burns to her arms from a gas stove explosion.¹⁵² Charwoman Minnie Rogers had ‘frequently been drinking heavily’, to ease the pain of decade-long sacral backache.¹⁵³ Conversely, Hannah Jones and Eliza Jackson were aware that they were unwell, because both were

¹⁴⁵ Lily Langley (MS: 1905; Part I). ¹⁴⁶ Prudence Cooper (EVS: 1911; Part I).

¹⁴⁷ Cullen, ‘Patient Records’, pp. 120–121. ¹⁴⁸ Rebecca Shopin (MS: 1908; Part II).

¹⁴⁹ Clara Hughes (EVS: 1909; Part II). ¹⁵⁰ Miriam Silverston (MS: 1905; Part II).

¹⁵¹ Silverston’s residence in King’s Lynn was, by 1907, one of five for female alcoholics run in Britain by the Church of England Temperance Society. See Stephanie Olsen and Gerald Wayne Olsen, ‘Church of England Temperance Society (CETS) Inebriate Homes’, in Jack S. Blocker, Jr., David M. Fahey, and Ian R. Tyrell, eds., *Alcohol and Temperance in Modern History. Volume I* (Santa Barbara, CA: ABC-CLIO, 2003), pp. 157–8; p. 158.

¹⁵² Dorothy Temblett (MS: 1908; Part II). ¹⁵³ Minnie Roger (EVS: 1913; Part I).



Illustration 2.1 Dorothy Temblett in better days (postcard dated 21 July 1904), Author's Collection.

currently unable to enjoy their daily pints or occasional little whisky, as alcohol caused unpleasant sensations or vomiting.¹⁵⁴

There were, of course, 'accidental' instances of self-treatment. A couple of falls appeared in the notes, which resulted in bizarre vulval

¹⁵⁴ Hannah Jones (EVS: 1911; Part I); Eliza Jackson (EVS: 1913; Part I).

or vaginal injuries. They usually occurred after unlikely household incidents. Maria Blackmore fell off a chair and injured herself 'in the genital area' nine years before admission; she had not been pregnant for seven years after this fall.¹⁵⁵ Annie Hammond was admitted under the influence of drink, having stepped from a table onto a chair for reasons unexplained. Her inebriation was such that she did not need an anaesthetic to have her labial laceration repaired.¹⁵⁶ Unlike Mrs Hammond, Polly Cole explained her strange positioning after a fall. When reaching to pull down a blind, she had fallen and the 'rail of the bedstead passed between her legs'. Profuse haemorrhage resulted. Curiously, the phrase 'removal of a 4½ months foetus' was crossed out, but still visible.¹⁵⁷ While either woman's actions may have been deliberate attempts to bring on a miscarriage, there were other cases in the patient records of the Gynaecological Department where a successful abortion had been carried out. One of the oddest stories involved sitting in the wrong place at the wrong time. Maud Hazell, a 24-year-old single dancer with two children, had suffered two miscarriages in eighteen months, after the birth of her last child. While she was insistent that she had still been menstruating, the private doctor she had seen before she came to the RFH had removed clots and suggested she had miscarried a three months' foetus. She then proceeded to mention that she had accidentally, a month before this alleged miscarriage, sat on a crochet hook, which had entered her vagina and had been difficult to remove.¹⁵⁸ Four years before admission, Nellie Claxton stated that she had brought on a miscarriage with a penholder.¹⁵⁹ Both Agnes Herr and Annie Morris described situations involving 'syringing for [vaginal] discharge', a treatment frequently recommended by both female surgeons for cleanliness, when something went wrong. Herr's douche was simply soap and water, she noted, but she had a miscarriage half-an-hour after 'treatment'.¹⁶⁰ She had been married for eight years and had three children under six; vaginal douching, she insisted, was something she had done for years. Morris, conversely, was aware that she had 'hurt herself'; she had been sent to the RFH by a private doctor and subsequently miscarried in hospital.¹⁶¹ In contrast to Mrs Herr, Annie Morris was a single, 25-year-old housemaid. Both, however, used the same accident while legitimately carrying out recommended medication to explain their circumstances.

¹⁵⁵ Maria Blackmore (EVS: 1910; Part I).

¹⁵⁶ Annie Hammond (MS: 1904).

¹⁵⁷ Polly Cole (MS: 1906; Part II).

¹⁵⁸ Maud Hazell (MS: 1908; Part II).

¹⁵⁹ Nellie Claxton (EVS: 1913; Part I).

¹⁶⁰ Agnes Herr (MS: 1908; Part II).

¹⁶¹ Annie Morris (MS: 1908; Part II).

Agnes Herr and Annie Morris were frank enough about what had happened to them while treating themselves, but there were a number of other cases where women spoke very openly about contraceptive practices to prevent pregnancy. In public women might have been 'very reluctant to proclaim that they had attempted abortion which was regarded by respectable opinion with the same horror as infanticide',¹⁶² but private consultation with medical and surgical practitioners elicited a very different narrative and offered a stark insight into the desperate lengths some women were prepared to go to regulate their families. While Knight has claimed that before 1914 women generally used drugs rather than instruments to procure abortion, the patients of the RFH employed both methods.¹⁶³ Gertrude Blacksley, a 21-year-old married woman, explained succinctly that she was 'in the habit of using sponges in the vagina to prevent pregnancy'.¹⁶⁴ As she was unable to remove the sponge this time, she utilised a button hook; in so doing, however, Mrs Blacksley lacerated her vaginal wall with the hook, caused profuse haemorrhage, and had to come to hospital to have the tear repaired. Sarah Barnett had been married for four years, already had four children and most certainly 'did not wish for another'. She calmly noted that she passed a glass syringe into her vagina to induce abortion. This resulted in a panhysterectomy, because of the peritonitis caused by her actions.¹⁶⁵ Lilian Walker was told of her pregnancy at Gate, the RFH's Casualty Department.¹⁶⁶ She promptly returned home and passed a knitting needle two or three times into her vagina. Additionally, she took five or six different drugs in gin 'with intent to produce abortion'. Although she had only one child, Mrs Walker had tried unsuccessfully to abort it as well. She neither lived with her husband of a decade nor saw him; although the dead foetus and their last meeting three months before appear to have coincided. Emily Franklin, who was 33 and married with six children, admitted taking a couple of pennyroyal pills, known abortifacients, just before she miscarried.¹⁶⁷ She further acknowledged having taken the same number when she lost another child the year before. Two years ago, she had brought on a premature birth at six months by lifting

¹⁶² See Pamela Knight, 'Women and Abortion in Victorian and Edwardian England', *HWJ*, 4 (Autumn 1977), 57–69. Also Davin, 'Imperialism and Motherhood'.

¹⁶³ Knight, 'Women and Abortion', 60. ¹⁶⁴ Gertrude Blacksley (MS: 1907; Part I).

¹⁶⁵ Sarah Barnett (EVS: 1912; Part II). ¹⁶⁶ Lilian Walker (EVS: 1910; Part I).

¹⁶⁷ Emily Franklin (EVS: 1913; Part I). Pennyroyals appear in Knight's list of easy available cheap remedies, which include 'colocynth (commonly known as "bitter apples"), hiera picra ("hikey pikey" in popular terminology), tansy, [. . .], apiol (combined with steel), gin and gunpowder (the latter bought from the ironmongers), gin and salts, iron and aloes, caraway seeds, turpentine, washing soda and quinine'. See 'Women and Abortion', 60.

heavy weights: the child died. Kate Davey placed the blame for five years of pelvic pain on an abortion induced at three months by an injection into the uterus, which had resulted in peritonitis.¹⁶⁸ Others did not give as much information about their background, but their physical condition led to a diagnosis. Fear of the consequences of an attack by a patient perhaps encouraged Dorothy Neal, a nurse at Colney Hatch, to introduce a long, narrow, sharp and pointed instrument into her vagina.¹⁶⁹ Before she was examined, the note-taker expressed frustration at this 'slightly hysterical' woman, who 'burst into tears when questioned about the accident', which had involved a patient apparently kicking Miss Neal in the abdomen. Only closer inspection under anaesthetic revealed internal injuries inconsistent with an external blow. Others were unable to discuss the reasons behind their circumstances because their actions were lethal. Two cases where treatment had been procured but not properly administered stand out to warn of the dangers of self-medication.¹⁷⁰ Although she did not want to prevent conception, long-standing invalid Annie Cox, who was 'very delicate and has always lived at home', sought to ease her pain by inserting a menthol cone inside her vagina. An abscess formed around the cone and Miss Cox died of septic peritonitis after surgical removal of the object. The most shocking case was that of 'Constance Webb', whose notes queried a criminal abortion. When she was opened up by Mary Scharlieb, twin foetuses were discovered, covered in a white powdered substance, which also appeared in the vaginal vault. Mrs Webb's abdomen was described as 'almost gangrenous', offensive gas escaping as she was operated upon. Despite the removal of her uterus and right ovary, Constance Webb died of acute toxæmia and peritonitis. Bruising was later found on her arms and right hip, suggesting that she was held down while this procedure was performed. While self-treatment might save doctors' fees or personal embarrassment, or even another mouth to feed on limited funds, some of the cases seen by Scharlieb and Vaughan-Sawyer indicated that not everyone who tried to medicate themselves was successful in achieving their ends. Even if they did ensure that conception would no longer be possible, as in the case of Constance Webb, whose generative organs were surgically removed, they might not live to experience or benefit from the consequences of their drastic actions.

Some were prompted to seek treatment due to remarks made by others about their changing physical appearance. More often than not, the

¹⁶⁸ Kate Davey (MS: 1907; Part I). See note 38 for more references to Miss Davey in the notes.

¹⁶⁹ Dorothy Neal (MS: 1904).

¹⁷⁰ Annie Cox (MS: 1904); Constance Webb/Mary Ross (MS: 1908; Part I).

patient herself was the one who noticed problems with her own body. In some cases, however, it was someone else, and it was the opinion of that other which propelled the patient to seek medical attention. Many women first noticed symptoms after sex; dyspareunia being a common sign of gynaecological problems and especially malignancy. For example, Emma Hanchett and Elizabeth Goode were diagnosed with carcinoma of the cervix; both became aware that something was wrong after coitus resulted in pain, bleeding and an unpleasant odour in the latter's case.¹⁷¹ Of just over 1400 patients examined, however, only one man encouraged his wife to see a doctor. Emma Binns explained that it was her husband who noticed her 'getting thinner' and 'has been anxious for some time that [she] should seek medical advice'.¹⁷² For other patients, especially those who were single or widowed, physical changes were observed by friends and relatives, whose comments cast a shadow over a previously good reputation. The gradual enlargement of the abdomen, accompanying fibroids or ovarian cysts, could resemble pregnancy even to the medical man, as confusion over the case of Olive M. Goodwin made clear. At first glance, therefore, even the most virginal could appear otherwise. Edith James, a 38-year-old single governess, had felt her abdomen enlarging for the past six or seven years without obvious cause.¹⁷³ The reactions of others determined her next move. At first, friends reassured her that she must simply be suffering from flatulence, and so she did nothing about her condition. Then, however, her abdomen became 'large enough for people to remark about it'; the switch here from friends to people suggested that strangers had made insinuations about her circumstances. The discovery that Miss James had multiple uterine fibroids immediately restored any damage to her reputation and surgery returned her waistline to one more suitable to her situation. Widowed actress Dorothy Temblett was less delicate than Miss James in her description of the accusations she had thrown at her. Her increasing abdomen, due, it was discovered to an enormous ovarian cyst, which reached to her ribs, had led to slurs that, in spite of what she argued, she 'must be pregnant'.¹⁷⁴ Such outside interference in the progress of a patient's illness certainly conceptualises 'clinical interactions', as Sally Wilde has suggested, 'in a more complex and realistic fashion' than the simplicity of the doctor-patient relationship.¹⁷⁵ Often, as the histories of some of the patients imply, there was a well-meaning (or otherwise) intermediary

¹⁷¹ Emma Hanchett (EVS: 1913; Part II); Elizabeth Goode (MS: 1904).

¹⁷² Emma Binns (MS: 1906; Part II).

¹⁷³ Edith James (MS: 1904). This is a different woman to Vaughan-Sawyer's patient of the same name detailed in note 72 above.

¹⁷⁴ Dorothy Temblett (MS: 1908; Part II). ¹⁷⁵ Wilde, 'The Elephants', 22.

in the case, providing a wider picture of the reasons why patients sought or waited for treatment. If women delayed their search for a cure to their ailments through a mixture of denial and stoicism, they could be provoked into seeking help more swiftly if their reputations were attacked publicly or a loved one urged them to act quickly to remedy the effects of evident ill-health.

In the Hospital

So far the composition of the patient base and the reasons for attendance at the RFH have been explored in this chapter in order to determine what brought female patients to the hospital to seek treatment in the first place. When women were admitted into the Gynaecological Department's beds, they were examined, re-examined and conclusions made as to whether or not their case was an operative one or whether rest might lead to recuperation. The period before and after operations, the minutiae of daily hospital life were all recorded in the notes, as were patient reactions to their treatment. Vaughan-Sawyer's 1911 lecture about the patient asked for consideration to be given to what 'bulk[s] large in the patient's eyes', the 'source of great trepidation' which the 'ordeal' of hospitalisation represented.¹⁷⁶ The initial courage summoned up to seek medical opinion was only the beginning of the patient narrative and an examination of the time spent on the ward is essential to understanding the experience of women who passed through the Gynaecological Department between 1903 and 1913.

Case notes were initially divided into a number of sections, which broadly followed the description of circumstances by the patients themselves. After a history of symptoms, the physical examinations by medical and surgical personnel were detailed. The differences in the ways patients responded to this part of the process proved fascinating. Such reactions were especially important because, as we have already seen, most women would not have been examined by a practitioner of the same sex before. As Mary Ann Elston remarks: '[q]ualified female professionals, it was argued, would bring great benefit to women whose modesty precluded them from seeking treatment from middle-class men'.¹⁷⁷ If the majority of patients had not sought female medical help before, it could be imagined that all would respond favourably to the chance to be examined by someone who 'understood' or 'knew' what it was like to experience such symptoms. While many faced examination calmly, this was by no means the case with all. Cullen has suggested that '[p]hysical examinations,

¹⁷⁶ Vaughan-Sawyer, 'The Patient', 352. ¹⁷⁷ Elston, "'Run by Women'", p. 78.

particularly the invasive (such as gynaecological examinations conducted with a speculum), demonstrate the growing acceptance of patient discomfort (both physically and emotionally) as an inevitable side-effect of clinical medicine.¹⁷⁸ Yet, in the gynaecological records, it was precisely the non-acceptance of physical discomfort and the problems attending what should have been straightforward examinations which dominated patient histories. At the RFH, women might have been privileged to be 'under' their own sex, but they still objected to and resisted the ways in which they were treated if it did not meet their expectations. A gynaecological examination was necessarily invasive and mostly instrumental, beyond the usual palpation and percussion, so it is not surprising that many were disgruntled by the process, even if it was carried out by a medical attendant of their own sex.

Twenty-year-old general servant Eliza Love's reaction to examination was mentioned as being very quiet, allowing herself to be examined without rigidity.¹⁷⁹ This was an unusual response to a vital part of understanding the cause of gynaecological complaint. More often than not, patients resisted, either deliberately or because their circumstances ensured that examinations were extremely difficult. The consequences of being unable to examine a patient initially should also be considered, as well as the practices to which the surgeon was compelled to resort to understand more clearly the origins of the symptoms described by the patient. Physical resistance was encountered frequently by those treating the patients at the RFH. Touch, even when carried out delicately, caused some to react strongly. The palpation of Elizabeth Taylor, who had a large abdominal tumour eventually discovered to be a collection of uterine fibroids, caused her 'sickening pain'.¹⁸⁰ Maria Asirti's pre-eclampsia altered her personality and she became violent, continually fitting, which, of course, impeded examination, and refused to allow anyone to touch her when she was still.¹⁸¹ She was described as very unruly and quite unconscious of what was going on around her, but she managed to resist treatment and could not be made to swallow anything. This ensured that she had to be fed nasally, to which she reacted with extreme violence. When her condition improved, Mrs Asirti became more manageable. Nineteen-year-old servant Maud Burge, however, who was suffering from an abscess of Bartholini's Gland, had no clinical excuse for her behaviour. Her brief stay was accompanied by rudeness, especially about Vaughan-Sawyer, who had been treating her at Out-Patients since the middle of 1903, as well as the RMO, Miss Denny, and the nurses of the ward upon which

¹⁷⁸ Cullen, 'Patient Records', p. 249.

¹⁷⁹ Eliza Love (MS: 1904).

¹⁸⁰ Elizabeth Taylor (MS: 1908; Part II).

¹⁸¹ Maria Asirti (MS: 1904).

she was placed. Although she was in great pain, Miss Burge would not permit anyone to treat the abscess, which was described as needing incision. She hesitated, but finally would not allow anyone to touch her. Unsurprisingly, she was discharged the following morning.¹⁸² Florence Bromley, a 22-year-old married woman, was so 'very intolerant' of examination that she resisted both at Out-Patients and then when admitted to the ward. As a consequence, 'examination was incomplete' and the patient discharged to be watched at Out-Patients.¹⁸³

While some resisted deliberately, others could not be examined for various physical reasons which prevented closer inspection. It was not just vaginal explorations which caused problems. Kate Rocca, for example, had no radial pulse in her right arm as her wrist had been damaged by being put through a broken window.¹⁸⁴ Helen Silver's vaginismus ensured that vaginal examination caused pain and muscle spasm: reactions she was incapable of controlling.¹⁸⁵ Likewise, Tamar Hillyard's body was hard to examine because of a 'vibrating' and 'pulsating' abdomen, which was due to nervousness.¹⁸⁶ Maud Hazell was very constipated when she was admitted, which made both vaginal and abdominal examination unsatisfactory and difficult.¹⁸⁷ Some patients were so thin or so fat that exploration was impeded by the shape of their bodies. Single nurse Ethel Hennessey admitted to having lost a considerable amount of weight over the previous nine months, due to adhesions forming after an appendectomy, and was described as 'very thin and rather pale'.¹⁸⁸ As she was 'so thin', Miss Hennessey's ovary and fallopian tube could not be felt on the right side; an indefinite mass only presented itself to the palpating hand. Conversely, Elizabeth Lawson was 'extremely fat', ensuring that examination was 'of little value'.¹⁸⁹ Elizabeth Newell's excessive 'stoutness' was blamed for an inability to palpate the fundus of the uterus, while Caroline Radford's heart sounds could only very faintly be heard because of the thickness of her chest wall.¹⁹⁰ The blame in Susan Carter's case for her being 'extremely difficult' to examine was attributed both to the 'amount of fat present' on her abdomen, but also to the fact that she obstructed vaginal exploration by 'hold[ing] her thighs tightly' together.¹⁹¹

¹⁸² Maud Burge (MS: 1904). This was not the last time Maud Burge appeared in the records, however. She must have thought better of her attitude towards the staff as she was admitted twice over the next nine years: (MS: 1906; Part I) and (EVS: 1913; Part II).

¹⁸³ Florence Bromley (MS: 1905; Part I). ¹⁸⁴ Kate Rocca (EVS: 1912; Part I).

¹⁸⁵ Helen Silver (MS: 1907; Part II). ¹⁸⁶ Tamar Hillyard (EVS: 1913; Part II).

¹⁸⁷ Maud Hazell (MS: 1908; Part II). ¹⁸⁸ Ethel Hennessey (EVS: 1910; Part I).

¹⁸⁹ Elizabeth Lawson (EVS: 1910; Part II).

¹⁹⁰ Elizabeth Newell (EVS: 1910; Part II); Caroline Radford (MS: 1905; Part I).

¹⁹¹ Susan Carter (EVS: 1910; Part II).

Examining a squirming or rigid patient was not an easy task. The fact that women in-patients were being seen by their own sex did not make a difference to those who were resistant, either deliberately or through no fault of their own, to clinical exploration.

For some patients, it was the prospect of further examination, potentially under anaesthetic, which led to a swift discharge from the hospital even before any real treatment, let alone operative measures, had been carried out. As we will see, surgery was both facilitated and stymied by anaesthetics. Those who resisted exploration while awake were often anaesthetised in order to facilitate diagnosis. As Scharlieb and Vaughan-Sawyer's RFH colleague, James Berry put it, '[g]eneral anaesthesia, by producing relaxation of the muscular wall, is of great assistance in deep palpation of the abdomen'.¹⁹² It was precisely this 'relaxation' which troubled a number of women patients in the Gynaecological Department. Even though examination was being carried out by members of their own sex, the 'fear of unconsciousness', as Snow has noted, was enough to put an end to hospital treatment for several patients, who would rather discharge themselves than undergo exploration where resistance was not possible.¹⁹³ The 'confidence' identified by historians of medicine of the patient in the surgeon was certainly not apparent for every one of the 1403 cases seen in the reality of day-to-day life on the wards of the RFH. Anaesthesia in particular, even in the early twentieth century, still caused particular dread.¹⁹⁴ Refusal to be put under any form of anaesthetic was one of the most prominent reasons for premature discharge from the hospital. In *Surgical Anaesthesia* (1909), H. Bellamy Gardner reassured his readers that 'the sex and age' of those undergoing vaginal procedures ('between twenty and forty-five'), rendered them 'comparatively easy to anaesthetise', but this was not borne out by the reaction of Scharlieb and Vaughan-Sawyer's patients.¹⁹⁵ Neither would the possible seriousness of the patient's condition prevent departure if the only way that anything further could be done for them would be under sedation. Mary Gunn, a 43-year-old widowed cook, was one example.¹⁹⁶ She was diagnosed as having suspected carcinoma of the uterus, because of her cachectic appearance, as well as irregular bleeding, abdominal pain and loss of flesh. Initial exploration had proved difficult because the patient was so

¹⁹² Berry, *A Manual of Surgery*, p. 128.

¹⁹³ Stephanie Snow, *Operations Without Pain* (Basingstoke: Palgrave Macmillan, 2006), p. 94.

¹⁹⁴ See Wilde, 'Truth, Trust' and Burney, *Bodies of Evidence*.

¹⁹⁵ H. Bellamy Gardner, *Surgical Anaesthesia* (London: Ballière, Tindall and Cox, 1909; New York: William Wood and Company, 1909), p. 217.

¹⁹⁶ Mary Gunn (MS: 1908; Part II).

ill and too tender to touch. Consequently, Scharlieb wanted to perform an examination under anaesthetic in order to ascertain whether or not her initial suspicions were correct, and simultaneously remove curettings from the uterus, which could be sent to the Pathology Department to determine diagnosis microscopically. What Mrs Gunn objected to was not the operation per se, but, as was specifically noted, 'examination under anaesthetic'. She left without any solid diagnosis being made.

Marian Freed was in a similar situation, although her queried carcinoma of the cervix had been caught early at Out-Patients by Vaughan-Sawyer, and was, therefore, potentially operable.¹⁹⁷ However, she too refused an anaesthetic and left the hospital after one day without further examination. Betty Schmottken had a mysterious tumour and abdominal pain, which was considered potentially a life-threatening ectopic pregnancy.¹⁹⁸ Scharlieb deemed it impossible to make certain diagnosis in her case without proper exploration under anaesthesia. The patient refused and discharged herself immediately. Rachael Eagle, a 29-year-old housewife admitted for endometritis and a torn perineum, had been attending Gynaecological Out-Patients for the previous two months.¹⁹⁹ She had initially refused admission because she had wanted to wean her baby, but when she did become an in-patient, she supported an initial examination. On being informed that there would be a further investigation under anaesthesia a day later, however, Mrs Eagle made sure that she discharged herself before this could occur. When told that she was pregnant, Gertrude Figg, who had 'felt as if her inside was dropping from her', took the news in and then agreed to undergo an exploratory examination under anaesthetic for a small adenoma of the cervix the following day.²⁰⁰ Overnight, however, Mrs Figg felt 'foetal movements' and refused to have the procedure, evidently concerned about the possibility of miscarrying her unborn child. The specialist would suggest that 'pregnancy forms no contra-indication to operation', but Gertrude Figg would not take the risk, and discharged herself.²⁰¹ Twenty-year-old single tailoress, Bertha Finkelstein, was the most contrary patient as far as the acceptance of anaesthesia was concerned.²⁰² Initially, she objected to any examination without anaesthesia, but when the time came for her to undergo investigation, she refused any anaesthetic and was discharged. A further attack of pain changed her mind and she was readmitted, finally accepting both examination and anaesthetic.

¹⁹⁷ Marian Freed (MS: 1905; Part I).

¹⁹⁸ Betty Schmottken (MS: 1908; Part II).

¹⁹⁹ Rachael Eagle (MS: 1907; Part I).

²⁰⁰ Gertrude Figg (MS: 1905; Part II).

²⁰¹ Howard A. Kelly, *Operative Gynecology. Volume I*, second edition (New York: D. Appleton and Company, 1906), p. 421.

²⁰² Bertha Finkelstein (EVS: 1911; Part I).

Anaesthesia did, however, have another function in the examination of female patients. It allowed women, particularly the single and thus (largely, though not exclusively) virginal, to be examined without feeling immodest or shamed by the situation on the one hand, and, on the other, to ensure that examination was indeed possible where tight or unruptured hymens prevented access to female generative organs in the first place. The American surgeon, Howard A. Kelly, of Baltimore, visited the RFH in the middle of 1905 and the autumn of 1910 and was present at a number of operations on gynaecological patients, as well as carrying some out.²⁰³ In his textbook *Medical Gynecology* (1912), Kelly extolled the virtues of anaesthesia when approaching those physically and morally sensitive to examination:

There should, of course, be no hesitation in the case of married women, or in cases of inflammatory disease. But there are many instances of young women who suffer from dysmenorrhoea pure and simple, when the question of examination must receive careful consideration. It is always best to exhaust all general therapeutic measures before making it [. . .].

With this precaution, an examination can be made without injury to the hymen, while, should any simple operation such as dilatation and curettage be indicated, it can be performed at the same time. Such a course enables the physician to dispense with the endless local treatments which are so objectionable in young women.²⁰⁴

In a number of cases examinations per vaginam were simply not made initially or without anaesthetic because the patient was 'unmarried'. This was noted, for example, in the records of Lizzie Hammant, Nellie Culling, Gertrude Rippon, Lucy Marsden, Alice Jones, Agnes Henman, and Emma Bevan.²⁰⁵ The latter three were 46, 48 and 52, respectively, so age was no barrier to ensuring the treatment was appropriate to the patient's marital status. In a further nod to delicacy, Clara White was not explored with a speculum, but with a far less intrusive finger 'to avoid tearing her hymen as she is single'.²⁰⁶ Others could not be examined physically without an anaesthetic precisely because of their virginal state. Twenty-eight-year-old Salvation Army officer Margaret Dingwall's

²⁰³ In 1905, Kelly operated on Mary Stapleton, Emma Beauchamp and Mary Ann Coleman (MS: 1905; Part I). On his second visit, in 1910, Kelly took 'stereoscopic photos throughout' the Caesarean Section performed on Alice Hollingshed by Ethel Vaughan-Sawyer. Miss Hollingshed had 'markedly deformed legs' and a scoliotic curve to her spine (EVS: 1910; Part II).

²⁰⁴ Kelly, *Medical Gynecology*, p. 112.

²⁰⁵ Lizzie Hammant (EVS: 1913; Part II); Nellie Culling (EVS: 1911; Part II); Gertrude Rippon (EVS: 1911; Part II); Lucy Marsden (MS: 1904); Alice Jones (MS: 1905; Part II); Agnes Henman (MS: 1904); Emma Bevan (EVS: 1911; Part II).

²⁰⁶ Clara White (EVS: 1913; Part II).

hymen was too tight to permit examination per vaginam. Under anaesthetic, however, Vaughan-Sawyer was able to obtain some curettings through a 'small orifice'.²⁰⁷ Housemaid May Groome's 'intolerance of manipulation' was overcome when anaesthetised, while 20-year-old Elsie Ward proved 'impossible' to examine satisfactorily without anaesthetic, as both James Berry and Mary Scharlieb discovered.²⁰⁸ Similarly, Kate Branfield's hymen, which was intact, became 'very dilatable' under anaesthesia, revealing how the body changed when unconscious.²⁰⁹ For one patient, the geographical location of the examination was what mattered, perhaps offering the only example of the 1403 cases where a patient placed trust in the institution to provide proper care. Four days before her admission, 21-year-old Jane Moore had given birth to her first child, but had suffered from a rising temperature ever since.²¹⁰ Mrs Moore refused exploration of her uterus under an anaesthetic at home, but expressed willing to have the identical procedure performed in the RFH.

While anaesthesia facilitated diagnosis, it also cured in a few instances. Margaret Smith was 'hysterical' during anaesthetic induction and when she came round, but her anaesthetisation had allowed RMO Miss Edmonds to remove a cervical polypus which had been causing eighteen months' pain and discharge.²¹¹ Single governess Edith James was deliberately given gas as an anaesthetic, because she was considered extremely nervous.²¹² In *Surgical Anaesthesia*, Gardner reminded the medical profession that it was well to put oneself in the position of the patient before giving an anaesthetic. '[W]ithout any previous experience of anaesthetics', he stated, 'most people would prefer to be put to sleep without passing through a long stage of semi-consciousness, by some vapour or gas which has as little taste as possible, and produces no sense of suffocation during the inhalation.'²¹³ The 'selection of the anaesthetic appropriate' to the patient was vital in ensuring the best possible outcome for patient, anaesthetist and operator alike, especially when the patient was of a nervous temperament.²¹⁴ Kate Williams, Beatrice Hart and Ethel Hoskins were anaesthetised with the prospect of discovering conditions which would warrant further procedures.²¹⁵ Miss Williams had pain in her back and a swollen, 'markedly distended' abdomen since a confinement the year before admission. Mrs Hoskins was supposed

²⁰⁷ Margaret Dingwall (EVS: 1911; Part II).

²⁰⁸ May Groome (EVS: 1913; Part I); Elsie Ward (MS: 1908; Part II).

²⁰⁹ Kate Branfield (EVS: 1911; Part II). ²¹⁰ Jane Moore (MS: 1908; Part II).

²¹¹ Margaret Smith (EVS: 1913; Part I). ²¹² Edith James (MS: 1904).

²¹³ Gardner, *Surgical Anaesthesia*, p. 26. ²¹⁴ *Ibid.*, p. 28.

²¹⁵ Kate Williams (EVS: 1910; Part II); Ethel Hoskins (MS: 1908; Part II); Beatrice Hart (EVS: 1913; Part I).

to be suffering from an abscess of Gartner's Duct, while Mrs Hart described nine months of amenorrhoea during which she thought she was pregnant. In all three instances, the induction of anaesthesia encouraged the swelling to subside. As Gardner noted, abdominal conditions such as those causing inflammation or toxicity and leading to contraction or rigidity often 'relax in the surgical degree of anaesthesia'.²¹⁶ Kate Williams left hospital consequently with a 'flat abdominal wall'. There were instances where the induction of anaesthesia had the opposite effect, and actually failed to assist the operator or help the patient. Ellen Magor's previous operation at the Hampstead Hospital a year before her admission to the RFH and the evident relaxation of her body at the time had ensured that a formerly lax vagina was made so tight during a perineorrhaphy that the patient subsequently experienced dyspareunia.²¹⁷ While most relaxed under anaesthesia and gynaecological examination was more easily carried out, two patients resisted. Thirty-two-year-old single woman Edith Edwards' very tight hymen was torn laterally when a Hodge pessary was inserted under anaesthesia by RMO Miss Mccredy to ease backache and profuse menstruation.²¹⁸ Her reaction, if she was informed of the tear, was, unsurprisingly, not noted. Unlike Kate Branfield's anaesthetic yielding, Mary Horton, 'a very healthy and well-developed' 28-year-old nurse, still resisted.²¹⁹ Her athleticism and strong physique permitted the administration of a deep anaesthesia, but this was 'pushed so far' that she stopped breathing for a bit and had to be given artificial respiration. In similar fashion to Miss Edwards, a slight tear had to be made in the mucous membrane as Miss Horton's hymen was still so tight. From the description of such cases, it is understandable why some preferred, especially if they were single, to refuse an anaesthetic rather than worry about what any potential future husband might imagine.

Deaths from anaesthesia still occurred at the beginning of the twentieth century and popular mistrust would have made patients nervous about the administration. Burney has commented upon the 'ambiguous position of anaesthesia' at the turn of the twentieth century. It was 'more institutionally grounded than ever before, but at the same time vulnerable to the charge that, a half-century of experience notwithstanding, it remained a dangerous and unreliable practice.'²²⁰ Only one patient died from the effects of anaesthesia in the decade explored by this chapter: 15-year-old Gladys Perks, from chloroform poisoning.²²¹ Others were, however, legibly affected by anaesthesia or the operative process itself and

²¹⁶ Gardner, *Surgical Anaesthesia*, p. 208.

²¹⁷ Ellen Magor (EVS: 1913; Part II).

²¹⁸ Edith Edwards (EVS: 1910; Part II).

²¹⁹ Mary Horton (EVS: 1911; Part I).

²²⁰ Burney, *Bodies of Evidence*, p. 141.

²²¹ Gladys Perks (EVS: 1910; Part I).

this must have caused some consternation to those awaiting their own procedures on the ward. Gardner in *Surgical Anaesthesia* and Burney more recently have focused on the most serious consequences of surgical shock and the treatment of emergencies, but there were smaller, although still troubling, reactions to an operation. Most patients, for example, were sick after an anaesthetic, often when they had been returned to the ward to be heard, if not observed, by others. Fifteen-year-old Minnie Earle, who suffered from a regurgitation of mucous during her operation for the removal of tubercular fallopian tubes, ended up with ether bronchitis.²²² 'Rather neurotic' Annie Gilkes disproved Gardner's theory about nervous patients being more troublesome during and after anaesthesia by taking two hours to come round post-operation and remaining apathetic for a further three days.²²³ Physical injuries were suffered by others. Jane Marshall, Kate Branfield and Annie Dryden were all burnt by the anaesthetic; the first on her cheek and the second more generally on her face, while the last had a blistered chin.²²⁴ Conjunctivitis affected Olivia Risley after her surgery, while Ellen Wilson suffered from a sore tongue, as did Annie Dryden, and Louie Carren, whose lips and eyes were also affected.²²⁵ Saline infusions also caused problems after an operation, which added secondary suffering to the original site. Cora Sergent had very tender breasts at the location where saline was infused during her procedure, and painful swelling emerged.²²⁶ Similarly, Alice Grenville noticed a sore lump under her breast where saline had been administered.²²⁷ Such small, slight injuries might not be significant in comparison with major surgery, but they would have caused women additional suffering during a time of recuperation, as well as worrying others on their ward about the process they were about to experience.

Resistance to surgical intervention was frequently caused by the patient themselves, whether deliberately or involuntarily, but sometimes delays in alleviating disease, pain or ill-health were attributed to the very poor general condition of the patient in the first place. A number of women were simply 'unsuitable' cases for surgery. There were a variety of reasons why, despite the necessity for surgical treatment, patients were often sent away without a vital operation or kept in for a while before they became suitable candidates to undergo the strains of a potentially lengthy procedure.

²²² Minnie Earle (EVS: 1912; Part II).

²²³ Annie Gilkes (EVS: 1913; Part I). Gardner, *Surgical Anaesthesia*, p. 63.

²²⁴ Jane Marshall (EVS: 1910; Part II); Kate Branfield (EVS: 1911; Part II); Annie Dryden (EVS: 1912; Part II).

²²⁵ Olivia Risley (EVS: 1910; Part I); Ellen Wilson (EVS: 1913; Part I); Louie Carren (EVS: 1913; Part I).

²²⁶ Cora Sergent (MS: 1907; Part II). ²²⁷ Alice Grenville (EVS: 1910; Part II).

As already mentioned earlier, Alice E. Howes' tendency to bruise easily encouraged the hospital to communicate with her own doctor for fear of haemophilia affecting her treatment. Laura Helsdown was admitted twice in 1908 and acknowledged that she bled easily when she cut herself and was liable to spontaneous bruising; several large purpura were present on her limbs. She returned after the removal of a cervical polypus had led to non-stop bleeding since her initial discharge. After rest, the bleeding stopped: no further operation was advised because of her possible condition.²²⁸ Edith Peacock bled subcutaneously during her operation, while Gertrude Rippon, who had previously suffered from bleeding gums after dental extractions, was further discovered to have a haematoma beneath the skin after her procedure.²²⁹ Haemophilia in women was considered 'sufficiently uncommon' for a case to be recorded as a memorandum in the *BMJ* in May 1910, but the RFH saw four potential cases over a period of five years.²³⁰ In the late nineteenth century, surgery was to be avoided for haemophiliacs unless it was for a life-threatening condition and a conservative approach was recommended at all times, but Scharlieb and Vaughan-Sawyer were willing to give their possibly haemophiliac patients a chance, allowing them operative treatment when necessary.²³¹

Some patients suffered from problems with their heart. Annie Richardson was diagnosed as having double mitral disease and a breakdown in compensation, making the prospect of childbirth life-threatening, while Nellie Brown, despite claiming that she had 'always been strong', had mitral stenosis, which complicated surgery for carcinoma of the cervix.²³² With rest, Mrs Richardson was able to have her first child, and Mrs Brown a (likely) palliative operation, with the anaesthetic carefully tailored to assist her breathing during the procedure. Sometimes, anaesthetists at the hospital were young and inexperienced (male and female) house surgeons, learning all aspects of the surgical trade. Knowledge of this prevented an operation on Alice Attridge, whose mitral obstruction

²²⁸ Alice E. Howes (EVS: 1910; Part II); Laura Helsdown (MS: 1908; Part II). However, Mrs Helsdown was operated upon in 1909 and in 1912 when symptoms reoccurred (EVS: 1909; Part I) and (EVS: 1912; Part II).

²²⁹ Edith Peacock (EVS: 1913; Part II); Gertrude Rippon (EVS: 1911; Part II).

²³⁰ E.W. Squire, 'Haemophilia in a Female', *BMJ*, 1.2576 (14 May 1910), 1168. This case, like all three at the RFH, also showed no family history of the disease. For a contemporary view exploring a family where women were carriers (and 'free from the disease'), but never bleeders, see Ernest W. Hey Groves, 'A Clinical Lecture upon the Surgical Aspects of Haemophilia', *BMJ*, 1.2411 (16 March 1907), 611–14.

²³¹ J. Wickham Legg, *A Treatise on Haemophilia* (London: H.K. Lewis, 1872), especially pp. 113–14.

²³² Annie Richardson (MS: 1908; Part II); Nellie Brown (EVS: 1911; Part I).

needed to be supervised by a skilled administrator.²³³ Respiratory conditions, such as phthisis or bronchitis, frequently rendered a patient's condition 'inoperable'.²³⁴ Scharlieb and Vaughan-Sawyer both made decisions about whether to perform surgery in these circumstances or not based on the recommendation of their colleague J. Walter Carr, a general physician with interests in diseases of the chest and of the nervous system.²³⁵ This was the case for Florence Sutherland, whose tubercular lungs counted against surgical success if her tuberculous anal ulcer was removed under anaesthetic. With her present lung condition, surgery would be a 'serious matter', Carr concluded.²³⁶ Minnie Carr was not anxious to have an operation for salpingitis, but her phthisis rendered it impossible anyway; exactly the same happened two years later when she was admitted again.²³⁷ Esther Berensohn left without an operation being performed for dysmenorrhoea, anteverted uterus and sterility, because there were signs of phthisis in her lungs.²³⁸

On the whole, the older the patient the more likely they were to suffer from conditions which made surgery an increasingly risky business. As Mary Connor was 'somewhat senile and feeble-minded', 'very feeble and old for her [65] years', and troublesomely prone to removing vaginal plugs intended to improve her overall condition before operation, she was sent 'to the Infirmary' for further treatment.²³⁹ Catherine Fountain was 56, but 'prematurely aged and degenerate' with marked emphysema, making her a bad subject for anaesthesia. Gardner warned that '[o]ld people and those who are past middle age must be treated, if anything with greater care than the very young, because impairment of thoracic expansion and commencing degeneration of all parts of the system turn the balance against them in recovery from conditions of collapse'.²⁴⁰ Fifty-nine-year-old Elizabeth Tranter was 'not considered a good subject for operation' by Carr, but delaying the procedure, to ensure her bronchitis improved, gave her a better chance of undergoing

²³³ Alice Attridge (EVS: 1908; Part II). In October 1912, to give one example, anaesthesia was given by Mr Howell, a house surgeon. See *The Eighty-Fifth Annual Report for 1912* (1913), p. 8.

²³⁴ Interestingly, Gardner did not suggest calling off an operation because of respiratory problems. See pp. 66–87; especially pp. 74–5.

²³⁵ For Carr's expertise, see Cullen, 'Patient Records', especially pp. 72–3.

²³⁶ Florence Sutherland (EVS: 1909; Part I). Miss Sutherland had previously been operated on by Scharlieb in 1906 for the same anal ulcer, as well as an ovarian cyst, but her condition had rapidly deteriorated since this point, along with her ability to be anaesthetised successfully. She was named as Florrie Sutherland in this note (MS: 1906; Part II).

²³⁷ Minnie Carr (MS: 1907; Part II); (EVS: 1909; Part II).

²³⁸ Esther Berensohn (EVS: 1913; Part II). ²³⁹ Mary Connor (EVS: 1909; Part I).

²⁴⁰ Gardner, *Surgical Anaesthesia*, p. 61.

an operation for cancer of the cervix. There was indecision over her case, but her own 'anxiety to be operated on' overrode doubt and throughout the operation, her condition was described as excellent.²⁴¹ For Henrietta Hall, a combination of bad bronchitis and malignant disease of the ovary ensured that she did not even have the chance to improve her chest condition, dying before an operation could be performed.²⁴² Other patients were able to have an operation, but, as in the case of Nellie Brown, with carefully controlled anaesthetic conditions. Eliza Larkins' long-standing poor chest problems, primarily due to asthma, did not prevent surgery, but she was deliberately anaesthetised with chloroform, while Olivia Risley's bronchitis was not severe enough to stop an operation for uterine fibroids, but her circumstances affected the timing and type of anaesthetic administered.²⁴³

A life of poverty and hard work etched itself upon the bodies of many patients. Lack of care for themselves, whether through impoverishment or resulting from self-sacrifice for family members such as husbands or children, physically marked those seeking treatment. Premature ageing has already been mentioned, but appalling oral hygiene was endemic and often delayed operation. Teeth were so infrequently described as 'excellent' between 1903 and 1913, whatever the age of the patient, that the mouths of 20-year-old tailoress Bertha Finkelstein and 16-year-old collar binder Bessie Ellis drew attention less to themselves and more to the 1401 whose teeth were far from perfect.²⁴⁴ Indeed, a large number of patients had teeth removed while on the ward. Twenty-four-year-old Marie Widden, for example, had fifteen stumps removed from her upper jaw, while Alice Self, who was 29, had eight teeth removed on one of her many visits to the RFH.²⁴⁵ Simple items such as mouthwash and toothbrushes were recommended for some patients awaiting operation. Their appearance in the margin of the records, where treatment details were usually placed, stated their importance for surgical preparation, but also the fact that they were not familiar to every patient and, as such, constituted 'medicine' for many. Charlotte Kendall (36), who was admitted for an incomplete miscarriage, had teeth extracted and her septic mouth treated; she was also prescribed a toothbrush.²⁴⁶ Elizabeth Thompson (39) and Helen

²⁴¹ Elizabeth Tranter (EVS: 1913; Part I). Mrs Tranter's death from heart failure four days after her operation suggested that her state was otherwise.

²⁴² Henrietta Hall (MS: 1905; Part II).

²⁴³ Eliza Larkins (EVS: 1910; Part II); Olivia Risley (EVS: 1910; Part I).

²⁴⁴ Bertha Finkelstein (EVS: 1911; Part I); Bessie Ellis (EVS: 1911; Part II).

²⁴⁵ Marie Widden (MS: 1905; Part II); Alice Self (EVS: 1911; Part I). See also: (MS: 1906; Part I) (MS: 1906; Part II); (MS: 1907; Part II); twice (EVS: 1911; Part I).

²⁴⁶ Charlotte Kendall (MS: 1908; Part II).

Pinner (21) were given sanitas mouthwash and toothbrushes.²⁴⁷ As Riha has noted, patient records provide several ‘clues to social problems’, including poor teeth and dirtiness: ‘there seems to be no connection between these categories and living conditions: middle class housewives neglected the care of their bodies, domestic servants working in upper class households walked around with their heads infested with lice, and simple workers had their teeth kept in order’.²⁴⁸ Such a finding can be applied similarly to the case notes of Scharlieb and Vaughan-Sawyer. Of course, the very nature of gynaecological complaints ensured that it was difficult to guard against uncleanliness. In addition to a cachetic physical appearance, the dying often had a strange smell about them, and so unpleasantness was actually helpful in this instance. Sixty-one-year-old Ellen Parkins, for example, who was riddled with cancer and suffering from general wasting and weakness, had ‘a peculiar odour of breath suggesting malignant disease’ even before she was given an exploratory laparotomy and the diagnosis confirmed.²⁴⁹ Dirt was evidently a constituent part of working-class life, but, as Riha makes clear, dirtiness was not confined to the lowest, nor cleanliness to the highest. As we have already seen, the best teeth belonged to two working-class women. Although she had just come out of Holloway Prison, street hawker Elizabeth Langley fascinated because she had an unusual and unidentified skin complaint, not associated with her lifestyle. No mention was made of dirtiness, despite her occupation and circumstances.²⁵⁰ Other patients had septic conditions unrelated to their gynaecological concerns. Both Annie Ward and Elizabeth Seaton had septic fingers, although no mention was made of how either came to have such an injury.²⁵¹ Dirtiness also had another meaning. Annie Gold, whose vaginitis and endocervicitis appeared to stem from masturbation, was claimed to be ‘dirty in her ways’. To make sure she did not reactivate her problems, Mrs Gold had her hands bandaged while in the ward as a preventative measure.²⁵² The patient who was in the worst physical shape was a surprising one, especially given her profession. Dorothy Temblett (see Illustration 2.1), who had been ‘on the stage’ for nearly a decade since the age of 15, entered hospital in appalling physical circumstances, her head infested with lice. A vestige of self-respect evidently remained, as, while she agreed for it

²⁴⁷ Elizabeth Thompson (MS: 1908; Part II); Helen Pinner (MS: 1908; Part I).

²⁴⁸ Riha, ‘Surgical Case Records’, 278. ²⁴⁹ Ellen Parkins (EVS; 1912; Part I).

²⁵⁰ Elizabeth Langley (MS: 1908; Part II). It was surmised that she was covered in mollusca or fibromas; the description of her skin dominated the notes.

²⁵¹ Annie Ward (EVS: 1913; Part I) and (EVS: 1913; Part II); Elizabeth Seaton (EVS: 1912; Part I) twice; also: (EVS: 1911; Part II).

²⁵² Annie Gold (EVS: 1912; Part I).

to be cut short, she would 'not allow it to be shaved'. Her operation for an ovarian cyst was postponed until she could be 'got into a suitable state'.²⁵³ As Riha also discovered, lack of care was not simply confined to the poorest, and, as the female patients of the RFH revealed, dirt and dirtiness were not always to be found where most expected.

This section so far has explored the objections patients made to the examinations they were to undergo and the problems experienced by staff in dealing with the various complaints brought up and brought in by their patients. For some, the reality of life upon the ward, as well as the looming prospect of surgery became too much. There were two other key reasons why women discharged themselves from the gynaecological beds: dissatisfaction with their surroundings and the desire not to be operated upon. To take the former concern first. While the RFH was not supposed to admit those who sought 'rest', a few gynaecological patients expressed their gratitude for the peace and quiet their hospitalisation had afforded them. Although nothing abnormal was wrong with Annie Williams, for example, she was allowed to stay in hospital for general debility, weakness and backache. As a consequence, she was 'much improved by rest and feeding' for a fortnight.²⁵⁴ One patient objected to the 'feeding' given on the ward. Lottie Green's Jewish faith did not permit her to eat hospital food, other than bread and butter, and so she survived on vegetable soups brought in by her sons.²⁵⁵ For some patients, however, it was the lack of privacy and the sheer noise of a female ward which caused them to seek treatment in more congenial surroundings for which they would, of course, have to pay. Beatrice Allen, a 41-year-old widowed dressmaker, described as 'extremely nervous', discharged herself to go to a private home as she could not stand the noise, which worried her.²⁵⁶ Similarly, Mary Kenny discharged herself to seek treatment in a private nursing home.²⁵⁷ Those with very young babies would have their children admitted with them, which must have added to the strange sounds; however, this was too much for the unnamed mother of 14-day-old William Peaseton, who was sent out because she 'does not like having it here': 'it distresses her'.²⁵⁸ Sleep was disrupted for a number of other reasons, making hospital stays uncomfortable for some. Ruth Barden was only in for one night, because she slept badly, and discharged herself as soon as she could.²⁵⁹ Annie Solomons experienced bad dreams on the ward, and Nellie Fowler wandered in her sleep and talked about going to work.²⁶⁰

²⁵³ Dorothy Temblett (MS: 1908; Part II).

²⁵⁴ Annie Williams (MS: 1908; Part I).

²⁵⁵ Lottie Green (EVS: 1910; Part II).

²⁵⁶ Beatrice Allen (MS: 1907; Part I).

²⁵⁷ Mary Kenny (MS: 1908; Part I).

²⁵⁸ William Peaseton (MS: 1906; Part II).

²⁵⁹ Ruth Barden (MS: 1908; Part I).

²⁶⁰ Annie Solomons (EVS: 1913; Part I).

Julia Oulds was upset by a thunderstorm and the prospect of the dentist coming in the morning to remove her carious teeth, and Annie Hobbs also was unable to sleep before her operation.²⁶¹

The Central London location of the hospital affected those unused, like Norfolk resident Amelia Powles, to such 'strange surroundings'.²⁶² Annie Rondle, from East Ham, discovered that her sleep was disrupted by the metropolitan traffic.²⁶³ The 'great heat of the weather' in May 1913 was cited as affecting the recovery of washerwoman Mary A. Broyden, exacerbating her sheer exhaustion.²⁶⁴ Suffering and worry must have caused disruption to sleep, as well as the medication being taken by patients for the pain. It would not be only the individual disturbed, therefore, but others, influenced by illness, or drugs to which they were unused, calling out or moving around. Lily Connor's combination of chorea and pregnancy had resulted in mental impairment, which gave her wild delusions and she repeatedly tried to leave her bed.²⁶⁵ Phoebe Smith was also delusional after her operation and heard voices.²⁶⁶ Miriam Silverston, a morphine addict, took the drug and tried to commit suicide by biting on the mercury of a thermometer in the ward.²⁶⁷ While some experienced a rest from everyday life, for others the general atmosphere of the hospital, with its strange noises and odd behaviour was insupportable.

Some patients refused further treatment and discharged themselves because they felt cured already. This might have been either an attempt not to undergo an operation, or an unwillingness to spend any further time on the wards. Emma Slater's cyst burst, so, as far as she was concerned, she was well again and refused any more interference.²⁶⁸ Annie Goldstein was very averse to anything further being done for her. Having been given medicine for old peritonitis at Out-Patients she was reluctant to become an in-patient. When she did agree to come in, she said that she was feeling very much better and so was discharged.²⁶⁹ Four-times repeat patient, Maria Blackmore, though in great pain from bladder problems, had clearly had enough when she refused to allow a bladder sound to be passed and discharged herself.²⁷⁰ J. Augusta Smith was in a similar situation to Mrs Blackmore. She had a vesico-vaginal fistula, which continually evaded repair and was the result of a previous operation in which her uterus and appendages were removed. As a consequence, she was miserably incontinent: 'water constantly dribbles away'. The realisation

²⁶¹ Julia A. Oulds (EVS: 1911; Part II) twice; Annie Hobbs (MS: 1904).

²⁶² Amelia Powles (EVS: 1911; Part I). ²⁶³ Annie Rondle (EVS: 1913; Part I).

²⁶⁴ Mary A. Broyden (EVS: 1913; Part I). ²⁶⁵ Lily Connor (EVS: 1910; Part I).

²⁶⁶ Phoebe Smith (EVS: 1913; Part I). ²⁶⁷ Miriam Silverston (MS: 1905; Part II).

²⁶⁸ Emma Salter (MS: 1904). ²⁶⁹ Annie Goldstein (EVS: 1911; Part II).

²⁷⁰ Maria Blackmore (EVS: 1912; Part II).

that treatment was not working caused Mrs Smith to refuse all further interference and discharge herself. She had clearly had enough.²⁷¹ Some, away from their husband and children perhaps for the first time, thought better of their desire to seek treatment and returned home, indicating the pressure women were put under, even when seriously ill, to attend to their home and family. Nellie Hayes was convinced of the necessity for an operation, rather than risk a second attack of pain stemming from pelvic peritonitis, but she decided to go out 'for home reasons', and come back. She did not, however, appear again in the notes.²⁷² Scharlieb tried to encourage Priscilla Hawgood to remain in hospital while she was carefully observed for irregular bleeding, loss of flesh and backache, but she discharged herself two days later 'for family reasons'. She too was not seen in the future.²⁷³ If husbands encouraged their wives to leave hospital, whether deliberately or because women felt obligated to return home, they also had a more serious role. In a few instances, they were the ones who prevented women from having any form of operative interference. The consent, or otherwise, of a husband was rarely recorded, but objections stemmed exclusively from surgical procedures aimed to cut growths from female generative organs or the organs themselves. There was only one exception. Leah H. Greenwood's husband would not consent to an operation on her breast, for eczema of the right nipple, though he did not seem to mind about the procedure to remove her right ovary and fallopian tube.²⁷⁴ Interestingly enough, and whatever her husband ordered, the notes ended with a claim that Mrs Greenwood would return soon for the forbidden surgery.²⁷⁵ An accident during an operation would mostly have to be corrected on the spot to save the patient's life. Fifty-four-year-old Mary Seabrook, whose uterus was perforated when a sound was passed into it, did not have a necessary hysterectomy because she was weakened by the exploratory examination, as well as the RFH not yet having obtained her husband's consent.²⁷⁶ This was duly provided and the procedure was performed the next day. Two refusals came, however, from the most serious and life-threatening conditions. Mary A. Newland, who was 58, and suffering from extensive carcinoma of the cervix, informed Scharlieb from the outset that 'if she had cancer she would not be operated on as her husband would not allow it'. Annie Tompkins,

²⁷¹ J. Augusta Smith (MS: 1907; Part I). The original procedure was in (MS: 1906; Part II).

²⁷² Nellie Hayes (EVS: 1909; Part II). ²⁷³ Priscilla Hawgood (MS: 1906; Part II).

²⁷⁴ Leah H. Greenwood (EVS: 1909; Part I).

²⁷⁵ Although, again, there was no record that she did come back to Vaughan-Sawyer for this other procedure.

²⁷⁶ Mary Seabrook (EVS: 1904–1908; 1907).

meanwhile, sought to share the responsibility for refusing a procedure with her spouse. Mrs Tompkins had a malignant ovarian cyst and was unwilling to have any operation performed. She later altered this to 'she and her husband were unwilling that she have any operation'. While the examples of spousal refusal were few, the fact that they appeared at all limits the claim that the individual patient was able to make a choice about her health.²⁷⁷ In some cases, the necessity of considering others' opinions subsumed personal desires and suspicions about surgery. This was especially so for malignancy of the female generative organs, as we shall see in the next chapter, which ensured that some patients went untreated.

While consideration was afforded to close family members, other women expressed very clear opinions about what they did and did not want done to them. Elizabeth Tranter's 'anxiety' to be operated on has already been noted. Sterility was one condition where women frequently demanded that everything should be done to help them conceive. As Emily Harris explained, she was 'anxious that all should be done to make it possible for her to have children'.²⁷⁸ Many saw an operation in the RFH as the solution to all their problems. Katherine Miller, for example, came to see Vaughan-Sawyer for advice about becoming pregnant and was so 'excited' at the prospect of an operation allowing this that she was unable to eat or drink.²⁷⁹ The accounts of surgery performed by Scharlieb and Vaughan-Sawyer between 1903 and 1913 made frequent reference to patient requests such as these. Jennie Meek was very keen to have children and so made clear, from admission, the necessity of conservatism in any surgical procedure which she might undergo.²⁸⁰ Similarly, Annie Neal was treated conservatively for reduction of a double hydrosalpinx; an artificial ostia was subsequently formed as the patient was 'anxious for children'.²⁸¹ Alice Self, from Aldeburgh, Suffolk, one of 20 children, travelled to the RFH 'on her own initiative' because she was very anxious to have a living child and, desperately, had 'never known what it is to feel well'. Between the period covered by the notes, she attended five times: thrice under Scharlieb and twice under Vaughan-Sawyer. A Caesarean Section finally provided her with her desire in 1911 ('a fine

²⁷⁷ For 'patient choice', see Cullen, 'Patient Records', especially pp. 111–48 and Wilde, 'The Elephants' for the need to consider other factors affecting the doctor-patient relationship.

²⁷⁸ Emily Harris (MS: 1904).

²⁷⁹ Katherine Miller (EVS: 1913; Part I). Mrs Miller's cervix was widened to facilitate conception, but Vaughan-Sawyer doubted she would go on to conceive because of the position of her uterus.

²⁸⁰ Jennie Meek (EVS: 1910; Part II). ²⁸¹ Annie Neal (EVS: 1911; Part I).

boy’), although the notes also indicated that she was not thriving and later underwent sterilisation.²⁸²

Conversely, those who expressed a desire not to have any more children were also considered during surgery. Alice Oxford already had five children and ‘was not especially anxious to again become pregnant’. During an operation for removal of her right fallopian tube and most of her right ovary, it was remarked that the left side looked ‘fairly’ healthy, but that ‘no efforts were made to improve the condition’ because of her previous comments.²⁸³ Patients were also presented with choices: whether to have another simple procedure or undergo more serious surgery. Multiple patient Hagar Walker was a good example of such an offer. Although she had been curetted twice, in 1903 and 1906, she was still suffering from very profuse menstrual losses and pain. The curetting had helped to some extent, but the improvement lasted only for eighteen months and the problem began again, each time more severely than the former. Effectively, she was incapacitated for a fortnight in every month. As such, Vaughan-Sawyer asked her if she would prefer to undergo another dilatation and curettage or have the fundus uteri removed. Mrs Walker chose the latter.²⁸⁴ One of the more sickly patients, Edith Fenn, who, at the age of 24, had a long history of illness and gynaecological suffering, was told that a double oophorectomy would be the only cure, as previous palliative operations had been unsuccessful in alleviating her pain. Miss Fenn’s ‘willing[ness] to undergo it’ showed precisely how much she desired a cure, as she was effectively ‘disabled from following any occupation’ by her problems.²⁸⁵ At times, and in spite of the dangers or risks associated with a major operation, female patients saw it as the best option, one which would restore long-absent health, after years of un- or partially successful medical treatment.

Sarah Macey’s statement that she was ‘anxious to go home’ would probably resonate with the majority of patients in the gynaecological wards.²⁸⁶ Many expressed their gratitude after treatment. Olivia Risley felt ‘wonderfully strong’ after her operation, while Priscilla Greenaway was ‘very much better for the operation and is already regaining her

²⁸² Alice Self (MS: 1906; Part I); (MS: 1906; Part II); (MS: 1907; Part II); (EVS: 1911; Part I) twice. Her notes ended abruptly and the comments about sterilisation were on the front page, but not noted inside.

²⁸³ Alice Oxford (EVS: 1910; Part I).

²⁸⁴ Hagar Walker (EVS: 1911; Part I). Unfortunately, when Mrs Walker returned to the hospital in 1913, she had carcinoma of the cervix. For her other RFH in-patient stays, see note 69.

²⁸⁵ Edith Fenn (MS: 1908; Part II). See also (MS: 1907; Part II) twice.

²⁸⁶ Sarah Macey (EVS: 1904–1908; 1908).

colour and getting fat' after the removal of her uterus.²⁸⁷ Margaret Nixon labelled herself 'very fit', having become plump and gained colour by the time she left hospital.²⁸⁸ Eighteen-year-old Agnes Darley delighted in instant improvement after surgery for a multilocular ovarian cyst 'the size of a man's head', which had made her very sick and unable to eat properly for a year.²⁸⁹ Annie Rondle's sentiment that it had been good to be 'off her feet' would also have been understood by a number of hard-pressed patients.²⁹⁰ Time to themselves was relished, in spite of the institutional surroundings. Alice Lyles and Nellie Brown were observed reading, while Henrietta Bray sewed.²⁹¹ After aborting an unwanted fifth child with a syringe and having her uterus removed as a consequence, Sarah Barnett was described as reading the paper and looking quite happy.²⁹² For many rest would continue at a Convalescent Home, but others, like Louisa Aldred, said they felt well enough without further recuperation.²⁹³ Discharge from hospital did mean some alteration in the lives of patients. Women were warned to take things easy, and often not to return to work yet or to limit their household tasks. Annie Nash, for example, was encouraged to rest a great deal, sit with her feet up, and eat good food.²⁹⁴ Given the number of times a patient disobeyed a doctor's orders in the notes, often, like Emily Stolz, being told to rest for ten days after a miscarriage and doing so only for three, advice like this was not always followed.²⁹⁵ The cost of surgical supports could also prevent women from carrying out prescriptions. Annie Ambler was told to wear an abdominal belt, but could only have one when she could afford it.²⁹⁶ For Annie Bell, a belt fitted over a truss for hernia caused problems and ensured her corsets had to be altered.²⁹⁷ Inconveniences such as these show that life after surgery had to be adapted as best as the patient could manage.

Neither were cures guaranteed: the number of multiple attendees over a decade attested to this. Other than a recurrence of malignant disease, this was due primarily to the duties of wifhood and motherhood. Female surgeons could advise, as in the case of Frances Graves, who had been married for nine years, had given birth to nine children, eight of them now dead, that she was 'to avoid pregnancy', but such a suggestion

²⁸⁷ Olivia Risley (EVS: 1910; Part I); Priscilla Greenaway (MS: 1906; Part II).

²⁸⁸ Margaret Nixon (EVS: 1911; Part I).

²⁸⁹ Agnes Darley (MS: 1905; Part II). ²⁹⁰ Annie Rondle (EVS: 1913; Part I).

²⁹¹ Alice Lyles (EVS: 1911; Part I); Nellie Brown (EVS: 1911; Part I); Henrietta Bray (MS: 1905; Part I).

²⁹² Sarah Barnett (EVS: 1912; Part II). ²⁹³ Louisa Aldred (EVS: 1906; Part II).

²⁹⁴ Annie Nash (MS: 1908; Part II). ²⁹⁵ Emily Stolz (EVS: 1909; Part II).

²⁹⁶ Annie Ambler (EVS: 1911; Part II). ²⁹⁷ Annie Bell (EVS: 1911; Part I) twice.

required the co-operation of husbands as well. Plastic operations to repair tears occurred again and again between 1903 and 1913, often on the same women. Elizabeth Osborne and Florence Cruse were just two examples.²⁹⁸ The former had her perineum repaired in 1906, the stitches giving way, and a year later another operation was performed, while the latter also underwent surgery in 1906, only to return in 1907 because union was not complete. Both had suffered for many years with the consequences of tears sustained through childbirth. A rare letter from the patient themselves was with the file of Laura Toghill, written a year after Vaughan-Sawyer had removed her uterus for fibroids:

I am sorry to have to trouble you again, But [*sic*] I should be very gratefull [*sic*] if you could make it convenient for me to come and see you. I have been feeling very unwell for some months past, frequently loosing [*sic*] blood and I also feel giddy and faint with it at times you performed an operation on me twelve months ago last, April, 7th for tumour on the womb.

Her own doctor had recently died, and she did not like ‘to go to a strange, Doctor’ [*sic*], prompting this unusually direct correspondence with her surgeon in an attempt to regain her health.²⁹⁹ On the whole, though, patients were usually referred to the Out-Patient Department so that their surgeons could ‘keep an eye on them’: Sarah Wilhelmy and Amy Cook were both observed this way in case malignancy developed.³⁰⁰ While discharge from the hospital meant the end of treatment for some, for many others repeat visits, either to Out-Patients or again to the Gynaecological Department, were to be made over the years. As we shall see in the next chapter, the following-up of former in-patients was key to the way in which female surgeons operated.

Conclusion

This chapter has explored a decade in the lives of gynaecological patients under Mary Scharlieb and Ethel Vaughan-Sawyer at the Royal Free Hospital. Between 1903 and 1913, over a thousand women were seen, treated, and the majority operated upon. Female patients were from all backgrounds, of all ages and of varying willingness to be treated. The reaction of the actual patient to surgery is rarely considered in the history of medicine, and such a case study certainly permits a refutation

²⁹⁸ Elizabeth Osborne (MS: 1906; Part II) and (MS: 1907; Part II); Florence Cruse (MS: 1906; Part I) and (MS: 1907; Part II).

²⁹⁹ Laura Toghill (EVS: 1904–1908; 1908). Mrs Toghill did not appear again in the notes, so perhaps saw Vaughan-Sawyer privately.

³⁰⁰ Sarah Wilhelmy (MS: 1908; Part II); Amy Cook (EVS: 1911; Part I).

of the old tale that women were 'passive and preyed upon' by male surgeons, as Morantz-Sanchez notes.³⁰¹ But, as has been shown here, not all female patients wanted to be helped surgically, regardless of the sex of their surgeon. Indeed, more often than not, this would have been the first time the majority had experienced the care of a medical woman. Despite arguments about women's suitability for examining female patients, the 'special sympathy' that was said to exist between them,³⁰² very few sought out assistance from their own sex until they entered institutions. When they had spent time on the wards, however, many returned, either through geographical propinquity, or, as in the case of Laura Toghill, because the surroundings, as well as the personnel, were by now familiar. Some sought rest in the RFH, but for others it was a source of fear and torment. The variety of response to illness and treatment has been considered and general patterns drawn without flattening out the individual reactions to hospitalisation in the early twentieth century. Case notes, though composed in another hand, allow the patient's voice to be heard, often loudly and clearly, through their opinions about their health, their account of the trajectory of illness, and all the idiosyncrasies expressed throughout their time in hospital. They also permit a more personalised insight into how the layperson viewed the medical profession and, specifically, their reaction to the surgical advances which had characterised the previous half-century.

³⁰¹ Morantz-Sanchez, 'Negotiating Power', 292.

³⁰² Dally, *Women Under the Knife*, p. 204.