
6.7

The medicalisation of the hospital in Enlightenment Edinburgh, 1750–1800: the case of Janet Williamson (1772)

Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford, Oxford University Press, 1999), pp. 231–51.

The Edinburgh Royal Infirmary was founded in 1729, one of the first of many voluntary hospitals founded in Britain in the eighteenth century. Increasingly, during this period, the hospital became the site of clinical instruction. In the case of Edinburgh, its most famous exponent was William Cullen (1710–90), whose neurophysiological theories constitute one of the most important innovations in medicine in this

period. After studying at Glasgow and Edinburgh, he rose through the ranks of the Scottish medical profession and was finally rewarded with a chair in medicine at Edinburgh University in 1766. During this period, he became well acquainted with all the leading figures of the Scottish Enlightenment and, through his own reputation, helped to establish the university as one of the most important centers of medical education in eighteenth-century Europe.

At the heart of Cullen's new medical theory lay the idea that the key to the functioning of the human body lay in the nervous system. He also set out to reclassify diseases according to new criteria based on his novel neurophysiological theories. Most infectious diseases were classified in the category of *Pyrexiae* or febrile diseases, which might assume various forms. One such was *synochus*, an inflammatory fever accompanied by delirium, which he diagnosed in the case of the patient, Janet Williamson, in 1772.

On Sunday morning, December 13, 1772, a young woman, Janet Williamson, came to the gates of the Royal Infirmary of Edinburgh 'desirous of accommodation in the house,' perhaps accompanied by a relative or neighbor. Tired, restless, and aching all over, she had been battling severe headaches and a fever for about a week. 'Fevers' were notorious, especially during Edinburgh's wet winters. Now Janet also felt an 'oppression' in her chest, in spite of the fact that someone had bled her three days earlier to ease the symptoms. Directed by the porter, she must have proceeded to the hospital's waiting room. . . . Why would a young woman such as Janet seek admission to the hospital, especially on the 'Scotch Sabbath?' . . .

Unlike other British voluntary establishments, the Infirmary admitted sick persons every day. Aged 19 and single, Janet Williamson was listed in the Infirmary's General Register of Patients as a servant. . . .

[. . .]

To screen applicants properly, the hospital needed to ascertain the 'deserving' nature of the poor who applied for admission. For this purpose, unless there was an emergency, the Infirmary required a letter of recommendation from known Edinburgh citizens or pastors from other Scottish parishes. . . .

For Janet and other potential patients, therefore, the first task was to find a current subscriber provided with valid letters, not always an easy proposition. Persons like Janet were usually lower-class individuals who had been judged by their superiors worthy of charitable support

because they demonstrated self-reliance and a willingness to work instead of being idle. . . . From a mercantilist standpoint, Janet was considered an investment, because of illness now in need of assistance lest she slide into total poverty, degradation, and thus become another burden to society. Her employers among Edinburgh's middle and upper classes were expected to provide the necessary help for ensuring Janet's recovery so that she could return to be a productive worker in her community.

[. . .]

Janet's sponsor could not be identified in the General Register – perhaps an omission by an overworked medical clerk. On the other hand, she may simply have carried a certificate attesting to her employment status if her master contributed regularly to the hospital's Servants' Fund. With the participation of Edinburgh's Presbytery, this special endowment had been created during the 1750s, and annual fund drives on 'Infirmity Sunday' kept the treasury alive. . . .

[. . .]

Back at the Admissions Room, Janet must have been interviewed after waiting patiently for some time. The hospital's physician-in-ordinary on call usually questioned newcomers before his noon rounds. By now, in medicalizing institutions such as the Edinburgh Infirmary, religious admission rituals had been replaced by bureaucratic and medical ones. Having successfully passed the social filter because of her status as a deserving servant, Janet now needed to pass the clinical test of eligibility. Her history was important for the physicians deciding whether she would be admitted. These encounters could be frustrating and deceptive, as prospective patients tried hard to tell doctors the 'right' stories about their sufferings to ensure admission. Physicians, in turn, were on the lookout for symptoms or signs that clearly marked particular diseases, and the applicants went out of their way to provide them. . . .

The clinical test thus served as a second important screening device to separate those who, in the eyes of the admitting professionals, would probably benefit from institutional care, as opposed to the hopelessly sick or those who feigned illness, who 'had been long accustomed to lodge in hospitals and expected to meet with good entertainment and to pass the winter with us'. For this purpose, the admitting physicians needed to determine whether the presumed ailment was 'proper', meaning not only that it was suitable for hospital management but also that, with adequate treatment, the patient had a good chance to recover.

This policy implied that, as a general rule, individuals suffering from acute, self-limited, and benign diseases were admitted. . . .

[. . .]

Perhaps unknown to Janet, her arrival coincided with an accelerated admission of fever cases to the Infirmary's teaching ward, open during the university's academic year from November 1 until April 30. The physician then in charge of this unit was William Cullen (1710–1790), professor of the theory of medicine at the University of Edinburgh. Perhaps the most accomplished and most famous English-speaking clinician of his time, Cullen was soon to assume the presidency of the local Royal College of Physicians. He not only managed the 24-bed teaching ward (divided into male and female sections), he was also responsible for a biweekly course of clinical lectures in which he discussed the clinical management of his cases. Since the subject of fevers was traditionally taught at the peak of its appearance during January, Cullen could often be found in the Admissions Room, personally interrogating potential teaching candidates and dictating his findings to a clerk. In December 1772, the word was out that the professor wanted more fever cases for his ward. Four women suffering from this condition had already been hospitalized, but Cullen always aimed at presenting a number of typical cases to his students. By meeting his pedagogical criteria, Janet became the fifth such person within three weeks admitted to the teaching ward.

After the interrogation was completed and the decision to admit Janet reached . . . [she] finally went up to the female teaching ward, a 12-bed chamber, 50 by 26 feet long and located in the west wing, now virtually a fever ward, where she would have been greeted by the other inmates. . . .

[. . .]

Janet Williamson was probably visited the day after her arrival by William Cullen. . . . Followed by a 'train' of assistant physicians and students, university professors such as Cullen made their entrance at a predetermined hour – usually noon – eagerly awaited or dreaded by the patients, who greeted the procession in silence. . . . Bodily postures and discharges, as well as the gross appearance of the tongue, were always checked and carefully noted [and] [b]odily functions such as pulse, respiration, appetite, digestion, motion, and excretion were also routinely recorded. At times, the patient's complaints prompted the use of special diagnostic tests, including urethral inspections with probes and catheters. Tubes were employed to check the throat and printed cards

to determine visual acuity. When appropriate, a description of sputum, feces, blood, and urine was appended to the clinical chart, relating the physical characteristics and quantities of such discharges.

. . . Janet had no appetite and was constipated; her skin was described as hot. Cullen counted her pulse with his famous hourglass – a fast 120 and full. . . .

[. . .]

. . . Janet's clinical history and febrile symptoms suggested a diagnosis of synochus.²¹ . . . Cullen chose to begin a traditional 'antiphlogistic' (antifebrile) regimen consisting of a low diet, emetics, purgatives, and bloodletting to 'starve a fever'. For him and other attending physicians, dietary prescriptions constituted the first line of therapy. During daily rounds, detailed food instructions were issued, with orders for drugs and other procedures. . . .

[. . .]

Besides receiving rest and regular food, Infirmary patients were subjected to treatments with physical methods and drugs. 'Nothing is more evident,' wrote Cullen, 'than that bloodletting is one of the most powerful mean of diminishing the activity of the whole body, especially of the sanguiferous system.' Indeed, the withdrawal of blood retained its importance in spite of the significant shifts in medical theory since ancient times. Cullen justified bloodletting because it could lessen the tension and spasms occurring in a febrile body. He had recast the traditional therapeutic strategies designed to restore humoral balances, with the focus now on adjusting bodily excitement through either nervous stimulation or sedation. Among the agents considered stimulants were meat, wine, exercise, fresh air, warm baths, and tonic drugs; the depressant regimen included rest, a vegetarian diet, bloodletting, purging, and antispasmodic and sedative medicines.

To the trained eye, the sudden removal of four to eight ounces of blood seemed indeed to improve several cardinal symptoms accompanying fevers. Pulse rates fell, body temperatures declined, pain sensations lessened, the reddish color of the skin paled, and the patients were overtaken by a feeling of relaxation, even faintness, and sleep. Although temporary, such physiological responses suggested to eighteenth-century practitioners that bloodletting was still a useful measure in all inflammatory states and the keystone of their antiphlogistic regimen. Thus, during her first two days in the infirmary, Janet

²¹ A continuous or uninterrupted fever.

was bled eight ounces and also given a saline enema. Cullen also ordered ipecac powder,²² his favorite fast-acting emetic, designed to cleanse the weak stomachs of all fever patients. In a sense, these were traditional measures that most individuals employed under similar circumstances at home. Janet's reaction went unrecorded.

When patients experienced a very high fever and were delirious, infirmary physicians often also ordered fomentations with flannel cloths dipped in hot water, believing that they produced a relaxing and soothing effect. In Janet's case, the nurse fomented her legs and feet hourly while she was delirious, not only to quiet her down but also to allow other patients in the teaching ward to get their night's rest. When her condition worsened, and she began complaining of chest pains and a persistent cough – both signs of a respiratory infection – an expectorant, a mucilaginous²³ mixture, was added to the regimen.

To complicate matters, the surgical clerk found it impossible to locate a good vein in Janet's arm or hands to draw the blood. Therefore, he was forced to obtain blood from a foot and recorded that her symptoms were somewhat relieved. . . .

[. . .]

Cullen ordered a second withdrawal of eight ounces of blood from his patient on the evening of her third day. The measure apparently provided more relief of Janet's symptoms. The emetic, too, was finally having an effect, making her throw up several times, as well as causing her to pass several stools. Janet's pulse was still around 120 but softer and regular. Night delirium and sweats continued. Fever patients were ordered to remove their soaked clothing periodically for washing, but if no additional shirts were available, they lay naked under the sheets. Concerned about her recent respiratory symptoms, Cullen now also ordered the creation of a blister on Janet's back between the shoulder blades, not however for the reason that humoral therapeutics suggested such a course, namely to remove harmful substances from the body. Rather, in Cullen's neurophysiological theory, blisters stimulated the body and nervous system and thus neutralized the action of fever-producing substances. . . .

[. . .]

On the sixth day of her hospitalization, Janet reached a critical stage in her illness, a subject traditionally debated by practitioners. The fever

²² A drug made from the root of the ipecacuanha plant, native to South America, and widely used for its purgative and emetic properties.

²³ Viscous or gum-like.

seemed to abate and her cough was less frequent, but partial deafness was still a problem and the blister had failed to rise. For the first time, however, the patient was able to take some food. Cullen prescribed a powder of golden root or *virga aurea*, a bitter, astringent remedy designed to counteract systemic debility. To the delight of her attending physicians, she seemed to tolerate this bitter powder. Then, on December 22, Janet became quite nauseated, forcing Cullen to discontinue the medication without telling her that she was experiencing a side effect of the remedy. A day later, she was clearly on the mend, sleeping a good deal and free of delirium, with a lower pulse and more appetite.

At this point, Janet may have been switched to the Infirmary's middle diet consisting of cooked meat and vegetables. Fomentation of her feet and legs continued as did the administration of an expectorant mixture after her cough became more productive. Following Christmas Day, Janet slowly improved, her pulse now 80. However, part of her arm at the elbow had begun to hurt and swell, a feared complication of an earlier venesection attempt. . . .

[. . .]

Finally, on New Year's Eve, Janet's status was officially changed to that of a convalescent, and she was placed on a full diet.