Methods and Issues/Problématiques et méthodes


Part 1:
An Overview of the Continuities and Changes in the Content and the Forms of Records

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Since about 1960 historians have employed a greater variety of sources for historical inquiry than previously. By posing a whole new range of questions about the past, social history has spurred historians, as well as sociologists, anthropologists, and geographers, to broaden the sources they use to include materials often not well represented in traditional archival institutions. Examples of unusual sources that readily spring to mind are sound recordings, ephemera such as postcards and posters, personal case files, and statistically-oriented documents such as registers and financial books of account. The history of hospitals and of medicine both have been subjected to renewed examination by scholars who exhibit this modern omnivorous taste for sources. Traditional celebratory histories of the institution, often based on personal memory alone, now have been joined by more analytical
efforts based on a wide selection of pertinent sources, many located in the hospital but hitherto unused for scholarly purposes. Historians of medicine, in particular, have begun to examine the hospital and its role in the development of medical practice and in so doing are drawn to use the full range of historical records of hospital practice.

The published fruits of such recent research, and the emergence of new lines of inquiry from this work, clearly indicate that hospital records are valuable historical sources. While it is true that value is partly relative—conferred on the records by the heightened interest of historians in these new sources for their work—it is certainly equally true that the value of contemporary records for historical investigation is an immutable quality inherent in the records themselves. Records have an organic relationship with the activities they document and this most intimate tie makes them of unequalled value to historical studies. Unlike books and journal articles, which are the conscious, creative products of intellectual activity, and unlike autobiographies or other memorial re-creations, records form part of the action they document: a cheque accomplishes the disbursement of money and it also is a record of that disbursement. Over a period of time records quite naturally change as the structure of the institution, its processes, and its functions change. Hospital records clearly deserve to be better known to further an appreciation of their special characteristics and to encourage their use.

Locating new sources and then using them raises problems for the researcher, however. First, no single work provides a comprehensive guide to existing hospital records; both published guides and unpublished lists located at individual repositories are selective either in the institution whose records are included or in the geographical area they cover. Secondly, historical documents are, for the most part, still located only in the hospitals concerned: few hospitals have deposited records in an archives. Finally, once a suitable cache of historical records has been located and research into them begins, the user must first understand how the records were created and used in the hospital in order to assess their strengths and weaknesses in relation to his or her own questions. Users need both a guide to sources and an analysis of their characteristics.

My earlier study aimed to provide for these two needs by listing the records of 28 hospitals in Ontario and giving a history of these records by concentrating on the holdings of four representative institutions: the Kingston Psychiatric Hospital, the Kingston General Hospital, the Queen Elizabeth Hospital (in Toronto), and the Cornwall General Hospital. It seemed that both objectives—making known the historical records of hospitals and preparing a history of records—could be better reached by undertaking a second, parallel project in another geographic area. Not only would this enhance the listings of records,
providing researchers with a guide to the holdings of other institutions, but also it would strengthen the conclusions about the history of records because these could now be based on evidence derived from diverse hospitals in two different areas. From among the areas available to be surveyed was one that provided a set of institutions and a society quite different to that in Ontario: London, England. The records of 29 hospitals in London were thus also listed and those of four representative institutions, the Springfield Hospital, The London Hospital, the Royal Marsden Hospital, and the Brook General Hospital, were examined in detail. As far as possible in both areas I supplemented existing guides by surveying institutions that had not made any archival provisions for their records.

Despite the lack of a consolidated general listing of hospital records some important research tools exist that can assist researchers in locating them. Published guides to holdings are a good place to start assembling information about the records available for study. For Canada and Great Britain the most important of the general guides having national coverage are Janet Foster and Julia Sheppard, comps., British Archives, 2nd ed. (Macmillan, 1989), which lists the holdings of major institutions in England and Wales; and the Union List of Manuscripts (National Archives of Canada, 1975 with supplements to 1982), which records information about the holdings of most major Canadian repositories. Several published guides to the holdings of various provincial and university archives also are invaluable tools for locating hospital records deposited in these institutions.

Specialist guides by theme are very useful tools; however, only a few are published and available widely. For Ontario the Directory of Medical Archives (Hannah Institute, 1983) includes a section on hospital records. In Britain, a large number of unpublished guides to specific collections are available at the National Register of Archives. Particularly important for locating records in Britain is the consolidated list of hospital records prepared by a joint listing project of the Public Record Office (PRO) and the Wellcome Institute for the History of Medicine. The list, available on request at both the PRO and the Wellcome Institute Contemporary Medical Archives Centre, provides access to the records of many hospitals which are not found in any published form.

Consolidated general guides and thematic guides need to be supplemented by a thorough review of the pertinent published hospital history; frequently, the footnotes and/or bibliography will indicate what primary sources exist and where they are located. Once these sources have been checked, researchers should always review the holdings of established repositories; their lists of records are generally unpublished but are available for consultation in their reading-rooms. Finally, researchers should note that many hospital historical records
remain in the custody of individual hospitals; their records may not be listed in a consistent way and very few of these institutions are able to assist readers with historical interests.

The arrangement of both published and unpublished guides and lists identifies records in a consistent and standard way: title, quantity held, and outside dates are the traditional identifiers. This information is very useful as a preliminary guide for research. The title of the record, which identifies the form and broad subject matter, as in minute book or general ledger, directs knowledgeable users in the first instance to the most appropriate places for the information they seek. The quantity held by the repository helps the reader plan a research visit and, perhaps even more importantly, is a clear indication of the completeness of the record and the detail in which information is recorded. The outside dates of any given title show the completeness of the series and identify the gaps in the records which may be pertinent to a research project. In "A Guide to Historical Records in Hospitals in London, England and Ontario Canada, c. 1800-c. 1950, Part 2" I present a consolidated list of the historical records located in 57 hospitals, 29 in London, England, and 28 in Ontario, Canada compiled during the survey of hospitals I undertook between 1983 and 1987. The list, presented in a standard format, permits similar records from all of the hospitals surveyed to be arranged together.

General guides to records and detailed lists for individual institutions help build a consolidated picture of holdings; however, they do not provide specific direction to particular types of information. By their nature, guides and lists cannot analyze the composition of the records in sufficient detail to permit either an assessment of their pertinence to any given project or an appreciation of their changes over a period of time. It is particularly important, therefore, to know about the changes in individual types of documents and in series of records generated by hospitals.

The analysis of records presented here thus explores the continuities and the changes in the records of the 57 hospitals included in the survey. This discussion does not follow the nine categories used to organize and to list the records in "Part 2"; rather it cuts across this general classification of records to seek other common characteristics. To assist readers in referring both to the appropriate general class and to specific records listed in "Part 2," all references to the general classes here appear in quotation marks, as in "Policy and Management" or "Patient Care," for example, and footnotes give specific section numbers.

As the following discussion will show, distinct and discernible patterns in the accumulated holdings of the surveyed hospitals indicate that custom was a strong influence on the forms of records; that is,
traditional types of records arranged in customary ways were created regularly and consistently between 1800 and 1950. But the records were not static and they underwent significant changes beginning in the 1880s and accelerating after the turn of the century. Production increased; new categories and series of records and types of documents developed, adding variety and complexity to hospital records; and printed forms and typescripts eventually replaced manuscripts in both traditional and new series. There are also some specific points of contrast between the records of different types of hospitals and between institutions in London and Ontario. The idiosyncrasies are related either to the type of hospital and the special emphasis of its medical practice or to the differences in administrative arrangements. But overall, differences serve to highlight the common features of records which transcend institutional boundaries.  

THE TRADITIONAL ADMINISTRATIVE RECORDS

The accumulated records of hospitals are remarkable for their consistency. Traditional series of records such as minutes, reports, ledgers, and registers were regularly produced. Collectively, these series signify the strength of custom and its formative influence on the way business was recorded. Such records, of course, are not unique to hospitals but are the usual products of administration in general. Customary practices of group government and financial control remained strong during this period of development and change precisely because they were sufficiently flexible to be useful for managing new institutional arrangements. The resiliency of custom in the documentary habits of hospitals is further demonstrated by the introduction of minutes, ledgers, and registers into the record practices of new groups and departments which developed in these institutions. Clearly, the production and keeping of traditional types of documents was a stable element in the records of the hospitals surveyed.

Minutes

Minutes were regularly and consistently kept by Governors and Trustees of voluntary hospitals in both London and Ontario, established by deeds of trust, letters patent, and acts of incorporation, and by their deputed boards and committees. Minutes were also a customary record in the public authority hospitals in London. Very few survive from Ontario’s psychiatric hospitals, and since public authority institutions after Confederation were administered as an integral part of the civil establishment of the province, minutes were no longer created. Minute books dominate the accumulated records of the “Policy and Management” and “Associated Organizations” categories and con-
stitute over half of the titles in the "Departmental" class. Between c.1890 and c.1950, the diversification of administration by the delegation of continuing responsibilities to committees and departments was accompanied by the development of new and distinct series of minutes which were kept by these groups as an official record of business and as the documentary expression of their authority.

The development of numerous series of minutes in voluntary hospitals was accompanied by the migration of administrative detail from the Governors' or Trustees' minutes to those of its boards and committees. The deputed groups not only were the de jure governors between meetings of the full board but also were the de facto managers of the hospital and, in particular, administered specific functions, special tasks or departments. Samaritan organizations and auxiliary groups which developed in association with the hospital also adopted the traditional minute as the prime record of collective action. The teaching function for nurses, midwives, and in some hospitals, for medical students was integrated into hospital administration through the delegation of corporate authority which was expressed in official minutes. Some groups, committees and functions were unique to a hospital; others were common to several institutions. But these groups conducted business and expressed their authority in minutes which were the usual and customary record of group management and decisions.

Hospital minutes were kept in traditional ways. Until the 1890s they were manuscript; correspondence or extracts of correspondence, reports, by-laws, and rules were copied by hand into the books. The minutes were customarily selective, recording only the decisions taken by the group, but there are exceptions. Hospital minutes for the nineteenth century often combined verbatim transcripts with the summary selective minute. Moreover, the early books of the weekly or monthly board were a hybrid record containing the details of financial transactions, out-patient services and the admission and discharge of in-patients. The minute books of the boards and many sub-committees are indexed or have marginal glosses. The minute books of all groups are normally verified, including all changes in text. Although minutes were a universal and customary record of group management and decisions, until the end of the World War I the extant books in London and Ontario bear the strong individual stamp of successive recording secretaries which confers on each administration a unique identity. This means that despite the similarity in the form of the record, there are numerous variations in style and in detail related to the individual practices of the hospital secretary or minute-keeper.
Reports

Formal reports were a tradition of voluntary hospitals and were officially required from the superintendent and officers of public authority institutions. Three broad groups of reports are represented in the list: annual reports which include financial statements and patient statistics; staff and committee reports; and visitors’ reports. Until the early years of the twentieth century reports were copied into the minute books. Only the annual reports survive as numerically significant series in both public authority and voluntary hospitals. The annual reports of the Board or Committee and of the superintendent of public authority hospitals are invariably printed, bound in convenient runs and, as a testament to their public character, are available beyond the confines of the hospital in other institutions and in reference libraries. Annual reports are narrative summaries of the hospital year supplemented by financial schedules, patient statistics and, in the case of voluntary hospitals, by lists of benefactors and gifts. Although the annual reports are a public epitome of the financial and medical business which had been transacted that year, there is great variety in the types of information included and in the way information is presented. The lack of standardized presentation is particularly evident in the different forms of financial statements and patient statistics among institutions.

Periodic internal reports of staff and visitors as well as inspectors’ reports are not well represented in the records of hospitals. Although staff reports became ubiquitous and regular by the early part of the twentieth century, they are most often located in the minute books. Only a few series survive as separate runs. Reports of third-party inspections, which were required by statute for public authority institutions, and by the by-laws of voluntary hospitals, are not extant for all hospitals nor are the runs complete. The gaps are more apparent than real for the reports of official inspections of public authority hospitals; these can be found in the records of the appropriate central agency. However, the gaps are more significant for the reports of the visitors of voluntary hospitals because no duplicates are retained elsewhere. Some important differences exist between the third-party reports in public authority and voluntary hospitals. Statutory inspections were official operational and financial audits of hospital affairs undertaken regularly, usually quarterly, and published annually. Visitors’ reports in voluntary hospitals were presented weekly and were particularly concerned with problems in daily management. In Ontario, the visiting role was honorary and never fully integrated as part of the management of the institution. After 1874, the Ontario government undertook the regular inspection of voluntary hospitals.
Financial Records

The customs of book-keeping and the cash books of account, common in business, were kept by hospitals and their samaritan societies, auxiliary groups, and nursing schools to document receipts and disbursements.17 By the 1880s separate ledgers, journals, and cash books were regularly kept as part of a customary system of institutional financial control. The summary and classified general ledger, prepared monthly from the books of original entry, was common to London and Ontario hospitals and it was treated as the most important financial book of record. Voluntary hospitals also kept separate ledgers for business transactions and paying patients, and segregated the general ledger to provide distinct sections for donations and subscriptions.18 Public authority psychiatric hospitals also maintained ledgers by account. They established special books to record the financial activity of the farm and garden operations, which they ran as a business, and to document the receipt of money for the support of patients.19 Ledgers were also introduced to document the details of wages, salaries, and pensions of staff. Journals, cash, and day books were books of original entry. They recorded individual transactions, on a daily basis, according to the item or service involved and to the cash payment made.20 These chronological books, supported by vouchers, orders, and bills, controlled the hospital’s daily cash account by providing a central control over diverse accounting documents.21 The ledgers and books of original entry are manuscript, bound, uniform in size and fully authenticated by signatures and audit marks.22

Correspondence and Registers

Correspondence and registers were the customary records of administrative offices. However, few complete runs survive in any of the hospitals represented in the list.23 Registers were kept by the hospital office either to record events, much like a ship’s log, or more commonly, to summarize the contents of written communications and the administrative actions that took place following registration.24 Hospital and departmental correspondence documented all aspects of administration, and they were the most detailed records of daily business. There are only broken series of main office correspondence in the hospitals surveyed. The surviving records and supporting evidence derived from the records of other institutions show that until World War I incoming correspondence and memoranda were maintained chronologically either as dockets or, more commonly, as letterbooks.25 Manuscript or tissue copies of out-letters were also kept in letterbooks and in chronological order. Individual indexes were prepared for these books and supplemented the registers that controlled correspondence.
and other important documents, such as deeds, trusts, plans, and contracts that were filed in the main office.

The principles of summarization and control embodied in traditional document registers were extended to embrace other functions in the hospital so that the register, as a type of record, was introduced to control surgical and medical functions, departmental activities and employment. Operations and Surgical Registers, Operations and Operating Room Registers, and Operations and Anaesthetic Registers were the first to develop; they were later joined by other registers which documented other new functions or activities. Registers were also kept to document the service and perquisites of hospital pupils, nursing probationers, employees, and staff. The traditional summary register achieved its fullest development in the hospital as the record which controlled the admission and discharge of patients. Like minute books and financial ledgers, the traditional form and purpose of the register proved to be a flexible and useful type of document for those activities unique to hospitals.

A common responsibility assumed by hospitals was the establishment and maintenance of a system of general patient registration to record the reception of patients, the reasons for admission and subsequently the termination of the patients' stays. The registration function was documented in separate special-purpose books although there are examples, particularly at an early date or in small institutions, of admissions and discharges being recorded as a matter of course in the minute books of either the Board or the Committee. Nevertheless, the registration of patients was a function that eventually received separate documentary status in all hospitals.

Initially, patient registers were introduced to provide consolidated control over the documentation which supported patient movement. But the patient register, under different titles, soon developed to become a multi-purpose administrative record that was used not only to register documents, but also to control the movement of patients, the assignment of beds, and the location of the patients' clinical records. Titular differences aside, the form, substance, and function of the various books in any given hospital are comparable to their counterparts in another. Some hospitals maintained a general register that consolidated the admission, diagnosis, length of stay and termination of stay of each patient in one book. Most institutions in both London and Ontario kept separate absence, discharge, transfer, and death books to record the movement and status of patients while under the authority and care of the hospital. The categories of information in each register were defined by the institution according to need, legal requirements, and custom. These categories were ruled and/or printed on ledger sheets to provide a set format for the registration of each
patient. Patient registers were particularly important to the hospital. Sequential entries, one line per patient, led naturally to a numeric definition of each patient. By the 1880s the register was used to assign and record the numeric identifier that was unique to each patient admitted. The registers were also well integrated into the statistical reporting system of hospitals. The columnar arrangement of categories encouraged and facilitated statistical summaries of activity.

THE TRADITIONAL CLINICAL RECORDS

The earliest clinical records represented in the lists begin in the 1880s, although evidence in the minutes and in the records themselves clearly indicates that clinical records were kept well before this time. Without significant examples of the early books it is impossible to know how the surviving records may have differed from their predecessors; however, the extant Medical Registers, Medical Journals, and Casebooks have common features of form and structure that differ fundamentally from their successors. Two precedents influenced the structure of hospital clinical records: the customs of private medical practice and of the strong institutional tradition of registration.

Case notes were prepared by the hospital’s medical staff. In voluntary hospitals, case notes were the particular and private preserve of the practitioners. Professional habits and the traditions of the staff in individual hospitals rather than official institutional rules shaped the customs of clinical record-keeping. The keeping of case records in public authority hospitals was prescribed in by-laws and official regulations. In psychiatric hospitals a legal need existed for regularity and system in recording so that the custody and care of patients could be monitored. However, the personal documentary habits of professional medical practice still shaped the content of clinical records, while official rules established common forms. In both types of hospital, registration was a potent influence. Summary recording and categorization of cases provided control over patients and conceptualized actions and events for reporting purposes. After c. 1870 the development of the office of the Registrar in London teaching hospitals extended the concept of summary case registration to embrace hospital medical and surgical experience. The registrars were practitioners whose duties included specific responsibilities for the classification of and reporting upon the hospital’s clinical practice. It was the work of this office that introduced standards for case records within individual voluntary hospitals.

The function of registration was the bridge which united the earlier and later forms of clinical records. Hospital registers recorded both the admission of patients and the official receipt of the documents which authorized admission. Token survivals of early admission documents
and governors' tickets at voluntary hospitals in London and Ontario clearly show that the process of achieving a place in these hospitals was once well documented. However, support documents for the patient registers exist now as complete series only at psychiatric hospitals. Admission and discharge orders and warrants at these hospitals were not only the documentary source for the registers, but also the legal authority to confine and to discharge patients; consequently, they have independent documentary value. Psychiatric hospitals in London and Ontario maintained separate series of orders. Differences in the types of documents and their arrangement between the two areas are related to statutory requirements. But on the whole, the orders series in London and Ontario psychiatric hospitals are similar.

Each docket, pertinent to one patient, contains at least the warrants of admission and discharge and can have additional documents including information schedules, certificates of physicians, transfer warrants, probation bonds, and copies of death certificates. These are printed forms, mostly prescribed and defined by statute, with the appropriate information filled in by hand. Admission and discharge orders were maintained as separate series until the twentieth century when this documentation was united with other records and combined with the patients' clinical file.

The earliest extant clinical records located in the survey are in the form of Medical Journals. These were required by statute and by-law in psychiatric hospitals in London and Ontario. None survive for Ontario's psychiatric hospitals. Medical Journals were an early form of patient record and had the chronological attribute of the register. The Journals recorded particular events in the history of the patient while in the care of the institution: injuries, physical disorders and bouts of illness, and the use of physical restraint and seclusion. Unlike the casebooks, and later the case files which were structured around the patient, Medical Journals subordinated the individual to institutional actions. Their function was to provide a chronological profile of events. The format of these books permitted the regular monitoring of the discipline and overall health of the institution — particularly important in psychiatric hospitals — but was an impediment to tracing the history of any given patient, which could only be done with great difficulty.

Extant casebooks begin in the 1880s. These large manuscript volumes document the previous medical history, hospital treatment, and results of each case admitted. The internal structure of the books was determined by institutional custom, legal requirements, and therapeutic needs. A case record commences with a summary of the patient's register entry and contains subsequent observations and comments which were entered according to a prescribed schedule. These books give very little information about therapy and while
entries were prepared regularly, the observations are of a general nature and often quite perfunctory. By contrast, the casebooks at voluntary hospitals generally contain specific information about the therapy or surgical procedures employed in each case but are uneven in the amount of detail provided and in the frequency of recording. One or two pages were set aside at the time for the notes on each patient. More extensive entries for any patient were accommodated either by setting aside space at the end of each volume or by binding groups of records after the patient had left the care of the hospital. The rigid folio casebooks were discontinued in 1906 in Ontario's psychiatric hospitals, and in 1920 at public authority hospitals in London.

Differences in the construction of casebooks between voluntary and public authority psychiatric institutions are overshadowed by the common features the books share as a type of record. Casebooks are large, fixed in format and in arrangement. They were the formal clinical record prepared as a digest of direct observations and actions that had been initially recorded in other documents such as ward notes and attendants' reports. Very few of these latter documents survive as part of the case record; moreover, since they may or may not be mentioned in the case record as sources, it is important to review all associated series when examining case records. Casebooks are structured chronologically. Therapeutic decisions and practices are not highlighted by consistent placement within the record nor are these books classified for medical purposes in the selected hospitals before 1895. Although the individual patient is the declared focus of the casebooks, they resemble the Medical Journals and registers by their fixed arrangement and chronological structure.

THE CHANGES IN HOSPITAL RECORDS

Important changes in hospital records began in the 1880s and accelerated after the turn of the century. New categories of records developed; well-established groups and traditional types of records were represented by a greater variety of series; and new types of documents emerged. Functional differentiation motivated the growing variety of records in virtually all categories. Hospital and departmental administrative functions were separately documented in unique books of record. Patient registers were joined by new series devoted to specific aspects of the registration function. Financial ledgers, wage and salary books, and casebooks/case files also developed along functional lines. Particularly significant were the fundamental changes in the way all hospital records were prepared and arranged. Between c. 1890 and c. 1945 typescripts replaced manuscripts; printed forms were widely introduced to achieve standardization; and loose files replaced bound volumes in the administrative and medical record offices.
Between c. 1880 and c. 1950 the records kept by hospitals became more complex. “Departmental Operations,” “Finance, Investments and Supplies,” “Employment,” “Teaching and Training,” and “Associated Organizations” emerged as significant new categories. Also, a wider variety of series was kept by those who administered the hospital, and new types of documents and series developed in many categories.

The extant records of the category for “Departmental Operations” include minutes, reports, and registers. The most important surviving series in the voluntary hospitals of both London and Ontario are the minutes of the Medical Staff and the Medical Committee; the majority of these committees were established between c. 1890 and c. 1945 to express the corporate authority of the hospital’s practitioner. Distinct departments developed after the turn of the century but very few administrative records of these divisions survive intact in the archives of hospitals. There are no committee minutes or administrative records from departments at public authority hospitals because they were administered centrally. However, evidence in other sources indicates that separate departments were a feature of the administration of these hospitals. Ontario’s voluntary hospitals indicate an overall consistency in their departmental and committee records, partly in response to the statutory requirements of the Public Hospitals Act in 1931. Although a more noticeable similarity exists among these records in Ontario than in London, the surviving series in Ontario are generally from the post-1950 period.

By contrast, the development of departmental registers and indexes in London and Ontario is similar. As soon as the medical business of the hospital became too complicated for informal controls to work satisfactorily, registers were developed to monitor work and to assist in the collection of statistics that could only be extracted with difficulty from narrative reports. The establishment of a register signified the emergence of a function as an important corporate activity. Significantly, extant departmental and functional registers predate the equivalent department and staff minutes by several years. A particularly clear example is provided by the Case Room and Delivery Registers and the Operating Room Registers in Ontario Hospitals. These emerged well before the extant runs of the obstetric, gynaecology, and surgery department minutes. Classified indexes were increasingly introduced after 1890 and were the product of a more complex research environment. The earliest and most important examples in the survey are the medical, surgical, and obstetrical indexes at the London Hospital which provide access to the clinical records by diagnosis, disease, and surgical procedure. In Ontario, operation, disease, and diagnos-
tic indexes were located from the post-1920 period. These records are the survivors of more extensive series of cross-reference books which were developed in hospitals after 1890.

The emergence of distinct and complex financial series was an important development in the records of hospitals. With very few exceptions there are no surviving separate series of financial records which date from the opening of the hospital. Records of daily financial transaction, such as receipts, vouchers, and order books, were kept but are no longer extant. Summary financial information by account, type of transaction, and by date was regularly recorded, initially, in the minute books of the deputed governing body. As hospitals grew, the simple process of balancing cash transactions in the minute books was at first supplemented and then supplanted by separate books devoted to financial activities. By the 1880s, a complex structure of financial control was in place; this is separately documented in ledgers, journals, cash books and in other account records.

Separate ledgers were also kept to record the salaries and wages of employees and these books add greater variety and detail to the financial documents of hospitals. Salaries, wages, and pensions of employees and the nature of the services they performed, for both temporary and permanent staff, were recorded weekly or monthly on folio wage sheets. These served first, as the hospital’s payment advice and secondly, as an acknowledgment of payment when signed by the employee upon receipt of wages. Wage sheets survive as significant series in large public authority hospitals in London such as the Springfield and Banstead Hospitals where they were bound in order to preserve their integrity. There are only a few examples of wage sheets in Ontario hospitals, notably in the records of the Bursar’s Office of the Queen Street Mental Health Centre. Various forms of time sheets, duty books, and service vouchers which supported the wage ledgers and authorized payment have not survived. Although wage and salary records were common to all types of hospital, public authority institutions developed differentiated series to document employment. This was in part a necessity because of the generally larger complement employed at these hospitals and in numerous jobs not directly associated with patient care. Staff employed in public institutions were also part of a much larger bureaucracy whose rules required the regular production of official records to document terms of service and payments. Wage ledgers were regularly signed off as confirmation of their authenticity and validity as an approved hospital record and were routinely included in hospital audits. The salary ledgers of officers and attendants were structured in a different way. They reflected the nature of service obligations and remuneration which was not based on hourly service but on a more amorphous professional basis. Pay-
ments were made monthly, instead of weekly, so that naturally a smaller volume of records was created.

"Teaching and Training" and "Associated Organizations" emerged as new categories of records, each one comprised of several distinct series. Records in these classes document the training of nurses, midwives and medical practitioners and the activities of samaritan and auxiliary organizations. Each school of nursing was directly operated by the hospital which governed its administration, determined its curriculum, and approved applications for admission. The administrative records of the schools emanated from the board of management, the chief matron's office and later, where appropriate, from a specially empowered committee of the governors/trustees delegated to oversee the school. The distinctive records of teaching and training include student registers, graduate rolls, and pupil files. The minutes of the governing committee and the school's annual reports, often issued as part of the hospital's published offerings, provide the most consistent evidence of curriculum. Only scattered lecture notes, instructors' outlines, and examination papers survive, partly because records of the teaching staff were considered the personal records of the instructors and were treated as such by the hospital. The earliest extant records in both London and Ontario and the most consistently maintained are the registers of probationers. Pupil files are located only in Ontario.

The most significant records in the category of "Associated Organizations" are the minutes of collective action, membership lists and rolls, and financial ledgers. The latter were particularly important for the samaritan societies whose prime purpose was to direct and control the granting of money to deserving patients of the hospital. Many samaritan societies, auxiliary groups, and medical societies were closely associated with the hospital through interlocking and mutually supporting administrative structures. The hospital and its associated organization often shared personnel. This was particularly true for the samaritan and medical societies whose officers and members were often important and influential people in the hospital. Consequently, the records of these organizations developed within the hospital and can only be understood in that context.

Within the "Policy and Management" category is a wider variety in the series of minutes kept by sub-committees of the board. The diversification of minutes begins in London in the latter part of the nineteenth century and becomes most noticeable around World War I. In Ontario, the extant minutes indicate that separate series began later, after 1930, and they are only clearly evident in the list after 1949. Diversification is also strongly evident in the "Patient Registration" category. Between c. 1880 and c. 1930, each aspect of registration achieved separate documentary expression. Functional differentiation of the patient
registers is particularly marked in psychiatric hospitals as a response to statutory requirements for specific documentation on the various movements of the patient population. Separate alphabetical indexes to the registers were devised and by 1930 in Ontario and 1945 in London, the indexes were maintained on cards. These indexes centralized references to the registers and other patient records of various types, including correspondence and clinical files.

Finally, two new types of records are generally represented in the hospitals included in the survey. First, the most numerically significant series common to all hospitals are press cuttings, which are arranged either chronologically or by subject in scrapbooks. The routine nature of some of the cuttings—notifications of meetings, public acknowledgements, and job advertisements—particularly in public authority hospitals, indicate that they were originally kept as proof that an official act had been published as ordered or that a contract for publication had been duly fulfilled. By 1940, however, the cuttings focus almost exclusively on the hospital, its activities and staff achievements. Secondly, photographs are found along with the annual reports, as separate items and as part of the patients’ registration record or clinical file. Positive prints or glass negatives of patients were included as part of the clinical file in public authority psychiatric hospitals in London and Ontario after the turn of the century. Photographs of the hospitals, their buildings, wards, staff, and activities exist as separate series and were reproduced as half tones in the annual reports. They are rarely identified by photographer or date of production. These photos were apparently taken for publicity purposes and kept for future reference.

Introduction of Typescripts and Standardization of Records

The most significant and all-pervasive innovation in record-keeping was the introduction of typescripts. These became common in the records of “Policy and Management” and “Patient Care” categories particularly after 1890. Until c. 1890, all types of hospital records in all categories are manuscript. By 1948, minutes, reports, clinical summaries, hospital correspondence, and pupil files are dominated by typescripts. Only financial records continued to be prepared in manuscript.

The details of the change from manuscript to typescript are very clear in the minute books, which are the most complete series in hospitals. The change from hand to machine production was closely associated with the practice of enclosures, which provide the first examples of typescript material. There were two types of enclosure: items that were logically part of the structure of the minutes, such as
motions, resolutions, and reports, and those that were supportive of business or illustrative in nature, such as letters received or sent. The earliest extant minutes were prepared by the secretary or clerk of the hospital in manuscript and the hands of successive secretaries are distinct and identifiable. Typescript enclosures become more frequent from c. 1890 to c. 1920. Items that would have been copied into the books are either pinned or pasted in and there are examples of triplicate inserts. By 1948 the transformation of the minutes from a manuscript document to a typescript record was complete. Documents supporting the transactions in the minutes were no longer either copied into the minutes or enclosed in the books. Instead, they were filed as a matter of routine in the main office. The minutes themselves were typed on loose pages and then enclosed in binders.

Printed forms were widely employed to achieve standardization. Prior to c. 1850, it was common for books of record, particularly ledgers and registers, to be individually customized by hand. Sheets of paper or bound books were purchased and then numbered and ruled by hand according to the purpose and style of the record. After c. 1880, record books were routinely purchased as prebound blanks. The format of registers, ledgers, and casebooks was defined by printed forms which were also widely employed for other repetitive records such as statistical reports, wage and salary records, and clinical histories. By 1900 most hospitals had developed unique numeric identifiers for their forms and these were used to control printing and re-ordering. Various duplicating processes and commercial printers were used to prepare multiple copies of items of business for meetings and for the distribution of financial statements, reports, tenders, contract price sheets, motions, and agendas. Standardization of entry was also achieved by the increasing use of rubber stamps with predefined categories in financial records by 1893, in registers by 1900 and in clinical records by 1925.

The use of printed forms remains the most potent documentary sign of a trend towards standardization which was marked even in narrative records. By 1900, the extant minutes of the governing and deputed governing groups at the selected hospitals were constructed to reflect a routine of official business which was regularly repeated. The variety and detail marking the earlier minutes disappeared under the pressures of an increased amount of business that had to be conducted. The arrangement of the annual reports and the various reports of hospital officers was gradually standardized within each institution. Finally, standardization is a feature of both casebooks and case files. Entries in the casebooks of psychiatric hospitals were made at regular periods and the types of observations required in all cases were well defined in the by-laws and in the habits of recording. Standardization was also
achieved in the narrative histories in voluntary hospitals by regularizing the placement of observations in free form sheets. Later, standard categories were printed on forms and separate forms developed partly to ensure that similar entries were made for individual patients under the care of different physicians.

The standardization of records was intimately associated with the habit of binding. Bound volumes dominate in the accumulated records of hospitals. There are very few extant examples of loose files, apart from the clinical case files in London and Ontario hospitals and the employee and pupil files in Ontario. Between c. 1900 and c. 1950 definite changes took place in the habits of binding. First, by c. 1900 most hospitals had switched from binding an accumulation of related records to purchasing volumes in advance to be filled up as required. The major exceptions are the minutes of the governing and deputed governing groups in London, which continued to be bound well after the records were prepared. Secondly, binders supplanted sewn volumes for minutes, general ledgers, and journals. The binder was introduced for financial records in Ontario as early as 1900 and was consistently employed by 1930. Binders had come into general use for minutes and for financial records by 1948 in both London and Ontario. The binder had all the advantages of sewn bindings while at the same time incorporating the flexibility which was the hallmark of loose files. Finally, binding was discontinued for clinical records as early as 1907 in Ontario's psychiatric hospitals in Ontario and by 1948 in London.

Changes in Format and Structure of Records

The narrative annual, staff and inspectors' reports were supplemented and then virtually supplanted by financial and patient statistics. Between 1890 and 1920, the annual published report blossomed into a substantial document of hospital activity replete with detailed analyses of business affairs and patient movement. The major structural innovations in the annual reports of all hospitals were the addition of summary tables, schedules, and statements and the increased use of photographs and illustrative material. The staff reports began as free-form narratives executed by hand in books submitted for review at board and committee meetings. By c. 1890 the narrative part of regular staff reports constituted only a small introduction to a much larger document incorporating various types of statistics on either the financial affairs of the hospital or the movement of patient population. In addition to this structural differentiation, reports of staff were often prepared on printed forms that defined the categories of information required and established their balance and proportion within the document. The narrative visitors' reports become less meaty after 1920 in both London and Ontario. The role of the visitors was generally
honorary and their reports became *pro forma* statements. In Ontario, the Inspector’s narrative report on public authority and voluntary hospitals was substantially reduced and detailed financial charts and patient statistics put in its place.

Particularly significant were the structural changes in the financial statements that documented the emergence of cost accounting and long-term financial planning in hospitals. Although original financial statements are extant as separate series in only a few institutions, complete runs of printed statements are found either in the minutes of governors and trustees or in the annual reports. Between c. 1880 and c. 1930, hospitals supplemented their annual statements of cash transactions with a balance sheet presenting a year-end profile of their financial position that balanced their assets and liabilities. Balance sheets rather than cash receipts and disbursements were first published in London around 1890 and in Ontario about 1900. In the last quarter of the nineteenth century, professional accountants began auditing the books and attesting to the accuracy of published statements, including the balance sheet. Between 1890 and 1948, financial statements were increasingly supplemented by additional schedules that gave more details of income and expenditures. Both the statements and the schedules were gradually presented in comparable formats in all hospitals. Financial reports, originally prepared to account for cash transactions, were extended to include an overview of the hospital's financial position comprised of investments and investment income, ordinary costs by department and function, extraordinary costs and income, and the financial position of building, endowment, and reserve accounts. Separate capital and maintenance accounts were introduced and, if warranted by either the size of the hospital or the complexity of its financial position, other types of accounts were also established by hospitals. By the 1890s depreciation, calculated on the lower of either cost or market value, was applied to equipment and capital assets. By 1946, general uniformity in financial statements among voluntary hospitals came about as a result of the standards recommended by the Metropolitan Hospital Saturday and Hospital Sunday Funds and the King Edward’s Hospital Fund in London, and the Hospital Association and government in Ontario. General uniformity in financial reporting in London arrived with the introduction of the National Health Service in 1948 and in Ontario with the establishment of the Hospital Services Commission in 1956.

Changes in the hospital financial books of record and patient registers also occurred. The introduction of double-entry techniques into the financial records of hospitals—in the London hospitals included in the survey after 1824 and in Ontario’s hospitals by the early part of the twentieth century—brought a change in ledger format to reflect this new
accounting practice. The common features of the format change of the patient registers are the separation of registers by sex and function, the generally reduced number of entries per page, the addition of specific columns for new information, and the periodic return of the series volume numbering to 1.

Finally, fundamental changes developed in the structure of correspondence, and in employee records, pupil files, and clinical case records. The traditional books and registers were replaced by loose files containing a high proportion of typescripts. By 1925 chronological letterbooks had been supplanted by loose files arranged by subject. Bound staff service records were gradually replaced by employee files as the arrangement of choice. A file of documents arranged by subject or by name became the preferred way to permit administrative documentation to accumulate. Unlike the fixed format books, files were flexible and could more easily accommodate a mixture of correspondence and forms, each with a particular functional purpose. By 1920, individual dossiers of discrete documents had replaced the registers as the primary record of pupil progress and achievement in Ontario’s schools of nursing.

Casebooks underwent significant changes in structure and arrangement in the last quarter of the nineteenth century and most noticeably after 1890. Separate and distinct types of documents were more frequently tipped or pasted in the casebooks. Positive photographs of the patient, temperature charts, and pathology reports were the most common enclosures. Additional documentation was not included with every case but only appeared on occasion. After the turn of the century flexible case files containing a variety of different forms and types of documents replaced casebooks. Separate activities, tests, and procedures received their own forms, which were then collected together with the clinical history and progress notes to form the case file. Unlike the casebooks and journals, which contained summary observations and transcriptions of documents, the case files brought together documents prepared by many people involved in treating the patient; thus the case file became integrated into clinical practice. The distinction between a first-generation and second-generation record—clearly evident in the casebooks, which were in large part prepared from original documents—disappeared in the case file, which now included a variety of discrete original documents. Correspondence and administrative forms also were gradually incorporated in the file so that all documentation pertinent to a patient was included in one place. Printed forms filled out by hand comprised the bulk of the documentation; the first typescript documents appeared in the selected hospitals in 1907 in Ontario and 1905 in London. Thus, case files became a mixture of manuscript and typescript documents and, in
some instances, included both original and carbon copies within the file. Typescript documents, prepared after the event, were a mixture of summaries and of "mirror" images of the original record. By 1947, the notes of daily care and nursing had become so voluminous that they were segregated from the main file to form a separate but parallel series.

REMARKS

Important points of comparison exist in the architecture of hospital records in London and Ontario. All hospitals maintained a corpus of similar records which became more complex and voluminous in the last quarter of the nineteenth and first quarter of the twentieth centuries. Homogeneity in the records was conferred by the similarity of record types which expressed functional purposes common to all hospitals, while unique features in the accumulated records were related either to the special functions of some hospitals or to differences in administration. In both London and Ontario similar patterns in the composition and growth of records overshadow specific differences, many of them related to the timing of change rather than to the substance of innovation.

The persistence of traditional types of records is a distinct feature of the holdings in the hospitals surveyed and strong evidence of the continuing importance of customary habits in records. Institutional management thrived on minutes and reports. Decision making, delegation of authority to appointed groups and officials, and the monitoring of job performance were formally accomplished by these records. Summary registers controlled business activities and patient movements, and by the 1880s casebooks had emerged to supplement the registers by giving substance to the patients' history and experience in the hospital. Moreover, the development of separate extensive financial series, casebooks and diversified patient registers indicates the importance of the traditional types of records produced by the conventions of group government and institutional management. Between c. 1850 and c. 1950 the strength of custom constitutes an element of stability in records.

But in addition to the resiliency of tradition, significant qualitative changes in the records of hospitals mark a departure from their documentary habits. The growth in the extent of accumulated records and their increased variety and complexity were general phenomena in both London's and Ontario's hospitals. A marked feature is the differentiation of traditional records on functional lines and the emergence of new categories and new types of documents which were well integrated into the record routines of hospitals. At the same time, standardization was introduced over a wide variety of narrative and
summary statistical records. This was accomplished, in part, by the introduction of printed forms for registers, financial ledgers and patient files. Manuscript records were first supplemented and then replaced by typescripts, and a greater number of copies were produced in the course of record-keeping. Between c. 1850 and c. 1950 the proportions of the various categories of records in the accumulated holdings of hospitals change, reflecting not only incomplete patterns of survival but also a change in the habits of record creation. In both London and Ontario the medical and surgical treatment of patients produced increasingly more documents so that the records of the "Patient Care" category dominate in the accumulated holdings by 1925. The growth of records, their increasing variety and standardization, and the change in preparation from manuscript to typescript is particularly pronounced between c. 1890 and c. 1950.

The development of records in the categories of "Patient Registration" and "Patient Care" highlights the paradox of strong traditions co-existing with rapid change. The category for "Patient Registration" is dominated by traditional registers, albeit more differentiated along functional lines and, overall, exhibits a consistency in structure and stability in content. By contrast, the patient clinical file underwent dramatic changes as traditional forms and modes of preparation were eclipsed by a multiplicity of new documents which could no longer be accommodated in traditional casebooks. These books were discontinued in favor of loose files in which a variety of separate documents could accumulate naturally as produced. The distinctive and similar patterns in the growth and diversification of records in all types of hospitals in both London and Ontario suggest that common influences affected the development of hospitals and hospital business and inter alia, had a formative impact on the creation and keeping of records.

NOTES


3 From among the numerous contemporary essays in hospital history that feature the use of a wide variety of hospital records as sources see Anne Borsay, "Cash and Conscience: Financing the General Hospital at Bath c 1738-1750," Social History of Medicine, 4, 2 (August 1991): 208-29.


6 The Hannah Institute for the History of Medicine and the Social Sciences and Humanities Research Council of Canada supported the project which included the survey of hospital records. The late William Ormsby, former Archivist of Ontario, encouraged a full investigation of hospital records in Ontario. Jane E. Sayers, Reader in Administrative History and Diplomatic, University College London and Julia G. A. Sheppard, Archivist, Contemporary Medical Archives Centre, Wel-lcome Institute for the History of Medicine supervised the survey and associated work. I am pleased to acknowledge the generous support of these institutions and to record my gratitude to these people.


8 Craig, “Part 2,” section 2.2.

9 Craig, “Part 2,” sections 2.2, 3.2, 9.3.

10 For example, see the House Committee Minutes, Sub-committee Minutes, and the Finance Committee Minutes, Craig, “Part 2,” section 2.2. It is important to note that many committees used the same minute book so that the function is documented but does not appear as a separate title in the list.


12 Craig, “Part 2,” section 8.2. The administration of the School of Nursing established at many London and Ontario hospitals is documented in the Board and Committee minutes and that of public authority psychiatric hospitals in Ontario in the records of the Inspector of Prisons and Public Charities, Archives of Ontario Record Group 63, hereafter cited as AO RG 63 and in those of the Department of Health, Archives of Ontario Record Group 10, hereafter cited as AO RG 10.

13 Craig, “Part 2,” section 2.5.

14 Craig, “Part 2,” section 2.5.

15 For inspection reports of Ontario hospitals see AO RG 63 and Archives of Ontario, Office of the Provincial Secretary, Record Group 8, Series I-I-D.


17 For the financial records in the categories of “Teaching and Training” and “Associated Organizations” see Craig, “Part 2,” sections 8.5, 9.8-9-10.

18 Craig, “Part 2,” section 4.2.

19 Craig, “Part 2,” section 4.2.

20 Craig, “Part 2,” sections 4.3-4.5.

21 There are no significant examples of documents for daily business and financial transactions located at any of the hospitals.

22 Ledgers are more widely represented and complete than the books of original entry.

23 For surviving records see Craig, “Part 2,” sections 2.6, and 2.13.

24 For document registers in the main office see Craig, “Part 2,” section 2.6.

25 For examples see Craig, “Part 2,” section 2.13.

26 Craig, “Part 2,” section 3.10.

27 Craig, “Part 2,” sections 5.2, and 8.4.

28 Craig, “Part 2,” section 6.3.

29 Craig, “Part 2,” section 6.3-6.5.


31 Admission and discharge documentation was united with the clinical files in Ontario in 1907 and in London in 1948.

32 Craig, “Part 2,” section 7.2.
There are references to the records in the Inspector’s reports. For example see Annual Report of the Inspector of Prisons and Public Charities, 1881, p. 37 and 1883, p. 42.

The admission orders and warrants series at the Kingston Psychiatric Hospital contains, *inter alia*, examples of numerous in-house forms recording the patient’s propensities or conditions which were prepared in daily care. None of these documents are included in the clinical records nor are they mentioned in the case narrative. For examples see AO RG 10, Records of the Kingston Psychiatric Hospital, 20-F-0, no. 1521, no. 1505, no. 1479, and no. 339.

For example, we know that separate departments were established at the London Hospital in 1904 and at the Kingston General Hospital; no records survive from these divisions.

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The only non-medical department with well-established records before 1900 was the nursing department. Although there were references to the existence of a variety of non-medical departments and to their records, none were located in the survey.

Many indexes are still maintained as active records and these were not included in the survey.

The exceptions are: ledgers and journals from the Homewood Sanitarium in Ontario (Craig, “Part 2,” sections 4.2, and 4.3), donation ledgers from the Brompton Hospital in London and the Brantford General Hospital in Ontario (Craig, “Part 2,” section 4.2), and a journal from the Springfield Hospital in London (Craig, “Part 2,” section 4.3).

Vouchers, time books, and the records of “tell-tale” clocks are mentioned in various other records. It is possible to trace the changes in the nature of employment, particularly in public authority hospitals in London, by tracking the changes in routines which were always approved by the Committee.

It is important to note that the transfer of nursing schools in Ontario to local community colleges in 1974 is responsible for the absence of records in the hospital.

These files contain the scholastic records of the trainees and constitute their official academic transcript.

The dominance of bound volumes in the accumulated holdings until quite late in the survey period indicates that binding was either confined to records destined to be retained for some time or that binding, undertaken for other reasons, ensured that the records so treated would survive.

In the selected Ontario hospitals, all minutes were habitually entered in bound volumes in the first instance with the exception of the early minutes of the Cornwall General Hospital.
59 It is important to note that the assets and liabilities were entered on the right and left sides of the balance sheet in London whereas the positions were reversed in Ontario which followed the North American custom.

60 No personnel files were found in London but several hospitals in Ontario had complete sets beginning in the 1940s (Craig, "Part 2," section 5.6).


63 Nursing notes were segregated from the main clinical file in Ontario by 1940 and separate series of nursing notes were also located in London, see Craig, "Part 2," section 7.4.